

## Legalization of euthanasia violates the principles of competence, autonomy, and beneficence

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**E**uthanasia” refers to killing or permitting the death of a person or a domestic animal in a quick and painless way intended to relieve unbearable suffering.<sup>1</sup>

In the Netherlands, where euthanasia was legalized in 2001, a physician may euthanize a patient or assist in that patient’s suicide if the physician is convinced that the patient’s request is voluntary, is well-considered and lasting, and that the suffering is unremitting and unbearable. The physician must also agree with the patient and another physician that there is no reasonable alternative.<sup>2</sup> These criteria imply that the competence and autonomy of the patient and the beneficence of the physician’s intent are essential to a decision in favor of euthanasia. However, through the examination of cases from both the Netherlands and Canada, I believe that euthanasia violates all of these principles and should not be legalized in Canada.

### Competence

Determination of the patient’s competence can be neither consistent nor standardized in a legal sense. Competence in bioethics means the mental ability to distinguish right from wrong and to manage one’s own affairs. The functional definition, however, is that the patient is competent until incompetence is demonstrated.<sup>3</sup>

Two issues arise from this ap-

proach. On the one hand, competence is decision-specific in practice; a person may possess the mental capacity to make his or her last will or to stand trial, and yet be found incompetent to make treatment decisions.<sup>3</sup> On the other hand, the legal criteria for competence are cognitive; as long as a person is able to reach a logical decision, the law is unconcerned with whether the decision is reasonable.<sup>3</sup>

Upon the patient’s request for euthanasia, the physician must decide whether the patient is legally competent, that is, having sound reasoning. This, however, is irrelevant to whether the patient’s request is reasonable. This discrepancy fundamentally distorts the consistency of the assessment because the “reasonableness” of the request is inevitably subject to the physician’s social and moral values. This leads to the problem of how the physician perceives what causes and constitutes incompetence. For instance, somatic illnesses can cause neurovegetative symptoms that induce or mimic psychotic disorders. In one study, depression occurred in 45% of terminally ill patients, while in another, 64% of terminally ill patients who desired early death were suffering from various degrees of clinical depression.<sup>4</sup> No criteria, however, have been established as to what degree of depression leads to incompetence.<sup>4</sup> It should be noted that some death wishes are reversible by pharmacological treatments. In studies of nonterminal depressed patients, recovery rates in response to a course of antidepressant pharmacotherapy are generally about 60% to 70%.<sup>4</sup> Unless all patients who desire death are treated psychiatri-

cally, the symptoms that mimic the psychotic disorders caused by neurochemical factors confound the standardization of incompetence and, hence, the determination of competence.

In the Netherlands, the complexities of determining competence are side-stepped in two ways. First, the physician who determines whether euthanasia is to be performed does not have to evaluate competence based upon a specific set of standards. The law simply states that “voluntary, well-considered, and lasting” requests are competent enough, and the judgment is solely at the discretion of the physician.<sup>1</sup> The only requirement is that the physician consult another experienced colleague.<sup>5</sup> However, this is not a meaningful requirement since he or she can choose whom to consult. According to Gomez, who conducted extensive interviews with physicians in the Netherlands regarding euthanasia, the real check against abuse lies in the integrity of the medical professionals.<sup>5</sup> However, whether such profound trust can be placed in any group of professionals is another question.

The second way the Netherlands deals with the issue of competence is by asserting that the nature of unbearable suffering does not have to be somatic. Severe psychiatric suffering is sufficient to allow euthanasia, as established in the Chabot case in 1994, in which Dr Chabot gave a lethal injection to a female patient suffering from severe depression and was disciplined only for not consulting another physician.<sup>2</sup> Hence, whether the euthanasia request is “well-considered” by a competent patient becomes a moot

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point; it is the physician who is ultimately responsible for a “well considered” decision to euthanize someone.

### Autonomy

Euthanasia also violates the principle of autonomy, or self-determination, and therefore contradicts the claim of euthanasia proponents who say we all have the “right to die.” Allowing euthanasia does not mean that the patient is allowed to die at his or her own choosing; it means that the physician is allowed to cause the death of the patient.<sup>1</sup> In other words, it is not a right that an individual enjoys, but the granting of permission to another to transgress. First, the patient is inherently vulnerable because of his or her position within the medical hierarchy. The patient relies on the physician not only for the evaluation of competence after the prognosis, as explained above, but for the prognosis itself. For example, the physician’s declaration that no hope exists for improving the patient’s pain management will determine what happens, regardless of whether the possibility of pain relief exists, unknown to the physician.

In the Nancy B. case, a female patient hospitalized in Quebec was desolate and dependent, and requested that her respirator be removed. The Coalition of Provincial Organizations of the Handicapped (COPHO) questioned whether Nancy B. was truly offered or given clear information about achievable quality of life experienced by people living in the community with mechanical ventilation.<sup>6</sup> In this case, her autonomy was compromised by her intellectual submission to the profession of medicine represented by the physician.

More subtly, euthanasia is inherently a public act as it encompasses the right to enlist the aid of a physician; every time a patient is euthanized, he or she puts the physician, another individual, in a position of committing homicide. Since the act is irreversible, the social and moral

responsibility rests on the physician, in addition to the legal responsibility of having to report to the coroner and being investigated for possible foul play. The result is that, according to the Dutch pro-euthanasia attorney Sutorius, “many physicians do not report euthanasia cases as the law

Legalization of euthanasia not only increases the likelihood that the practice of euthanasia will be abused for economic gain, but also that a patient may feel “obligated” to die. One British study, for example, reveals that relatives, friends, neighbors, and health care officials were more interested in

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requires, although the percentage of those who do is climbing rapidly.”<sup>7</sup> The increased report rate aside, no foolproof legal system can prevent physicians from simply reporting a “natural” death to prevent prosecution for euthanasia performed without the patient’s explicit request. Such situations constituted 55% of cases according to the Rummelink Report in 1991.<sup>8</sup> To say that euthanasia merely allows the patient to exercise an individual right is contradictory because this “right” is never individual.

### Beneficence

Euthanasia is not an act of beneficence, even if it may have benefits. Regardless of the extent of palliative care measures, some suffering will continue to be unbearable for individuals who have less capacity to cope with the experience than others, especially those in socially vulnerable positions.<sup>6</sup>

Euthanasia offers great financial incentives for those who take care of the suffering, including the patient’s family and the health care system.<sup>9</sup>

euthanasia than patients. Also, rather than fearing pain, patients commonly fear being dependent and being a burden to relatives, and this is more likely to be the reason for requesting euthanasia.<sup>10</sup> Moreover, practice of euthanasia assigns social worth and accordingly identifies those with the least “value,” who have little power to defend their positions in society, as those who may be euthanized.<sup>6</sup>

In the Netherlands, euthanasia has become allowed in one case after another because there is no legal distinction between unbearable sufferings from physical pain and from a psychological disorder, or between the position of an adult and of a child.<sup>11</sup> Recent changes in the Dutch legislation that embrace euthanasia for newborn babies and sick children—those with no power to give an informed consent—reflect the ever-expanding limits of what is socially acceptable.<sup>12</sup> At the same time, the social capacity to accept suffering is on the decline, a trend that is discussed even less than who may be euthanized next.

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Even though the health care system in Canada may lack the features thought to have made the legalization of euthanasia possible in the Netherlands (intimate physician-patient relationships, extensive palliative care,

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universal home-based medical treatment, and relative homogeneity of opinions among practising physicians and the public regarding euthanasia), the practice still has its proponents here. However, euthanasia is inherently not a right to be exercised. Not only does euthanasia violate the principles of competence, autonomy, and beneficence, it also changes what we see as socially permissible. Worst of all, legalized euthanasia puts people who are suffering and vulnerable at risk, and no legal safeguard can prevent abuse against this group in the name of “a right to die.”

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