

# *Euthanasia*

## *An Uncontrollable Power over Death*

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In the debate on euthanasia and physician-assisted suicide, there is frequent discussion of the validity of the slippery-slope argument. It is my conviction that, in theory and in practice, a sincere attitude in favor of the termination of life of people afflicted with unbearable suffering is intrinsically linked to the expansion of this attitude to favor the termination of the lives of more and more patients for more and more clinical and social indications. The pro-euthanasia mind-set rests on a widespread ignorance of the clinical benefits of palliative treatment, probably one of the most rapidly advancing branches of medicine, and its importance in the provision of humane care. In some countries, the prevailing disregard of palliative care leads to the bitter and pessimistic conviction that mercy killing is the only choice in the face of unendurable pain or refractory symptoms. In this short essay, some reasons are given to show that, once accepted as ethically defensible, euthanasia and physician assistance in suicide become uncontrollable.

In *Evangelium vitae*, Pope John Paul II stated his concern about the spreading character of the euthanasia mentality. He pointed out that there is an underlying attitude affirming that man is the lord of life and death, that he can control it openly or secretly. He also tells us that the threats against human life are not limited to individual cases or occasional situations; on the contrary, they constitute a systematic and scientifically programmed menace against life (*Evangelium vitae*, n. 17). We might think that the Pope is exaggerating. Not so. In this brief contribution, I will

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review the experience of Holland and Belgium. My conclusion is that once euthanasia is legally authorized, there is no way to stop it.

There are two reliable grounds to support this assumption. One is the individual behavior of doctors, as observed in physicians who succumb to the notion that euthanasia is professionally acceptable, even if it is seldom required. The other is related to society in general, as shown in the increasing pressure of the pro-euthanasia movement to legalize “compassionate” death, even within strict limitations.

### **An Ethical Poison for the Physician**

My first proposition can be formulated as follows: If a physician sincerely accepts the idea that it is right, from a professional and ethical perspective, to end the life of one of his patients, he will not stop there. It will be difficult for him, and also unjust, not to offer euthanasia to other patients who suffer in a similar way or are approaching a similar level of pain or anguish. He will find more reasons to offer “merciful” death to other patients, earlier, and with more zealous compassion. It happens then that, after some years, euthanasia will become incorporated into palliative medicine as one more tool. Eventually, as with many instances of terminal sedation, it may even replace other palliative measures.

The physician who grants “compassionate” death for the first time to one of his patients has two options. Either he recognizes that he has done wrong and he is profoundly sorry, or he rationalizes his action as a good deed. In the latter case, because of moral consistency, there is nothing to prevent him from repeating his action. Dutch and Belgian physicians who do not object to euthanasia are not psychopathic killers. Paradoxically, their mistaken compassion has led them down the path of euthanasia. In countries where euthanasia is allowed by law, the process follows a four-stage course:

*Stage 1.* The first phase may be measured in years. The physician resists applying the legal rule, but in very extreme cases he will use it with stringent criteria. In this stage, “compassionate” killing is an exceptional measure that is performed according to the established legal regulations and only after all palliative measures have been exhausted. In other words, euthanasia in this first phase is a desperate measure which is supposed to happen only once or twice in the course of one’s whole professional life.

*Stage 2.* The second phase corresponds to a period when the use of euthanasia becomes an acceptable and common measure, a situation triggered by extraordinary cases highly publicized in the media, by repeated “not guilty” verdicts in ambiguous cases brought before the courts, and by increasing social assent. Moreover, ethical repugnance is weakened by the perception that more than a few patients are put to death by respected and influential colleagues in accredited and prestigious hospitals. This environment can make euthanasia seem more universally acceptable and not restricted to “hard cases.” The physician finds himself on a proverbial slippery slope.

The old frame of mind changes, and euthanasia becomes a familiar procedure. Now the physician thinks that there are honorable and acceptable indications for euthanasia, making it preferable to other forms of treatment, especially if the patient asks for it. If he applies pragmatic criteria, euthanasia even seems to be superior to palliative measures. Why? Because in comparison with palliative care, it is more efficient, less painful, more aesthetic, more graceful, and economically less expensive. In addition,

some patients consider themselves entitled by right to a painless death; for the patient's relatives, euthanasia may be a practical solution to get rid of the spiritual suffering faced by both the beloved who is dying and themselves; for certain physicians, it becomes a useful and simple measure to save time and effort; and for health-care administrators, it is cost-effective. Therefore, euthanasia becomes not just one more therapeutic tool, competing with other palliative measures, but in many cases the procedure of choice.

*Stage 3.* This way of thinking leads to the third phase, in which physicians and nurses are moved by the ideals of compassion, justice, and efficiency to become active instruments of nonvoluntary mercy killing. Confronted by incompetent patients, they reason in this way: "It is terrible to live with this condition, to die so slowly and in such a pitiful way. I would not like to be one of the living dead. I would rather die. I am sure that if these patients could be awake for a moment and let me know their wishes, they would ask me to end their lives. The best thing for these patients and their families is a quick death with little or no suffering."

For the physician who has sincerely agreed to voluntary euthanasia, involuntary euthanasia is inevitable. To act as the interpreter of the will of the incompetent patient is a matter of coherence: the initial acceptance of euthanasia as a legitimate medical intervention becomes, to a certain extent, an unavoidable obligation. The physician may criticize the restrictions of a legal system which punishes the application of euthanasia to patients in a deep coma, those with advanced dementia, severely handicapped children, and others. He is ready to become an accomplice of those who feel free to end the lives of unwanted people.

*Stage 4.* The fourth phase has a pragmatic and utilitarian character. By now, the physician has fully embraced the moral conviction that it is best to euthanize even certain competent patients. Their lives are useless, even despicable, and have no "quality." They are unproductive social parasites, heavy consumers of medical care. Their request to stay alive under these conditions is nonsensical; they have no value, and it does not make sense to respect their wishes. They represent a waste of economical resources.

Is this a fictitious scenario or a scenario based on verifiable data? I consider it a realistic and accurate description of what has been happening for several years in the "social laboratories" of the Netherlands and Belgium. In 1999, based on available information, 15 percent of patients were put to death by physicians, without the patients' consent, on the basis of a physician's judgment of what was best for them. One must be reminded that in the Netherlands, the official statistical data are inaccurate because not even half of the cases of euthanasia are reported by law.<sup>1</sup>

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<sup>1</sup> Tony Sheldon, "New Penalties Proposed for Dutch Doctors Who Flout Euthanasia Law," *British Medical Journal* 329.7458 (July 17, 2004): 131. Tony Sheldon is the British Medical Journal correspondent in Utrecht. Since 1999, he has regularly published articles dealing with the irregular practice of euthanasia in the Netherlands. See also Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton and Company, 1998); and John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (Cambridge, UK: Cambridge University Press, 2002).

The Dutch health department does not know how to correct this abuse.<sup>2</sup> Since 1997, the Royal Dutch Medical Association, in an effort to counteract these abuses, has encouraged physicians to abandon euthanasia for assisted suicide, which is immune to the legal risks of mercy killing. Since this has not been effective enough, in 2002 the society asked its members to abandon assisted suicide and use “terminal sedation” instead, because terminal sedation has no legal implications in Holland.<sup>3</sup>

Euthanasia can be performed on malformed newborns and children with cerebral palsy, according to the recently legalized Groningen Protocol.<sup>4</sup> It can also be performed on patients with depression, elderly patients with pneumonia, people living alone, and those who perceive life as too much of a burden.

The resistance of Dutch courts to euthanasia is barely existent, as shown by the decision in the case of Dr. Wilfred van Oijen, who injected a woman with a lethal dose of a muscle-paralyzing agent. He was given a token sentence of one week in prison, even though it was claimed that the injection was a palliative treatment, given out of compassion. The Royal Dutch Medical Association came to the defense of Dr. van Oijen, criticizing the judicial verdict, by stating that with their decision “courts have turned palliative measures into criminal activity.”<sup>5</sup>

The legal boundaries are not very helpful, due to the indulgent interpretations of tribunals in cases of physicians who practice mercy killing. In cases where there was clear-cut evidence that the law was broken, the judge acknowledged that even though such cases are truly homicides, they can be justified because the action was done out of compassion. In the van Oijen case, although the physician was found guilty of murdering a dying eighty-four-year-old patient, “the appeal court ... accepted that he acted out of mercy and that it was ‘murder’ only in a legal and technical sense.”<sup>6</sup>

There is also another indication for euthanasia, which may be performed on patients who cannot bear to keep on living. They do not need to be sick, but only complaining of what has been termed “existential” suffering, or “suffering through living.”<sup>7</sup> The Royal Dutch Medical Association has stated that there is no reason

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<sup>2</sup> Raphael Cohen-Almagor, “Non-Voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives,” *Issues in Law and Medicine* 18.3 (Spring 2003): 239–257.

<sup>3</sup> Judith A. C. Rietjens et al., “Physician Reports of Terminal Sedation without Hydration or Nutrition for Patients Nearing Death in the Netherlands,” *Annals of Internal Medicine* 141.3 (August 2004): 178–185.

<sup>4</sup> Edward Verhagen and Peter J. J. Sauer, “The Groningen Protocol—Euthanasia in Severely Ill Newborns,” *New England Journal of Medicine* 352.10 (March 10, 2005): 959–962.

<sup>5</sup> Tony Sheldon, “Two Cases in Holland Clarify Law on Murder and Palliative Care,” *British Medical Journal* 329.7476 (November 20, 2004): 1206.

<sup>6</sup> Tony Sheldon, “Court Upholds Murder Verdict on Doctor Who Ended Woman’s Life,” *British Medical Journal* 326.7403 (June 12, 2003): 1351.

<sup>7</sup> Tony Sheldon, “Dutch Euthanasia Law Should Apply to Patients ‘Suffering Through Living,’ Report Says,” *British Medical Journal* 330.7482 (January 8, 2005): 61.

why such patients should be excluded from the physician's "area of competence," since they suffer for being alive.<sup>8</sup> The same medical society affirms that the case of involuntary euthanasia should be presented not to justice tribunals, but to multi-disciplinary boards of physicians and lawyers, because their members are better equipped to understand and explain the surrounding circumstances.

The Dutch experience clearly shows that when mercy killing is legalized, it is virtually impossible to put a brake on the potential abuse born out of the misguided compassion of the physician, fatigue of the family, and ineffective legal-control mechanisms. That was the conclusion reached by Great Britain's House of Lords after studying the Dutch experience of euthanasia.<sup>9</sup> In a mercy-killing environment, the true meaning of a physician's compassion is lost. The main conclusion from the Dutch experience is that euthanasia destroys the very foundation of medical care. The same can be said of the Belgian experience.<sup>10</sup>

The Dutch government has realized that they are powerless to enforce the laws of euthanasia in their country. It is out of their hands. They have threatened to reinforce the laws and make the punishment of physicians more severe. They stand paralyzed by the discovery that legalization of mercy killing has its own dynamics. It cannot be stopped. It is impossible to have a policeman at the bedside of every terminally ill patient.

### **A Narcotic for Society**

My second thesis is this: If a society reaches the conclusion that euthanasia or physician-assisted suicide should be legalized under stringent regulations, there will always be loopholes exploited by the pro-euthanasia movement to increase the number of mercy killings.<sup>11</sup>

During the early part of the twentieth century, the slogan "a compassionate death" was used by the Voluntary Euthanasia Society to justify the killing of terminally ill patients whose suffering could not be alleviated by physicians. This slogan lost its meaning when palliative treatment came into practice. By the 1960s, with the technological development of ventilators and cardiopulmonary resuscitation maneuvers, patients began to assert their right to reject those extraordinary measures, which were viewed as prolongations of agony and, as such, painful and useless. For patients with them, "living wills" represented legal guarantees that those "heroic measures" would not be used for them.

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<sup>8</sup> Ibid.

<sup>9</sup> House of Lords, *Report of the Select Committee on Medical Ethics* (London: HMSO, 1994).

<sup>10</sup> Luc Deliens et al., "End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey," *Lancet* 356.9244 (November 25, 2000): 1806–1811.

<sup>11</sup> Gonzalo Herranz, "Cultural and Thematic Dimensions of Pro-Euthanasia Movements: The Situation outside the Netherlands," in *The Dignity of the Dying Person: Proceedings of the Fifth Assembly of the Pontifical Academy for Life*, eds. Juan de Dios Vial Correa and Elio Sgreccia (Vatican City: Libreria Editrice Vaticana, 2000), 86–101.

The pro-euthanasia movement was forced to change its slogan to “the right to die with dignity.” This new formulation is not so much about compassionate euthanasia as it is about the right to choose death in the face of a supposedly degraded existence, biological aging, a disabling disease, burdensomeness to others or self, loneliness, advanced dementia, and so forth. In some cases it is not a matter of getting rid of physical pain, but of considering one’s life worthless. At the nucleus of this new demand is the idea that man is the absolute owner of his life and thus the owner of his death and the arbiter of the quality of his life. Therefore, he should have the legal right to decide when, where, and how to end his life. This is the way in which associations in favor of euthanasia present their propaganda on many internet Web sites. It is the speaking image of our hedonistic society, made up of persons obsessed with efficiency, who believe they have to enjoy absolute personal autonomy, who have lost faith in God, and for whom death has been reduced to a mere biological collapse.

In Europe, the United States, Canada, and Australia there is a new pro-euthanasia strategy: “submerged euthanasia.” It has strong similarities to the rhetoric of “back-street abortions,” a tactic so successfully used years ago for the legalization of abortion on demand. The new strategy consists in the public denouncing of a hidden and extensive practice of euthanasia at the hands of amateurish people or incompetent physicians. Roger Magnusson, at the University of Sydney, has published formal research on the unthinkable brutality practiced by incompetent persons on patients suffering from AIDS.<sup>12</sup> Magnusson’s findings describe an association of health-care organizations with funeral directors, and their attempts to erase evidence of criminal wrongdoing via cremation. Some physicians have attempted to justify their activity, stating that assisted suicide or mercy killing is part of their professional work, at the vanguard of the “new ethics.” Their behavior, as explained by Magnusson, is a culture of lies and death, a repulsive anthology of horrors and justifications which sadden the soul.

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<sup>12</sup> Roger S. Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (New Haven, CT: Yale University Press, 2002). For a more accessible source, see Magnusson, “Euthanasia: Above Ground, Below Ground,” *Journal of Medical Ethics* 30.5 (October 2004): 441–446, where the author describes some macabre cases of “underground euthanasia.” “Take Stanley, a therapist and former priest, who presided over the death of a patient who swallowed fifteen Seconal tablets (a barbiturate), but who failed to take an antiemetic. It was only after the patient had swallowed his own vomit that the drug took effect. In many cases doctors and nurses miscalculated the dosages required to achieve death and resorted in panic to suffocation, strangulation, and injections of air. Of the eighty-eight detailed narratives that interviewees gave to illustrate their euthanasia credentials, nearly 20 percent involved ‘botched attempts.’ Suffocations were referred to euphemistically as ‘pillow jobs’ by several interviewees: ‘It was horrible,’ said one doctor (now head of a large community organization). ‘It took four or five hours. It was like Rasputin, we just couldn’t finish him off.’ ‘I tried insulin, I tried just about everything else that I [had] around and it just took forever.... [It was] very hard for his lover. So I, um, sort of shooed the lover out of the room at one stage and put a pillow over his head, that seemed to work in the end [laughs, nervously].... That was one of the worst [clearing throat], one of the most horrible things I’ve ever done” (442).

### The Saving Power of Respect for Life

“I will give nobody a mortal poison, even if he asks for it.” This statement from the Hippocratic Oath has saved medicine from the permanent threat of becoming inhumane.

The future is in the hands of the physicians and of the sick. The physician must accept the challenge of building a genuinely compassionate and scientific palliative medicine, based on respect for the sick person as a reflection of God’s image. For the sick it is necessary to recognize that in our human condition, mortality and hope constitute a unity that must not be separated. A society which accepts euthanasia destroys true compassion, because the care of the weak and burdensome is replaced by their destruction. The legalization of mercy killing becomes an avalanche which cannot be controlled. It cannot be regulated as if it were an individual right to self-determination. Euthanasia is a social action. It cannot be enclosed in the sphere of individual autonomy. Society is not made up of individuals encapsulated each in their own shell.

Mercy killing is contagious. It is harmful for those who participate in it, those who practice it, and those who allow it. I wish to reinforce a key idea. The respect for the dignity of a man takes a particular form in medicine, in respect for the weak. Palliative medicine recognizes that man cannot be abandoned. Euthanasia abandons him and expressively tells him that his life is not worth living. Man is *res sacra miser*, a sacred and miserable being. This magnificent and graphic expression describes the situation of mankind facing terminal disease and the end of life. It holds firmly the inseparable coexistence of the sacredness of human life with the extreme misery of a progressive disease. When a sick person is considered under this light, with dignity even though miserable, we have found the cornerstone of medical ethics and the strongest condemnation of what is understood as mercy killing.

Euthanasia and assisted suicide are testing the true humanity of the physician and of the entire society. To meet this challenge, the physician has the support of the code of ethics carved into the intrinsic act of being a physician. He or she has been given the grace of God to venerate and love the life of everyone. As John Paul II tells us, that knowledge of the sacredness and inviolability of human life is “written from the beginning in man’s heart.”<sup>13</sup>

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<sup>13</sup> *Evangelium vitae*, n. 40; see also n. 39.