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## Why Should the World Medical Association not Change its Policy towards Euthanasia?



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In Maxence Van Der Meersch's popular novel *Bodies and Souls* Michele Doutreval, a young country doctor, the son of a well-known university professor in Angers, due to several turns of events, finds himself working in a small town in the North of France. One of the episodes in particular describes doctor Doutreval's great humanity and good approach to Medicine. On his way back home after a long day at work, he meets a man on his doorstep. The man, who looks clearly sorry to trouble the doctor at such a late hour, tells him that his little daughter, Franchina Ray is dying of tuberculosis and wishes to say goodbye. Michele's answer is concise but very illustrative: "Yes, sure. I'll be right back". He enters his house to greet his wife and to tell her that once again they will not be able to spend the night together. Then he sets out on his way to the sick girl's house where he stands by her side until she dies. The episode ends with the remark that it was late when the doctor finally got back home [1]. Medical science has certainly changed in the century that separates us from doctor Doutreval's

time, and it has changed irreversibly... Nevertheless, every doctor would wish to have the same availability and friendliness that Michele had in his medical practice.

It seems to me that Van Der Meersch's story can be a useful backdrop for the complicated topic of this article. Medical science changes with society, not only because today we have more diagnostic and therapeutic means than we used to have a few decades ago. The introduction of technology into medical care has caused a great transformation in the way of conceiving the doctor-patient relationship. Patients are each time seen by more and more professionals and this represents a temptation for the doctor, who can easily become another stranger at the bedside [2]. Moreover, autonomy, one of the basic principles of Bioethics, has induced many doctors to shirk their duty of providing advice and orientation, and barricade themselves behind technical means. It is within this complicated medical context and the prolongation of pathological processes, that the demand for euthanasia can insinuate itself. So far and with few exceptions, medical science, through its constituent bodies, has refused to take this path. However, social pressure is strong in some countries and consequently it is essential to engage in a calm and well-considered debate on the topic.

The World Medical Association (WMA), which defines euthanasia as "the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives", has condemned euthanasia since 1987 in a clear and explicit way, stating that "it is unethical". It then goes on to clarify what is and what is not euthanasia, by adding that "This does not prevent the physician from respecting the desire of a patient to allow the natural process of death

to follow its course in the terminal phase of sickness"[3]. Moreover, according to the 2002 resolution on euthanasia: "The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice and the WMA strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions"[4]. In this paper I would like to highlight some of the arguments that justify this policy bearing in mind that negative moral prescriptions are not an end in themselves, but are the starting point for a profound and creative reflection on medical assistance at the end of life; an end of life which has benefited immensely over the last decades from advances in palliative care. Unfortunately, the teaching of this area of medical science has been insufficient in many instances. For this reason, this reflection is also a call for a more substantial engagement in order to stimulate an increase in undergraduate and graduate training in this important field of modern medicine.

Since its inception, Medical Ethics has rejected euthanasia following a basic deontological principle: "doctors must not kill". Deontology, which is currently represented by Kantian ethics, highlights what can be done and what cannot be done. The rationale for these norms may vary according to the various moral formulations, but what is more important here is the assumption of a series of obligations and prohibitions; prohibitions of acts which contravene the good of the person or of society. Apart from the deontological argument, utilitarian arguments have also been added to recent debates on euthanasia. Their argument claims that a particular action is to be considered wrong not because there is a norm prohibiting it, but rather because the action goes against the greatest good for the greatest number of the people. For the case in point, the utilitarian or consequentialist argument rejects the practice of euthanasia.



Even though utilitarianism does not consider the practice immoral in itself, and in fact considers it justified in some cases, it accepts that allowing it would result in serious abuses. This form of argumentation has entered the bioethical bibliography using the term “slippery slope”.

## “Doctors must not kill”

The deontological principle condemning euthanasia finds its paradigmatic expression in the Hippocratic Oath, which has constituted the basis of Medical Ethics from the origins of medical science to this day. This text, dating back to the 4th century BC, states: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect” [5]. This is a brief statement, like the rest of the statements that are mentioned in the Oath, which instructs doctors not to provide patients with any means to end their lives. Actually, what the Oath condemns is what we know today as “assisted suicide”. However, medical tradition has always seen it as a prohibition of any lethal act on the part of the doctor. The anthropologist Margaret Mead explains that Greek medicine distinguished the doctor from the magician, when the definitive separation between to kill and to cure was achieved [6].

As concerns the current debate on euthanasia, this ethical rule is extremely important, for it was written in a social and philosophical context that widely favoured suicide. Platonists as well as cynics and stoics were in favour of euthanasia in the event of illness, and in some cases it was actually seen as an act of courage. Aristotle and Epicurus held a less positive outlook on suicide, though left certain space for its justification [7]. This is a significant fact, for even though it was a relatively common and socially justified practice, Medical Ethics considered it important for doctors to avoid in order not to contradict their profession which is precisely to cure and not to kill the patient. It was also important in order to avoid any

suspicion that doctors would anticipate their patients’ death.

Throughout the centuries, the moral principle “doctors must not kill” has been passed on from generation to generation as a basic pillar of the doctor’s vocation. For some, the idea of converting this rule into a mere *prima facie* principle, or a simple piece of advice that can be ignored in certain circumstances, constitutes an alteration, not of some peripheral element of Medicine but of its very essence: “The very soul of medicine is on trial” [8]. Lonnie Bristow, former president of the AMA, in a statement read before the Congressional Committee of the United States voiced the same opinion: “Laws sanctioning physician assisted suicide serve to undermine the foundation of the physician-patient relationship, which is grounded in the patient’s trust that the physician is working wholeheartedly for the patient’s health and welfare” [9].

Daniel Callahan, in his thought provoking book *The Trouble Dream of Life*, holds that the request for euthanasia is a manifestation of patients’ and society’s lack of trust in the healthcare system. Euthanasia would represent the illusion of being in control of illness at all times and of being able to put an end to life, when considered the best choice, without having to succumb to the dominance of technology that can keep people alive as long as possible. Fundamentally, there is a feeling of mistrust towards the doctor and his medicine. What the author finds paradoxical is that in order to protect itself from this technological assault, society would so easily choose this path and happily entrust the doctor with the power of deliberately ending a life [10]. This view appears as the bottom line in Herbert Hendin’s interesting book *Seduced by Death*, in which the history of euthanasia in the Netherlands is described directly by the people who have been involved in it and which concludes with the message that it is not worth following this path. The author is of the personal view that there is no moral issue in ap-

plying euthanasia to specific cases; but the European experience shows the great influence the legalisation of this practice has on the doctor-patient relationship. Ultimately this means increasing the power of medicine to decide end-of-life situations which are extremely complex and which could find in euthanasia a far too easy “solution” [11].

Another important aspect when considering euthanasia that goes beyond the doctor-patient relationship is the weighty matter of critically ill patients having to make a decision, and in a certain sense justify, their desire to carry on living. Although its proponents insist that the choice of euthanasia must be free from coercion, in practice this hardly ever happens. If the sick person is aware that her/his condition constitutes a burden to their family and the community, it is logical that she/he would wish to spare them the burden and decide for euthanasia for this reason. In 2002, Tonti-Filippini, an Australian bioethicist (who recently passed away), wrote an open letter in plain and direct language to the then Prime Minister of his Country, Mike Rann, concerning a legislative proposal in favour of euthanasia. He pointed out that for people like himself, who found themselves in a situation eligible for euthanasia, the last thing they needed was precisely such a possibility. What they needed was human contact, support and good medical care, since their critical state of health was already dulling their will to fight...and to live [12]. It seems to me that this aspect of the matter is rarely taken into serious consideration, whereas it should give healthcare professionals food for thought.

## Slippery slope

The debate on euthanasia has increasingly given greater weight to moral arguments based on consequences caused by actions and on healthcare policies. The “slippery slope” argument holds that if a law is passed allowing euthanasia for a number of very concrete cases and with strict conditions,

this would not prevent abuse. Experience proves, moreover, that in time the restrictions are weakened and euthanasia ends up being applied to patients who in principle should have been excluded.

Before we move on to study this issue, let us look at some data. Even though these numbers do not represent “a fall down the slope”, they certainly deserve special attention, as they are illustrative of this situation bearing in mind that when the law in favour of euthanasia was approved in the Netherlands and Belgium in 2002 the thought was that it would apply to a very limited number of cases. As a matter of fact in the Netherlands it was legalised in 1984 as a result of a decision of the Dutch Supreme Court. In the debates previous to the ratification of the law, they talked of limit cases in which medical care, it was held, was incapable of providing a satisfactory answer. Instead what has been witnessed over the years has been an annual increase in the practice of euthanasia as more and more justifications have been given for it. It is true that, in the years following the approval of the law in favour of euthanasia in the Netherlands, there was a slight decrease in the number of cases compared to the previous years. In 2001, deaths from euthanasia and assisted suicide represented 2.6% of all deaths, whereas in 2005 they represented 1.7% [13]. Nevertheless, after the numbers settled, there has been a considerable increase over the last few years. In the 2003 report of the *Regional euthanasia review committees* which gives data from the first year of the promulgation of the law, 1815 cases of euthanasia and assisted suicide were recorded; in 2004, they increased to 1886 and in 2005, they reached 1933 cases. In the 2015 report, the total number of deaths by euthanasia and assisted suicides was 5516 [14]. It is also worth noting as Van Der Heide does in her 2007 article that apart from the recorded increase in cases of euthanasia over the years, there has been a parallel increase in cases of continuous deep sedation intended as a means to hasten patients' death. In 2001, the deaths from con-

tinuous deep sedation amounted to 5.6% of all deaths, whereas in 2005 the number had risen to 7.1%. Increased numbers have also been recorded in cases referred to as “voluntary stopping of eating and drinking” which, according to the *Royal Dutch Medical Association* (2011), account for up to 2500 deaths a year. Although the *Dutch Medical Association* considers this practice distinct from assisted suicide, in our opinion there is hardly any difference between the two [15]. These statistics help give an idea of the situation regarding euthanasia and similar practices at the end-of-life in the country with the most experience of such issues.

Going back to the “slippery slope” argument, special mention should be made of the works of Professor John Keown, who has produced one of the most in-depth studies of the debate over voluntary euthanasia from a legal perspective, and who offers a good overview of this tool of moral reasoning [16]. He distinguishes two main aspects of the argument: an empirical and a logical one. The first is a simple observation: in those places in which euthanasia was approved for persons with incurable illness associated with intolerable suffering and who would repeatedly request for an end to their lives, it has been seen that, over the years, euthanasia has been performed on patients with curable illnesses, who did not have intolerable suffering or who had not requested to die. The logical aspect of the argument, holds that the specific precautions, which are taken with the specific purpose of reducing the practice of euthanasia to only limit cases, disappears not only because of the practical question at the moment of implementation, but also because of a theoretical reason. What justifies euthanasia in certain limit cases, making reference to patient autonomy or to the fact that some patients would be better off dead, can also be used to justify its practice when patients voluntarily ask for it even if they do not have intolerable suffering such as in the case for elderly people. Similarly, non-voluntary euthanasia would be also considered justifiable in those

cases in which chronically unconscious patients are considered to be better off dead.

Some authors claim that “the Dutch experience” demonstrates a sufficiently transparent system in which the incidence of euthanasia abuses would not occur frequently [17]. However, a considerable number of authors have found flaws in the system, and the inability of avoiding a slip down the “slippery slope”. Raphael Cohen-Almagor, another author who has made an in-depth study of euthanasia in the countries that have legalised it, is of the same opinion. In one of his articles, he writes that, although some deny slipping on the “slippery slope”, the two major studies carried out in Holland in 1990 and 1995 show that frequently, it is the doctors who first propose euthanasia or the patient's family members who initiate the discussion process; these initiatives in turn have a marked influence on the decision-making process. In other cases, patients' requests are not adequately evaluated; and more seriously, and in quite a number of cases, people who did not ask for euthanasia end up dead [18].

The entire system controlling euthanasia in the Netherlands and Belgium relies on the information gleaned from questionnaires completed by doctors for each case and sent to the relevant Commission for evaluation. This control system fails in the assessment of less clear cases or when not all the legal provisions have been followed. In a study published in the *British Medical Journal* in 2010, Smets et al. analysed questionnaires sent to doctors in Flanders covering a period in which there had been 137 certified cases of euthanasia out of a total of 6202 deaths. The conclusion of the study was that only half of the cases of euthanasia were reported to the Commission. In some cases, the error was due to the fact that doctors did not consider the death as due to euthanasia; in others it was due to the feeling that completing the documentation was an administrative burden, or that not all the legal requirements had been applied. Some doctors



even claimed that euthanasia was a private matter between the doctor and patient [19].

A number of monographs have been written on the subject of the “slippery slope” [20]. Due to limited space, we will only mention three major points: euthanasia for the elderly people who are not suffering from any incurable illness; euthanasia for newborns or minors and euthanasia for patients with depression. The first point is a clear example of the “slippery slope” argument in action. At the beginning, the law required an incurable illness, which would cause intolerable suffering. However, according to the 2015 “Code of Practice” of the *Regional euthanasia review committees* in the Netherlands, the practice of euthanasia is granted to those elderly people who think that their lives are no longer worth living and would rather die than continue living. The text goes as far as pointing out that this question was the issue of previous debate but which has been resolved as it has been noted that intolerable suffering is not only caused by terminal illnesses but also by many geriatric conditions [21]. It is easy to understand how difficult it is for doctors to evaluate such a request. There are very few objective elements foreseen by law on which a request could be based to justify a more or less autonomous decision to end one’s life, independent of one’s health.

Euthanasia is also problematic when considered at the opposite extreme of age. In the first years of the debate on euthanasia and during the drafting of the first legislation, the practice of euthanasia was intended for adults, who could provide a valid consent. In the Dutch situation, it only took a few years to extend euthanasia to those over 16 without their parents consent, and to those between 12 and 16 with parental consent [22]. Neither did it take long to justify euthanasia for newborns born with serious conditions [23]. Although it may be true that these are very complex cases, in which the best interests of the child are being sought, it is also true that in their justification the basic moral element of autonomous decision is lost.

In 2014, Belgium abolished the age limit on euthanasia. A similar problem arises when euthanasia is granted to people with psychiatric illnesses, and in particular those who suffer from depression. In these cases, it is very hard to ascertain that the request to die is the result of a well informed decision made with the minimum amount of interior freedom required for such a decision.

## A final thought

Although many points and much of the debate on euthanasia could still be analysed and addressed, based on what has been said so far, it appears quite clear that euthanasia is presented as a “help” and even as a “solution” for a few hopeless cases. We can conclude that, from both a medical and ethical point of view, it represents an inadequate solution to a real problem; a solution that, as we have seen, leads doctors and patients to get used to it and to consider it as one more therapeutic option. This in turn explains the growing number of euthanasia cases every year.

We believe that Medicine has much more to offer and that, today, its ability to deal with many symptoms is incomparably better than it was a few years ago. In many articles that describe the experience of euthanasia in the Netherlands and Belgium, pain, and generally pain caused by cancer, is one of the major reasons why people ask for euthanasia [24]. In some cases, it is true that treating this kind of pain might be very difficult, but modern palliative care is capable of alleviating the majority of this type of pain. The problem is that, often, physicians do not possess the appropriate competence to do so. The fifth report of the *Federal Commission for Control and Assessment of Euthanasia* in Belgium (2010-2011) indicates that, of all the doctors who had received requests for euthanasia, only 10% had been trained in palliative care. This figure appears to us to suggest that the solution to requests for euthanasia, which in reality are always a request for help, lies in this direction. A

request for help can be answered in many different ways, but not all the answers are equally beneficial. As we said at the beginning, closing the door on euthanasia should represent a starting point for substantially improving professional training in the terminal care of patients.

Therefore, we believe that WMA should not change its policy on euthanasia. A policy based on a Medical Ethic thousands of years old, which does not involve any external control of medical care but rather is a constant stimulus to better the care of patients in the final moments of their lives, always guaranteeing their personal autonomy.

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## References

1. Maxence van der Meersch. *Bodies and Souls*. New York: Pellegrini & Cudahy, 1948.
2. David J. Rothman. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New Brunswick: AldineTransaction, 2008.
3. WMA. Adopted by the 39th WMA in Madrid, Spain, October 1987 and reaffirmed by the 170th Council meeting in Divonne-les-Bains, France, May 2005 and by the 200th WMA Council session in Oslo, Norway, April 2015: <http://www.wma.net/es/30publications/10policies/e13/> (consulted on 15.09.2016).
4. WMA. Adopted by the 53rd WMA General Assembly in Washington, May 2002 and reaffirmed in view of the revision by the 194th Council meeting in Bali, Indonesia, April 2013: <http://www.wma.net/es/30publications/10policies/e13b/> (consulted on 15.09.2016).
5. Hippocrates. *The Hippocratic Oath*. In Ludwig Edelstein *Supplements to the Bulletin of the History of Medicine*. Baltimore: Johns Hopkins Press, 1943; 3.
6. Cfr. Nigel M. de S. Cameron. *The New Medicine: Life and Death after Hippocrates*. New ed Chicago; London: Bioethics Press, 2001; 162.
7. William Frankena. *The ethics of respect for life*. In O. Temkin, W.K. Frankena, S.H. Kadish (eds.) *Respect for life in medicine, philosophy, and the law*. Baltimore: The Johns Hopkins University Press, 1977; 37-38.



8. W. Gaylin et al. 'Doctors Must Not Kill'. JAMA 259, No.14 (April 8, 1988): 2139–40.
9. Massachusetts Medical Society on the Ballot on Prescribing Medication to End Life (November 6, 2012), p. 6.
10. Daniel Callahan. The Troubled Dream of Life: In Search of a Peaceful Death. Washington DC: Georgetown University Press, 2000.
11. Herbert Hendin. Seduced by Death: Doctors, Patients, and Assisted Suicide. New York: W. W. Norton, 1998.
12. Published in the Herald Sun (21.11.20110): <http://www.heraldsun.com.au/blogs/andrew-bolt/a-dying-man-explains-why-euthanasia-is-so-dangerous/news-story/ec8b23ae-24376e980085f88ef0837b3e> (consulted on 15.09.2016)
13. Agnes van der Heide et al. End-of-Life Practices in the Netherlands under the Euthanasia Act. The New England Journal of Medicine 356, No. 19 (May 10, 2007): 1957–65.
14. This data can be consulted on the website del Regionale toetsingscommissies euthanasie: <https://www.euthanasiacommissie.nl/> consulted 15.09.2016).
15. Royal Dutch Medical Association. The Role of the Physician in the Voluntary Termination of Life. Amsterdam: KNMG, 2011; 34–36. <https://www.knmg.nl/over-knmg/contact/about-knmg.htm> (consulted on 15.09.2016).
16. John Keown. Euthanasia, Ethics and Public Policy: An Argument against Legalisation. Cambridge: Cambridge University Press; 2002.
17. Bregje D. Onwuteaka-Philipsen et al. Trends in End-of-Life Practices before and after the Enactment of the Euthanasia Law in the Netherlands from 1990 to 2010: A Repeated Cross-Sectional Survey. Lancet, 380, No.9845 (September 8, 2012): 908–15; Bernard Lo. Euthanasia in the Netherlands: What Lessons for Elsewhere? Lancet 380, No.9845 (September 8, 2012): 869–70.
18. This study shows 1000 cases of speeding death without request in 1990 and 900 cases in 1995: Raphael Cohen-Almagor. Non-Voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives. Issues in Law & Medicine 18, No. 3 (2003): 239–57.
19. Tinne Smets et al. Reporting of Euthanasia in Medical Practice in Flanders, Belgium.
20. David Lamb. Down the Slippery Slope: Arguing in Applied Ethics. New York: Croom Helm, 1988; Iñigo Ortega Larrea. Eutanasia: ética y ley frente a frente. Rome: Pontifical University of the Holy Cross, 1996; Roberto Aguado Aguaron. El cuidado del enfermo en la fase terminal: un estudio moral a partir de la práctica de la eutanasia en Oregón – USA. Rome: Pontifical University of the Holy Cross, 2003; Javier Vega Gutiérrez, La pendiente resbaladiza en la eutanasia: una valoración moral. Rome: Pontifical University of the Holy Cross, 2006.
21. Regional euthanasia review committees. Code of Practice. The Hague, April 2015: <https://www.euthanasiacommissie.nl/actueel/nieuws/2016/mei/27/code-of-practice-translated-in-english> (consulted on 15.09.2016).
22. More information on the practice in the Netherlands can be found on <https://www.government.nl/topics/euthanasia> (consulted on 15.09.2016).
23. Eduard Verhagen and Pieter J.J. Sauer. The Groningen Protocol — Euthanasia in Severely Ill Newborns. New England Journal of Medicine, 352, No.10 (March 10, 2005): 959–62.
24. See for example the Code of Practice (2015), p.13.

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