GROUPE EUROPÉEN DE RECHERCHES SUR LA JUSTICE PÉNALE
EUROPEAN RESEARCH GROUP ON CRIMINAL JUSTICE
ΕΥΡΩΠΑΪΚΗ ΟΜΑΔΑ ΕΡΕΥΝΑΣ ΓΙΑ ΤΗΝ ΠΟΙΝΙΚΗ ΔΙΚΑΙΟΣΥΝΗ

DÉLINQUANCE ET INSÉCURITÉ EN EUROPE

CRIME AND INSECURITY IN EUROPE

BRUYLANT
BRUXELLES
2001

TITRE XV

STRUCTURING THE ISSUES IN EUTHANASIA

BY

MARIA CANELLOPOULOU BOTTIS

IONIAN UNIVERSITY

As a lawyer specialized in medical law, I chose to speak of euthanasia. The question of euthanasia lies at the border between medical ethics and criminal law. It is, so to speak, a gray area which the prosecutors usually try not to touch (1). People, also, have all sorts of opinions about euthanasia. The Criminal Codes, still, are sharp : in Greece (2), US, UK and other countries, euthanasia is typically murder, or at least manslaughter.

We talk of euthanasia and what do we think of? A terminally ill patient, too frustrated by a horrible illness, one we would never imagine on ourselves, a patient in fact begging to die. Or else, a patient who the doctors and the family believe would be « better off » dead. The patient may be in a coma, maybe an irreversible one. Still, we must always add to these cases a very large category of patients usually ignored in the legal texts, which are written as if the *adult* terminally ill person is only concerned : the defective newborns. The question of euthanasia, then, arises not only at the end of life of an adult, but also at the beginning. Babies also have been subjected to euthanasia and there have been physicians brave enough as to confess they were the ones who were actively involved with their death (3).

(1) See G. GINEX, « A Prosecutor's View on Criminal Liability for Withholding or Withdrawing Medical Care : The Myth and the Reality », *in Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients*, Doudera & Peters, 1982, p. 205.

(2) In Greece, euthanasia is treated largely as murder, with the exception of art. 300, where there are lighter penalties in case of a terminally ill patient begging to die and killed with his own consent. But this is only a rare case of the whole of the euthanasia possible cases.

(3) R.S. DUFF, A.G. CAMPBELL, « Moral and Ethical Dilemmas in the Special-Care Nursery », *New England Journal of Medicine*, 1973, 289, 17, pp. 890-894.

Now, when we talk of babies dying because a physician or their parents decided that they should, we are normally upset. This, put this way, does not fit into our idea of a democratic society, a state protecting the rights of people — and which right is more valuable than the right to life ? Allow me, though, to note here that there are newborns suffering from terminal illnesses too, not only adults, and there are babies whose life would be judged by a majority of people as completely unbearable — babies who cannot see, hear and whose brain is severely and irreversibly damaged, or babies who will be in excruciating pain for weeks before they die « of natural causes ». To say it bluntly : certainly not babies one would elect for his family. These babies are not the idea people have for a baby — a baby is a wonderful creature, deserving all care and affection possible. I could replace « baby » here with the word « newborn », to avoid, in a way, these images of beauty and love. But we have to be sincere. These defective newborns are still babies.

But then again, the question of euthanasia arises every time a physician gives a no-code order, that is an order « not to resuscitate », also called a DNR order (« do not resuscitate »). In these cases, if a patient suffers for example a cardiac infarct, the health care team will just let the patient die. It could also be a matter of luck : there has been a case where the nurses had to bet on whose physician round the infarct would happen, therefore to bet on the patient's time left, because the alternating doctors disagreed on the DNR order, one writing and the other erasing the order from the patient's chart (4).

As far the issues of euthanasia have not been at all structured and the cases seem like and still different. I would like now to clear the picture, as far as I can and as far as the picture can really be cleared.

A legally and conceptually correct way to distinguish between categories of patients whose cases could be related to euthanasia is the distinction between *competent* and *incompetent* patients. Medical competency is another « painful » question of medical lawyers and ethicists, but for this discussion, we can accept that a patient is competent if he or she can understand medical information and the consequences of medical action or inaction. Roughly, an adult in

(4) M. Van Scoy-Mosher, « An Oncologist's Case for No-Code Orders », *in Legal and Ethical Aspects, op.cit.*, p. 16.

sound mind is competent. A minor is usually not; a newborn is certainly not.

The impact of this difference between patients is in euthanasia cases more than important : a competent patient can, according to the law, *generally* decide if she wants to live or die, whereas an incompetent patient cannot, and a proxy will play the part of the decision-maker there.

I. — Competent Patients and Euthanasia

This is Dr. Kervokian's land. I remind you, as I probably need not, of the infamous « Dr. Death ». Kervokian currently resides as prisoner n. 284797 in Oaks Correctional Facility of Eastlake Minessota, US. That is, he is in prison condemned at last, after three trials, to serve a term of 10-25 years in prison, for the « murder » of Tom Youck. Tom Youck suffered from amyotrophic lateral sclerosis (ALS), a terminal horrible disease which would paralyze him to death. He did not want to wait and see this, so he had Dr. Kervokian help him to die, his wife and brother agreeing that his pain should end. Kervokian injected him, so this was a case of « active euthanasia » (for those who believe that there is a legal difference between active and passive causes of death). So, the prosecutor, usually absent in cases of euthanasia in hospitals, entered the picture. But Kervokian had taped Youck's death and given it to CBS news, *challenging* nationwide the prosecutors to charge him. No one can suppose that doctors engaging everyday in — at least passive — euthanasia will ever have to answer questions before a jury as defendants (5).

No matter how much we may condemn Dr. Kervokian's actions, the question remains. Should a competent patient wanting to end his life be allowed to do so? Is there a right to die? It has been held in the US that a competent patient may refuse treatment, even if this treatment is lifesaving (6). The living wills laws are, in essence,

(5) « ... as a general matter, the legal process is not anxious to intervene when doctors help terminally ill patients in intractable pain take their own lives... », Furrow, Greaney, Johnson, Jost & Schartz, « Medical Law US », *International Encyclopaedia of Laws*, ed. Kluwer, US 186.

(6) Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, rehearing denied, certiorari denied. Bouvia could live more than ten years in a « ... painful existence, endurable only by the constant administration of morphine... », Bouvia *id.* Bouvia was 28 years old, suffering from arthritis and cerebral palsy.

the legalization of this right to die. There are some questions, though, if the patient would direct nutrition and hydration to be withheld. Nutrition and hydration reflect society's utmost limit of care, and living wills laws in the US sometimes do not permit an advance directive of nutrition and hydration withdrawal. The prosecutor may also enter the stage if nutrition and hydration was withheld and a patient starved, in effect, to death (7).

But even if a competent patient may legally ask for « passive » euthanasia, that is to ask for a respirator to be withdrawn, for an antibiotics treatment to be withheld, for an IV line to be disconnected from his body, all this resulting to his death, this has not, as yet, been legally treated equal to a plead to simply kill him. In other words, there is a right to die, but this does not encompass a right to demand from a physician to actively kill a patient. Physician assisted suicide, as it is called, is illegal. What Kervokian does is illegal. He did it at first in Michigan, where aiding suicide was not prohibited; then, when Michigan, to attack him, passed laws making assisted suicide a felony, he moved his activities to other States.

We sense, as lawyers, the troublesome nature of the distinction between active and passive forms of « killing » — in the main part of criminal law, in the law of murder and homicide, there is no such thing : we accept that whoever has a legal obligation to act and to prevent another's death is guilty for his death even if it was the result of an omission and not of a commission. Omission and commission of an act which brought about a criminal result are legally equivalent. It is only psychological that an act seems different than doing nothing : it is only psychological that a physician who sees a patient dying from lack of oxygen and does nothing about it is less guilty than the one who pulls away the oxygen mask, therefore « lets the patient go ».

The right distinction, therefore, is not between « killing » and « letting go », as much as is has gained so much support in the past, but

(7) G. Oakes, « A Prosecutor's View of Treatment Decisions », *in Legal and Ethical Aspects, op. cit.*, p. 199.

in « justifiable killing » and « unjustifiable killing » of the patient (8). The word « kill » may bother you but does it matter how we name it ? Is it better if we rename it as « self-deliverance » or « assisted suicide » ? Again, as in the case of « newborn » and « babies », I do not wish to engage in a lawyers' favorite game, the game of naming things as it suits us. No : it does not matter if we state bluntly that the physician has killed his patient. The question is whether there was justification for this killing.

Anyway, the truth is, as a commentator noticed, that passive euthanasia is « a fait accompli » in modern medicine and to continue arguing if we may « let the patient go » is « as dead as Queen Ann » (9).

But the balance of values here has too many times been misstated and misunderstood. The competing interests, as we see them in texts of judicial decisions or in legal theory, are usually the interest of the State to preserve life, at all costs (because life is seen as an « absolute » value) and the interest of the patient to be free of pain and suffering; commentators weigh death and pain and decide that they cannot put pain at a worse position than death. Death is always the ultimate horror-death is never good.

But when we talk about competent patients, this balance is completely wrong. The real question is, what is more important : the State's interest in preserving life or the patient's *freedom of choice* — the choice between life or death, the choice, usually, between a death at the manner the State will allow, or the death the way the patient wants to experience. The real question, than, becomes, how can the State force an individual to die at a manner that the individual does not want ? Where is the value of the citizen's person, if the State can nullify all the citizen's competent decisions concerning one more facet of life, namely death ?

The Bouvia case where, I remind you, the right to die was upheld, was based on the right to privacy. A decision to die was framed in terms of a private choice. The privacy doctrine, used in other medical ethics problems too, like abortion, may seem ade-

(8) « ... Nothing about either killing or allowing to die entails judgments about actual wrongness or rightness or about the beneficence or maleficence of the action... neither killing or letting die is per se rightful or wrongful... both are prima facie wrong but can be justified under some circumstances... », T.L. BEAUCHAMP, J.F. CHILDRESS, *Principles of Biomedical Ethics*, New York-Oxford, Oxford University Press, 1994, p. 225.

(9) J. FLETCHER, *Humanhood : Essays in Biomedical Ethics*, 1979, p. 151.

quate to cover the euthanasia question for competent patients as well. It is not so, because at the end the privacy doctrine does nothing to make real of a right to choose to die.

I will be more explicit : the right to privacy, as conceptually conceived until today and applied by the courts, both Greek and courts of the common law, is not supposed to create positive rights (10). It is a right « to be let alone », sure, but it is not a right which for example would oblige a physician to comply with the patients' wishes in an active way. It would never *oblige* a physician to turn off a respirator — although it could very well be used as a shield to the same doctors' liability, if he happened to actually turn the respirator off, according to the patient's wishes. But if the doctor refused to do so, the patient could not allege that his right to privacy, his right to die, *obliges* the doctor to act according to his wishes.

But if not privacy, is there another constitutional principle to aid the competent dying patient ? Strangely, the last until today effort to protect the terminally ill patient's right to die at the US Supreme Court level was to base this right on the constitutional principle of equality. This kind of legal reasoning, which I will explain right away, shows, I think, what despair can do to lawyers trying to find a « home » for the competent patient's right to die with dignity. It is the old legal game — find the correct « name » and then you may win — procedure versus common sense, the forms of actions still ruling from their graves.

The classifications between patients attacked in this last case decided by the Supreme Court of United States in 1997 (11) were these of the patients who are terminally ill and *also* are on life support systems and of the patients who are terminally ill but *are not* on life support systems. The New York law banning physician assisted suicide, the lawyers said, discriminated between these two kinds of patients, allowing the first class to demand all support systems to cease functioning, virtually demanding and achieving certain death, whereas the second could not equally ask for a lethal injection. So, the first class was allowed to choose to die, whereas

(10) « ... The right to privacy is not thought to require social change... it is not even thought to require any social preconditions... », C. MCKINNON, « Roe v. Wade, A Study in Male Ideology », *in Abortion : Moral and Legal Perspectives*, New York, 1984, pp. 45-54.

(11) Vacco et al v. Quill, SC 95-1858, June 26, 1997.

the second class was not. So, the argument goes, the Equal Protection Clause was violated. True, it was only a matter of luck if as a patient your terminal disease would require a respirator or not, therefore, it was a matter of luck if you could end your life as you pleased.

Again, the Supreme Court noted (as it is also the result of the privacy doctrine) : « ... the equal protection clause creates no substantive rights.. » (12) (It does not follow that you have a right to active euthanasia, just because you have a right to a passive one). Being equal to another human being, the Court said, as I understand it, in like situations, does not mean that you have a right to make sense of this equality. Equality, just like privacy, cannot be of any help, because it is too much of a shield and too little of a sword.

The Court also stated that there is certainly a difference between assisting suicide and withholding treatment — in effect, sustains the meaningless difference between killing and letting go. A lethal injection will be, according to the Court, if administered, the direct cause of death of the patient — not the underlying disease. But if a respirator is off, the direct cause of death is the disease and not the act of turning the machine off. What we allow, the Court said, is *the disease* to be the cause of death.

So, the individual again disappeared in front of the immense powers of the State. Just to prove this, the three gravely ill patients who took this case to the Court had died when the decision was delivered. As they had stated in their declarations, they had no chance of recovery and faced the prospective loss of bodily function and integrity and increasing pain and suffering. They died not as they were trying to be allowed to, but as the State thought through the legislative (the New York statute) power and as the judiciary power (the Supreme Court) thought they should. We do not find in the decision anything concerning this intense conflict between the individual's autonomy and liberty and the State's interest in preserving life. (If the analysis went that way, the Supreme Court would be in real trouble.) We only find only far-fetched, suspect distinctions between omissions and commissions of deadly actions.

(12) *Ibidem*.

To close the discussion of a competent patient's euthanasia, I would like to add that the use of the criminal code provisions of murder, or generally homicide, in order to resolve a physician assisted suicide or a passive euthanasia case (a « let go » case) is wrong (13). These provisions were not intended to resolve this kind of behavior and in euthanasia the motive has to play an extremely important role, whereas motives are irrelevant in typical murder cases. It is this kind of inappropriate use of the law that frightens the physicians who believe in their oaths to help their patients as much as possible. It is, therefore, up to the legislative power to research and draft laws to protect all parties interested.

II. — Incompetent Patients and Euthanasia

Here is the heart of the problem of euthanasia — for if a patient is competent, we can always defer to his own will as a justification for his death. But if a patient *never had a will* (defective newborn cases) *or has no will any more* (patient rendered incompetent), then to kill him (I continue to stress « killing ») must be justified by the most certain of our legal and moral principles.

There are, of course, even here, the relatively (14) easy cases : where the patient was prudent enough, and I must add, terrified enough by the current state of the law, so as to have signed a « living will » stating his medical preferences, when and if he should be at a terminal and also incompetent state.

All other cases must be resolved by proxies — the family, the physician, the medical ethics committees that may exist to support hospital decisions, a guardian or even the courts. These « adjudicating » bodies often disagree; too often, too, we see that each of them declares that it should be awarded sole authority to decide. We see the parents of a seriously handicapped newborn wondering in a rage what a physician has to do with the decisions that *they* will have

(13) « ... The American law on homicide, heir to 500 years of English common law development, is simply not adequate to deal with the proper termination of life support systems. Applying the criminal law in this area seems wholly misdirected and utterly foolish... », Furrow, Johnson, Jost & Swartz, *op. cit.*, p. 1170.

(14) Because a living will may, at times, require interpretation of its meaning.

to live with all of their lives (15), decisions that deeply affect the constitutionally protected idea of the integrity of the family. We also see the doctors trying to protect their real patient, often a child, and struggling to persuade the courts that they are right. The courts too have in a way declared sometimes that these kind of questions are in their province (16).

These conflicts, also, have blurred the true picture, because what has been usually lost in these endless debates was not *who* should decide, but *by which standard.* Are we correct to even mention an autonomy interest of an incompetent patient or should we just adhere to the best interests standard? Naturally, there has been no uniformity in the answers we have so far.

Let me make this clearer. Under the theory of substituted judgment, the life support systems of an ex-competent terminally ill patient could be withdrawn if we have reasons to believe (the theory demanding a really strong evidentiary standard) that they would reach this decision (termination) themselves (17). On its face, this theory advanced by the courts is a neat way to prove that nobody living would like to bear, at least typically, the weight of this decision. So, we « throw » this decision on the incompetent, just like a criminal defense team will, if needed, blame the victim to rescue a client. We rescue everybody else — family, physicians and last, but not least, the court itself — and find the justification for this killing to prior wishes of the patient.

The hypocrisy of all this, or, at least its definite clash with reality, has been very well documented. The Saikewicz decision, where the Court ordered treatment for leukemia to stop for an incompetent 65 years old patient, because this is what he would have chosen, if he was competent, has been a constant source of criticism. The question « if he would be competent what would he choose? » is equivalent to « if it snowed all summer would it than be winter? » (18). Physicians also note that, no matter what a

(15) See for example the parents' frustration and anger in the Baby Andrew case, described in detail in R. STINSON, P. STINSON, *The Long Dying of Baby Andrew*, Atlantic, Little Brown, 1983.

(16) Superintandant of Belchertown State School v. Saikewicz, 373 Mass., 728, 370 N.E.2d 417.

(17) In Re Conroy, 98 N. J. 321, 486 A.2d 1209, also In Re Eichner, 52 N.Y.2d 363, 438 N.Y.S.2d 64, Cruzan v. Director, Missouri Department of Health, 492 U.S., 110 S.Ct. 2841,111 L.Ed.2d 224.

(18) N. RHODEN, « Litigating Life and Death », *Harvard Law Review*, 1988, 102, pp. 375, 380.

patient may say he would do if terminally ill, they do change views when they are *actually* terminally ill (19). The factor of terminal illness (not present when one declares that he prefers death to a painful life but is currently perfectly healthy, smoking and drinking in a bar with his friends) is a factor that reverses all kind of conclusions about previous wishes. Incompetent patients do not have wishes. And our standards to decide about their death cannot have anything to do with these wishes, unless they have been documented in a living will or a durable power of attorney.

For the incompetent patient, therefore, and this includes the tragic cases of seriously handicapped newborns, the only standard is the best interests standard. One should allow euthanasia, passive or active, for I believe it is the same, if death is in the incompetent patient's best interests. You can of course directly accuse me for inviting in the discussion an endless debate about what is quality of life and whether we are ever permitted to make this kind of quality of life judgments. Allow me though to mention that we have to admit that we make quality of life judgments *all the time.* It is quality of life that it is hidden behind any decision that prefers death to life for an incompetent, even if it is presented as a « previous wishes » decision or whatever.

Finally, there is also a question of justice to address. We are no Gods; and we also have limited resources. This is not a brave society, rich or advanced enough to embrace and love all creatures, no matter their disabilities — and in these cases, we talk about extremely severe disabilities, disabilities that could also mean a total absence of the brain function. I do not see how we, as a society, can upkeep on a respirator a « person » with no brain function at all, especially when there is a line of patients waiting to use the same limited resources. It is for us to justify life, *not death,* for example, of a newborn in persistent vegetative state, non reversible, in the intensive care unit which could last for any number of years. If we surpass the question that this is not a life worth to be lived (the best interests question) we still are left with the question of justice : What about the mental trauma and the financial burden of the family ? (20) And what about the resources that could be used to help another person in a better condition ?

(19) M. Van Scoy-Mosher, *op. cit.*, pp. 14-15.
(20) G. Oakes, *op. cit.*, p. 196.

All the above discussion may be liable to another well-known criticism : that it has nothing to do with law, that it easily falls into the realm of medical ethics alone, a place where « dogmatic » or « classic » lawyers feel uneasy or indifferent. Where is the dogmatic analysis of « the law » in all this? This looks like a sociological analysis of the death problem.

Permit me to say that, as the decision to withdraw life support systems has been lately recognized as not a purely medical decision, it is also not a purely legal one. The legal discussion in these cases and the relevant cases of criminal liability cannot and must not be seen as purely legal ones. If we see it this way, we will be guilty of all what the physicians have been traditionally accused for : their indifference to the feelings of their patients and an authoritative monopoly of decision-making. If it is not a purely legal one, then even *a court* ordered withdrawal of life support must be based on considerations not only purely legal, but also medical, social and ethical ones.

At the beginning of this announcement, I said that the question of euthanasia lies at the border between medical ethics and criminal law. Where the line shall lie, it is impossible to say; at least, we must always try to draw it.