01.04.2017 **Position Statement on:**

Euthanasia

The Scottish Council on Human Bioethics (SCHB) recognises that some persons may wish their lives to end because they find them unbearable. It understands that these are very difficult situations where a lot of compassion and sympathy is required. However, to take active steps to end one's life, as in euthanasia, cannot be supported by the SCHB for the following reasons:

1. Palliative care can address the suffering of a terminally ill person

Advocates of euthanasia suggest that it would enable persons, who become terminally ill and find themselves in an unbearable situation, to avoid suffering a slow, drawn-out death.

In response to this the SCHB notes that:

Physical suffering and/or other symptoms can be effectively addressed, in up to 95% of patients, with appropriate medication, when treated by healthcare professionals with the relevant expertise.[1,2] Similarly, patients with an illness such as motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death. But studies from the most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens.[3]

In addition, the administration of appropriate amounts of sedative drugs may be considered when persons are in the dying stages, to manage agitation, distress and restlessness. These indications can occasionally occur when the patients are no longer capable of working through their issues or are barely conscious as a result of their disorder rather than the drugs they may be taking. In these cases, palliative care can help patients (and sometimes also their families) by calming their symptoms.
Usually, the treatment is a matter of gradually increasing the level of drugs according to effect. However, there are occasions when a patient is very agitated and rapid use of large doses of drugs is essential for the safety and comfort of the patient and others.

Experts agree, therefore, that most physical suffering can be alleviated by a range of measures including surgery. When the suffering is caused by psychological distress or depression, this can usually be identified and an appropriate medical response provided. Thus, physical suffering or depression should not be a motive for euthanasia if appropriate palliative care is available.[4]

Nonetheless, there may be rare occasions where a patient's symptoms cannot be completely controlled. Often these are patients who cannot resolve an issue or cannot cope with a symptom, such as with severe breathlessness. Some may also have significant psychological and/or existential distress which they find difficult to address. Indeed, almost all patients with symptoms which cannot be completely controlled have elements of this distress which is not recognised as physical.
These individuals, who are already drowsy and dying of their illness, may then request some form of sedation to relieve the burden of such suffering, in which case it may be possible to manage their distress

[1] Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the rarest cases. See also: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml Pain: Some doctors estimate that about 5% of patients don't have their pain properly relieved during the terminal phase of their illness, despite good palliative and hospice care.

[2] When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it may lengthens life and improves its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

[3] Neudert C, Oliver D, Wasner M, Borasio GD., The course of the terminal phase in patients with amyotrophic lateral sclerosis. J Neurol. 2001 Jul;248(7):612-6.

[4] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 14.

and agitation. In other words, drugs may be administered and monitored to induce a state of decreased or absent awareness (unconsciousness) in order to increase comfort in the dying process while not shortening life.[5]
This of course is dose dependent and high levels of opiates can limit fluid intake, as well as suppress respiration. Rarely, agitation is such that very high doses are required but clinicians tend to be wary of using high doses in case they bring about premature death.[6]
It is very unusual for palliative care to have to use continuous sedation to keep a lucid patient asleep in order to address intolerable physical and/or mental distress. Sedating people deliberately to deal with their suffering, except in the terminal phases, is a very rare occurrence in the UK.

However, it is important that patients with difficult symptoms are aware that complete relief is sometimes beyond the realm of medicine. In this regard, it should be noted that palliative care not only includes medical assistance but endeavours to provide non-clinical support and the right environment for patients to express and work through their distress.[7] Very few patients request euthanasia when their physical, emotional and spiritual needs have been adequately addressed.

2. Inherent human dignity is enduring and can never be lost

Advocates of euthanasia suggest that individuals should be able to determine their own dignity and quality of life, unrestricted by the moral, cultural, religious, or personal beliefs of others. For example, it has been proposed that persons who fear that they will lose their dignity during the final stages of a terminal illness should be able to 'die with dignity' before these stages occur.

In response to this, the SCHB notes that:

Palliative care respects the human dignity of individuals at all the stages in which they find themselves. But a distinction should be made between inherent human dignity (which reflects the permanent, immeasurable, indivisible, inviolable and equal value as well as worth of all persons) and non-inherent human dignity (which is a variable dignity that can be lost and is dependent on, for example, a person's social interactions, professional position in life, how he or she is treated, or on other variables).

It is indeed incorrect to suggest that any person can ever lose his or her inherent human dignity. Though inherent human dignity cannot be reduced to a science concept, it should be recognised in every person to an equal extent. This is in accordance with the ***United Nations' Universal Declaration of Human Rights*** which affirms in its preamble "*the inherent dignity and … the equal and inalienable rights of all members of the human family"* as *"the foundation of freedom, justice and peace in the world".*
In other words, the principle of equality associated to the inherent dignity of all human beings demands that all individuals believe that they have the same dignity.
This means that society has a choice. It can believe that all individuals have the same inherent dignity which enables a just and civilised society to exist. Or it can believe and accept that some individuals can actually lose their inherent dignity either completely or partially so that their lives should be ended. In this case a society based on equal rights ceases to (and cannot) exist.

At present, human beings live in a society where inherent human dignity is universal and where each and every person is expected to acknowledge, respect and recognise the same dignity in others which cannot be created, modified or destroyed by an individual, a majority or a State. Inherent human dignity is also independent of the suffering a person may experience in contrast to non-inherent human dignity which can be affected by suffering. Indeed, in a civilised society, suffering cannot take precedence over inherent human dignity. The worthiness and value of a life cannot depend on how much pleasure or suffering a person experiences during this life.

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[5] Nathan I Cherny, 'Sedation for the care of patients with advanced cancer', Nature Reviews Clinical Oncology 3, 492-500 (2006)
Susan Anderson Fohr. 'The Double Effect of Pain Medication: Separating Myth from Reality', Journal of Palliative Medicine. April 2005, 1(4): 315-328.
Nigel Sykes, Andrew Thorns, 'Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making', Arch Intern Med. 2003;163(3):341-344.

[6] In a Europe-wide study the highly variable results bring into question whether existing guidelines for pain relief were applied appropriately. Bilsen J. et al. Drugs used to alleviate symptoms with life shortening as a possible side effect: end-of-life care in six European countries, *J Pain Symptom Manage*. 2006 Feb;31(2):111-21.

[7] For example, with the consent of the patient, the number of visitors may be reduced so that he or she can work things through.

Legalising euthanasia would mean that society would accept that some individuals can actually lose their inherent human dignity and have lives which no longer have any worth, meaning or value.
It would mean denying the inherent human dignity which is due to an individual, in order for him or her to be legally killed. It would give the message that inherent human dignity is only based on subjective choices and decisions and whether a life meets certain quality standards.

In this regard, it should be noted that a society that no longer believes in the inherent dignity of human life cannot offer any valid arguments against the taking of life of others, who may be considered unworthy of inherent human dignity. It becomes a society that has lost its trust in the intrinsic value and meaning of life and cannot comprehend why it should be endured.
This is in complete opposition to a responsible benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost their autonomy.
Therefore, in order to function consistently, society must reject the option of euthanasia if it does not want to undermine basic societal and fundamental values.

3. Inherent human dignity and the proper functioning of society takes precedence over absolute autonomy

Advocates of euthanasia suggest that a person's fear of disability and dependency should enable him or her to die while he or she is still autonomous and that euthanasia would enable self-determination to exist. In other words, individuals have the right to take decisions concerning their own life and death situations in accordance with their own values and beliefs. These should not be imposed by a court, a physician or a family member. It is a question of freedom and equality in the face of death.
Thus, advocates of euthanasia suggest that nobody has the right to impose on the terminally-ill and the dying an obligation to live out their lives when they themselves have persistently expressed the wish to die.

In response to this, the SCHB notes that:

Full and complete individual autonomy undermines the concept of inherent human dignity. Indeed, though this concept is very important in society, the recognition of every individual's absolute autonomy contravenes the very basis of inherent human dignity and the proper functioning of an interactive society. Accepting such an extreme form of autonomy would represent the atomisation and isolation of each human being. Civilised society, as such, would then cease to exist. In the same way as car drivers do not demand absolute autonomy in the manner in which they drive, individuals cannot demand absolute autonomy in the manner in which they live or die.
Moreover, autonomy cannot take precedence over inherent human dignity. It is only because society believes in the inherent human dignity of persons, that it respects their autonomy.[8]

In addition, being dependent on others should never be associated with a loss of dignity. All are born dependent on others, and many will die dependent on others. Being dependent on others at different times in a person's life is a basic characteristic of human existence.

Finally, the legalisation of euthanasia may undermine the autonomy, and impose a level of coercion on, medical and other health care professionals or on dependent, vulnerable individuals. They may then feel obliged to carry out an act of euthanasia against their wishes or personal beliefs.

4. Inherent human dignity is grounded on an interdependent society

Again, a distinction should be made between inherent and non-inherent human dignity. In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives.
As the UK Supreme Court judge, Baroness Brenda Hale, indicated "*Respect for the dignity of others is not only respect for the essential humanity of others; it is also respect for one's own dignity and essential humanity. Not to respect the dignity of others is also not to respect one's own dignity*."[9]
But the reverse is also true: 'Not to respect one's own inherent dignity is not to respect the inherent dignity of others'. The senior lawyer, Patrick Devlin, indicates: "*The reason why a man may not consent to the*

[8] Likewise, the concept of a person being a burden to society is inimical to autonomy, as somebody who truly is autonomous by definition cannot be a burden.

[9] Brenda Hale, Dignity, Journal *of Social Welfare & Family Law.* Vol. 31, No. 2 (2009), pp. 101–108 (p.106).

commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against society."[10]
In other words, persons who consider that their lives are no longer worth living or that they have lost their inherent dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse situations are also not worth living and should be ended. It would mean that inherent human dignity is no longer inviolable or universal.

Similarly, persons who believe that their lives are no longer worth living or that they have lost their inherent dignity must reject the worth, value and meaning that others, such as their family, friends and even society, are recognising in their lives. In addition, for a person to consciously deny and reject the value, meaning and worth given by others to his or her life, without attenuating circumstances such as a psychological disorder, means rejecting these other persons' capacity to confer dignity which is tantamount to undermining their personhood.

As the House of Lords Medical Ethics Select Committee in 1994 indicated, belief in the special worth of human life is at the heart of civilised society. It is the fundamental value on which all others are based, and it is the foundation of both law and medical practice.[11] The prohibition of intentional killing is thus the cornerstone of the law and social relationships. It protects each individual impartially, embodying the belief that all are equal. Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. This means that, with euthanasia, the interests of the individual cannot be separated from the interest of society as a whole.[12] In other words, personal opinions about worth, meaning and value of human life matter to the whole of society.

5. Euthanasia should not be considered as a medical procedure

It is often suggested that euthanasia should be considered as a medical procedure undertaken by healthcare professionals.

In response to this, the SCHB notes that:

Euthanasia actually undermines the traditional goal of medicine, namely to cure and care but not to harm or kill patients.
It is also important to recognise that it is not easy, from a psychological perspective, for a physician (or any other person) to take part in euthanasia.

Research, moreover, demonstrates that most sustained demands for euthanasia are actually considered by persons suffering from existential problems or because they have an extreme concept of control and independence.[13] Thus, the argument in favour of euthanasia is more about control than medicine.

6. Euthanasia would undermine the relationships of health care professionals with their patients

Advocates of euthanasia suggest that curing disease and bringing about death are not mutually exclusive roles since the intention in both cases is to relieve suffering. It is further argued that the primary role of the physician is to care for his or her patients, which must therefore entail respecting their autonomous wish to die.

In response to this, the SCHB notes that:

While all admit the inevitability of death, intentionally and actively pursuing the death of a patient, fundamentally changes the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may then become hardened to death and to causing death, particularly when patients are old, terminally ill, or disabled. Legalising euthanasia would give persons, such as physicians, power that

[10] Devlin, P., The Enforcement of Morals, London, 1965, p. 6.

[11] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 34.

[12] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 237.

[13] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

could be too easily abused, and a responsibility that they should not be permitted to have. It is not up to physicians to decide whether or not a life is worthwhile.[14]
If assisted suicide is accepted, a number of vulnerable people and their families may begin to mistrust the real intentions of their doctors.

Historical precedent in The Netherlands demonstrates that progression to involuntary euthanasia requires only four accelerating factors: favourable public opinion, a handful of willing physicians, economic pressure and no convictions for those involved. If legislation allowing euthanasia comes into effect, and political and economic interests are brought to bear, the generated momentum could prove overwhelming.

7. Euthanasia should not be legalised just because it is occurring in secret

Advocates of euthanasia suggest that the practice of clandestine, illegal euthanasia carries the greatest potential for abuse. They argue that the pressures that can influence end-of-life decisions will be more pernicious if euthanasia remains an underground practice. Further, the gap between law and practice must be reconciled if respect for the rule of law is to be maintained.

In response to this, the SCHB notes that:

The law should not be changed just because something, which is illegal and unethical, such as murder, is being practised in secret. If this happened it would completely undermine the rule of law in a country.
In addition, by prohibiting euthanasia, it is possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged according to a good standard of fairness and compassion.

Moreover, as reflected by the situation in Belgium, legalising euthanasia does not diminish the number of illegal acts. This number may even increase because a certain leniency may develop in undertaking such acts.[15] In some circumstances, there also seems to be some confusion as to what can be considered as an act of euthanasia.[16]

8. International legal instruments oppose euthanasia

It has been suggested that only those with religious or other non-secular beliefs are opposed to euthanasia and that they should not be able to stop those who believe in the autonomy of the individual to choose when to die.

In response to this, the SCHB notes that:

The belief in the inherent dignity and inviolability of human life is, in fact, based on international globally accepted secular principles such as the ***United Nations' Universal Declaration of Human Rights.***

Moreover, the ***Council of Europe Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying***[17], which is the latest text on the issue, indicates in Article 9.c. that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

> *i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*

[14] In very rare cases, physicians such as Harold Shipman, may actually feel empowered in being able to provoke death. Harold Shipman: The killer doctor, BBC News, 13 January 2004, http://news.bbc.co.uk/1/hi/uk/3391897.stm

[15] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 50.

[16] Agnes van der Heide et al., End-of-Life Practices in the Netherlands under the Euthanasia Act, *N Engl J Med* 2007; 356:1957-1965,

[17] Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

These texts emphasise the universal, absolute, inalienable and intrinsic nature of the concept of inherent human dignity. They support the notion that *no person* (including oneself) can lose his or her inherent human dignity at any time in his or her life. To reject such a notion would not only seriously challenge the whole concept of inherent human dignity but would be an extremely serious precedent in a world that has fought so hard to recognise the same dignity in all persons.

9. Distinction between acts and omission

Proponents of euthanasia frequently refer to the lack of distinction between acts and omission. They argue that there is not a significant difference between actively killing someone and refraining from an action that may save or preserve that person's life.[18]

In response to this, the SCHB notes that:

In a medical context, there is a moral duty for the physician to undertake what is reasonable to save and preserve life.
If a physician consciously refuses to initiate certain lifesaving interventions with the primary intention of bringing about the death of a patient, then this could be considered as murder. If, on the other hand, a physician follows good medical practice and addresses the best interests and well-being of the patient and does not initiate futile and burdensome interventions and this, as a side effect, shortens the patient's life, then no objections would normally be brought against the physician.
In other words, the critical distinction between murder and good palliative care is related to the physician's intention, which is an extremely important concept in law.

10. Euthanasia would undermine the protection due to the most vulnerable persons in society

By legalising euthanasia, vulnerable people may begin to consider the procedure as a possible option for releasing family members, carers and the broader society from the responsibility of providing support. In other words, they may believe that they are a burden and that their death is a greater good.

The House of Lords Select Committee recognised this risk by indicating in 1994: "*We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life*." [19]

This means that in a responsible and civilised society vulnerable people need to know that society is committed first and foremost to their well-being, even if this does involve expenditure of time and money. The manner in which the weakest and most vulnerable members of society are treated reflects the true identity of a society because it reveals its core values.

Moreover, if it is the case that a person accesses euthanasia in order to just make things easier for the carers, this may have profound consequences on the carers themselves who may then believe that they are the reason for the person's death.

11. The request to die may not reflect the patient's real wishes

Though sadness may be present in a patient faced with the news of his or her approaching death, this may be seen as a normal response in such a situation.

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[18] For example, it is considered morally wrong to push someone into a river to his or her death but there may not be a moral duty to leap into the river to save someone who is drowning.

[19] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - p 49, para 239.

Generally, however, experience shows that once people receive palliative care and are comfortable, with their fears concerning suffering being addressed, they often change their minds about wanting to end their lives.[20]

There is also good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can often be alleviated by personal support and treated in most cases.[21] States of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely confident that a request for a life to be ended does not arise from a disordered state of mind.
Moreover, detecting depression is very difficult even for a specialist practitioner, let alone a GP. This is especially difficult for a patient who has a chronic physical illness.
In other words, whilst many people are competent to make decisions about their wish for euthanasia, many are not. This opens the possibility that a decision to end a person's life could be made by a second person such as a nominated proxy. The complexities arising from such conditions could lead to serious abuse.

12. Neither suicide nor euthanasia should be seen as acceptable outcomes

The attempted suicide of an individual, such as a young person, is never seen as something to be encouraged in society even if they believe that they have lost all meaning and hope in life. This is because society still believes that the person has inherent dignity and value. Thus, great concern is raised regarding the individual's state of mind and the fact that he or she may need psychological assistance or counselling. It would be completely unethical to help someone commit suicide in these circumstances. As a result, it is difficult to consider how any form of euthanasia can be considered.

Moreover, with euthanasia or assisted suicide, as opposed to suicide, another person must believe that it would be preferable for the person wishing to die not to continue living. In other words, euthanasia and assisted suicide, reflect the unacceptable belief by one person that another person has lost, or will lose, his or her value of life to such an extent that his or her life is not worth living and should be ended.

When society acknowledges the acceptability of one person being willingly involved in the death of another, dangerous consequences as to the manner in which the whole of society considers the value, meaning and worth of human life are to be expected.

13. Gradual widening of categories

In certain countries, such as in Belgium and The Netherlands, there is now evidence of an 'incremental extension' in the scope of euthanasia. In other words, there is a steady increase in numbers with a gradual widening of the categories of persons with respect, for example, to age and the seriousness of the condition, as well as who can be considered for euthanasia, implying that the value and worth of certain lives in these countries is diminishing.

[20] Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, Lancet, Vol. 338, 1991.

[21] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

Scottish Council on Human Bioethics

01.04.2017 **Position Paper on:**

Euthanasia

1. Definitions and general information

Euthanasia: Comes from the Greek roots *eu* (well) and *thanatos* (death), literally 'to die well' or 'a good death'. The term is generally understood as a voluntary intervention (an intentional act or omission) with the aim of ending the life of a person by someone else who believes that, because of suffering, it would be preferable for this person to die rather than to continue living. The key motive is intent. Euthanasia has, as its first objective, to bring about intentionally (and without any undue pressure) the death of a person.

Intervention in the health field: Any intentional activity, withholding of activity or the withdrawal of activity in the health field. Interventions include:

- Medical treatment: Any positive intentional activity designed to address a specific physical or mental disorder in the best interest of the person. Assisted nutrition and hydration are not generally recognised as treatments.

- Basic care: Any positive healthcare activity which is part of the fundamental needs of a person and does not specifically address a physical or mental disorder.

Direct Euthanasia may take the form of:

- Active Euthanasia: Generally understood as an active intervention to end the life of a person by someone else, by the use of drugs or other methods.[22]

- Passive Euthanasia: Euthanasia without active intervention, whereby life sustaining treatment, nutrition and/or hydration are withheld or withdrawn from a patient by someone else with the primary intent of hastening a patient's death. In the UK, these terms are not generally used within the medical profession.[23] Passive euthanasia should be distinguished from the practice whereby medical treatment, nutrition and/or hydration can be withheld or withdrawn in specific circumstances but without having as its primary intent to bring about the death of a person.

Indirect Euthanasia: Term sometimes mistakenly used to describe the Principle of Double Effect.

Principle of Double effect: In the context of 'end of life' circumstances, the Principle of Double Effect may include the administration of drugs to a patient in order to relieve pain, the consequence of which may shorten his or her life though this is not the intent. Such an administration of drugs is generally considered 'good medical practice' and not euthanasia. In this regard, it should be noted that the principle of double effect is becoming less relevant to end of life care since the drugs that alleviate pain do not generally reduce life expectancy.

Palliative Sedation: Sedation in the context of palliative medicine is the monitored use of medications to bring about a state of decreased or absent awareness (i.e. unconsciousness) in order to relieve the burden of otherwise intractable suffering.[24]

[22] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[23] Ibid.

[24] Nathan I Cherny, Sedation for the care of patients with advanced cancer, Nature Reviews Clinical Oncology 3, 492-500 (September 2006)

Voluntary Euthanasia: Emphasises the express intent of the person wanting to die, and distinguishes it from mercy killing or any other form of killing. Voluntary euthanasia is performed by another person and at the autonomous request of an informed and competent patient. It takes place when the request is either given contemporaneously to the action of killing or beforehand if the request still represents the view of the person.

Non-Voluntary Euthanasia (sometimes defined as 'Mercy Killing'): Generally indicates an intervention by a person to end the life of a patient who is, at the time of its performance, incompetent and therefore incapable of assenting to it.

Involuntary Euthanasia: Generally indicates an intervention by a person to end the life of a competent patient who has capacity and which is performed against his or her will. In other words, where the patient is not consulted or where the patient's opposition to euthanasia is ignored (whether or not it is assumed that it is in the person's best interests).

Suicide: The intentional ending of one's own life. Includes:

- The vast majority of cases where the person ending his or her own life is not of sound mind with appropriate decision making capacity.

- The very rare cases where the person ending his or her own life is of sound mind with appropriate decision making capacity. These cases include:

    - Suicides with an active intervention whereby persons (who are not dying and are of sound mind with decision making capacity) make a conscious and contemporaneous decision to actively bring about their own death.

    - Suicides without an active intervention whereby persons (who are not dying and are of sound mind with decision making capacity) make a conscious and contemporaneous decision not to accept or to withdraw from life sustaining treatment with the *intention* of bringing about or hastening their own death.[25] This form of suicide recognises the prerogative of a patient not to accept a medical intervention even if it may save his or her life. This prerogative is recognised in most countries.[26,27]

      This kind of suicide is different from voluntary passive euthanasia in that the responsibility for the death rests solely with the person who dies.[28]

Assisted Suicide: The act whereby a person aids, abets, counsels or procures a suicide or an attempted suicide of another person.

Physician Assisted Suicide: The act whereby a physician prescribes a lethal medication to a person, but the person administers the dose himself or herself.

Persons approaching the end of life: Individuals who are likely to die within the next 12 months.[29]

Persons whose death is imminent: Individuals who are likely to die within a few hours or days.

[25] Harris, J.D.F. 1995. 'Physician-Assisted Suicide and Euthanasia: Let Me Count The Ways'. *Canadian Medical Association Journal* 153(7):884-885. For example: Woman who refused treatment after losing 'sparkle' dies, 3 December 2015, http://www.bbc.co.uk/news/uk-34991931; http://www.bailii.org/ew/cases/EWCOP/2015/80.html.

[26] It is important to realise that a refusal of life-sustaining treatment is not necessarily suicidal. Someone approaching the end of life may refuse treatment because it is burdensome or risky or because they are not convinced of the benefits.

[27] An example of an application of this judgement is given in the case where a woman paralysed from the neck down was given the right to die - BBC - 2002: http://news.bbc.co.uk/1/hi/health/1887281.stm
These cases may be defined by some people as forms of passive suicide.

[28] With voluntary passive euthanasia another person must agree that a person's life should be ended and takes responsibility for ending this life.

[29] General Medical Council, Treatment and care towards the end of life: Good practice in decision making, May 2010, p. 8.

2. Principles and purpose

The key issue in euthanasia is intention since allowing terminally ill patients to die when there is nothing more that can be done to relieve their symptoms or treat their illness has long been part of good medical practice.
On the other hand, letting patients die when useful symptom-relief or treatment can be given is negligent. Some argue that certain forms of pain relief can shorten the lives of patients with terminal disorders and therefore the doctor is actually aiding the patient's death. But under the Principle of Double Effect this is deemed ethically acceptable, since the doctor's intended outcome is pain relief and the unfavourable result of shortening life is not the intent. In reality, however, successful pain relief can extend life as appetite and well-being improve.

3. History

The Hippocratic Oath, which was written in the 4th Century BC and attributed to the Greek Hippocrates (c.a. 460-380 BC), who was considered as one of the fathers of western medicine, unequivocally prohibits euthanasia and assisted suicide. It states that: *"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."*
On the other hand, the English philosopher, Francis Bacon (1561 – 1626) suggested that it was part of a physician's duty to alleviate pain even if that meant killing the patient.[30]

Recent debates emerged in the United States and Britain in response to ideological currents gaining ascendancy in the late 19th and early 20th centuries. This culminated with probably the greatest abuse taking place under the Nazi euthanasia program which was code-named T-4. This referred to Tiergartenstrasse 4, the headquarters of the corresponding administrative system which set-up the T-4 establishments. The order underlying the so-called T-4 programme empowered selected physicians to grant "*mercy killing to those deemed incurable according to the best available judgement of their state of health*".[31]

In the course of the T-4 programme, some 70 000 institutionalised psychiatric patients were euthanised from the end of 1939 onwards. Most killings were concealed by false declarations of death, and the death notices bore false signatures. Under the earlier child euthanasia programme, a start had already been made on the identification and killing of children with disabilities of whom at least 5,000 were euthanised.
A further 20,000 disabled inmates fell victim to searches conducted in the concentration camps. The euthanasia programmes were officially terminated in August 1941 after their existence was discovered and gave rise to public protest, including strong opposition by the Catholic clergy.[32,33] Unofficially, however, euthanasia practices continued in Germany until the summer of 1943.[34]

4. England and Wales – Legislation, Case Law

4.1. Developments

There was a series of cases during the 1970s and 1980s in which defendants who had helped another person to die were prosecuted for manslaughter. Several were allegedly advised to plead not guilty on the grounds of diminished responsibility.

In 1992, Dr. Nigel Cox was found guilty of giving a lethal dose to a dying woman whose pain he could not relieve. However, he was neither imprisoned nor dismissed from his hospital job.

In 1994, an all-party committee of the House of Lords unanimously agreed that the law should not change to permit euthanasia. The committee argued that "*It would be next to impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law was not abused."*

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[30] End of Life Assistance (Scotland) Bill, Policy Memorandum, Scottish Parliamentary Corporate Body 2010.
[31] This is a quotation from the personal authority granted by Adolph Hitler to Reichsleiter Bouhler Dr. Brandt in October 1939, backdated to 1 September 1939. In German National Ethics Council, Self-determination and care at the end of life, Opinion, 2006, page 33.

[32] German National Ethics Council, Self-determination and care at the end of life, Opinion, 2006, page 33.

[33] J.A. Emerson Vermaat, 'Euthanasia' in the Third Reich: Lessons for Today?, Ethics & Medicine, 18:1 (2002):21-32.

[34] Ibid.

The House of Lords committee also rejected the suggestions that a new offence of 'mercy-killing' should be created: *"To distinguish between murder and mercy-killing would be to cross the line which prohibits any intentional killing, a line which we think it essential to preserve"*[35].
However, the committee supported the right of physicians to withdraw medical treatment from patients, particularly those in a persistent vegetative state. This means that if a treatment would "*add nothing to the patient's well-being as a person*" it need not be given.

Following a proposal by Lord Joffe to introduce a ***Patient (Assisted Dying) Bill***, in February 2003, a House of Lords Select Committee prepared a report entitled "***Assisted Dying for the Terminally Ill Bill***" in April 2005. This report indicated that if an assisted dying bill was considered, it should distinguish clearly between assisted suicide and voluntary euthanasia. This led Lord Joffe to re-introduce a new version of his bill entitled ***Assisted Dying for the Terminally Ill Bill*** into the House of Lords on the 9th of November 2005 in a form which would legalise assisted suicide but not euthanasia. However, this was unsuccessful.

4.2. Present situation:

In England and Wales, the term euthanasia is not defined in law and would be regarded as murder. It is murder or manslaughter for a person to undertake an act that ends the life of another, even if he or she is simply complying with the wishes of the other person concerned.[36] In these countries, murder is a common law offence.

Case Law:
In the medical setting, ***R v Cox* (1992) 12 BMLR 38** confirmed that if a medical professional carried out an action with the intention of ending a life, whether or not for compassionate reasons or at the patient's request, this would constitute murder.[37]

The current position in England and Wales is that euthanasia is unlawful and anyone alleged to have undertaken such an intervention is open to a charge of manslaughter. Similarly, medical treatment which is given to a patient with the specific intention of hastening or inducing death, whether at the patient's wish or not, is considered to be illegal.

In 2010 an English woman, Frances Inglis, was found guilty of murdering her brain-damaged son (Thomas) after the court of appeal ruled that mercy killing is murder. While acknowledging that this was a tragic case, the Lord Judge stated that "*However disabled Thomas might have been, a disabled life, even a life lived at the extremes of disability, is not one jot less precious than the life of an able-bodied person*." Adding: "*His life was protected by the law, and no one, not even his mother, could lawfully step in and bring it to a premature conclusion*."
Lord Judge also explained: "*The latest statute to address the problem of mercy killing, currently in force, expressly includes as mitigation for the offence the offender's subjective belief that he or she was acting out of mercy, but that belief and motivation, however genuine, does not and cannot constitute any defence to the charge of murder*." Furthermore, he explained, "*the law of murder does not distinguish between murder committed for malevolent reasons and murder motivated by familial love*".[38]

5. Scotland – Legislation, Case Law

5.1. Developments

Euthanasia and assisted suicide became devolved matters for the Scottish Parliament under the ***Scotland Act 1998***, Schedule 5 (Reserved Matters), Part II (Specific Reservations), Head J (Health and Medicines).

[35] House of Lords: Report of the select Committee on Medical Ethics, HL 21 - I, January 1994.

[36] Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

[37] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[38] Caroline Gammell, *Frances Inglis: mother who killed brain-damaged son is told 'mercy killing is murder'*, The Telegraph, 12 November 2010.

In this regard, it should be noted that the term euthanasia is not defined in Scottish law and would be regarded as murder or culpable homicide (a common law offence).[39]

On the 23rd of April 2009, Ms. Margo Macdonald MSP presented a Private Member's ***Proposed End of Life Choices (Scotland) Bill***[40] to the Scottish Parliament which sought to legalise both euthanasia and assisted suicide. This obtained 20 signatures out of the required 18 parliamentary supporters meaning that the proposed bill could continue through the legislative process. In January 2010, Ms. MacDonald submitted her ***End of Life Assistance (Scotland) Bill*** to the Scottish Parliament.[41] But this was rejected on the 1st of December 2010 by 85 votes to 16 with two abstentions.

5.2. Present situation

The present situation is best characterised by the Deputy Minister for Health and Community Care, who indicated in a response before the Scottish Parliament on the 11th of November 2004, that "*Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification. There might be cases in which the circumstances of the offence would make a charge of culpable homicide more appropriate than one of murder, and a court would take all the circumstances of the case into account before sentence was pronounced. However, if the accused was convicted of murder, a sentence of imprisonment would be mandatory*."[42]

Case Law:
After a landmark case in 1996, the then Lord Advocate issued a statement declaring that he would not authorise the prosecution of a physician who, acting in good faith and with the Court of Session's authority, withdrew life-sustaining treatment from a patient in a persistent vegetative state with the result that the patient died. The case had been brought by the patient's Health Board, seeking assurances that the withdrawal of food would not result in civil or criminal actions against healthcare professionals.[43]

6. Legislation, Case Law and Regulations - International

6.1. International

Council of Europe:

European Convention on Human Rights:

Two articles of the European Convention on Human Rights (ECHR) protect the right to life, namely:

Article 2.1:
Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 8:
1. Everyone has the right to respect for his private and family life…..
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

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[39] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[40] The proposal may be viewed at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/17939.aspx

[41] End of Life Assistance (Scotland) Bill Committee, 1st Report, 2010, available at: http://www.scottish.parliament.uk/parliamentarybusiness/PreviousCommittees/19514.aspx.

[42] Scottish Parliament Official Report - 11.11.04: http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876

[43] Scottish Parliament Official Report - 11.11.04: http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876

Council of Europe Parliamentary Assembly Recommendation 1418 (1999):

The latest provisions on euthanasia are included in Article 9.c. of the Council of Europe Parliamentary Assembly Recommendation 1418 (1999) which states that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

In January 2012, the Parliamentary Assembly of the Council of Europe passed a resolution entitled *"Protecting human rights and dignity by taking into account previously expressed wishes of patients"* which states as a fundamental principal: "*Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited*."
Furthermore, an amendment was passed stating that "*surrogate decisions that rely on general value judgements present in society should not be admissible and, in case of doubt, the decision must always be pro-life and the prolongation of life*".

6.2. Other countries

Australia:

In the Northern Territories of Australia the ***Rights of the terminally Ill Act 1995*** came into effect between 1st of July 1996 and the 5th March 1997 when the Australian Federal House of Representatives passed an anti-euthanasia Bill. During this time, seven people officially sought to use the legislation to die.

Netherlands:[44]

In the Netherlands, though a person does not have a right to euthanasia, the ***Termination of Life on Request and Assisted Suicide (Review Procedures) Act*** came into effect on the 1st of April 2002. The Act incorporates an amendment to Article 293 of the Criminal Code to the effect that although any person who terminates another person's life at that person's express and earnest request remains liable to a term of imprisonment or a fine, such an act shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation and fulfils the stipulated due care criteria, by which the attending physician must:

- be satisfied that the patient has made a voluntary and carefully considered request;
- be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement (note: it is not a condition that the patient is terminally ill or that the suffering is physical);
- have informed the patient about his or her situation and his or her prospects;
- have concluded, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
- have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in the four above indents; and
- have terminated the patient's life or provided assistance with suicide with due medical care and attention.

Similarly, any person who intentionally incites another to commit suicide, if suicide follows, is normally punishable under Article 294 of the Criminal Code by a term of imprisonment or fine, but commits no offence if the above due care criteria are fulfilled.

[44] Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

The new legislation also includes regulations regarding termination of life on request and assisted suicide involving minors. Children of 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardian are required.

Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so.

In all cases, the physician must report his or her act to the municipal pathologist. The report is then examined by a regional review committee to determine whether it was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.
If the committee agrees that the physician has practised due care, the case is closed. If not, the case is brought to the attention of the Public Prosecutor who has the power to launch his or her own investigation if there is a suspicion that a criminal act may have been committed.

Belgium:[45]

In Belgium, the 2002 legislation making possible Euthanasia is similar to that of The Netherlands. Thus the law does not specify the method to be used by the physician, even though he or she must describe it in the official form to be forwarded to the Federal Evaluation and Control Commission.
In 2014, Belgium became the only country in Europe to officially allow children of all ages to access euthanasia, provided parental consent is granted.

Luxembourg:

As of March 2009, Luxembourg is the most recent country to have legalised euthanasia and assisted suicide. In the legislation, individuals suffering from a terminal or incurable illness are able to have their lives ended after receiving the approval of two doctors and a panel of experts.

[45] Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee