

Occasional essay

Deathbed disputation: a response to Peter Singer

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Peter Singer, the well-known Ira W. DeCamp Professor of Bioethics at Princeton University, begins his review of my recent book *Death Talk*¹ with the statement that it failed to persuade him to change his mind that voluntary euthanasia should be legalized.² This is no surprise. Professor Singer is internationally famous for his intensely utilitarian ethics and his advocacy of the legalization of euthanasia. What is disappointing about Singer's review, however, is his failure to address the arguments against euthanasia and physician-assisted suicide that are presented in my book. Dismissing in one stroke not only my arguments and analysis but the work of the large number of scholars and authors whom I cite, Singer claims that *Death Talk* offers "astonishingly little" to override "a patient's considered views in this most intimate of decisions."

It is vitally important that we give close attention to the quality of the arguments proffered as "considered views" in the euthanasia debate. This is no TV game show, but an urgent matter of social values and public policy being played out in many countries, especially in the media. For example, in May 2002 in Queensland, Australia, 8 pro-euthanasia lobbyists were present at the suicide of a 69-year-old woman, Nancy Crick. This case, which was front-page news, preceded by only 3 days a scheduled debate on euthanasia between the lobby's leader — a physician, Dr. Philip Nitschke — and myself, at the annual general meeting of the Australian Medical Association. It remained on the front page when it was revealed that an autopsy found no evidence of a recurrence of the bowel cancer for which Mrs. Crick had previously been treated.^{3,4} But it is not only medical facts that some of the people who agree with euthanasia and physician-assisted suicide get wrong. To promote their cause they also deliberately confuse definitions, legal concepts such as causation, and the results of polls. I call their position "euthanasia by confusion."

In his review, Singer is intolerant of what he considers an excessive repetitiveness in *Death Talk*. My restatement of certain arguments was calculated to serve a wide range of readers and to allow individual chapters to stand on their own — an approach that I hope will help to dispel confusion. Of more concern, however, are his claims about what the book omits, namely,

detailed examinations of the situation in Oregon, where physician-assisted suicide has been legal since 1997, and the Nether-

lands, where for 20 years physicians have openly carried out voluntary euthanasia, and where the practice is now legal under specified conditions.⁵

Although *Death Talk* does contain references to the Oregon legislation, Singer is correct that there is no systematic examination of it. In contrast, the book includes considerable discussion of euthanasia and physician-assisted suicide in the Netherlands. Even had I wanted to discuss the Oregon situation in more detail I would have encountered serious obstacles. Drs. Kathleen Foley and Herbert Hendin have recently documented the secrecy that surrounds the Oregon Health Department's approach to cases in which patients are assisted in suicide pursuant to the provisions of the Oregon Death with Dignity Act, and the great difficulty that exists in obtaining the information necessary to report on how the legislation functions in practice.⁵ They write:

the desire of so many Oregon officials to keep from public scrutiny the facts about assisted suicide in Oregon, is particularly troublesome. ... Particularly disturbing in Oregon — and most similar to the Netherlands — is that those administering the law and those sanctioned by government to analyze its operation have become its advocates and its defenders.⁵ (p. 173)

According to Foley and Hendin, secrecy is an important part of their defense strategy.

As to the Netherlands, Singer describes my knowledge as "shaky" on the following grounds:

In an exchange with Torsten Nielsen, an advocate of legalized euthanasia, [Somerville] takes him to task for relying on a 1990 Dutch study that was repeated in 1995 "with different results in relevant and important aspects." Nielsen responds that the results of the 1995 study were not much different from those of the 1990 study. Somerville then claims that the 1995 study "provides evidence of serious abuses of euthanasia" but fails to specify in what way this evidence is different in the later study. (It isn't.)⁶

So, what are the facts? Was there, contrary to Singer's assertion, a change in the evidence between the first and second study? And were there serious abuses?

To answer these questions it is necessary to quote Hendin's research⁶ at some length:

Comparing the data for the 1990 and 1995 [Dutch] studies is re-

vealing. From 1990 to 1995, the death rate from euthanasia increased from 1.9 percent to 2.2 percent of all deaths, when based on interviews with 405 Dutch physicians selected from a stratified random sample. The rate increased from 1.7 percent to 2.4 percent when based on responses to a questionnaire completed by more than 4,600 physicians in both years. The increase in euthanasia deaths, ranging from 16 percent to 41 percent (from 573 to 1,064), would seem significant, but the Dutch investigators do not regard it as such even though they give “generational and cultural changes in patients’ attitudes” as a possible explanation for the increase.⁶ (p. 101–2)

. . .

By 1995 there had been an increase in the number of deaths in which physicians gave pain medication with the explicit intention of ending the patient’s life from 1,350 cases [in 1990] to 1,896 (1.4 percent of all Dutch deaths). . . . As reported by the physicians in the 1995 study, in more than 80 percent of these cases (1,537 deaths), no request for death was made by the patient. Since these are cases of nonvoluntary, and involuntary (if the patient was competent), euthanasia, this is a striking increase in the numbers of lives terminated without request and a refutation of the investigators’ claim that there has been perhaps a slight decrease in the number of such cases.⁴

If one totals all the deaths that resulted from euthanasia, assisted suicide, ending the life of a patient without consent, and giving opioids with the explicit intention of ending life, the estimated number of deaths caused by active intervention by physicians increased from 4,813 (3.7 percent of all deaths) in 1990 to 6,368 (4.7 percent of all deaths) in 1995. Based on data from the questionnaire study, this is an increase of 27 percent in cases in which physicians actively intervened to cause death. Of the more than 6,000 deaths in which physicians admit to having actively and intentionally intervened to cause death, 40 percent involved no explicit request from the patient for them to do so.⁶ (p. 105)

Whether we are for or against the legalization of euthanasia and physician-assisted suicide, and quite apart from whether we believe that intentionally inflicting death is inherently wrong, if we believe that increases in the number of people on whom death is inflicted, especially those who have not given their consent to such infliction, matters, there are important and major differences between the 1990 and 1995 survey. Singer states that “[t]he Dutch trust their doctors not to leave them to their suffering.” In light of the above statistics, this can also be stated as the Dutch can trust some of their doctors to kill them, whether or not they want to be killed. Indeed, they would probably have interpreted my father’s statement (which Singer refers to in his review) that he wanted to live as long as he could, but not if he had to endure such terrible pain, as a consent to euthanasia.

And what about my claim, disputed by Singer, that the Dutch studies revealed there were “serious abuses”? Singer states that I should have pointed out that much of what I describe as “serious abuses” is exactly what I describe elsewhere

as good medical practice: namely, withholding or withdrawing life support, or giving life-shortening doses of pain-relieving drugs. The only difference is that the more direct and honest Dutch study is prepared to describe such acts as medical decisions that shorten life, whereas Somerville focuses not on what a

doctor knows the dose will do, but on what a doctor, in the privacy of his or her conscience, “intends” it to do (supposedly, to relieve pain, not shorten life).²

While Singer is certainly not confused — on the contrary — I would suggest that he read more carefully my chapter on euthanasia by confusion — in particular, the sections about intention and causation, even if only to reject with more sophisticated arguments the detailed legal analysis of the concepts outlined in that chapter. What Singer — like most people who favour the legalization of euthanasia — seems either to deny or to fail to appreciate is that maintaining the integrity of the concepts of intention and causation in the context of euthanasia matters to the law far outside that context. Damage to those concepts in the context of euthanasia would necessarily harm them in the criminal law in general, and in other areas of law.

The chapter on euthanasia by confusion explains how people who advocate the legalization of euthanasia deliberately confuse ethically and legally acceptable refusals of treatment, and the provision of treatment necessary to relieve pain but which could shorten life, with intentionally killing the patient. They do so to promote the acceptability of the latter and without addressing the substantive argument that the former are different in kind from the latter. In the passage from his review quoted above, Singer uses exactly this technique to explain the Dutch statistics on “serious abuses,” by which I meant giving lethal injections to people who have not consented to euthanasia. He equates ethically and legally acceptable refusals of treatment and the provision of treatment necessary to relieve pain, with “medical decisions that [have a primary intention to] shorten life,” that is, euthanasia.

Singer also criticizes me for not asking why the Dutch parliament would “vote overwhelmingly” for voluntary euthanasia if there were “serious abuses.” In doing so he reveals a serious and common misunderstanding of democratic decision-making. Democratic decision-making has no moral status per se; it is only as morally aware as its participants, the voters. Just because most people and, therefore, their representatives in parliament favour euthanasia, does not mean that they are making a morally appropriate choice. It could mean (one hopes very rarely), that most people are unable to make proper, moral choices. It could even mean, as it did in white South Africa during Apartheid, that most people deliberately choose evil.

Singer’s comment about the situation in which I went “berserk” to obtain pain relief for my father — “[W]hat about the unfortunate 99.999% of patients who do not have such well-qualified and passionate advocates?” — is empathetic but misses the point. Patients should not have to depend on qualified and passionate advocates to obtain such treatment for themselves: they have an ethical and legal claim to it. In other words, pain relief medication should be given routinely to all patients who need it — unless, of course, they refuse it. My father’s awful experience occurred

in 1982. The provision of pain relief is still not perfect, but it has improved vastly in the last 20 years with the development of palliative care as a medical specialty. Also, the ethics and law of the provision of pain relief and of rights of access to it have developed in important ways in the last 10 years. These are explored in the 4 chapters that make up section 3 of *Death Talk*, “Untreated Pain and Euthanasia.”

In his review, Singer employs another technique used by those who support euthanasia, which again I address in *Death Talk* (p. 107): the reversal of the burden of proof in the justification of euthanasia. He does this when he says that I cite “no evidence to support the conclusion that, judged by the criteria used in the Dutch studies, doctors end the lives of more nonconsenting patients in the Netherlands than in any other country where euthanasia is illegal.” Quite apart from the question of whether such a reversal of the burden of proof is justifiable (in my view, it is not) and the difficulty of procuring such evidence, it misses the point of why those people who oppose euthanasia do so — again, a matter discussed in *Death Talk* (p. 120). They believe that euthanasia is inherently wrong, because it is inherently wrong to intentionally kill another person (unless one has no other option when acting in defense of one’s own or another’s life).

Singer continues as follows:

Indeed, there is considerable evidence from several studies, including one that I carried out with colleagues in Australia,⁷ to suggest exactly the opposite: where voluntary euthanasia cannot be discussed openly, doctors end the lives of more patients without obtaining the informed and considered consent of the patient.²

But, according to David Kissane, the survey study that Singer and his colleagues carried out was unsound. It contained key questions that “combine[d] both actions or omissions that did not seek to prolong life with those aimed at hastening death.”⁸ Kissane writes:

This conflation ... led to their grossly flawed conclusion that in 36.5 percent of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient’s life. The ... actions or omissions aimed at not prolonging life [incorporated in this statistic] would include a doctor who appropriately decided not to initiate futile intensive care or ventilatory support for a patient dying from terminal cancer. The wide range of ordinary treatment decisions that have nothing to do with intention to kill but were included in their questions, rendered any comparison with the Dutch [studies] meaningless.⁸ (p. 207)

Pro-euthanasia advocates present end-of-life decision-making as a straightforward, simple and clear process. They have long relied on “facts,” the validity of which it has been difficult to challenge. These facts include statements such as that a substantial proportion of physicians and nurses carry out euthanasia; that most people want euthanasia legalized; that people requesting euthanasia are not suffering from depression and their competence can easily be determined; that the risks of legalizing euthanasia

are less than the risks of continuing to prohibit it; and that abuses of legalized euthanasia can be readily prevented. In *The Case Against Assisted Suicide* Foley and Hendin assemble a very different reading of the facts of end-of-life decision-making, particularly in the context of legalized euthanasia in the Netherlands and physician-assisted suicide in Oregon. That decision-making is complex and nuanced and can be radically changed by changing the circumstances in which it takes place.

One’s choice of a physician is such a circumstance, because even if they try not to do so, physicians cannot avoid influencing their patients. The less physicians know about palliative care, the more they favour legalization; the more they know, the less they favour legalization.⁹ Dr. Nitschke has no training in palliative care. Another finding: in the absence of a long-term physician–patient relationship, 94% of Oregon psychiatrists surveyed did not feel very confident that they could assess a patient’s competence in a single visit, and the majority of psychiatrists willing to evaluate a patient’s competence for assisted suicide favoured the practice (p. 152–3).⁵ And in “a survey of 1,177 physicians who treated a total of more than 70,000 patients with cancer in the previous six months, 76 percent of the physician respondents reported that lack of knowledge was a barrier to their ability to control pain (p. 298).”¹⁰

In the Netherlands, suicidal patients over 50 years of age are asking for euthanasia instead of dying by suicide (p. 112).⁶ In Oregon, approximately 50% of the patients in each of the groups who either made a request for a lethal prescription or were given such a prescription or who committed suicide, received no palliative care intervention of any kind. But almost half of the patients who did receive such an intervention changed their minds about assisted suicide (p. 114).⁵ The physician’s complex role in preventing patients from entering a state of hopelessness in the face of death, a state that correlates with a desire for euthanasia, is now being recognized.^{11,12} To offer assistance in suicide or euthanasia to terminally ill people is to offer them death instead of hope — indeed, it is actively to eliminate any hope that might be present and the possibility of finding it. Viewed that way, such an offer is a truly nihilistic response.

Everyone, especially health care professionals, because they care for dying people and strongly influence society’s decisions about euthanasia, must fully inform themselves of such facts before they decide where to stand on legalizing euthanasia. As a result of such information becoming available, a new group of people who oppose euthanasia is emerging. The traditional opponents are those who believe it is inherently wrong to kill another human being. The more recent opponents — some of whom have favoured legalization in the past¹³ — are coming to believe that abuses cannot be prevented and that the most vulnerable people in our societies — especially disabled and aged people — would be placed at the greatest risk of being victims of the abuse of legalized euthanasia and physician-assisted suicide.

There is, however, a further critical lesson in such facts.

If we want to make the legalization of physician-assisted suicide and euthanasia unlikely, we must ensure that comprehensive, integrated and sensitively delivered palliative care is available to everyone who needs it.

The argument between Peter Singer and me is at base a conflict of world views that results in a disagreement about what the principle of respect for life requires of us, as both individuals and a society, in a postmodern, secular society.

Singer seems to take what I have called elsewhere a “pure science” or “gene machine” world view.¹⁴ In relation to death, this means that when we are past our “best-before” or “use-by” date, we should have the right to be checked out as quickly, cheaply and efficiently as possible. Euthanasia fulfills those requirements. Singer’s is a highly individual rights-based, rational and logically grounded approach to death. It gives very little credence or weight to the harms and risks to society, and the institutions of medicine and law, that legalizing euthanasia and physician-assisted suicide would involve. And, while it is based on true compassion, it leaves no room for human mystery. People who are uncomfortable with mystery (and its companion, uncertainty) often turn mysteries into problems to which they seek solutions. Legalizing euthanasia is an obvious solution to the problem of death, but it would be destructive of the mystery of death.

I take what I call a “science spirit” world view.¹¹ We are highly complex, biological beings, as the extraordinary and mind-opening advances of contemporary science have shown us, but we are more than gene machines. We also have a human spirit, by which I mean the intangible, invisible, immeasurable reality that we experience and that gives meaning to life and makes it worth living — that deeply intuitive sense of relatedness or connectedness to other people and to the world and the universe in which we live. By human spirit I do not intend to include anything religious or a belief in the supernatural, although this concept can accommodate such beliefs. Rather, I am trying to identify a concept that can encompass the deep wisdom — the “memes,” or units of deep cultural information — that humans pass on from generation to generation. What constitutes that deep wisdom is difficult to articulate adequately, but that is not a reason to dismiss either its existence, its intrinsic worth, or its crucial role in human flourishing. And it is particularly important to have deep wisdom in relation to human death.

I use the term “secular sacred” — which Singer criticizes in his review — to try to capture the idea that there are some things, even in a secular world, that deserve profound respect. For example, we must be concerned not to harm the intangible realities that make up the human spirit, through which as individuals and a society we find meaning in life. Euthanasia directly threatens the human spirit, because respect for the mystery of death is essential to maintaining respect for the mystery of life — and that, I believe, is essential to maintaining respect for life itself. I hasten to add — because I know that Professor Singer will dismiss what I have just written — that by the mystery of death I mean seeing human death as something more than simply a

biological event; it need not be seen as encompassing anything supernatural.

Pursuant to this view, we see each human death as involving not only the dying person and his or her family, but also the community as a whole. In our secular society, medicine and the law uphold the value of respect for life. What would be the effect on these institutions, and on society, if the law permitted physicians to give lethal injections to their patients? What impact would teaching medical students how to give such injections have on them? And what would be the impact on the value of respect for life in 22nd-century Canada? Those questions lead to one more: Are we more likely to find answers to such questions that we can live with if we continue to prohibit euthanasia, or if we legalize it?

In an ironical sense, Singer’s review is reassuring, because if this is the best that such a gifted person can do in rebutting the case against euthanasia, those who oppose its legalization may take heart. In short, through employing the pro-euthanasia techniques of analysis and argumentation, and the rhetorical strategies that I describe in *Death Talk*, Singer uses the review as just one more opportunity to promote euthanasia through confusion.

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Competing interests: None declared.

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