Euthanasia and Related Practices Worldwide

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The present paper examines the occurrence of matters relating to the ending of life, including active euthanasia, which is, technically speaking, illegal worldwide. Interest in this most controversial area is drawn from many varied sources, from legal and medical practitioners to religious and moral ethicists. In some countries, public interest has been mobilized into organizations that attempt to influence legislation relating to euthanasia. Despite the obvious international importance of euthanasia, very little is known about the extent of its practice, whether passive or active, voluntary or involuntary. This examination is based on questionnaires completed by 49 national representatives of the International Association for Suicide Prevention (IASP), dealing with legal and religious aspects of euthanasia and physician-assisted suicide, as well as suicide. A dichotomy between the law and medical practices relating to the end of life was uncovered by the results of the survey. In 12 of the 49 countries active euthanasia is said to occur while a general acceptance of passive euthanasia was reported to be widespread. Clearly, definition is crucial in making the distinction between active and passive euthanasia; otherwise, the entire concept may become distorted, and legal acceptance may become more widespread with the effect of broadening the category of individuals to whom euthanasia becomes an available option. The "slippery slope" argument is briefly considered.

Keywords: Euthanasia, assisted suicide, legal situation, worldwide.

Introduction

Organized medicine has today an ambivalent attitude towards death and dying. With technological advances at its disposal it has, in the recent past, sought to delay death for as long as possible. In that way, it triumphed with the semblance of power in face of life's single certainty. More recently, such pointless acts of triumph have been giving way in some jurisdictions to the opposite tendency, namely, bringing death forward in time. Either way medicine assumes a God-like role.

The medical profession is divided in the light of this pressure for change. Attitudes of individuals vary, particularly with reference to religious beliefs and age. A study of doctors in Australia found that young doctors are more "advanced," in terms of accepting euthanasia, than are older doctors [Kuhse & Singer, 1988]. A

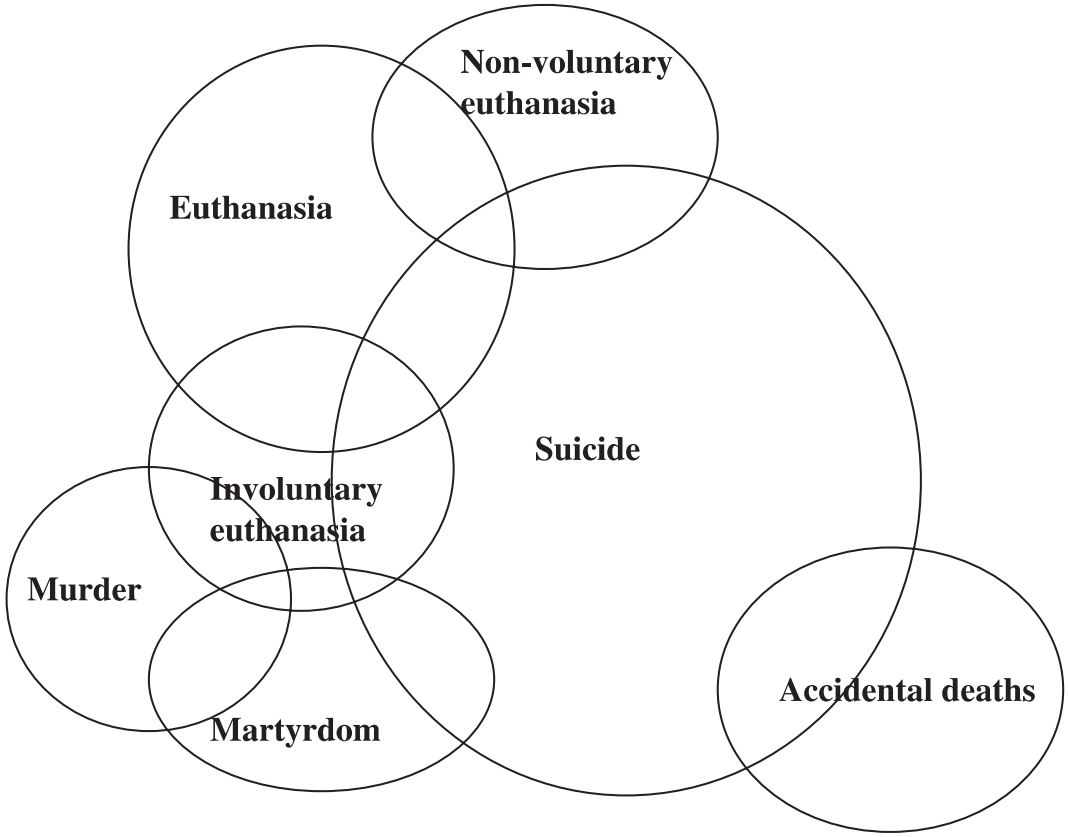

Figure 1. Death from external causes: The relationship between suicide and euthanasia.

similar study among National Health Service (NHS) doctors in Britain discovered that doctors who held religious beliefs were less likely to desire a change in the law prohibiting euthanasia [Ward & Tate, 1994]. In relation to age, Stevens and Hassan [1994] in Australia found that younger doctors receive more requests for euthanasia, while in a Dutch study it has been reported that young doctors are more likely to discuss euthanasia with their patients [Pijnenborg et al., 1994]. In general, it has been noted that medical organizations tend to be more conservative in their policies than their individual members [Ward & Tate, 1994].

Surveys done in a number of countries (e. g., Britain, Australia, the USA, Canada, and the Netherlands) have revealed a willingness, if not a desire, among medical practitioners to have the law changed with regard to euthanasia and assisted suicide [Van der Maas et al., 1991; Cohen et al., 1994; Stevens & Hassan, 1994; Ward & Tate, 1994; Mishara, 1995]. Despite the high profile of some doctors such as Jack Kevorkian (no longer registered) and the utterances of some proselytizing medical groups, it is not medicine that has been defining this culture of change. Rather, the drive for change has come from the general populace and, in some countries, from the judiciary. Indeed, organizations that support change in the laws against euthanasia exist worldwide, including Japan, Germany, and the Netherlands [Yamauchi et al., 1992].

The courts, having ruled on particular cases in countries around the world, have had a definite influence in defining more clearly the law of the respective land and often breaking new ground on what constitutes individual rights. Examples include the Karen Quinlan case in the USA [Karen Ann Quinlan Case, 1976], the Tony Bland case in England [Airedale NHS v Bland, 1993], and an anonymous case in Ireland. The grounds for legally induced passive euthanasia were defined in each of these cases.

At the time of writing, active euthanasia is still illegal worldwide. Nevertheless, it is permitted in the Netherlands provided the doctor adheres to strict guidelines and makes a declaration to the appropriate authority. If this does not happen and the doctor is found out, he will be prosecuted. Explicit requests for physician-assisted suicides are not uncommon in psychiatric practice in the Netherlands, but it is said that these requests are rarely granted [Groenewould et al., 1997]. Physician-assisted suicide was legal in the Northern Territories of Australia for a short time, but this was reversed in a closely contested Senate debate in the Australian Parliament in March 1997. Meanwhile, in July of 1997, the Supreme Court of the United States ruled that citizens do not have a positive right to demand assisted suicide [Churchill & King, 1997]. This will have repercussions, not only in the United States, but also across the world.

Definition is, of course, always problematic. If a definition is narrow, too few cases may be included, making generalization difficult; if too broad, many diverse cases are grouped together and the concept loses meaning. Many forms of unnatural death relate one to another (as shown in Figure 1), and this may aid in definition—although, here again, there may be dispute because some may not accept as meaningful the concepts of nonvoluntary and involuntary euthanasia. Furthermore, what is visually meaningful depends both on the degree of abstraction by the viewer as well as his or her level of sophistication and familiarity with the various concepts used. The figure was constructed as an attempt to elucidate the subject for the average practicing clinician.

Suicide is the intentional taking of one's own life. Many accidents are due to the individual's own activities where it is assumed that these were not embarked upon with a view to killing oneself. However, there is some link between acute and chronic risk-taking, on the one hand, and suicide on the other: Some individuals are ambivalent as to whether they live or die and may express this ambivalence in both risk-taking (which may lead to accidental death) and suicide.

Euthanasia is the bringing about of the death of another person with a view to ending uncontrollable suffering. This is different from the Nazi usage, which is briefly discussed further below. If euthanasia is done by agreement, it is called *voluntary euthanasia*.

If a patient is competent but does not give consent, it is called *involuntary euthanasia*. A case of involuntary euthanasia occurred recently in a notorious case in Japan which is presently the subject of a criminal investigation [British Medical Journal, 1996]. There, a doctor killed his friend, without giving him the true diagnosis, prognosis, or seeking his consent, because he could no longer reduce the suffering. Martyrdom overlaps with suicide if the individual deliberately provokes his own death, and may overlap with involuntary euthanasia depending on consent and the belief patterns at play. The law may regard cases of involuntary euthanasia and martyrdom as representing murder. Legally, involuntary euthanasia is murder and as such was not the subject of this enquiry. However, there is a fundamental difference between murder and involuntary euthanasia: With involuntary euthanasia physicians act in what they believe to be the best interests of a competent patient with a fatal/terminal prognosis. Unlike murder, there is no malevolent intent. The relationship between suicide and involuntary euthanasia thus lies in the fact that death is purposely brought about to allow an individual to escape from a seemingly intolerable situation.

If the person is incompetent and cannot give consent, it is called *nonvoluntary euthanasia*. The most notorious case of the latter in recent times was the death of King George V in 1936, at the hands of his physician, Lord Dawson, who did not consult the King's relatives, his ministers, or his own medical colleagues, although he did forewarn the media [Ramsay, 1994]. More usually, living wills, or those closest to the patient, i. e., relatives, best friend (if they have the powers of attorney), colleagues or, on occasion, the courts, are consulted and a joint decision is made.

Some would prefer to limit the word euthanasia to what was described above as voluntary euthanasia. However, the terms nonvoluntary and involuntary are widely used and have validity here [House of Lords Select Committee on Medical Ethics, 1994; The New York State Task Force on Life and the Law, 1994]. There is also a time dimension to the distinction between voluntary and nonvoluntary euthanasia: A person may competently request euthanasia but, because of illness progression or onset of confusion, become incapable of affirming this request. This, in many countries, is now routinely recognized in the process of giving others the power of legal attorney over one's affairs, should a dementing illness arise. The law requires that one be

mentally competent at the time the decision is made to enter into such arrangements—and not at the time the power is handed over when the applicant is usually confused.

Clinicians make a distinction between *active* and *passive euthanasia*. In active euthanasia a substance is given which is by nature lethal. This occurred in the case of Lillian Boyes, when Dr. Tony Cox administered potassium chloride [Harris, 1995]. In passive euthanasia treatment may simply be discontinued, as in the case of Tony Bland, a victim of the Hillsborough disaster in England. Or treatment is never commenced. The law did not use the word euthanasia when discussing cases such as that of Tony Bland [House of Lords Select Committee on Medical Ethics, 1994]. Furthermore, many moral philosophers do not see a real difference between active and passive euthanasia [Rachels, 1986; Dworkin, 1993]. A further distinction is made between giving medication to relieve suffering in dosages that are known to have harmful side effects, to the extent of possibly hastening death, and giving a similar level of medication with the intention of causing death. Because the law ultimately deals with intention in criminal matters, the latter is definitely illegal while the former may not be.

Physician-assisted suicide may overlap with both voluntary euthanasia and suicide itself. In all three, death is brought forward in time. There are a number of distinctions, however. With suicide, the method is usually painful and unpleasant, whereas with euthanasia and physician-assisted suicide (PAS) it frequently is not. In euthanasia, someone else kills the individual, while the individual kills himself in suicide and PAS. In the latter case, he is helped either by advice or by means put at his disposal, such as an appropriate dosage of oral medication or, more rarely and dramatically, by giving access to a machine that will discharge a lethal bolus of poison into an already cannulated vein at the flick of a switch placed under the patient's own control. Finally, suicide is generally something one does on one's own, albeit often in a social context, whereas physician-assisted suicide and euthanasia result from the implementation of the terms of a contract entered into by at least two people, most usually a doctor and a patient.

A pictorial representation, as in Figure 1, of "deaths from external causes" may run the risk of conflating diverse perspectives, namely, intent to kill, the manner of death, and the legal ascertainment of cause of death. The situation is further confused by conflict between the dimensional and categorical approaches. Generally, the law prefers to deal in categories—either death is intended or it is not intended. Clinical medicine, however, is more sensitive to degrees of intention, including the presence of ambivalence when it comes to arranging the death of oneself or of others.

The present paper endeavours to see how widespread some of the above-mentioned practices are worldwide. But before we do so, it should be said that the language of euthanasia has been vitiated and confused by the use made of the term during the Nazi regime. National Socialism identified some groups, such as Jewish people and the mentally ill, as pathogens in the body politic and as a result proceeded to systematically murder them to satisfy their delusional views of racial health [Burleigh, 1994]. Apart from the obscenity of these acts, an essential difference between what happened under National Socialism and what is being considered presently is the answer to the legal question *cui bono* (who benefits)? Under the Nazi regime it was assumed that the society of the Third Reich benefited, whereas in the more recent usage of the term, it is proposed that, ideally, the individual benefits.

Method

After examining conceptual and definitional aspects of euthanasia and related practices, we undertook an international inquiry into the occurrence of such practices.

There are 51 member countries or jurisdictions affiliated to the International Association for Suicide Prevention (IASP). Each of the national representatives was sent a twenty-item questionnaire dealing with legal and religious aspects of suicide, attempted suicide, euthanasia, and physician-assisted suicide. The questionnaire was written in a yes/no format (forced choice; see Appendix 1). The respondents were also encouraged to clarify and defend any forced-choice decision made by giving a more detailed explanation where they thought appropriate. Follow-up letters, faxes, and, in a few cases, telephone calls ensured a response from 49 of the 51 countries (Table 1). No response was obtained from Peru or Nigeria.

Results

Each of the 49 countries answered every question, and where there was doubt explanations were given. A few national representatives consulted widely before replying. In the analysis, the decision taken by the respondents on any item was taken as final.

In 12 of the 49 countries active euthanasia is thought to occur in practice (Table 1). In 10 of these 12, it occurs either secretly or the law chooses to ignore it. At the time of the study, active euthanasia was permitted only in two countries: the Netherlands and the Northern Territories of Australia, and then only in restricted circumstances. Since then, a decision taken by the Australian Senate to rescind the existing legislation in the Northern Territories has reduced this number to one. In eight countries (excluding the Netherlands and the Northern Territories), active euthanasia is not prosecuted either because the penal code does not deal with euthanasia or such a case has never been judged before the courts. In eight countries, nonvoluntary active euthanasia is believed to occur. Passive euthanasia is a much more widely accepted condition, occurring in 23 countries. Nonvoluntary passive euthanasia occurs in a total of 30 countries.

In 44 countries, assisted suicide is listed in the criminal code as a crime. At the time the study was carried out, the physician could legally assist and be present (without sanction) during patient suicides only in the Netherlands and the Northern Territories in Australia. In three countries, Germany, Sweden, and the United States, the matter is apparently not considered in law. In 45 countries, the Medical Council investigates doctors who assist in suicide with the possible sanction of striking their names from the Medical Register; in the other four the matter is not considered.

Discussion

There appears to be worldwide openness with regard to passive euthanasia. In almost half of the surveyed countries (22 out of 49) it is legally permitted and in over half, nonvoluntary passive euthanasia is practiced. However, in most countries (41 out of 49), active euthanasia would be prosecuted while in 12 countries it is said to occur secretly. The practice was legal in only two of these 12 countries at the time the study was carried out. This has since been reduced to one, i. e., the Netherlands.

In most countries (44 out of 49) assisted suicide is a crime and the Medical Council, or its equivalent, prosecute its members for providing such assistance. It is a philosophical as well as a legal question as to why so many countries countenance passive euthanasia yet turn their face against assisted suicide and active euthanasia. Obviously, there may be historical and religious reasons of relevance.

However, with respect to the latter, the matter is not clear-cut. Active euthanasia reportedly occurs in

Table 1
Occurrence of Euthanasia in IASP-Affiliated Countries

Argentina	Pakistan	India[4]	France[3,4]	Australia[1,3,4]
Bulgaria	Portugal	Korea[4]	Iceland[3,4]	Germany[1,3,4]
China	Russia	Norway[4]	Indonesia[3,4]	Switzerland[1,3,4]
Cuba	Taiwan	Romania[4]	Israel[3,4]	United States[1,3,4]
Czech Republic	Poland[1]	Spain[4]	New Zealand[3,4]	Yugoslavia[2,3,4]
Estonia	Austria[3]	The Netherlands[1,3]	Slovenia[3,4]	Belgium[1,2,3,4]
Hong Kong	Ireland[3]	Lichtenstein[1,4]	South Africa[3,4]	Canada[1,2,3,4]
Iran	Sweden[3]	Greece[2,4]	Sudan[3,4]	Denmark[1,2,3,4]
Italy	Brazil[4]	Turkey[2,4]	Great Britain[3,4]	Mexico[1,2,3,4]
Lithuania	Hungary[4]	Finland[3,4]	Japan[1,2,4]	

[1]Active euthanasia thought to occur (12 out of 49 countries)
[2]Nonvoluntary active euthanasia thought to occur (8 out of 49 countries)
[3]Passive euthanasia thought to occur (23 out of 49 countries)
[4]Nonvoluntary passive euthanasia thought to occur (30 out of 49 countries)

four countries with religious sanctions against suicide: Australia, Liechtenstein, Mexico, and Poland.

This study does not support the unsubstantiated contention that active euthanasia is "common" worldwide. At most, it occurs in a quarter of the countries surveyed and in the vast majority of these it is both clandestine and illegal. Those who fear the advent of increased social acceptance of euthanasia often look to the "slippery slope" argument to substantiate their case. As pointed out in the introduction, comparisons with the Nazi conception of euthanasia are inappropriate.

The "slippery slope" argument against euthanasia has two related formulations, the conceptual and the numerical. The conceptual may be narrowly or broadly focused. At its narrowest, it would be available only to the terminally ill in great suffering. However, the concept has broadened to include, first, the chronically ill and, more recently, the psychologically ill, both regarded to be in great suffering [Kelleher, 1997]. But why stop there? In an autopsy study of 100 Irish suicides [Kelleher et al., 1998], seven men (six under 36 years of age) were found not to be mentally ill when they ended their lives. If assisted suicide were legally available, would they have had to declare themselves mentally ill before they could avail of the service? The Dutch argue that, numerically, there has been little expansion of the euthanasia numbers with the widening of the criteria, the number of reported cases of physician-assisted suicide levelling off by 1991, and the increase in the total number of reported cases of euthanasia and physician-assisted suicide being associated with a change in the notification procedures [van der Wal et al., 1996]. This view is disputed by others [Keown, 1995; Hendin et al., 1997]. It would be surprising if legalization worldwide was not followed by an increased demand.

Overall, the results imply a hidden need illegally met in some countries but officially criminal in most. The data, however, do not address or answer the moral question about the relationship between what is and what ought to be. Nor do they question the premises on which laws relating to the termination of life are based. It would be presumptuous to assume that such data as reported here would alter such premises. Yet, if modern society continues along the road of emphasizing the autonomy of the individual, changes in the law in relationship to dying are inescapable. Whether this will ultimately change our concept of civilization remains to be seen [Kelleher, 1997a].

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Appendix 1: Questionnaire on Suicide, Euthanasia and Assisted Suicide

Answer for the people and country you represent. Please give, on a separate sheet of paper, explanations and numbered notes for each question answered positively. Also, state your own personal views if they differ from the views of those you represent.

1. Is suicide a crime?
2. Are there civil sanctions against suicide?
3. Are there religious sanctions against suicide?
4. Is attempted suicide (parasuicide) a crime?
5. Are there civil sanctions against attempted suicide?
6. Are there religious sanctions against attempted suicide?
7. Is active euthanasia (i. e., direct killing) permitted in law?
8. Does active euthanasia occur in practice?
9. Is active euthanasia, if known, prosecuted?
10. Is passive euthanasia permitted in law? (e. g., switching off the life-support machine or not giving artificial feeding)
11. Does nonvoluntary active euthanasia occur? (non-voluntary means the patient is incompetent, e. g., advanced dementia or permanent vegetative state)
12. Does non-voluntary passive euthanasia occur?
13. Do physicians actively assist in administration of capital punishment? (as opposed to pronouncing the executed dead)
14. Are advanced directives (living wills) used?
15. Have living wills the force of law?
16. Is assisted suicide a crime?
17. Are physicians allowed to assist in suicide?
18. Can the physician be present while the patient commits suicide?
19. Will the Medical Council, or an equivalent professional body, prosecute physicians who assist in suicide?
20. Are books or manuals on how to commit suicide legally on sale?
21. Have you personal views, as opposed to the collective ones you represent, which you would like to express?