GRASPING THE NETTLE

Doctors do it, nurses help them, and the public nods approval, but the law calls it a crime. For some it exemplifies respect for human dignity, self-disregarding compassion - the epitome of medical care. For others it is a denial of the sanctity of human life, flouting the authority of God and degrading a fine professional ethic.

Whether or not it is eventually decriminalised, voluntary euthanasia will remain contentious for as long as moral issues are debated and religious opinions differ. The polarisation is almost complete and middle ground is hard to find. Those with misgivings are stranded there. For some, uncertainty comes from the thought of a venture into uncharted territory; others lack information or, more likely, have a goodly stock of misinformation.

The proponents of voluntary euthanasia seek to change the law so that it will no longer be an offence for a doctor to accede to an informed and persistent request from a hopelessly ill patient for active help to die swiftly and peacefully. “Physician-aid-in-dying” the Americans call it. “A gentle act of merciful clinical care” said a working party of the British Institute of Medical Ethics. Only the patient can initiate the procedure, only a doctor may respond, after obtaining a second opinion. The key word is “voluntary”: patients and doctors to whom it is unacceptable are free to stand aside. So why the fuss?

Fuss there is in plenty, if the delicately worded Vatican declaration condemning voluntary euthanasia, and similar statements on behalf of other mainstream churches, can be so called. There have been more robust responses from right-to-life sources. A Lutheran pastor summed it up when he stated that voluntary euthanasia is, simply, “contrary to the Will of God”. Doctrinal imperatives, depending as they do on an unverifiable source, cannot be debated but should be respected. So should the right to differ and so should the feelings of doctors who cannot face the paradox of ending life out of respect for human dignity. The ultimate question is not “Do I agree?” but “What right have I to deny the option to others?”

Respect for the freedom of individual conscience implies that our right to life embraces the right to surrender that life in certain circumstances - and in those circumstances one may legitimately seek help to do so. If it can be right to take the life of another in a “just war”,for example, or in self-defence, as most churches maintain, how can it be wrong for a doctor to provide requested relief to a patient in otherwise irremediable distress, who can no longer live life as it should be lived? “There is”, says the philosopher James Rachels, “a great difference between being alive and having a life”.

Voluntary euthanasia is not a new concept: the Greeks had a word for it. But the current debate is new and closely related to advances in modern medicine, conferring on us the mixed blessing of prolonged life and raising the spectre of delayed and distressful dying. We die no longer from infection but of degeneration. For a long time the debate teetered around a supposed vital distinction between “passive” and “active” euthanasia, passive meaning withholding or withdrawing life-preserving treatment (so-called “omission”), and active, providing or administering a lethal dose (so-called “commission”). Passive was good, or at least acceptable; active was bad, evil really. Now the fog has cleared. Any act, whether of omission or commission designed to hasten death stands condemned, and so does the poor patient who asks for it. But if death is hastened by an act intended to avoid burdensome or ineffectual treatment, or relieve suffering, there is no wrongdoing. Those who try to walk the tightrope of this fine and unverifiable distinction have been compared to the prelates of long ago who disputed how many angels could dance on the point of a needle and agreed on a number.

At ground level, so to speak, there is another perspective. Voluntary euthanasia is an established feature of medical practice, not merely a disputed area of religious and medical ethics. In Victoria in 1987, 29% of doctors who responded to a survey had actively helped a patient to die; 60% wanted the law changed to give patients the option and themselves the

discretion. A similar survey of nurses in 1991 recorded 75% in favour of law reform – they spend more time at the bed face. The Roy Morgan public opinion poll in 1996 found 76% in favour of voluntary euthanasia.

Should we not give patients the right to choose; doctors the discretion to act in their interests; and everyone the safeguards needed to ensure confidence in the procedure? At the time of writing the Dignity in Dying Bill 2001 is before both Houses of South Australian State Parliament, where it may be accepted, improved, or rejected.

It is said that if you try to brush a nettle aside it stings you. If you grasp it firmly, it doesn't. But that takes courage.

Dr Eric Gargett PHD.
Former President
South Australian Voluntary Euthanasia Society