EDITORIAL

Euthanasia and physician-assisted suicide: ongoing controversies

When, back in 2002, Chao et al[1] reviewed the topic of euthanasia, there was a trend toward legalising it in a few countries. The Netherlands had just passed a bill in April 2001 to legalise the practice of euthanasia and physician-assisted suicide (PAS) and Belgium was in the process of doing so. Before the bill, Dutch physicians had practised euthanasia and PAS under a set of guidelines agreed by the Royal Dutch Medical Association and the Dutch Ministry of Justice in 1990. The Northern Territory of Australia had, in May 1995, passed the Rights of the Terminally Ill Act. It was overturned by the Federal Senate in 1997, shortly after the first death by euthanasia under the Act. In the US, Oregon first passed the Oregon Death and Dignity Act (ODDA) as a ballot initiative in 1994. When it became State Law in October 1997, the federal government took the case to the Supreme Court.[1]

Since then the debate has barely begun in Hong Kong. Chao et al[1] highlighted a number of contentious points, among them the use of the term "passive euthanasia". This term has been used by some people together with "active euthanasia" to categorise euthanasia according to whether death is due to the omission ("passive") or commission ("active") of a medical act. It is problematic because the legal debate on euthanasia is really concerned with assisted dying by an active medical act, and so-called "passive euthanasia" is often unnecessarily confused with the right of a mentally competent and informed patient to refuse or forgo life-sustaining treatments. In Hong Kong, euthanasia is defined as "direct intentional killing of a person as part of the medical care being offered", thus focusing on the active act.[2]

There are guidelines in both the UK and Hong Kong for withholding and withdrawing life-sustaining treatments in the terminally ill.[3,4]

Only Belgium has followed the Dutch pathway by legalising euthanasia. In the US, Oregon permits PAS but not euthanasia under the ODDA. Doctors have been practising PAS according to the ODDA since 1997, before the Supreme Court eventually ruled against the federal challenge in 2006. The Council of Europe remains opposed to legalising euthanasia in Europe. In 2003, this stand was somewhat embarrassingly questioned in a report produced by their very own Social, Health and Family Affairs Committee ("The Marty Report"). The debate is ongoing.[5]

In the UK, in June 2005, the British Medical Association (BMA) transiently declared a neutral stance on assisted dying, following a vote by members at the 2005 annual meeting. In 2006, BMA members voted again on the subject at their annual meeting but this time a majority opposed legislation for assisted dying. The BMA accordingly dropped its neutral stance and resumed its longstanding position of opposing all forms of assisted dying.[6]

Two other UK medical organisations—the Royal College of Physicians and Royal College of General Practitioners—also transiently declared neutral stances on assisted dying, but found their position misrepresented by the media as one moving towards support for legislation. Both reverted to their original anti-legalisation position in 2006.[7]

Medical professionals opposing legalisation of assisted dying fear, among other practical and moral concerns, that the "slippery slope" of euthanasia may be disastrous. Pro-legalisation authors argue that the "slippery slope concerns" may already be outdated, given recent empirical findings from the Netherlands and Oregon. Battin et al[8] reviewed available data from the Netherlands and Oregon to state that, "although the available evidence had not yet provided conclusive proof, it does show that there is no current factual support for so-called 'slippery slope concerns' about the risk of legalisation of assisted dying."[8] The review found that legalisation of euthanasia and PAS had not resulted in heightened risk among vulnerable groups such as uninsured people, the poor, people with chronic non-terminal illnesses, and children. Likewise, Quill[9] quoted data from the Netherlands and concluded: "…there is no evidence of 'slippery slope' deterioration in terms of increased numbers of assisted deaths".

Such an understanding of "slippery slope concerns" may be too simplistic. In these reviews, "slippery slope" is operationally defined in terms of risk ratios and incidence of euthanasia deaths. Quill[9] interpreted the "slippery slope" to mean increased total numbers of assisted deaths, while Battin et al[8] considered it to be determined by whether euthanasia and PAS would be practised more frequently in vulnerable groups. But the original "slippery slope" concerns are categorical rather than statistical in nature. The worry is really this: in the beginning, euthanasia and PAS are proposed to assist dying in willing, terminally ill patients; once the door has opened, euthanasia will slip over into non-voluntary killing of the demented, the mentally handicapped, and other non-terminally ill groups.[10] It should also be noted that even among terminally ill cancer patients, there may well be subgroups of vulnerable patients.

The point is therefore *not* whether vulnerable patients are statistically more likely to die from euthanasia than the general population. The slope is slippery in that more and more vulnerable patient categories may be brought into the legalised euthanasia scope.

The fear of sliding down the "slippery slope" is not an undue worry, as there are active moves to broaden the indications for euthanasia. In the Netherlands, children as young as 12 years can now be considered for euthanasia treatment, with both parents' consent, and children aged 16 to 17 years do not require parental consent, though parental involvement is required.[11]

Euthanasia in the Netherlands has also been extended to dementia patients. In the 2004 annual report of the five committees receiving doctors' reports on euthanasia deaths, it was judged that, "although in general patients with Alzheimer's disease could not always comply with the requirements, in specific circumstances they could." In the first reported case of a dementia patient dying by euthanasia, the patient had the diagnosis for 3 years, had expressed that he did not want to endure the full course of his illness, and asked for help to commit suicide. Based on these, he was considered to be "suffering hopelessly and unbearably" and therefore meeting the criteria for euthanasia.[12]

Next in line may be neonates and infants. In December 2004, the Groningen Academic Hospital in Amsterdam put out guidelines ("The Groningen Protocol") permitting doctors to actively perform euthanasia on infants deemed to be suffering from unbearable pain, arguing that this should be as acceptable as euthanasia in consenting adult patients.[13]

It would seem that, in the case of the Netherlands, the "slippery slope concern" may be phrased as "where will euthanasia end?" In Hong Kong, the question may be "where will public debate on euthanasia begin?" Locally, in 2004, a patient, Siu-pun Tang, who had been confined to bed with tetraplegia for 13 years, wrote an open letter to the Chief Executive of Hong Kong, pleading for his right to die and legalisation of euthanasia. Although subsequent rehabilitation treatments enabled him to come off mechanical ventilation and to regain meaningful activities, Tang remained a champion for the cause of legalising euthanasia. In 2007, he published his autobiography—polemically titled *I want euthanasia*—to trigger public debate on the subject of assisted dying. Medical professionals need to contribute more than just watchful eyes to this looming issue.

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