

Defending the Council of Europe's Opposition to Euthanasia

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ABSTRACT: The concerted campaign around the globe to legalize euthanasia and/or physician-assisted suicide is one of the greatest contemporary challenges facing the pro-life movement. The campaign for change has scored some successes, notably in the Netherlands, Belgium, and Oregon. But it has suffered even more reverses, particularly when the weaknesses of the arguments for reform have been convincingly exposed. Pro-life academics have a significant role to play in exposing those weaknesses. This paper illustrates the inadequacy of those arguments in the context of a recent, and unsuccessful, attempt to push Europe toward legalization.

In the ongoing international debate about the legalization of euthanasia, a significant point of reference has been the recommendation against legalization passed in 1999 by the Parliamentary Assembly of the Council of Europe.¹ Recommendation 1418 urged member states “to respect and protect the dignity of terminally ill or dying persons in all respects.”² To this end it recommended a trio of means:

¹ “Protection of the Human Rights and Dignity of the Terminally Ill and the Dying,” Council of Europe, Recommendation 1418 (1999). Available at: <http://assembly.coe.int/Documents/AdoptedText/ta99/erec1418.html>. The Council of Europe, which should not be confused with the European Union, was established in 1949 in order *inter alia* to defend human rights.

² *Ibid.*, at para. 9.

- recognizing and protecting a terminally ill or dying person's right to comprehensive palliative care...;
- protecting the terminally ill or dying person's right to self-determination...;
- upholding the prohibition against intentionally taking the life of terminally ill or dying persons.³

In relation to this third means it added:

recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the 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.”⁴

More recently, moves have been made to revise the Council position. In September 2003 a Report entitled “Euthanasia” was passed by a narrow majority of the Council's Social, Health and Family Affairs Committee.⁵ The Report comprised a Draft Resolution (of nine paragraphs) and an Explanatory Memorandum (of sixty-three paragraphs). The Memorandum was written by Mr. Dick Marty, a “radical-liberal” member of the Parliamentary Assembly and the Committee's Rapporteur. In April 2004 the Parliamentary Assembly voted to send the report back to the Social, Health and Family Affairs Committee for reconsideration.⁶ A revised report was produced in February 2005.⁷ This chapter will consider these reports in turn.

³ Ibid.

⁴ Ibid.

⁵ “Euthanasia Report of the Social, Health and Family Affairs Committee of the Council of Europe.” 10th September 2003 (Doc. 9898). <http://assembly.coe.int/Documents/WorkingDocs/Doc03/EDOC9898.htm> (“Marty I”).

⁶ <http://www.coe.int/NewsSearch/InternetNewsSearchDateKW.asp?lmLangue=1&qNewsExpMonth=4&qNewsExpYear=2004&KW=marty&Submit=Go>

⁷ “Assistance to Patients at End of Life,” Report of the Social, Health and Family Affairs Committee. 9th February 2005 (Doc. 10455) <http://assembly.coe.int/Documents/WorkingDocs/Doc05/EDOC10455.htm> (“Marty II”).

The Marty Report (2003)

THE REPORT'S REASONING AND RECOMMENDATIONS

The Report stated that some doctors practiced active, voluntary euthanasia upon or assisted in the suicide of terminally-ill patients who experienced "constant, unbearable pain and suffering without hope of any improvement."⁸ It added that this practice was usually "confined to the shadows of discretion or secrecy," that decisions could be taken in an arbitrary manner, that pressures from the family could be more pernicious "if exercised in the dark and beyond any procedures or control," and that it was "this reality" that carried "the greatest risk of abuse."⁹ Further, penal and professional sanctions were very rare. Hence, there was a "striking divergence" between law and practice that had to be reconciled if respect for the rule of law were to be maintained.¹⁰ The closure of this gap was one reason, it claimed, why legislation was passed in 2002 in the Netherlands and in Belgium to permit voluntary euthanasia subject to "rigorously regulated and controlled conditions." Such legislation was designed:

to bring such practices out of the grey area of uncertainty and potential abuse by establishing strict and transparent procedures, mechanisms and criteria which doctors and nursing staff have to observe in their decision-making.¹¹

Further, it was difficult to distinguish ethically between active voluntary euthanasia and the withholding or withdrawal of life-sustaining treatment when it was known that, as a result, the patient would die sooner, which the Report described as "passive euthanasia."¹² The Report went on:

⁸ Marty I (Draft Resolution) para. 1.

⁹ *Ibid.*, at para. 2.

¹⁰ *Ibid.*, at para. 3.

¹¹ *Ibid.*, at para. 4.

¹² *Ibid.*, at para. 5.

Nobody has the right to impose on the terminally ill and the dying the obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it.¹³

Its argument continued that we now respected “a person’s choice to take their own life” and avoided making value judgments about it, a development that could in no way be interpreted as a devaluation of human life. Moreover, palliative care could not take away unbearable pain and suffering in all cases and, in any event, the issues went beyond the alleviation of pain:

¹³ *Ibid.*, at para. 7.

the degree of patients' own suffering, including mental anguish and loss of dignity that they feel, is something that only they can assess. Individuals suffering in the same situation may take different end-of-life decisions, but each human being's choice is deserving of respect.¹⁴

In light of the above considerations, the Draft Resolution recommended that member states

- collect and analyse empirical evidence about end-of-life decisions...;
- promote public discussion of such evidence...;
- promote comparative analysis taking into account in particular the results of the legislation in the Netherlands and Belgium, "notably their effects on practice in the matter of euthanasia" and, in the light of the evidence and public discussion,
- consider whether legislation should be envisaged, where it has not already been introduced, to exempt from prosecution doctors who agree to help terminally-ill patients undergoing constant, unbearable pain and suffering without hope of any improvement in their condition, to end their lives at their persistent, voluntary and well-considered request, subject to prescribed rigorous and transparent conditions and procedures.¹⁵

SOME CRITICISMS

The Report was flawed, not least because it repeatedly overstated the arguments for legalization and downplayed or ignored the arguments against.

(a) *The Rule of Law*

¹⁴ Ibid., at para. 8.

¹⁵ Ibid., at para. 9.

The Report claimed that the rule of law supported legalization. However, just as the opening paragraph of Recommendation 1418 noted that it is the vocation of the Council of Europe “to protect the dignity of all human beings and the rights which stem therefrom,” so too the rule of law affords protection to all citizens, recognizing their fundamental equality-in-dignity. Just as no one is above the law, so no one is beneath the law. A law permitting voluntary euthanasia would, for the first time, allow certain private citizens to kill other private citizens on the basis of the arbitrary judgment, historically denied in Western law and medical ethics, that they would be better off dead. In short, the rule of law, to which the arbitrary exercise of power (and especially power over life and death) is repugnant, surely tells not for but against legalization.

(b) *“Closing the Gap”*

The argument that there is a “striking divergence” between the law and medical practice and that the gap must be closed if respect for the rule of law is to be maintained is unconvincing. First, the assertion that there is a “striking” discrepancy between law and practice is controversial. Obtaining reliable data on the incidence of the offenses of murder and assisted suicide by medical practitioners is, not surprisingly, difficult. The surveys cited by the Report that allegedly demonstrate a “striking” discrepancy in countries where euthanasia and assisted suicide are illegal must be read with caution. For example, the Report pointed out that, according to a survey of UK doctors,¹⁶ almost 60% replied that they had been asked to hasten death and that 32% had complied. These are not insubstantial figures. However, they require some qualification. The 60% includes 14% who were asked to let the patient die “through deliberate inaction,” which the survey defined as “passive euthanasia.” And the 32% who said that they had taken active steps to end a patient’s life represented only 9% of all of the doctors who had been sent a questionnaire. Nor did the survey ask how often euthanasia had been performed. Moreover, unlike the three comprehensive surveys into end-

¹⁶ B. J. Ward and P. A. Tate, “Attitudes among NHS Doctors to Requests for Euthanasia,” *British Medical Journal* 308 (1994): 1332.

of-life decision-making in the Netherlands that have been carried out by Professor van der Maas *et al.* since 1991, the UK survey, as its definition of “passive euthanasia” indicates, did not consistently define “euthanasia” in terms of the *intentional* hastening of death, which may have led to some confusion. Nor did the UK survey involve interviews with doctors, something that van der Maas found important in clarifying the thinking of his respondents in distinguishing euthanasia from other end-of-life decisions.¹⁷ Further, another UK survey, commissioned by the

¹⁷ J. Keown, *Euthanasia, Ethics and Public Policy* (Cambridge UK: Cambridge Univ. Press, 2002), p.94 n22. The three surveys are: P.J. van der Maas, J.M.M. van Delden, L. Pijnenborg, *Medische beslissingen rond het levenseinde. Het onderzoek voor de Commissie onderzoek medische praktijk inzake euthanasia* (The Hague: SDU Uitgeverij Plantijnstraat, 1991); G. van der Wal, P.J. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde. De praktijk en de meldingsprocedure* (The Hague: SDU Uitgevers, 1996); G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen, and P.J. van der Maas, *Medische besluitvorming aan het einde van het leven: De praktijk en de toetsingprocedure euthanasiae* (Utrecht: De Tijdstroom, 2003). For an analysis of the first two surveys, see J. Keown, *op. cit.*, Part III. For an analysis of the

BBC and involving a sample of health professionals twice as large as the survey cited by the Report, disclosed that only 4% had assisted suicide, either by providing drugs or advice.¹⁸ Similarly, a US survey found that only 6% of physicians there had performed euthanasia or assisted suicide, the author of the survey concluding that it was a “rare” event.¹⁹ And Professor van der Maas has written that the proportion of deaths in the US from euthanasia and physician-assisted suicide is likely to be “small.”²⁰

third, see R. Fenigsen, “Dutch Euthanasia: The New Government Ordered Survey,” *Issues in Law and Medicine* 20 (2004): 73.

¹⁸ S.A.M. McLean and A. Britton, *Sometimes a Small Victory* (Glasgow: Institute of Law and Ethics in Medicine, 1996) App. III, Table 17, at pp. 31-32.

¹⁹ D.E. Meier *et al.* “A National Survey of Physician-Assisted Suicide and Euthanasia in the US,” *New England Journal of Medicine* 338 (1998): 1193.

²⁰ P.J. van der Maas and L.L. Emanuel, “Factual Findings” in *Regulating How We Die*, ed. L.L. Emanuel (Cambridge MA: Harvard Univ. Press, 1998), p. 151.

Secondly, even if there *were* a serious discrepancy between the law and the practice of voluntary euthanasia, it would not follow that the gap should be narrowed by relaxing the law. Many criminal laws are regularly broken. Some prohibitions, such as the law against possessing hard drugs, are frequently breached without detection, but it does not follow that the law should therefore be relaxed to accommodate those who snort cocaine. The Report seemed simply to assume that if voluntary euthanasia was practiced, it should therefore be condoned.²¹ But what if, as much evidence suggests,²² voluntary euthanasia is carried out on patients whose autonomy is compromised by clinical depression

²¹ Revealingly, the Draft Resolution did not propose that in the light of whatever evidence might emerge from studies into the incidence of euthanasia there be a review of various options, including improvement in the provision of quality palliative care and/or tighter enforcement of the criminal law. It proposed solely that member states consider legalizing euthanasia. That this appeared to be the Report's not too skillfully hidden agenda was also suggested by its underlying argument in principle for reform. For, if there is a right to voluntary euthanasia, why should it not be recognized by law, whatever the evidence about its current incidence?

²² See generally, New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (Albany NY: Health Education Services, 1994); J. Keown, op. cit.

or whose suffering could be alleviated by palliative care? In other words, why did the Report seem to assume that the problem with the alleged gap between the criminal law and medical practice lay with the former rather than the latter, that the law was bad and the practice good? Was Dr. Kevorkian a model of good medical practice? Of the sixty-nine people he assisted in suicide, only a quarter were terminally-ill.²³ Why assume that the law should accommodate Kevorkians in practice rather than in prison?

Thirdly, if the law against voluntary euthanasia is occasionally broken, so too is the law against non-voluntary euthanasia (both in jurisdictions where, like the UK and US, voluntary euthanasia is illegal and in jurisdictions, notably the Netherlands, where it is legally permitted). If the Report believed the gap between the law and practice of voluntary euthanasia militated in favor of legalization, then why not the gap between the law and practice of non-voluntary euthanasia?

Fourthly, relaxing the law to allow euthanasia to be performed in certain circumstances would not mean that euthanasia would be performed only in those circumstances. Legislative proposals for regulating euthanasia typically set out procedural requirements aimed at *monitoring* the practice of euthanasia; they do not seek to *prohibit* the practice of euthanasia that fails to satisfy those requirements. In other words, the potential for abuse, for breaking the law against murder and assisted suicide, remains. Indeed, it may well be that legalizing euthanasia in certain circumstances would result in euthanasia in other circumstances being regarded by the criminal justice system as less, not

²³ L. Roscoe, J. Malphurs, L. Dragovic, and D. Cohen, "Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998," *New England Journal of Medicine* 343 (2000): 1735-36 (Correspondence).

more, serious, that is, as a lower, not a higher priority. It is noteworthy that in the Netherlands *very* few doctors have been prosecuted for breaching the requirements for lawful euthanasia and that those doctors who have been convicted of murder have typically been dealt with by the courts with striking leniency.

Finally, advocates of legalization often allege that in countries where voluntary euthanasia is illegal, there is a higher incidence of *non*-voluntary euthanasia than in countries where voluntary euthanasia is lawful and that legalizing voluntary euthanasia would reduce the incidence of non-voluntary euthanasia. Euthanasia advocates argue that doctors are currently “forced” to practice non-voluntary euthanasia precisely because voluntary euthanasia is unlawful. This is unpersuasive. If voluntary euthanasia is unlawful, then so too is non-voluntary euthanasia. How can the same prohibition that deters them from performing the former encourage them to perform the latter? Legalizing voluntary euthanasia, far from discouraging the non-voluntary variety, would surely do the opposite. For it would send out a signal that killing patients, at their request, can benefit them. Many doctors would then reasonably ask why patients should be denied this benefit merely because they are unable to request it.

(c) *The Dutch Experience*

The Report implicitly endorsed the Dutch and Belgian legislation. It described the procedures prescribed by the legislation as “strict and transparent” and claimed that the Dutch surveys have shown that “close monitoring” is possible. There is a problem with this: the Dutch surveys have shown precisely the opposite.

For example, the so-called “strict and transparent procedures” in the Dutch legislation (which essentially enshrine guidelines that have been in operation since 1984 when the Dutch Supreme Court first declared voluntary euthanasia lawful) include a requirement for doctors to report all cases to the authorities. The three Dutch surveys carried out by Professor van der Maas *et al.* have demonstrated that *a clear majority of*

*cases has been covered up by doctors.*²⁴ In other words, in the bulk of cases there has not even been an opportunity for control. Even in relation to the minority of cases that *has* been reported, the report is filed by the doctors, who are hardly likely to disclose that they have breached the guidelines. The surveys have indicated, moreover, that failure to report is by no means the only important requirement that has been widely ignored, with virtual impunity, by Dutch doctors. In breach of the requirement for an “explicit request” by the patient, thousands of Dutch patients (mainly, but not exclusively, incompetent) have been intentionally killed without request. Indeed, the survey authors have remarked that *it is the responsibility of patients to make it clear if they do not want to be euthanized should they become incompetent.*²⁵ So much, then, for euthanasia being confined to those who explicitly request it. Mr. Marty cited these surveys²⁶ but made no mention of this revealing remark nor of many of the surveys’ other disturbing revelations. Again, the conspicuous failure of the Dutch regulatory mechanisms over the past twenty years has been repeatedly demonstrated by

²⁴ J. Keown, *op. cit.*, at pp. 113, 132; R. Richard Fenigsen, *loc. cit.*, at pp.73, 77.

²⁵ Dr. Richard Fenigsen translates the relevant passage on p.201 (ll. 22-27) of the third survey (G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen, and P.J. van der Maas, *op. cit.*) as follows: “Due consideration should be given to the question how termination of life without explicit request can be prevented. It should be the responsibility of the patients, (their) next of kin, the doctors, the nurses, and the management, to clarify, well in advance, orally and in writing what are the wishes of the patient concerning the end of his life; for example, as a statement of will or as advance care planning.” [“Het verdient overweging om na te gaan op welke wijze levensbeeindigend handelen zonder uitdrukkelijk verzoek kan worden voorkomen. Hier ligt een verantwoordelijkheid voor patienten, naasten, artsen, verpleging en management, om vroegtijdig, mondeling en schriftelijk, duidelijkheid te creeren over de wensen van de patient met betrekking tot diens levenseinde, bijvoorbeeld door middel van wilsverklaringen en advance care planning.”] I am grateful to Dr. Fenigsen for this translation (Personal communication, 31st January 2005).

²⁶ Marty I (Explanatory Memorandum) at para. 20-24.

commentators of whose work Marty seems oblivious.²⁷ Also notably absent from the Report is any reference to the serious concerns that have been expressed, not least about the non-voluntary euthanasia of disabled newborns, by the UN Human Rights Committee.²⁸

In short, there is indeed a “striking divergence,” but it is between the law and the practice of euthanasia in the Netherlands. Another gap, hardly less striking, is that between the reality of Dutch practice and its representation by the Marty Report.

²⁷ See, for example, C.F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York NY: Free Press, 1991); H. Hendin, *Seduced by Death: Doctors, Patients and Assisted Suicide* (New York NY: W.W. Norton 1998); J. Keown, op. cit. The focus in this chapter is on the Dutch rather than the Belgian experience, partly because Dutch law has approved euthanasia for much longer (and there is accordingly more evidence about Dutch practice) and partly because the Belgian law largely emulates the Dutch law.

²⁸ [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/CCPR.CO.72.NET.En?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CCPR.CO.72.NET.En?Opendocument) para. 5-6.

(d) Changing Attitudes toward Suicide

The Report also presented a contentious interpretation of changing attitudes to suicide. In England, for example, the decriminalization of suicide by the Suicide Act 1961 reflected, as the Government of the time made abundantly clear,²⁹ not a condonation of suicide but a realization that criminal punishment was an inappropriate way of dealing with the suicidal. As Lord Bingham confirmed in the *Pretty* case, in which the House of Lords rejected an alleged right to assisted suicide, the Suicide Act 1961 conferred no right on anyone to commit suicide.³⁰

(e) Public Opinion

The Report claimed that public opinion polls show a majority in favor of legalization. Such polls must, however, be read with no little reserve. A report commissioned by the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill concluded that research conducted hitherto into public health sector attitudes to the legalization of euthanasia was

limited in value and cannot be accepted at face value as an authentic account of

²⁹ J. Keown, *op. cit.*, at pp. 64-66.

³⁰ *Regina (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department Intervening)* [2002] 3 WLR 1598. His Lordship stated (at paragraph [35]): "Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success. But while the 1961 Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide, as section 2(1) makes clear."

opinion within the United Kingdom. The subject matter is extremely complex and sensitive and therefore very challenging for anyone attempting to gain a meaningful understanding of opinion.³¹

It added:

This is particularly the case with regard to the attitudes of the general public, whose real views on euthanasia are clearly obscured by a lack of information on the subject and by the lack of opportunity to reflect in an informed way upon the implications of any change in the law for themselves and for society.³²

In any event, even if the Marty Report's claim were true, it could hardly be allowed to dictate law and public policy any more than a finding that a majority of people favor capital punishment.

(f) *Equating Euthanasia with Non-Treatment*

³¹ *Report of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill*, HL Paper 86-I (2005), para. 232.

³² *Ibid.*

The Report's equation of "euthanasia" with the withdrawal of life-sustaining treatment when the shortening of life is foreseen, which it described as "passive euthanasia," is misleading. The Report defined "euthanasia" as "any medical act intended to end a patient's life at his or her persistent, carefully considered and voluntary request in order to relieve unbearable suffering."³³

How, then, can the withdrawal of treatment when the doctor merely *foresees* that it will shorten life count, on the Report's own definition, as "euthanasia"? For one thing, it is doubtful whether withdrawal, and particularly withholding, can properly be characterized as an "act."³⁴ For another, even if there were foresight of death, it would not follow that there was also an intention to end life. For the report to conflate these two forms of conduct, which there are cogent ethical reasons to regard as distinct, invites confusion. Moreover, by defining "euthanasia" as "active, voluntary euthanasia," the Report adopted the controversially narrow Dutch definition. One danger of this definition is that it can be used (as it has been in the Netherlands) to deflect discussion of non-voluntary and involuntary euthanasia on the ground that they are not "euthanasia" and therefore lie outside the boundaries of the euthanasia debate.

(g) *Misrepresenting the Case against Euthanasia*

³³ Marty I (Explanatory Memorandum) at para 8.

³⁴ Yet Marty boldly asserted that withdrawal is "an act of commission, if ever there was one." *Ibid.*, at para. 59.

The Report stated that opponents of legalization reject the claim that “each individual, out of respect for his or her dignity and value, has a right to take decisions concerning his or her own life and death in accordance with his or her own values and beliefs, as long as no harm is done to others, and not to have these imposed.”³⁵ It would have been less misleading to have stated that opponents of euthanasia, while supporting the right of patients to make a wide range of decisions concerning their medical treatment, reject *one* decision as being incompatible with the patient’s dignity and value: the decision to be intentionally killed, or to be helped to commit suicide. Moreover, to prohibit that choice does not deny the patient’s dignity but affirms it, just as disallowing other choices that a person may want to make, such as to be executed rather than be imprisoned or enslaved rather than free, equally respects his or her inalienable dignity. The fact that, through depression or pain or loneliness, some patients may lose sight of their worth is no argument for endorsing their misguided judgment that their life is no longer worth living. Were the law to allow patients to be intentionally killed by their doctors, the law would be accepting that there are two categories of patients: those whose lives are worth living and those who are better off dead. What signal, moreover, would that send out to the sick, the elderly, the disabled, and the dying?

The Report went on to imply that opponents of euthanasia are imposing on the terminally ill “the obligation to live out their life in unbearable suffering and anguish....”³⁶ On the contrary, many of the leading opponents of euthanasia, such as the late Dame Cicely Saunders, foundress of the hospice movement, have devoted their lives to the alleviation of suffering and anguish. The standard case against euthanasia recognizes the right of patients to refuse treatments because they are futile or too burdensome, and to be treated with palliative drugs, even if

³⁵ Ibid., at para. 55

³⁶ Ibid., at para. 56.

it is foreseen that death will come sooner. It does *not* hold that life should be preserved at all costs; that is a cheap caricature.

COUNTER-ARGUMENTS NOT MET

The Report glossed over several important counter-arguments. For example, it mentioned but nowhere rebutted the counter-argument that legalizing voluntary euthanasia leads as a matter of practice and of logic to non-voluntary euthanasia. This counter-argument runs that the slide will occur, as a matter of practice, because “safeguards” to prevent it cannot be made effective and, as a matter of logic, because the case for voluntary euthanasia for the terminally ill contains the seeds of its own extension to those who are not terminally ill or to those who cannot request it. The failure of “safeguards” as a matter of *practice* is amply demonstrated by the Dutch experience. That experience also illustrates the force of the *logical* “slippery slope,” which is a product of the unresolved tension in the argument for voluntary euthanasia between patient autonomy and patient welfare.

(a) *Respect for Patient Autonomy*

The Report stated that opponents of euthanasia dismissed “the individual’s right to take decisions concerning his or her own life and death in accordance with his or her own beliefs and values, as long as no harm is done to others.”³⁷ It concluded that consideration should be given to exempt from prosecution doctors who agree to help “terminally-ill patients undergoing constant, unbearable pain and suffering without hope of any improvement in their condition, to end their lives at their

³⁷ *Ibid.*, at para. 62.

persistent, voluntary and well-considered request...."³⁸

³⁸ Ibid. (Draft Resolution) at para. 9(iv)

If, however, there is a right to make decisions concerning life and death in accordance with one's own values and beliefs, why should euthanasia not be available to *any* autonomous person who believes for whatever reason (terminal illness, chronic physical or mental illness, "tiredness of life," bereavement, divorce, unemployment, and so on) that their life is no longer "worth living"? By imposing conditions such as "terminal illness" on candidates for euthanasia, why was the Report not denying each individual's "right to take decisions concerning his or her own life and death in accordance with his or her own values and beliefs"? Interestingly, the former Dutch Health Minister, Mrs. Borst, a leading defender of the Dutch euthanasia regime, has stated that she thinks the elderly should be able to obtain suicide pills that they could take if they simply felt "tired of living."³⁹ Mr. Marty could not claim to be unaware her viewpoint: it was pointed out by the author in his response to Mrs. Borst's speech at a hearing on euthanasia held by his Committee in Paris in 2002.⁴⁰

(b) *Respect for Patient Welfare: The Life "Not Worth Living"*

No responsible doctor would kill a patient merely because the patient requested it, however autonomously, any more than a responsible doctor would amputate a healthy leg just because the patient requested it. Indeed, in the Netherlands doctors refuse many autonomous requests for euthanasia. The doctor grants the request only if the *doctor* judges that the patient is right in thinking that death would be a benefit. But if the doctor thinks that he or she can make this judgment (that the patient would be better off dead) in relation to a patient who asks for euthanasia, why cannot the doctor make that decision in relation to a patient in the same situation who is unable to request it? In other words, if death would benefit the patient, why should it be denied the patient merely because of incompetence? Illustrating the force of this counter-argument, in 1996 two Dutch Courts of Appeal, adapting the reasoning

³⁹ CNN.COM/WORLD 14th April 2001.

⁴⁰ A hearing that, like the Report, was unbalanced: invited speakers in favor of legalization markedly outnumbered those against.

previously used by the courts to justify voluntary euthanasia, held it lawful for doctors to give lethal injections to disabled babies.⁴¹ More recently, the public prosecution service has endorsed guidelines, passed by the Dutch Paediatric Society, permitting non-voluntary euthanasia of certain neonates.⁴²

(c) *Expert Committees*

Mr. Marty's Explanatory Memorandum concluded:

⁴¹ J. Jochemsen, "Dutch Court Decisions on Nonvoluntary Euthanasia Critically Reviewed" *Issues in Law & Medicine* 13/4 (1998): 447.

⁴² T. Sheldon, "Dutch Doctors Adopt Guidelines on Mercy Killing of Newborns" *British Journal of Medicine* 331 (2005): 126.

As a lawyer and a legislator, I note that all over the world, doctors are ending the lives of patients, often in secrecy and with a sense of guilt. The law seems to want to ignore this fact of life, whereas it ought to have the courage to address it. Decriminalising euthanasia, rather than keeping the ban, might enable us to better supervise it and also prevent it.⁴³

Mr. Marty seemed unaware that around the world the case for legalizing voluntary euthanasia has been considered by “lawyers and legislators” time and again and that they have, with few exceptions, rejected that case. He omitted even to mention important reports such as that of the New York State Task Force (1994), whose members, both pro- and anti-euthanasia in principle, unanimously rejected legalization on the ground that it would be socially disastrous.⁴⁴

The Marty Report appeared in September 2003. It was scathingly criticized by the Council's Committee on Legal Affairs and Human Rights later that month.⁴⁵ Mr. Kevin McNamara, this Committee's Rapporteur, called in his Explanatory Memorandum for the Parliamentary Assembly to reaffirm Recommendation 1418 rather than to adopt

⁴³ Marty I (Explanatory Memorandum) at para. 62.

⁴⁴ See n22, *supra*.

⁴⁵ “Euthanasia: An Opinion by the Committee on Legal Affairs and Human Rights.” 23rd September 2003 (Doc 9923). Rapporteur: Mr Kevin McNamara, U.K., Socialist Group. (“Legal Opinion”). <http://assembly.coe.int/Documents/WorkingDocs/Doc03/EDOC9923.htm>.

the Marty Report.⁴⁶ The Marty Report was debated in April 2004 by the Parliamentary Assembly.⁴⁷ The Assembly decided not to vote on the text and charged the Social, Health and Family Affairs Committee to prepare a new text bringing together the widely diverging viewpoints expressed in the debate. In February 2005, the Committee produced a revised report.

MARTY REVISED (2005)

⁴⁶ Legal Opinion (Explanatory Memorandum) para. 4.

⁴⁷ <http://www.coe.int/NewsSearch/InternetNewsSearch.asp?KW=marty+&lmLanguage=1&Submit=Search&L>.

The revised Report comprised a Draft Resolution of six paragraphs and an Explanatory Memorandum by Mr. Marty running to fifty-one paragraphs and four appendices (outlining respectively the law in the Netherlands, Belgium, Switzerland and proposed legislation in France).⁴⁸ The revised Draft Resolution was noticeably more conservative than the original. The original's focus on euthanasia, including its explicit recommendation that member states consider the legalization of euthanasia, was replaced by an emphasis on the promotion of palliative care and on the prevention of euthanasia in secret. However, not least when read in the light of the accompanying revised Explanatory Memorandum (which was, by contrast, barely amended), the revised Draft Resolution remained open to serious objection.

THE REVISED DRAFT RESOLUTION

The more conservative tone of the Report was reflected in its change of title, from "Euthanasia" to "Assistance to Patients at End of Life." Moreover, its opening paragraph affirmed that it was "important and necessary" to reaffirm the "fundamental principle" in Recommendation 1418 of protecting the dignity and rights of all human beings. The paragraph continued: "The Assembly takes this opportunity to reiterate

⁴⁸ "Assistance to Patients at End of Life," Report of the Social, Health and Family Affairs Committee, 9th February 2005 (Doc. 10455) <http://assembly.coe.int/Documents/WorkingDocs/Doc05/EDOC10455.htm> ("Marty II").

its unwavering belief that this principle means, *inter alia*, that it is forbidden to cause someone's death deliberately."⁴⁹

However, the remainder of the Draft Resolution proceeded, by leaving open the option of legalizing euthanasia, to saw off the branch on which this reaffirmation sat. No sooner had the first paragraph of the Draft Resolution reaffirmed Recommendation 1418's opposition to intentional killing than paragraph two stated that the Assembly could not ignore certain facts, such as that the Netherlands and Belgium had enacted laws that permitted euthanasia; that Bills to legalize it had been introduced in "numerous" other countries; that in several countries opinion polls suggested a majority favored legalization; and that euthanasia was practiced in countries where it was illegal "in proportions well in excess of what was previously believed." Further undermining the Draft Resolution's stated opposition to intentional killing, paragraph three stated that euthanasia was a "very delicate" issue that touched on the "moral, religious and cultural values of our societies" and that it therefore followed that the solution to the problem "cannot be the same for all countries." It was "essential" that these "different sensitivities" be respected "while reiterating the inviolable principle that human rights and dignity must be respected."

⁴⁹ Marty II (Draft Resolution) at para. 1.

Paragraph four recommended that member states should implement a genuine policy of assistance to patients at the end of life that did not cause them to want to die, as by promoting palliative care (including care in their own homes) and the avoidance of superfluous treatment. However, paragraph five proposed that “greater transparency” be achieved so as to reduce as far as possible the practice of euthanasia “in secret or in a legal vacuum” and that procedures be introduced, where they did not already exist, clearly defining the responsibilities of medical and nursing staff and ensuring the traceability of all decisions, thus facilitating effective monitoring. That the Draft Resolution was open to the legalization of euthanasia became even clearer in paragraph six, which reiterated that in view of the “diversity of cultural and religious sensitivities” among member states, it was “hardly possible to recommend a universal model for all to follow” and that member states should analyze the Dutch and Belgian experience and relevant Bills currently being discussed in other countries, and should “prevent euthanasia from developing in a shroud of secrecy because of legal uncertainties or outdated norms.”⁵⁰ We should note that it does not say to prevent euthanasia from developing, but to prevent euthanasia from developing in secrecy.

In short, the Draft Resolution’s first paragraph was progressively undermined by its subsequent paragraphs. Moreover, neither it nor the accompanying Draft Explanatory Memorandum pointed out why, if euthanasia was a “very delicate” issue that touched on the “moral, religious and cultural values of our societies,” it therefore followed that the solution to the problem could not be the same for all countries. Until very recently it *has* been the same and, with few exceptions, still is. And is not capital punishment an issue that also touches on moral and cultural values but that is nevertheless prohibited by the Council of Europe?

The Draft Resolution’s suggestion that euthanasia is practiced in

⁵⁰ Ibid., at para. 6(v).

secret because of “legal uncertainties and outdated norms” rings hollow. Leaving aside that we are not told what these “uncertainties” are, nor why they are “outdated,” nor how they promote secret euthanasia, the undisputed reality is that the legal norms in the Netherlands, which are of recent vintage, have conspicuously failed to prevent the practice of euthanasia in secret.

That the revised Report remained sympathetic to the legalization of euthanasia, despite its opening paragraph, becomes even clearer when the revised Draft Resolution is read in the light of the revised Explanatory Memorandum.

THE REVISED EXPLANATORY MEMORANDUM

As has been noted, the revised Draft Resolution was more conservative in tone than its original version. Not so the revised Explanatory Memorandum (again drafted by Mr. Marty), which remained little more than a crude polemic for legalization.⁵¹ Given that the revised version is vulnerable to the same objections leveled above at the original version,

⁵¹ In his conclusions Mr. Marty commented that the answer to the questions he raised about patient autonomy, dignity, and the practice of secret euthanasia should “not necessarily” be the legalization of euthanasia, at least as a solution applicable to all members states (*ibid.*, explanatory memorandum, at para. 49). It seems clear, however, that “not necessarily” for “everyone” did not mean “not” for “anyone.”

little remains to be said. Three additional points, however, may be made.

First, the revised Memorandum criticized “the silence in which this issue is more often than not enshrouded”⁵² and announced that a “long-repressed debate” had now been launched in several countries.⁵³ Mr. Marty’s understanding of the history of the subject is no sounder than his grasp of its other dimensions. The truth of the matter is that the legalization of euthanasia has been debated since the nineteenth century. Bills were introduced in the US from the early twentieth century and in the UK from the 1930s.⁵⁴ The debate has intensified over the last twenty years, not least as a result of the decision of the Dutch Supreme Court in 1984 to permit voluntary euthanasia. The intensification has been reflected by the publication of reports of expert bodies such as the New York State Task Force in 1994⁵⁵ and the House of Lords Select Committees in 1994⁵⁶ and 2005,⁵⁷ by widespread media coverage of the

⁵² *Ibid.*, at para. 12.

⁵³ *Ibid.*, at para. 49.

⁵⁴ E.K. Emanuel, “The History of Euthanasia Debates in the United States and Britain,” *Annals of Internal Medicine* 121/10 (1994): 793.

⁵⁵ See n22, *supra*.

⁵⁶ “Report of the House of Lords Select Committee on Medical Ethics,” HL Paper 21-I (1994).

issue (illustrated by the Diane Pretty case⁵⁸), and by the voluminous academic literature on the subject. So much, then, for the debate being “long-repressed.”

A second point concerns the revised Memorandum’s claim, in relation to the Netherlands and Belgium, that “[t]he initial indications would not seem to point to any increase in the number of cases of euthanasia or any other types of abuse.”⁵⁹ The reality of the matter is that there was a substantial increase in the number of cases in the Netherlands between 1990 and 1995 and that cases of unchecked abuse, from the practice of euthanasia without request to non-reporting, have been numerous.

⁵⁷ See n31, *supra*.

⁵⁸ *Pretty v United Kingdom* (2002) 66 BMLR 147, ECtHR.

⁵⁹ Marty II (Explanatory Memorandum) at para. 51.

A third point concerns the persistence of errors in the revised Memorandum even though they had been exposed by the Legal Affairs and Human Rights Committee. For example, this Committee (rightly) concluded that the Dutch euthanasia surveys had demonstrated “a disturbingly high incidence of euthanasia...without the patient's explicit request and an equally disturbing failure by medical practitioners to report euthanasia cases to the proper regulatory authority.”⁶⁰ Mr. Marty's revised Memorandum did not respond to such objections and persisted in its misrepresentation of the Dutch experience.⁶¹ Similarly, the Legal Affairs Committee urged that the withholding or withdrawal of treatment because, for example, its burdens outweighed its benefits “should not be confused with voluntary active euthanasia or physician assisted suicide where the intention is to accelerate or cause death by withholding or withdrawing treatment.”⁶² Again without meeting this objection, the revised Memorandum maintained its controversial definition of withholding or withdrawing life-support as “passive euthanasia.” Indeed, it even compounded matters by asserting that “euthanasia” was commonly practiced and supported this with a comment by the French Health Minister that many life-support machines were switched off every year! The Minister was further quoted as saying that an end should be brought to this “unacceptable hypocrisy.”⁶³ There is, of course, no hypocrisy in prohibiting intentional killing while allowing the withholding or withdrawal of treatment that is futile or too burdensome. Indeed, it may strike the reader as remarkable that a Report

⁶⁰ Legal Opinion (Conclusions of the Committee) Amendment D.

⁶¹ Marty II (Explanatory Memorandum) at paras. 26-30; 51.

⁶² Legal Opinion (Conclusions of the Committee) Amendment E.

⁶³ Marty II (Explanatory Memorandum) at para. 48 n15.

that affirmed the prohibition on intentional killing while paving the way for its legalization should have accused the present law of hypocrisy.

CONCLUSION

The core argument informing the Marty Report—that because euthanasia takes place illegally the Council of Europe should, in the light of empirical evidence, consider legalizing it so as to “bring it out into the open” where it could be better “controlled”—has been undermined by the evidence from the Netherlands. This is hardly surprising: if some doctors are prepared, when voluntary euthanasia is illegal, to ignore the law of murder that prohibits it, why should they be expected, when it has been legalized, to observe the guidelines that permit it? And, as the Dutch slide down euthanasia’s “slippery slope” confirms, once the rhetorical mask of autonomy is stripped away, the true face of euthanasia is revealed: the judgment that certain patients are better off dead. The Marty Report, in its original and revised versions, is an exercise in failed cosmetic surgery. Indeed, it reads less like an informed report from a Council of Europe Committee and more like a propaganda pamphlet from a euthanasia pressure-group.

On 27th April 2005 the Parliamentary Assembly voted by 138 votes to 26 (with 5 abstentions) to reject the Marty Report.⁶⁴

⁶⁴ <http://www.coe.int/NewsSearch/InternetNewsSearchDateKW.asp?lmLangue=1&qrNewsExpMonth=04&qrNewsExpYear=2005&KW=marty&Submit=Go>