The doctor as moral agent, with reference to the distinction between killing and “letting die”

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Abstract

In the bioethics literature, arguments about the nature of the distinction between killing and “letting die” seem irresolvable. There is a disparity between the dominant (consequentialist) opinion on this issue and that of the medical profession. No previous studies have investigated how doctors who work with the dying understand the distinction in the medical context. The aim of my research was to explore the moral reasoning of these clinicians in relation to this question. A focused ethnographic study involved thirty Melbourne doctors (thirteen palliative care physicians, nine oncologists, six intensivists, and two advocates of physician-assisted suicide) of whom eighteen were male and twelve female, with an age range from 31 to 77 years. Half had a religious belief (Jewish or Christian) and half were atheist/agnostic.

Participants agreed that it is permissible to withhold or withdraw life prolonging medical treatment under certain circumstances, that doctors have a moral obligation to relieve suffering, that doctors are very unwilling to kill patients and that, if active voluntary euthanasia were legalised, doctors would not be morally obliged to perform it.

Two major themes are identified. The first is that of “taking control”, that is, that in medical killing, but not in “letting die”, the doctor is perceived as taking control over a patient’s death. Participants used a combination of up to five criteria which all needed to be met to make the distinction between killing and “letting die”: that it involves an act, not an omission: that it is artificial, not natural, that the doctor causes death, not the underlying disease, and that death is certain to result. Twenty two doctors maintained the traditional moral distinction between killing and “letting die”, five did not think active voluntary euthanasia was necessarily always wrong but thought that the distinction has some moral significance in the medical context, and three did not consider it to have any moral significance. Several features of the moral reasoning of the doctors in this study are identified, including that it is from the perspective of the doctor as moral agent, that it involves extensive use of stories and particular, concrete situations, that they have an inclusive understanding of “letting die”, that they generally reject consequentialist reasoning, and that the moral significance of the distinction is not reducible to the wrongness of any one criterion but depends on the wrongness of killing.
The second theme is that of “killing and the role of the doctor”. In many cases the belief that active voluntary euthanasia (AVE) is wrong was associated with the belief that killing is generally wrong, but twenty five of the participants said they thought that killing was either not part of, or actually antithetical to, the role of a doctor. Only four participants justified AVE or physician-assisted suicide in terms of the goals of medicine, two in relation to achieving a good death, and four in relation to the relief of suffering.

The findings of this study suggest that future bioethics argument about the distinction between killing and “letting die” and the permissibility of active voluntary euthanasia and physician-assisted suicide should include a greater emphasis on the role of a doctor and the goals of medicine, as understood by its practitioners.
Declaration

This is to certify that

i) the thesis comprises only my original work towards the Ph D,
ii) due acknowledgment has been made in the text to all other material used,
iii) the thesis is less than 100,000 words in length, exclusive of tables, bibliographies and appendices

Denise Cooper
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All opinions expressed in this work are my own, as are any errors and shortcomings.
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Chapter One  Introduction

What does it mean for a doctor to be a moral agent? At the simplest level, it connotes that a doctor, like all other competent and reasonably mature human beings, is a being who has the capacity for moral judgment, and whose behaviour therefore is capable of moral evaluation. At another level, one might think of an agent as the subject of an action, which raises questions of whether actions must be intentional or involve bodily movement (Hornsby, 1995a), how agency is related to volition, responsibility and causality (Hornsby, 1995b), and the moral distinction between actions and omission to act, of which the moral distinction between killing and “letting die” is an example with particular relevance to medical practice.

At yet another level, speaking of a doctor as a moral agent may imply an emphasis on the moral dimension of medical practice, the moral nature of much medical decision making, and the moral responsibility of doctors. The term has been used in this way in relation to doctors (Savulescu, 1995) as well as other professionals, including nurses and teachers (Bergem, 1990; Hamric, 1999). However there is a strand in bioethics which, while acknowledging the moral nature of many medical decisions, seeks to minimize or even eliminate the influence of doctors’ own moral convictions and commitments in these decisions. For example, there is the view that respect for the autonomy of the patient means that health care workers should give precedence to the moral values of patients over their own (Neuberger, 1994). The implication is that doctors should seek to set aside their own moral judgments and assume a purely technical role in facilitating the patient’s goals. Another view is that doctors should judge the best course of action in the light of both the patient’s wishes and “general moral principles”, rather than their own moral principles (or those of their profession) (Kennedy, 1991).

“The doctor as moral agent” might be taken further to imply that doctors have particular moral responsibilities qua doctors. In virtue theory the focus is on the character of the agent making a decision about right action, rather than solely on the nature of the act itself, or its consequences. The work of Alasdair MacIntyre has been especially important in the contemporary argument about whether medicine as a practice has an internal morality, which generates particular moral obligations and necessary virtues for
doctors, or whether doctors should be guided only by the application of universal moral principles to medical practice (MacIntyre, 1984).

This thesis has its origins in two observations and two claims.

The first observation is that, although there is no single view or even consensus among philosophers or bioethicists (who also include lawyers and some medical practitioners), there is a notable disparity between the dominant bioethical opinion ¹, on this issue and the attitude of the medical profession, at least as expressed in the codes of medical associations. Many influential writers in the field of bioethics are convinced on the basis of consequentialist theory that there is no morally significant difference between killing and “letting die”, and wish to persuade clinicians of this. Yet almost all medical associations distinguish between both the withholding or withdrawal of inappropriate, futile or unwanted life-prolonging medical treatment, and the administration of symptom relieving drugs which may be foreseen but not intended to hasten death, on the one hand and the administration of a lethal injection on request and physician-assisted suicide, on the other. They hold that the former may be morally permissible, even morally required under certain circumstances, while maintaining their opposition to the latter.

Possible explanations for this disparity include social conservatism among doctors, medical traditionalism, and simple ignorance or philosophical naivety on the part of the medical profession. With more education in ethics, it might be supposed that attitudes will gradually change, and doctors come to see the lack of logic in their position.

The first claim comes from MacIntyre, and provides an alternative explanation for the disparity. Drawing on the Aristotelian tradition, MacIntyre suggests that those engaged in different moral practices see things differently, since the internal goods of their practices and the virtues which enable the achievement of those goods are particular to each practice. He claims that these goods “can only be identified and recognized by the

¹ One author claims that contemporary philosophers (with some significant exceptions) tend to find the ethical relevance of the distinction “somewhat obscure and elusive in those circumstances where the expected outcome is virtually identical” (Thornton, 1999, p.415), thus assuming the dominance of consequentialism among philosophers. The dominance of utilitarianism in particular is such that one philosopher actually defines bioethics as “medical ethics as conceived and practiced by philosophers working in the utilitarian tradition” (Maclean, 1993, footnote 6, p.205). However I will not use the term ‘bioethics’ in this restricted way.
experience of participating in the practice in question. Those who lack the relevant experience are incompetent thereby as judges of internal goods” (MacIntyre, 1984, pp.188-189). This would mean that clinicians are better placed than academic philosophers to understand the distinction between killing and “letting die, as it applies in medical practice, in relation to the internal goods (or goals) of medicine. The second, related claim, is that, indeed, the ability to “see” the distinction in the medical context is intrinsic to being a good clinician (whether or not it can always be maintained in other contexts) (Gillett, 1994, p.315).

The second observation is that doctors not trained in philosophical or legal language tend not to be represented in the bioethics discourse. Indeed the whole tradition of professional medical ethics (as formulated by those who practice medicine) has tended to be discounted by the relatively new discipline of bioethics, and the moral perceptions of clinical practitioners under-represented. Ironically, the necessary attention to the experience of patients in bioethical discourse has coincided with a tendency to discount the experience of practicing clinicians. And yet it is clinicians who are required to act on particular ethical decisions in the clinical context - they are the moral agents in either killing or “letting die” situations. Therefore, if MacIntyre and Gillett are correct, a key voice is missing in much of the bioethics debate.

This thesis seeks to address this deficiency by exploring the opinions and beliefs of medical practitioners about the nature of the distinction between killing and “letting die” in medical practice. It seeks to give them a voice in the bioethics discourse on an issue which, some believe, goes to the heart of medicine.
Chapter Two  Contextualising the arguments (1)

2.1 Introduction: The importance of contextualisation
The focus of this thesis is on medical killing and medical “letting die”, so that the practice of medicine is the primary context in which the discussion of the distinction between them is located. In this chapter I examine two further contexts in which arguments about the nature of the distinction between killing and “letting die”, and its moral significance, take place.

Philosophical discussion about the distinction is often conducted in a theoretical, abstract way which pays little attention to the social, professional, historical, political and legal contexts in which both killing and “letting die”, and the debate about the significance of the distinction between them, take place. Sometimes the argument is so abstract as to be framed in mathematical terms 2.

Another feature of the philosophical literature on the topic is the use of hypothetical examples, such as the “trolley problem” 3 (Foot, 1980; Kamm, 1996; Oddie, 1997; Thomson, 1976). Many of these examples are instances of conflict, in that an agent has to choose between two prima facie wrong acts which will each result in the death of at least one person (Malm, 1989, p. 239). Most of these hypothetical examples seem far-fetched and unrelated to medical practice, although similar conflicts do occur, though rarely, in obstetric practice. However, advances in medical technology have provided a number of concrete and everyday situations where the question “Is what we are doing to this patient ‘killing’ or is it ‘letting die’?” is a very real and pressing one. These situations include the withholding of life saving treatment (such as artificial ventilation, artificial nutrition and hydration, dialysis, blood transfusions and even antibiotics), and the withdrawal of such treatment. In addition, palliative care sometimes includes the administration of analgesics and sedatives which have the potential to shorten life. As these practices became accepted as legal, and as morally permissible by the medical profession, it was argued by some that there was no moral difference between them and

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2 For example, the symbolic logic used in Oddie’s analysis of the “trolley problem” (Oddie, 1997).
3 “Edward is the driver of a trolley, whose brakes have just failed. On the track ahead of him are five people; the banks are so steep that they will not be able to get off the track in time. The track has a spur leading off to the right, and Edward can turn the trolley onto it. Unfortunately, there is one person on the right-hand track. Edward can turn the trolley, killing the one; or he can refrain from turning the trolley, killing the five” (Thomson, 1976, p.206).
the administration of lethal drugs to a competent patient at their request, with the intention of causing death (Active Voluntary Euthanasia or AVE ⁴), or the prescription or provision of such drugs to a competent patient at their request (Physician-Assisted Suicide or PAS). This was one of a number of arguments put by advocates for the legalisation of one or both of these practices.

So the backdrop of bioethical discussion about the distinction includes the continuing public debate about the morality of AVE and PAS, political campaigns to legalise these practices, and a series of court cases which ruled on the legality of certain medical practices under certain circumstances.

2.2 The linguistic context
Thinking about killing and “letting die” cannot be abstracted from the way people use and understand words. One way that any distinction between them may be confused is through the use of ambiguous language. Terms like “hastening death” and “not prolonging life” are sometimes used interchangeably, and do not make clear what is actually envisaged. The ambiguous terms “assisted death” and “aid in dying” (the latter now being used increasingly for what used to be called active voluntary euthanasia (Jonsen, Siegler, & Winslade, 2002, p.138)), could well be understood to be part of good medical care, but they are used to include assistance or aid to die, not just in alleviating any symptoms or distress in the dying process. The “right to die” is used both of the right to refuse life-prolonging medical treatment on one’s own behalf or through an advance directive or a surrogate decision maker, and of the claimed right to assistance in committing suicide, or the right to be killed on request. The term “medical end-of-life decision” conflates active euthanasia (whether voluntary or not), treatment abatement, and administration of pain relief which may shorten life (Kuhse, Singer, Baume, Clark, & Rickard, 1997).

While “killing” has generally been construed as active and “letting die” as passive, some writers turn the active/passive distinction on its head, when arguing that killing is sometimes morally preferable to “letting die”. Ronald Dworkin speaks of “allowing to die” when he means assisted suicide or AVE, and conversely describes the failure to

⁴ Throughout, except when citing others, I shall use the term “active voluntary euthanasia” to refer to the administration of lethal drugs to a competent person at their request (not necessarily by a doctor), rather than the more ambiguous “euthanasia”.
provide these as “forcing people to live” or “making them die (horrible deaths)” (Dworkin, 1993). To “make someone die” implies doing something, but it is AVE or assisted suicide which require doing something. Similarly, Peter Singer describes women who died in obstructed labour when their attendants refused to crush the skull of the baby as dying “at the hands of devout Roman Catholic doctors and midwives” (P. Singer, 1994, p.193), again suggesting that something was actually done when it wasn’t. Perhaps, as has been suggested, “the words are chosen to suggest the opposite of what they actually stand for” (Wierzbicka, 1996, p.58).

An illustration of the difficulties this linguistic confusion or lack of clarity can cause is provided by the response of the BMA’s annual representative meeting to a motion that “doctors are obliged to accede to clear requests by patients that their life should be allowed to end”. The mover thought that this would be uncontroversial, merely acknowledging the obligation to respect a competent patient’s refusal of treatment. However others thought the motion was open to misinterpretation, and the chairman of the medical ethics committee said that if passed it would “produce BMA policy which supported euthanasia and doctor-assisted suicide” (Beecham & Wise, 1998, p.17).

The different ways that people use the word “kill” also leads to confusion. In general usage “killing”, at least when applied to killing human beings, has a negative moral connotation. So, while the distinction between killing and “letting die” is generally taken roughly to correspond with a distinction between an act and an omission, “killing” is sometimes used to indicate a negative moral evaluation of the act or omission that results in death (Sulmasy, 1998). A parent who failed to feed her infant would often be described as having killed the child, and some who oppose the withdrawal of feeding tubes under certain circumstances are apt to describe this as killing, even murder (Keown, 2003). In this way, ordinary language reflects the moral convention that killing is ordinarily wrong, and “letting die” does not seem a strong enough term for omissions we judge to be culpable because someone ought to have acted. Conversely, those who advocate the moral permissibility of medical killing in certain circumstances wish to avoid this negative moral connotation by the use of softer alternative terms such “mercy killing”, “euthanasia”, or “dying with dignity”. An example of this is the rejection of the word “killing” in a report because “this word is generally used to indicate a violent act.

5 Such use of language raises an interesting question about the role of moral philosophy: whether it is to clarify what we ordinarily mean, or to change our language and practices.
in war or crime, rather than to describe a gentle act of merciful clinical care” (Institute of Medical Ethics, 1990, p.610). So sometimes acts which cause death are not called “killing”, and sometimes omissions are called killing.

The conventional usage of the term “killing” to indicate a negative moral evaluation is responsible for some of the confusion about the distinction between killing and “letting die”, and is used in many arguments which seek to show that the distinction is incoherent because it does not accord with ordinary moral intuitions. If a doctor negligently fails to commence ventilatory support for a patient who requires it, a sense of the wrongness of her behaviour may indeed lead us to describe this as “killing”. But as Dan Callahan argues, “it is only our historically created, humanly devised moral rule about the moral responsibility of physicians that allows us to speak of a doctor’s ‘killing’ a patient (in this situation)” (Callahan, 1993, p.82). If the distinction is to be useful in moral decision making, it must be able to distinguish conceptually between killing and “letting die”, and not simply say “this is killing because it is wrong”, or “this is ‘letting die’ because it is not wrong”. To say that what the doctor did was not killing, but “letting die”, is a conceptual, not a moral distinction, and need not mean that we think she acted rightly, if we accept that “letting die” may be (but is not always) as wrong as killing.

It is often supposed that the difference between killing and “letting die” corresponds to that between “active euthanasia” and “passive euthanasia” (Gibson, 1998). Yet these terms are used in different ways. Gibson defines “euthanasia” as “bringing about the death of another, for his or her own good”, and distinguishes between active and passive euthanasia on the basis of the means employed: active euthanasia is “by means of a positive act, for example, administering a lethal injection”, and passive euthanasia by means of “an omission, for example, failing to administer life saving medication” (Gibson, 1998, p.23). But are all cases of “letting die” “passive euthanasia”? What of situations where patients refuse treatment against medical advice? Most definitions of “euthanasia” include the element of an intention to cause death. And some require that death is brought about by an act not an omission, such as that of the 1994 Report of the House of Lords Select Committee on Medical Ethics: “a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering”.

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6 This discussion raises difficult issues in the theory of act description, which are outside the scope of this study (Anscombe, 1957; D'Arcy, 1963).
thus excluding “passive euthanasia”. Others, particularly in the Catholic tradition, define it in a wider sense as “the intentional termination of life by act or omission” (Keown, 2002, p.12), or as the 1980 Vatican Declaration on Euthanasia has it: “By euthanasia is understood an action or omission which of itself or by intention causes death, in order that in this way all suffering may be eliminated” (Gula, 1986, p.39).

The law, in fact, does define some omissions which cause death as killing. Homicide is “the killing by whatever means of one human being by another” (Polk & Ranson, 1991). What is critical is that death is caused, and this may be brought about either by a positive act or by an omission to act (Ferguson, 1997, p.370). The New Zealand Crimes Act makes this explicit in its definition of homicide as “causing the death of another person, by any means whatsoever, direct or indirect, by any act or omission (New Zealand Crimes Act 1961 sections 158 and 164). Similarly the Queensland Criminal Code 1899 says “Except as hereafter set forth, any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person”(Section 293). By definition therefore, killing in the legal sense includes some cases which might be described as (impermissible) “letting die”, and a doctor could be prosecuted for manslaughter (or even murder if there was an intention to cause death) for failing to provide medical treatment when she had a duty to provide it, and the failure resulted in the patient’s death. The law does not define “letting die”, but distinguishes under certain circumstances between killing and certain medical practices such as the withdrawal of artificial ventilation or artificial nutrition and hydration, or the use of potentially life shortening analgesics or sedatives, which are commonly (and in the philosophical literature) described as examples of “letting die”, by declining to call these cases of killing. The history of the development of case law in this area will be included in the next section.

2.3 Debate about the distinction in its historical context
Developments in public opinion, clinical practice and the law have shaped the debate about the distinction between killing and “letting die” in the last forty years. The ability of modern medicine to prolong life by use of respirators and artificial nutrition and hydration raises the question of when it is morally and legally permissible for doctors to withhold or withdraw such treatment, and I will discuss the legal resolution of this question in various landmark cases in the U.S, the U.K. and Australia. The other
medical practice which raises the issue of the difference between killing and “letting 
die” is the administration of symptom relieving drugs such as analgesics or sedatives at 
the end of life which are often thought to hasten death. I will discuss whether this 
practice does in fact hasten death, with particular reference to the practice of palliative 
sedation, including so-called “terminal sedation”.

There is a long tradition in common morality, moral philosophy and medicine of 
making a distinction between killing and “letting die’ or “allowing to die”. The 
Hippocratic tradition proscribed the administration of a lethal substance to a patient 
while advising physicians to refrain from intervening in clearly terminal cases. Even 
Peter Singer acknowledges that his (utilitarian) approach “need not regard failing to 
save as equivalent to killing. Without some form of prohibition on killing people, 
society itself could not survive… So in everyday life there are good grounds for having 
a stricter prohibition on killing than on allowing to die” (P. Singer, 1994, p.196). And as 
another author who does not believe that the distinction is morally significant admits, 
“Common sense seems to say that it is one thing to allow people in developing nations 
to die, quite another to send them poisoned food to kill them” (Isaacs, 1995, p.355). 
However, prominent and influential voices in bioethics today claim that the distinction, 
at least in some contexts, is confused and mistaken. The well known Principles of 
Biomedical Ethics claims that “these distinctions (killing/letting die, act/omission and 
active/passive) are unsatisfactory for many of the purposes to which they have been 
put” (Beauchamp & Childress, 1994, p.219).

I will use the term “letting die” to refer to two broad categories of medical decisions: the 
withholding or withdrawing of potentially life-saving or life-prolonging medical 
treatment (treatment abatement), and the administration of symptom relieving drugs 
which may be foreseen , but are not intended, to shorten life. Although most 
philosophers use “letting die” in the medical context to refer only to the former (J. 
Boyle, 1977; Gert, Bernat, & Mogielnicki, 1994; Gibson, 1998; Gruzalski, 1981; Kary, 
1980; Kuhse, 1998; McCormick, 1997; Philips, 1985; Quinn, 1997; Rachels, 1975; 
Steinbock, 1980a; Sulmasy, 1998; Tooley, 1980; Walton, 1980) 7, other authors include 
the both categories in their discussion of the distinction between killing and “letting die”

7 The term “letting die” has also been used in relation to the decision whether to crush the head of an 
unborn child and thus kill the child, or not to do this, and thus allow the mother in obstructed labour to die 
(Casey, 1980).
(Begley, 1998; Ferguson, 1997; Gostin, 1993). The two are linked in that both are, or are claimed to be “common and generally non-controversial practices in the care of patients at the end of life (which) lead to their deaths” (Cavanaugh, 1998, p.375) and examples of “physician conduct hastening death” (Cantor & Thomas, 2000). Both figure prominently in arguments that the law is hypocritical in that, while it prohibits AVE And PAS, it allows doctors intentionally to end patients’ lives in other ways.

2.3.1 “Letting die” by withholding or withdrawing treatment

As medicine’s capacity to significantly prolong life increased, so did arguments about the distinction between killing and “letting die” by treatment abatement. In 1966 the British consequentialist philosopher Jonathan Bennett had used the example of the situation where the life of a woman in labour can only be saved by crushing the skull of, and thus killing, her unborn child (a conflict situation) to mount an attack on the notion that it is always wrong to kill (in this case the child) but is permissible to refrain from action even if the foreseen but unwanted consequence is the death of another (the mother). He stated that he could find no previously published account of “the extremely strong philosophical case” against this line of thought (Bennett, 1980, pp.109-110). But in the 1970’s the argument began to centre on examples of the deliberate withholding or withdrawal of medical treatment in cases where prolongation of the patient’s life was not considered to be in their best interests. In 1974, U.S. philosopher Michael Tooley, (who was also then a Research Fellow at the Australian National University) argued at a conference on medical ethics that the killing versus “letting die” distinction was irrelevant (Tooley, 1980). In 1975, fellow American philosopher James Rachels published “Active and Passive Euthanasia” in The New England Journal of Medicine, in which he claimed that “the bare difference between killing and letting die does not, in itself make a moral difference” (Rachels, 1975, p.79). Both Tooley and Rachels were responding to a 1973 statement adopted by the American Medical Association to the effect that while it condoned the cessation of extraordinary means to prolong life, “mercy killing” was contrary to its policy. They referred to withholding or withdrawal of potentially life-prolonging treatment at the request of a terminally ill patient, and the withholding of life-saving surgery in infants with serious but non-fatal disability, such as Down Syndrome, and attacked the AMA statement as unsound.

With the introduction of Positive End Expiratory Pressure ventilation in the late 1960’s and the era of respiratory intensive care (Kotur, 2004) came the possibility of keeping
seriously brain damaged individuals alive for many years, and with it, the dilemma for doctors of if and when they might withdraw artificial ventilation. Catholic moral philosophy had distinguished between “ordinary” means (which should be used) and “extraordinary” means (which are optional) of preserving life since 1595, a position which was reaffirmed by Pope Pius XII in 1957 in the context of medical treatment and procedures (Gula, 1986), and referred to in the statement of the American Medical Association above, but this distinction did not address the legal responsibilities of doctors to provide the means of preserving life. Although competent patients had a well established legal right to refuse any medical treatment, there was uncertainty about whether life-sustaining treatment could be refused on behalf of an incompetent patient, and whether doctors withdrawing life support could be liable to criminal prosecution.

A number of cases which served to clarify the legal situation came to the U.S. courts. The first was the 1976 landmark case of Karen Quinlan, who at 22 was in a persistent vegetative state (PVS) after a drug overdose. The New Jersey Supreme Court ruled that the hospital respect the request of Karen’s guardian (her Catholic father) that the

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8 “Ordinary means of preserving life are all medicines, treatments, and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience. Extraordinary means of preserving life... [are] all medicines, treatments and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit” (Kelly, 1958, p.129).

9 This right has been recognized in the U.S. since the beginning of the twentieth century as grounded in the Due Process Clause of the Fourteenth Amendment to the Constitution (Gostin, 1997).

10 This term is commonly used, although “persistent” is potentially misleading since it implies irreversibility, whereas a vegetative state is frequently temporary. The Australian National Health and Medical Research Council now uses the term “post-coma unresponsiveness” (National Health and Medical Research Council, 2004). The diagnosis is a clinical one, based on “lack of evidence of awareness of the self or the environment, of interaction with others, or of comprehension or expression of language” (Jennett, 2002, p.355). It may be distinguished from coma by the periods of wakefulness, when the patient opens her eyes, and by occasional non purposeful movements including facial movements and a startle response to visual and auditory stimuli (Giacino et al., 2002). These features sometimes lead onlookers to believe that the patient is aware and responsive to them, as in the Schiavo case (see below). Patients breathe on their own and have intact cough, gag and involuntary swallowing reflexes, so that theoretically they my be fed by hand, with considerable time and effort. In practice almost all require artificial nutrition and hydration, and when this is withdrawn death results within one to thirty days (Cranford, 1988). There is a high mortality in the first year, but after this the annual mortality reduces which each year that passes, so that some patients have survived for twenty years or more. After one year in traumatic cases and three or six months in non-traumatic, it is considered reasonable to declare the vegetative state permanent. Although there are occasional and usually unverified instances of “recovery” after one year, such patients almost always remain severely disabled (Jennett, 2002, p.355). PVS should also be distinguished from the minimally conscious state (MCS), in which “minimal but definite behavioural evidence of self or environmental awareness is demonstrated, such a following simple commands, gestural or verbal yes/no responses, intelligible verbalization or purposeful behaviour. The prognosis is much better than for PVS, with fifty percent of patients who had MCS following traumatic brain injury in one study having no to moderate disability at twelve months (Giacino et al., 2002, p.350-351).
ventilator be withdrawn. Although the court declared that she had a constitutional “right to die”, Karen actually survived, unconscious and without a ventilator, for another nine years. And what a “right to die” means, in either a legal or an ethical sense, remained confusing and controversial (Brower, 1996). Some commentators saw the ruling as opening the way for AVE (or even active involuntary euthanasia, as the refusal of treatment was made by a third party on behalf of the incompetent patient) (Larson & Amundsen, 1998, p.167).

The late 1970’s and early 1980’s was a time of increasing interest in the “right to die” worldwide. In 1976, several U. S. states passed laws strengthening the rights of patients to refuse life-saving or life-prolonging treatment through advance directives. In 1980 the Hemlock Society was founded in California, launching the campaign for “assisted dying” in America, and in the same year the World Federation of Right to Die Societies (advocating AVE) was formed in Oxford, with groups from eighteen nations. In 1984 the Netherlands Supreme Court granted immunity from prosecution to doctors who performed AVE or PAS under certain conditions (Euthanasia Resource and Guidance Organization, 2005). This period also saw the publication of many articles on the topic of killing and “letting die”, some of which specifically addressed the distinction (or lack of it) between killing and treatment abatement, in bioethics (Gillett, 1988; Nowell-Smith, 1989), philosophy (Atkinson, 1983; J. Boyle, 1977; Callahan, 1989; Foot, 1977; Green, 1980; Gruzalski, 1981; Kary, 1980; Lombardi, 1980; Walton, 1980) and medical journals (Gillon, 1986a). Books by prominent utilitarian philosophers also addressed the topic (Glover, 1977; Harris, 1985; Kuhse, 1987), and the essays by Bennett, Tooley and Rachels were reprinted and published, together with others arguing for or against the moral significance of the distinction, in Killing and Letting Die (Steinbock, 1980b). However there were no signs of a consensus. In 1985 Helga Khuse, who had argued against the moral significance of the distinction, admitted that “we might have a better hope of arriving at an answer” on the permissibility of AVE euthanasia by finding an alternative to the argument about acts and omissions (Kuhse, 1985, p.611).

In 1990, another landmark case concerning the refusal of life-sustaining medical treatment was settled in the U.S. Supreme Court. The family of 32 year old Nancy Cruzan, who had been in a persistent vegetative state for seven years following a car accident, applied for permission to withdraw her tube feeding. The Court ruled that competent patients have a "constitutionally protected liberty interest in refusing
unwanted medical treatment", a right that was described as “what is in common parlance referred to as a ‘right to die’ (Cruzan v. Director, Missouri Dept of Health, 497 US 261 (1990), cited in (Gostin, 1997, p.1523)). Cruzan was incompetent, but the court (ultimately the U.S. Supreme Court) required clear and convincing evidence of what her wishes would have been. In the U.K. in 1993, doctors were given permission to stop tube feeding and antibiotics in the case of Tony Bland, who had been in a persistent vegetative state since 1989 (Airedale NHS Trust v. Bland [1993] AC 789). The decision was confusing because, while it explicitly relied on the distinction between actively causing death (for example, by administration of a lethal drug, which it called “euthanasia”) and a medical decision not to provide or to cease providing medical treatment (Lord Goff, Airedale, at 865), a majority of the five Law Lords agreed that “the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland” (Lord Browne-Wilkinson, Airedale, at 881). Did they mean that the intention was to bring about (or cause) his death, or to let him die? Intentionally causing death is usually called “murder”. Singer said that the conclusion seemed inescapable that the decision allows doctors to kill their patients, and that the traditional sanctity of life ethic had been abandoned and replaced by a quality of life ethic (P. Singer, 1995).

The cases so far described have involved family members wishing to withdraw life-sustaining treatment from incompetent patients, but others have involved relatives opposing medical decisions to forego such treatment. The first was the case of 87 year old Helga Wanglie, deemed to be permanently unconscious after a cardio-pulmonary arrest, whose husband refused to allow her treating doctors to discontinue artificial ventilation (Cranford, 1991). The hospital sought, unsuccessfully to have her husband replaced as her legal guardian, and in the cases which have come before U.S. courts since, so far none have authorised hospitals to withdraw treatment against the wishes of surrogate decision makers (Cantor, 1996). On the other hand, U.S. courts have not punished doctors for refusing to provide or to continue to provide treatment which they considered inappropriate, despite family wishes, as seen in the case of Gilgunn v Massachusetts General Hospital (1995), where Joan Gilgunn unsuccessfully sued the hospital and two of its doctors for withdrawing artificial ventilation from her brain damaged and comatose mother (Capron, 1995).

In the 1990’s, the focus of euthanasia advocacy in the United States moved from AVE to PAS. Dr. Jack Kevorkian first used his “suicide machine” in 1990, and ballots were
brought before voters in Washington, California and Oregon to legalise PAS. A palliative care physician, Timothy Quill, published an account of assisting the suicide of “Diane” in *The New England Journal of Medicine* (Quill, 1991), and went on to become a prominent advocate for the legalisation of PAS. He and a number of other doctors (Meier, 1992; Quill, Cassel, & Meier, 1992; Watts & Howell, 1992) argue that there is a moral difference between PAS and AVE, and that one might support the legalisation of the former but not the latter. The distinction between killing and “letting die” continued to be discussed in bioethics (Gert et al., 1994; Gillett, 1994; Gostin, 1993), philosophy (Isaacs, 1995; McMahan, 1993; Quilter, 1993; Winkler, 1991), medical (W. Cartwright, 1996; Council on Ethical and Judicial Affairs, 1992; Gert, Bernat, Hanover, & Mogielnicki, 1995; Institute of Medical Ethics, 1990) and nursing journals (Dines, 1995). There was a debate in *The Archives of Internal Medicine* as to whether discontinuation of dialysis was a form of euthanasia (Carlson & Shahryar, 1995a, 1995b; Karlawish & Siegler, 1995). It was noted that “the public debate seems stuck on a misleading distinction between commission and omission” (Flynn, 1993).

But it seemed that the sticking point might have been overcome in 1996, when two federal Courts of Appeals held state prohibitions against assisting suicide to be unconstitutional when applied to physicians and their competent terminally ill patients (*Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) and *Quill v. Vacco*, 80 F. 3d 716 (2nd Cir.1996)). They decided that no rational moral distinction could be drawn between PAS and the termination of life support. In *Compassion*, Judge Reinhardt drew on the majority opinion in *Cruzan* and decided that “Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one’s own death” (Kaveny, 1997, p.129). The judgment in *Quill* relied on a different argument, based on the Equal Protection Clause of the Fourteenth Amendment, that a New York Law prohibiting assisting suicide “does not treat similarly circumstanced persons alike”, since people in the final stages of illness on life-support systems are allowed to ask that they be withdrawn and so hasten their deaths, whereas terminally ill patients not on life-support are not allowed to ask for assistance in hastening death. But both judgments redescribed the right to refuse treatment as “the right to hasten death” (Kaveny, 1997, pp.132-133).
Appeals against the rulings in *Compassion* and *Quill* were heard in the U.S. Supreme Court, and such was the public interest in these cases that sixty *amicus curiae* briefs were submitted, forty one of which opposed the view that there was a constitutional right to assistance in committing suicide (Coleson, 1997), including those on behalf of the American Medical Association, the American Geriatrics Society (Lynn, Cohn, Pickering, Smith, & Stoeppelwerth, 1997), the United States Catholic Conference, and a group of bioethicists. Briefs urging the Court to affirm this right included those on behalf of the American Medical Students’ Association, another group of bioethicists and a group of moral philosophers, who claimed that when a patient wishes to die (but not otherwise), there is no pertinent moral difference between a doctor terminating treatment that is keeping a patient alive, and providing lethal pills, since they are only different means to the same end (Rawls et al., 1997).

In the event, the U.S. Supreme Court invalidated the previous decisions of the Courts of Appeals, ruling unanimously that there was no fundamental right to assistance in committing suicide, and that distinguishing legally between asking for such assistance and the refusal of life saving treatment was in accordance with fundamental legal principles of causation and intent (*Vacco v Quill* 117 S. Ct. 2293 (1997)). Not surprisingly, many more articles arguing for or against a moral distinction between withdrawal of therapy and PAS and/or AVE were published around this time, in bioethics (Ferguson, 1997; Hopkins, 1997; Kuhse, 1998; Lowe, 1997; Quinn, 1997; Rachels, 1998; Sulmasy, 1998; Thornton, 1999), philosophical (Brock, 1999; Thomson, 1999; Weithman, 1999) and medical journals (Alpers & Lo, 1997; Burt, 1997; Churchill & King, 1997; Gates, 1997; Gorman, 1999; Gostin, 1997).

In Victoria, Australia, the issue of the legal permissibility of withdrawing artificial nutrition and hydration from an incompetent patient was tested in 2003 (the year before data collection in this study commenced), when a man sought permission from the court to cease such feeding for his wife who had advanced dementia (*Gardner; re BWV [2003] VSC 173*). The case was complicated by the fact that the *Medical Treatment Act 1988* (Vic), while clearly establishing the right of competent patients to refuse medical treatment, and subsequently amended to extend that right to a period when they may become incompetent by appointing an agent with Enduring Power of Attorney (Medical Treatment), specified that the “medical treatment” which could be refused did not
include “palliative care”, which was defined as including “the reasonable provision of food and water” (Plueckhahn, Breen, & Cordner, 1994, pp.145-146).

There was a further case which attracted a great deal of media attention in the U.S. and Australia during the latter part of data collection in this study. A forty one year old Florida woman, Terri Schiavo, had been in a persistent vegetative state for fifteen years, and her husband Michael and Catholic parents, Bob and Mary Schindler, engaged in a protracted legal battle over removing her percutaneous endoscopic gastrostomy (PEG) feeding tube. The case was both complicated and complex. The case was complicated, because it involved numerous court proceedings, Right to Life and disability advocacy groups, and the removal and reinsertion of the tube twice. It raised the issue of the separation of powers (Anonymous, 2003a) when the Florida legislature passed legislation (which became known as “Terri’s Law”) in October 2003, enabling Governor Jeb Bush to overturn a court decision to remove the tube, and have it reinserted. Two days before the final removal of the PEG tube on March 18, 2005, the U.S. Congress passed a bill directing the US Federal Court to hear an appeal by the Schindlers against that decision by a Florida court. The Florida law was subsequently deemed unconstitutional by the Florida Supreme Court, and the Federal Court declined to hear the appeal (Wolfson, 2005). Terri died thirteen days after the tube was removed.

The Schiavo case was complex, because there were several points of disagreement between the two parties. The first was whether Terri was indeed in a persistent vegetative state. Medical witnesses disagreed, and although a court found in 2002 that she met the criteria for that diagnosis, her parents believed that she had some awareness and responded to them, that further tests were required to determine her capacities, and that hyperbaric therapy could improve her prognosis (Dresser, 2004). (The autopsy findings were consistent with the diagnosis of PVS (Fins & Schiff, 2005)).

The second issue in contention was what Terri’s own wishes would have been. Although a Florida court ruled in 1998 that, in the absence of a living will, there was clear and convincing evidence that she would have refused artificial nutrition and hydration, the evidence was in fact weak, based on a few oral statements to friends and family, and formed the basis for subsequent appeals (Dresser, 2005).
A third point of disagreement was whether PEG feeding represented ordinary or extraordinary means of keeping someone alive. Although the Schindlers cited their Catholic faith as the basis for their view, there was disagreement amongst Catholic theologians on the issue of whether patients in PVS ought to be provided with artificial nutrition and hydration (ANH). On the one hand there was strong Catholic (and Evangelical) opposition to removing Terri’s feeding tube, as there had been in previous legal cases such as that of Hugh Finn in Virginia, and Nancy Jobes in New Jersey. It was argued that to remove the feeding tube would be “euthanasia” and contrary to Catholic tradition, because tube feeding could not be seen as extraordinary means since it neither caused a great burden to Terri nor was useless, but was rather beneficial in keeping her alive (P. J. Boyle, 2003). In an amicus curiae brief opposing the removal of Nancy Jobes’ feeding tube, the New Jersey Catholic Conference had argued that because in the Catholic tradition there is a positive moral duty to prolong life, nutrition and hydration which are “basic to human life” and “clearly distinguished from medical treatment” should always be provided to PVS patients (New Jersey Catholic Conference, 1987, pp.582 -583).

However a number of Catholic moral philosophers think that this reasoning is mistaken. Some say that it represents vitalism, an elevation of “mere physical existence” above all other values (Anonymous, 2003a; Panicola, 2001). It is argued that ANH for a patient in PVS is an extraordinary treatment, since the preservation of life in such a state is not a benefit, and places an unacceptable burden on both the patient and society in terms of the resources it requires (Anonymous, 2003a). The burden for the patient in this case is not the suffering caused by the treatment, since he or she is neurologically incapable of experiencing suffering, but rather the burden of the disease itself, including “horror or repugnance at the state in which one will be left by the treatment” (Sulmasy, 2005, p.51). It may also be argued that removing ANH from a patient in PVS is not killing, as long as the intention is not to kill, but to recognize the limits of life, which is a basic but limited good. According to this view, when medical treatment can offer no hope of pursuing the spiritual goods of life, as in PVS, there is no duty to preserve life and the patient should be allowed to die (Panicola, 2001).

A statement made during a Vatican congress by Pope John Paul II on March 20, 2004 unfortunately served only to increase confusion about Catholic teaching on the use of artificial hydration and nutrition:
I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering (Pope John Paul II, 2004).

While this might be interpreted to mean that ANH is always morally obligatory for patients in PVS, the Canadian Catholic Bioethics Institute offered an alternative interpretation in the light of existing Catholic tradition. This emphasises that the words “in principle” allow for some exceptions, and that ANH should only be considered morally obligatory when it did not conflict with other duties and was not overly burdensome, costly or complicated (Canadian Catholic Bioethics Institute, 2004).

Thus, medical opinion and the law continue to draw a distinction between killing and “letting die” by treatment abatement, even in the case of mechanical ventilation and ANH.

2.3.2 “Letting die” by use of treatment which might shorten life
Arguments that the use of analgesia which might or even certainly would hasten death was morally indistinguishable from killing began in the 19th century, following the discovery, acceptance and increasing use of drugs such as chloroform and morphine. British school teacher Samuel Williams argued in 1872 that it was inconsistent for a doctor to refuse to put a suffering patient to death “outright” when he had “no scruple in giving temporary relief by opiates, or other anaesthetic, even though he were absolutely sure that he was shortening the patient’s life by their use” (Emanuel, 1994b, p.796).

In 1981, U.K. paediatrician Dr. Leonard Arthur was acquitted of a charge of attempted murder after he had given orders for the administration of large doses of dihydrocodeine and nursing care only (with no feeding or fluids) to a newborn baby with Down syndrome following the rejection of the child by his parents. The defence argued that this was a case of “letting die” rather than killing because it involved foreseeing rather than intending death, and that it was standard medical practice. However, some commentators believed that Dr. Arthur was fortunate to have been acquitted, as judging
by the doses administered, he seemed to have clearly intended the baby’s death (Cordner, 1982; Gerber, 1982; Gillon, 1986b). The case provided critics of the distinction with an example where it seemed to be clearly spurious (Kuhse, 1984).

The difficulty in distinguishing between killing and “letting die” through the use of drugs at the end of life which are intended to relieve symptoms, but which may shorten life, is brought into sharp relief by the practice of so called “terminal sedation”. This was the other issue raised by the Supreme Court’s ruling in Vacco v. Quill. In The New England Journal of Medicine, lawyer David Orentlicher claimed that while rejecting PAS, the court had in fact endorsed “euthanasia”, through endorsing “terminal sedation”, which he said was ethically more problematic than AVE or PAS (Orentlicher, 1997). Others also interpreted the judgment as an endorsement of “terminal sedation” (Luce & Alpers, 2001).

However, the term “terminal sedation” has various meanings. The practice of heavy sedation in the final hours or days before death, to induce continuous sleep in patients with severe physical symptoms uncontrollable in any other way, was first described in 1990 (Ventafridda, Ripamonti, De Conno, Tamburini, & Cassileth, 1990) and the expression “terminal sedation” first appeared (but was not defined) in 1991 (Enck, 1991).

Discussion of the ethics of “terminal sedation” involves distinguishing and addressing four separate though related questions. First, is it justified to withhold artificial nutrition and hydration in palliative care, and if so, under what circumstances? Second, does analgesia and /or sedation actually shorten life when administered to the terminally ill, and if so, under what circumstances? Third, what are the indications for sedation at the end of life? Finally, under what circumstances might doctors sedate or otherwise assist patients who choose voluntarily to stop eating and drinking?

A 1991 paper, co-written by an Australian palliative care physician and a medical ethicist, described a management approach to the terminal phase of illness, in which no form of ANH is given. The terminal phase was defined as where “death seems inevitable and imminent”, with clinical evidence of the dying process including poor appetite, weight loss and failure of physiological systems (Ashby & Stoffell, 1991, p.1322). English geriatrician Gillian Craig expressed her concern about this practice,
particularly when the patient’s inability to eat and drink was a consequence of sedation, and argued that sedation without hydration might sometimes cause death (Craig, 1994). Craig’s article generated a debate in the *Journal of Medical Ethics*. Ashby and Stoffell responded that the intention of the practice of sedation plus withholding of ANH was not to alter the timing of death, nor was it a hospice policy to use sedation to mask the effects of dehydration. They argued that ANH, as an invasive, unpleasant and sometimes risky treatment, was not normally justified in patients who had stopped eating and drinking as part of the natural dying process, although it might sometimes be required to treat symptoms of dehydration (Ashby & Stoffell, 1995). Yet Craig remained concerned about patients who were not imminently dying but needed sedation, with fatal dehydration as a consequence if ANH were not provided (Craig, 1996).

It is widely believed in the community, and often stated in the bioethics literature, as well as in English case law (*In re J (Wardship: Medical Treatment*) [1991] Fam 333, 46, per Lord Donaldson MR; *R v Cox* [1992] 12 BMLR 38, per Ognall J; *Airedale NHS Trust v Bland* [1993] AC 789, 865,867 per Lord Goff) and in the majority opinion of the U.S. Supreme Court (*Vacco v. Quill*) that effective pain relief necessarily hastens death. 1997 saw the publication of two papers attacking what were called the fallacies (Ashby, 1997) and myths (Wall, 1997) surrounding the use of narcotics in palliative care, as well as the argument that existing medical practices are morally indistinguishable from AVE or PAS. Ashby said that the accepted palliative care practice of gradually escalating doses had been used safely for at least 20 years with no evidence that that it caused or hastened death, and Wall that “in the majority of cases treatment of pain prolongs life rather than advances death” (Wall, 1997, p.121). In other words, the principle of double effect need not be invoked to justify the use of these drugs by skilled and experienced practitioners, because they do not have a “double effect” of causing death as well as treating pain. Hence, in 1991 Ashby and Stoffell could write that there was “no evidence that the skilled and appropriate delivery of palliative care measures shorten life” (Ashby & Stoffell, 1991, p.1323).

But sedation may be a different matter, at least under certain circumstances. In 1996, Ashby and Stoffell acknowledged that “it is possibly true that sedation may hasten the actual time at which relatively imminent death will occur” (Ashby & Stoffell, 1995, p.136), although two studies in the U.K. and one in Japan have shown no evidence that the use of opioids and sedatives in palliative care units decreases patient survival time.
when used in the last 48 hours (Morita, Tsunoda, & Inoue, 2001), few days (Stone, Phillips, Spruyt, & Waight, 1997) or week of life (Thorns & Sykes, 2000). Yet heavy sedation, combined with withholding of ANH, in a patient not imminently dying but some weeks or months from death, would hasten death, either through dehydration and/or through the effects of immobility and inhibition of coughing, producing sputum retention and hypostatic pneumonia. How could this kind of “terminal sedation” be distinguished morally from killing?

A 1996 paper claimed that the use of stupor-inducing sedation (without ANH) for emotional and spiritual suffering rather than physical symptoms, in a patient not imminently dying, is in fact “slow euthanasia, or “double effect euthanasia”, and that there is no meaningful moral distinction between this practice and PAS or AVE, the only difference being the rapidity of death, and the level of comfort of the doctor (Billings & Block, 1996). Unlike Craig, these authors saw “slow euthanasia” as relatively morally unproblematic, except when practiced without the patient’s request or agreement, and used its supposed acceptance by the medical profession as an argument for the acceptance of their preferred practice of PAS, as did other authors (Brody, 1996; Gauthier, 2001; Orentlicher, 1997; Quill, Lo, & Brock, 1997). But in the same issue of The Journal of Palliative Care, Balfour Mount strenuously defended the principle of double effect (PDE) as a means of distinguishing morally between “terminal sedation” and PAS or AVE (Balfour Mount, 1996).

A great deal of confusion results from authors failing to specify exactly what they mean by “terminal sedation”. In 1998, noting that there was no clear definition of the term nor any agreement about how frequent the practice was, Chater and colleagues undertook a survey of experts (fifty nine physicians and two nurses) from eight countries, predominantly Canada and the U.K. (Chater, Viola, Paterson, & Jarvis, 1998). For the purposes of the study, they defined terminal sedation as:

> the intention of deliberately inducing and maintaining deep sleep, but not deliberately causing death in very specific circumstances (namely) 1) for the relief of one or more intractable symptoms when all other possible interventions have failed and the patient is perceived to be close to death, or 2) for the relief of profound anguish (possibly spiritual) that is not amenable to spiritual, psychological, or other interventions, and the patient is perceived to be close to death (pp. 257-258).
Eighty nine percent agreed that terminal sedation, as defined, was sometimes necessary, and seventy seven percent said they had used it in the last twelve months. Forty percent agreed with the definition completely, eleven percent gave responses which could not be categorized, seven percent agreed with part (1) only, and fifteen percent agreed with modifications such as the replacement of “imminently dying” for “close to death”, or the use of the term “sedation in a dying patient”; some said the option of reversal of sedation or lighter sedation should be included. Those who disagreed tended to characterize terminal sedation as defined as “like euthanasia”.

Chater et al concluded that “these experts do not seem to equate their practice of sedating patients with anything other than symptom management” (p.262), and recommended that the term “terminal sedation” should be abandoned in favour of an alternative such as “titrated sedation in end-stage disease”, or “sedation for intractable distress in the dying”. Another definition of terminal sedation includes the stipulation that the patient is close to death (Hallenbeck, 1999). A group of Melbourne palliative care practitioners avoided using the term “terminal sedation”, noting that it is ambiguous, as it could imply either sedation in terminally ill patients (the term they used) or sedation for the purpose of terminating life (O’Connor, Kissane, & Spruyt, 1999). Some prefer the term “sedation in the imminently dying patient” (Wein, 2000). A 2001 U.S. review article said there seemed to be “a general understanding among palliative medicine practitioners today that it (terminal sedation) is sedation for intractable problems near the end of life” (Cowan & Walsh, 2001, p.403) and the authors considered that it involved the use of non-opioid sedatives to control acute or refractory symptoms in terminally ill patients with advanced and incurable disease, who are actively dying in that clinical signs indicate death will occur in hours or days.

We have already seen that there is no evidence that sedation in the imminently dying patient actually does shorten life. But “terminal sedation” is used by some authors to indicate a quite different practice, where the patient need not be imminently dying, and sedation is used in order to render the patient unconscious so that they cannot eat or drink, and ANH is withheld with the result that the patient dies. Melbourne surgeon Edward Brownstein distinguishes between sedation in the terminal phase (marked by certain clinical features, and where death will occur within seven days) and sedation in the early phase of palliative care, noting that, in the latter but not the former, it is
possible to establish a causal link between the sedation and death (Brownstein, 1999). Jansen and Sulmasy distinguish the two practices on the basis of intention, naming the latter “sedation toward death”, which could not be defended using PDE (Jansen & Sulmasy, 2002). It is uncertain how commonly this occurs, and although there was a celebrated case involving Australian euthanasia activist Dr. Philip Nitschke (Kissane, Street, & Nitschke, 1998), it is reported that very few physicians in the U.S. would be willing to practice it (Gunderson & Mayo, 2000).

However there remains a third category of terminal sedation, somewhere between sedation in the imminently dying and “sedation towards death”, where sedation most likely does shorten life, but death is not the intended, merely foreseen result of treatment. This is the only category of terminal sedation where PDE needs to be considered, and might arguably be invoked in order to provide a moral justification for the practice, although this remains controversial. Some authors argue that if sedation is administered to any but the imminently dying, it ought to be accompanied by artificial hydration at least (Brownstein, 1999; Craig, 1996). But “terminal sedation” continues to be defended using PDE by both medical practitioners (Glynn, 1999; Hallenbeck, 1999; Pellegrino, 1998; Sulmasy & Pellegrino, 1999) (Rousseau, 2000) and philosophers (J. Boyle, 2004; Cavanaugh, 1998) although it has also been argued that PDE cannot be meaningfully applied to it (Cantor & Thomas, 2000; Nuccetelli & Seay, 2000; Orentlicher, 1997; Quill, Lo et al., 1997).

The PDE is widely held to underpin the view of English (In re J (Wardship: Medical Treatment [1991] Fam 333, 46, per Lord Donaldson MR; R v Cox [1992] 12 BMLR 38, per Ognall J; Airedale NHS Trust v Bland [1993] AC 789, 865,867 per Lord Goff) and U.S. law (Vacco v. Quill) (New York State Task Force on Life and the Law, 1994) that the provision of pain medication is justified even if it hastens death, as long as this is not the intention of its administration. (It is generally assumed that this position also represents the law in Australia although it has not been tested in the Australian courts.) However, it is not clear that this would extend to all cases of “terminal sedation”.

Another controversial issue in sedation of the terminally ill is its place in the management of psychological symptoms and/or existential distress, especially in a patient who is not imminently dying. Palliative care physicians use sedation for severe refractory symptoms, but are more reluctant to provide it for emotional than for physical
suffering (Billings & Block, 1996). Reasons suggested for this include the poor understanding of doctors of such suffering and discomfort in dealing with it, lack of experience and skill in alternative forms of management, and the fact that such symptoms may occur in the early phase of terminal illness (Balfour Mount, 1996). Further, with psychological or existential suffering, there is more difficulty in establishing its severity and that it is truly refractory than with physical symptoms such as pain or dyspnoea (Cherny, 1998).

In 1993, a paper by U.S. physicians proposed voluntary refusal of food and drink (and also of ANH) as a practical and ethically non-problematic alternative to AVE or PAS, which could be offered to patients who want to die (Bernat, Gert, & Mogielnicki, 1993). They claimed that in patients close to death, thirst and hunger are often diminished anyway, and such patients need not suffer. However, they also suggested that if the process is likely to take some weeks and unpleasant symptoms are involved, physicians should be willing to prescribe sufficient doses of narcotics and benzodiazepines to relieve symptoms, accepting “the possibility of a hastened death as a complication” (p.2727). However, this procedure may not be as ethically unproblematic as claimed. For supporters of AVE and PAS, it is an unacceptably slow and perhaps unpleasant method for the patient and their family (Quill, Lo et al., 1997). Others would regard suggesting this option to a patient, as an “alternative” to AVE/PAS, as being complicit in suicide, while recognizing that not all decisions to stop eating and drinking are suicidal (Jansen, 2004). However, if the patient’s purpose in stopping eating and drinking was to die, providing clinical support to such a patient might be regarded as assisting a suicide. Further, providing heavy sedation to such a patient, especially if she were not close to death, would be very similar to the type of “terminal sedation” designated “sedation toward death”.

Case reports of voluntary refusal of food and fluids by terminally ill patients are rare, but a study of hospice nurses in Oregon showed that, between 1997 and 2001, one third had cared for at least one patient who had deliberately hastened death in this way. This was almost twice as many as those who died in hospices as a result of PAS, which was legally available (Ganzini et al., 2003). Forty seven percent of the patients had an estimated life expectancy of more than a month, and most died within two weeks. For the majority, it was described as a “surprisingly peaceful way to die”, with none requiring heavy sedation (Jacobs, 2003, p.325).
2.3.3 The ongoing debate

The debate continues in the pages of journals of philosophy and bioethics, and sometimes in medical journals, without resolution. There is no evidence of a change in official medical opinion. However among professional bioethicists, the argument against the moral significance of the distinction seems to have gained the ascendancy. This is especially so in Australia, possibly due to the enormous influence of and respect for the utilitarian philosopher Professor Peter Singer, who established the Centre for Human Bioethics at Melbourne’s Monash University in 1980, and was based there for almost twenty years. Singer, often described as the world’s most famous contemporary philosopher, argues powerfully against the moral significance of the distinction in many works, including his popular books *Practical Ethics* (P. Singer, 1993) and *Rethinking Life and Death* (P. Singer, 1994). His colleague at the Centre for Human Bioethics, Helga Khuse, also attacked the distinction in articles (Kuhse, 1998, 2002) and in her widely read book *The Sanctity of Life Doctrine in Medicine: A Critique* (Kuhse, 1987). Singer and Kuhse also published their research in the *Medical Journal of Australia* (Kuhse & Singer, 1988; Kuhse et al., 1997).

In 1997, *Human Lives: Critical Essays on Consequentialist Ethics* was published, edited by two Melbourne University philosophers, who aimed to redress the imbalance of the domination of bioethics by consequentialism, and to “provide an antidote to what can truly be called the Establishment view” (Oderberg, 1997, p.3). Two chapters specifically defended the moral distinction between killing and “letting die”.

In the U.K., there continues to be a disparity between the view of the BMA on the distinction between killing and “letting die” (British Medical Association, 2000) and that of bioethicists such as utilitarian John Harris, and of at least some specialist bioethics committees. Harris’ much discussed paper “The Survival Lottery” suggests that, as there is no moral difference between killing and “letting die”, there could be a moral justification for killing a healthy person to harvest his organs for transplantation, thereby saving several lives (Harris, 1975).

An example of the discrepancy between British medical opinion and that of a specialist bioethics committee is provided by the 1990 report of a working party of the Institute of Medical Ethics, which rejected the moral distinction between killing and “letting die”,...
arguing that “when the intention and outcome of killing and letting die are equivalent (in each case a good intention and a fatal outcome) then the circumstances become the crucial factor in the moral evaluation” (Institute of Medical Ethics, 1990, p.613). The majority concluded that “assisted death” (defined as “an act by a doctor with the deliberate intention of hastening the death of a patient”, when requested) was justified under some circumstances. However, the BMA has not changed its policy, and continues to draw a distinction between treatment withholding or withdrawal and both physician-assisted suicide and “euthanasia” (British Medical Association, 2000) 11.

2.4 Conclusion
When doctors consider whether there is a distinction between killing and “letting die” in their practice, and whether it has any moral significance, they do so within particular and complex linguistic and historical contexts. Despite significant and ongoing challenges to the traditional view, medical opinion and the law continue to distinguish between killing and “letting die” by means of both treatment abatement, and of treatment at the end of life which might be foreseen, but is not intended, to shorten life.

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11 Delegates at the BMA’s annual conference in 2005 agreed not to oppose physician-assisted suicide or active voluntary euthanasia (BBC, 2005). However members at the 2006 meeting voted to reverse the decision by a margin of nearly 2 to 1 and to oppose legalisation of both practices. Ballots carried out by three major doctors’ associations showed that a clear majority opposed changing the law to allow these practices in Britain (Christian Medical Fellowship (UK), 2006).
Chapter Three  Contextualising the arguments (2): Key philosophical debates

3.1 Introduction
Arguments amongst doctors about the distinction between killing and “letting die” take place, not only in a particular linguistic and historical context, but also within the context of philosophical debates about the distinction (which are also themselves located in particular linguistic and historical contexts). In this chapter I outline the relevant philosophical debates, including arguments about the formulation of the distinction, the doctrine of acts and omissions (DAO) and the principle of double effect (PDE), and also arguments for and against the general wrongness of killing, and about whether there are particular reasons why it is wrong for doctors to kill their patients.

3.2 Disagreement between traditional and modern morality
Although this is not often made explicit, the debate over the moral standing of a distinction between killing and “letting die” is situated within the wider disagreement between traditional (non-consequentialist) and modern (consequentialist) morality. The former tends to uphold both DAO and PDE, and the latter to reject them. What the DAO and the PDE in particular, and non-consequentialist ethical theories in general have in common, is an understanding that evaluation of the consequences of an action or omission is not the only important factor in its moral evaluation (Gibson, 1998, pp.23-24). Both the nature of the act itself, and the character of the agent who performs it, may also be relevant. I will sketch an outline of the philosophical debate about the existence and relevance of the distinction between killing and “letting die”, without attempting to resolve the seemingly intractable disagreement between rival normative ethical theories.

3.3 The formulation of the moral distinction
Some authors assume that making a moral distinction between killing and “letting die” entails the claim that killing is, in some sense, worse than “letting die” (Isaacs, 1995; Thomson, 1976, p.1523). When “letting die” involves treatment abatement, this would imply that an act which results in death is always worse than an omission which has the same consequence. However it is not difficult to think of situations where omissions are just as bad as acts (Isaacs, 1995; Rachels, 1975; Thomson, 1976). The most famous example was provided by Rachels, of Smith and Jones, one of whom drowns his young
cousin in the bath, thus gaining a large inheritance, and one of whom, having come with that intention, merely stands by and watches as the boy drowns accidentally (Rachels, 1975). There are also cases where “letting die” is worse than killing (Kuhse, 1998; Rachels, 1975). But the claim that there is moral significance to the distinction between killing and “letting die” is not the same as the claim that killing is worse (or always worse) than “letting die” (J. Boyle, 1977).

Beauchamp and Childress maintain that killing is in itself not morally different from “allowing to die” because describing an act as one or the other “does nothing to determine if one form of action is better or worse, or more or less justified, than the other” (Beauchamp & Childress, 1994, p.225), and that “the conceptual distinction between killing and letting die cannot bear the weight of normative conclusions about policies or particular cases” (p.227).

However the so-called traditional distinction between killing and “letting die” does do something to determine if a form of action is justified, though it does not do everything. The claim is that while killing an innocent person is always wrong, some cases of “letting die” are also morally wrong, but some are not (Sulmasy, 1998). Boyle puts it more formally:

\[
\begin{align*}
& a) \text{ granted that one may sometimes wrongly let a person die, and } \\
& b) \text{ granted that if one wrongly lets a person die, this omission can be as morally reprehensible as killing a person would be,} \\
& c) \text{ there are many cases of letting die which are not wrong at all, whereas } \\
& d) \text{ most cases of killing – and all cases of directly killing the innocent (such as in the case of AVE) – are morally wrong (J. Boyle, 1977, p.435).}
\end{align*}
\]

Making the conceptual distinction does not do all the moral work, and we must still decide on other criteria whether a particular instance of “letting die” is morally permissible or not.

Nevertheless, some authors claim that we cannot even make a clear conceptual distinction between killing and “letting die”. And on this view, if there is no clear conceptual distinction between them, there can be no significant moral difference. “Accounts that uphold it (the distinction)… (must) provide some criteria, independently
of moral criteria, on the basis of which to make this distinction. For a distinction that we
cannot make is not going to be of much use, and so can hardly be considered morally
significant” (Isaacs, 1995, p.355).

Therefore I will first examine the conceptual distinction between killing and “letting
die” by treatment withholding/withdrawal in terms of the doctrine of acts and
omissions, and then I will examine why this might entail a moral difference between
them. Second, I will examine the distinction between killing and “letting die” by the use
of analgesia/sedation which will foreseeably hasten death in terms of the principle of
double effect, both from a conceptual and a moral perspective. Finally I will examine
some of the reasons why killing (and some cases of “letting die”) are considered to be
morally wrong.

3.4. The doctrine of acts and omissions (DAO)
This doctrine states that “there is, or is sometimes, a morally relevant difference
between an act and an omission, where the consequences of the act and the omission are
identical” (Gibson, 1998, p.23). The act/omission distinction may be formulated in a
number of ways.

3.4.1. The conceptual distinction between acts and omissions
We might say that an act is doing something which results in the patient dying, and an
omission is not doing anything (or refraining), with the same result. This distinction is
implied in the terms “active” and “passive” euthanasia. For some, the distinction is a
metaphysical one between acts and non-acts, defined on the basis of whether bodily
movement is involved (Isaacs, 1995). In the medical context, this seems a clear
distinction when a failure to instigate treatment is involved. But withdrawing treatment
sometimes (though not always) involves bodily movement, as when a doctor switches
off a ventilator, yet most people would call this “letting die”, not “killing”. In addition,
to use the criterion of bodily movement would entail a distinction between the
withholding and at least some cases of withdrawing treatment, which almost all ethicists
regard as having no moral significance, with the exception of some religious groups, in
particular Orthodox Jews (Sulmasy & Sugarman, 1994) 12.

12 Philosopher Susan Lowe argues that the request of a competent patient for the ventilator on which they
were chronically dependent to be switched off was “effectively a request to be killed”, but that the
problem could be overcome by using a ventilator which automatically switched itself off every 24 hours,
The distinction between acts and omissions that underpins the present law in Commonwealth jurisdictions (Airedale NHS Trust v. Bland [1993] AC 789 at 865) and in the U.S. (Vacco v. Quill, 117 S Ct. 2293[1997]), relies on a different criterion for the definition of an act than bodily movement alone. It relates to whether what the agent does “represents an interference in the normal course of nature” (Stauch, 2000, p.238). A doctor who has commenced ventilation has interfered in the course of nature, and discontinuation is a refraining from further interference which is not judged to be warranted. But if turning off a ventilator (or withdrawal of a feeding tube) is described as an “omission” when performed by the treating doctor (or her agent), would it also be an omission if performed by an intruder in the hospital, perhaps a relative who stands to gain by the patient’s death? One can argue that it would not, because the intruder interferes with the “second nature” brought into being by the doctor, and so acts, whereas the doctor doing the same thing “ceases his or her own previous interference in brute nature”, which is an omission (Stauch, 2000, p.238). Another way of putting this is that only someone who can be said to be treating a patient can also be said to omit treatment.

We might also say that there is a difference in causality between an act and omission. In the medical context, an act can be the immediate cause of death, whereas in the case of an omission, “when treatment is discontinued, it is the disease that kills the patient” (Pellegrino, 1992, p.96). But why should turning off a ventilator, for example, not be regarded as the cause of a patient’s death? Applying the traditional legal “but for” test, we could say that but for the doctor’s failure to provide treatment, the patient would have lived, at least for a short while and, in rare cases, some years longer.

However, using the “but for” test would mean that the omission of assistance by every person in the world who fails to provide it is causal in the death of say, a starving child, because but for their failure, the child would have lived. But in this case each omission is only part of a causal set which contributes to the lack of available food. Likewise, the omission of medical treatment is a necessary but not sufficient cause of death. Failure to provide (by withholding or withdrawing) medical (or any other) assistance to someone and had then to be switched back on (if the patient agreed) or not (Lowe, 1997). However the argument that there is a morally significant difference between switching off and failing to switch back on seems unconvincing.
cannot by itself cause that person’s death, since it is also necessary that she is in need of life-saving treatment or assistance, and that no one else provides it. A lethal injection, by contrast, is both a necessary and sufficient cause for death (Stauch, 2000). Similarly, we could say that to be described correctly as a killer, someone would need to be not merely a cause of death (one among many equally important causes), but the cause of death (Quilter, 1993).

Other commentators believe that the distinction between killing and “letting die” by foregoing treatment lies in the intention of the doctor and the patient. While the intention of both in AVE/PAS is necessarily that the patient die, in withholding or withdrawing treatment it need not be. The patient’s intention may be to be free of burdensome or simply unwanted medical intervention, and the doctor’s to respect a valid refusal of treatment, or to refrain from a futile or unjustifiably burdensome treatment and respect the natural dying process at the end of life (Quinn, 1997). Chief Justice Rehnquist of the U.S. Supreme Court used this reasoning in Vacco v Quill.

Daniel Sulmasy proposes the following definitions of killing and “letting die” through treatment withholding/withdrawal, which combine aspects of the above criteria:

1) “Killing” means “an act in which the agent creates a new, lethal pathological state with the specific intention in acting of thereby causing a person’s death.”

2) “Allowing to die” means “an act in which an agent either performs an action to remove an intervention that forestalls or ameliorates a preexisting fatal condition, or refrains from action that would forestall or ameliorate a preexisting fatal condition, either with the specific intention of acting that this person should die by way of that act or not so intending)” (Sulmasy, 1998, pp.57-58).

It should be noted that according to these definitions, by itself an intention that the patient die does not make an act “killing”. The improper withdrawal of treatment such as ventilation by a doctor, or even by a malicious interloper, even if the intention was that death should result, would not be killing but “letting die”. This may seem counterintuitive, according to the ordinary use of the word “killing” to denote a negative moral evaluation. However, according to the traditional distinction, “letting die” may indeed be as wrong as killing.
3.4.2. The moral significance of the distinction between acts and omissions

There is continuing disagreement about whether the conceptual distinction between acts and omissions is generally clear, in medical practice. But even if this distinction is clear, the question remains whether it has any moral significance. What is the basis of the moral difference between acts and omissions?

Most people, while acknowledging that we have responsibilities to save people’s lives, would hold that we have a greater responsibility not to kill them. This can be framed in terms of positive and negative duties - things we ought to do, and things we ought not to do. It seems that our negative duties are ordinarily more stringent than our positive ones: the duty to refrain from injuring is stronger than the duty to give aid (Foot, 1980). It is usually possible for a person to refrain from killing all the people on the planet, but not possible for her to save all their lives (Trammell, 1980, p.168). But if this is so in general, what about doctors, who have a very strong positive duty to save the lives of their patients”? Could they not be held responsible as much for “letting die” as for killing? The answer is that they could - if there is a duty to treat and they fail to treat. But there may be no duty to treat - if a patient refuses treatment, or the treatment is judged to be futile or excessively burdensome.

The moral significance of the distinction might also be framed in terms of the rights that other people have: positive (entitlement) rights to our help, and negative (liberty) rights in the way of non-interference with their bodies. At law we distinguish between the competent patient’s negative right to refuse treatment (which is absolute) and any positive right they might claim to request treatment. Whether or not a patient has a moral (and not just a legal) right to refuse treatment, failure to respect a patient’s refusal of treatment is normally much worse than declining to kill her. It would be to violate her liberty right to bodily integrity, whereas declining to kill her would be failing to honour her entitlement right to assistance.

However, according to consequentialism, there is only one moral duty: to promote good consequences. And so, one is just as responsible for the consequences of one’s inactions as of one’s actions: there is no morally significant difference between an act and an omission (Gibson, 1998). This is a very demanding standard, requiring that we must do everything we reasonably or even possibly can to save lives (McMahan, 1998).
3.5 The principle of double effect (PDE)
The traditional PDE specifies that when an action has two possible effects, one good and one bad, it is morally permissible if the action:

1) **is not in itself immoral**
2) **is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect although it may be foreseen**
3) **does not bring about the possible good effect by means of the possible bad effect, and**
4) **is undertaken for a proportionately grave reason** (Sulmasy & Pellegrino, 1999, p.545).

The term “double effect” was first used by Thomas Aquinas (1225-1274) who used the principle to justify killing in self-defence (J. Boyle, 1997). In the medical context, PDE means that “it can be morally good to shorten a patient’s life as a foreseen and accepted but unintended side effect of an action undertaken for a good reason, even if it is agreed that intentionally killing the patient or shortening the patient's life is wrong” (J. Boyle, 1997, p.51).

It is sometimes claimed that PDE could be used to justify PAS. It is argued that in PAS, the physician may have a number of intentions other than causing death, such as reassuring the patient that an escape exists, which the doctor hopes and expects will not be used, or relieving suffering, with death as “an inevitable but unintended side effect” (Quill, Dresser, & Brock, 1997, p.1768). However, in the first case, if the doctor had reason to believe the patient did intend suicide, the good effect of reassurance would not be a proportionate reason to risk the bad effect, and if he had no reason to believe this, it would not be a case of PAS but similar to other instances where patients stockpile and use drugs prescribed for other purposes. In the second case, PDE requires that the good effect (relief of suffering) not be achieved by means of the bad effect (death at least partly caused by the doctor’s action) (Sulmasy & Pellegrino, 1999).

3.5.1 Criticisms of PDE
Apart from the obvious disagreement that some would have with the view that intentionally killing a patient is necessarily wrong, there are three main criticisms that
have been made of this principle in the medical context: that death may not be a “bad effect”, the difficulty of distinguishing what is intended from what is foreseen, and that the principle is open to abuse.

Nowell-Smith claims that PDE is irrelevant to the distinction between AVE and “letting die”, since “it only comes into play if it is already agreed that the death of the patient to whom a doctor has administered AVE is a bad effect”. He continues, “Anyone who wants to use (PDE)... must also hold that the death of that person, no matter however brought about, is in itself a bad event” (Nowell-Smith, 1989, p.127). Others have argued similarly that death in the terminally ill suffering patient cannot be called bad (Gauthier, 2001; Syme, 1999, p. 38). The PDE was, however, articulated within a tradition in which life was a good, and death, as the extinguishment of that good, prima facie a bad thing. Catholic tradition also allows death need not be avoided at all costs, and that indeed under certain circumstances it may be regarded as not bad in the circumstances or even as a “blessing” (Gleeson, 2003). Similarly, although medicine is usually engaged in averting or postponing death, most doctors recognize that there comes a time when it must be accepted, even welcomed. What PDE does entail is that it is generally wrong for death to result from human action, but that under certain conditions such action may be justified. Therefore, it seems that this criticism fails.

A number of critics claim that distinguishing between what is intended and what is merely foreseen is problematic (Glover, 1977; Kuhse, 1987; Quill, Dresser et al., 1997). Intention may be difficult to validate externally (from the perspective of an onlooker rather than the decision-maker herself), although this does not prevent it being regarded as critical in law for the distinction between murder and manslaughter. And at least to a certain extent, intention can be deduced from actions, at least by an expert observer. So, if someone continues to use increasing drug dosages despite symptoms having been controlled, an observer might conclude that symptom relief was not the only goal of treatment. As one palliative care physician says, “It is axiomatic.. that effective measures that carry the least risk to life will be used” (Twycross, 1999, p.639).

Difficulty in external validation of intention is not a problem if PDE is used as a guide to making one’s own decisions rather than a means of evaluating the behaviour of others. A more serious objection is that even the individual may not fully know her own intentions: “according to modern psychology, human intention is multilayered,
ambiguous, subjective and even contradictory” (Quill, Dresser et al., 1997, p.1770). Some argue that attaching so much weight to the distinction between intention and foresight only encourages hypocrisy (Begley, 1998).

For the purposes of PDE, intention needs to be distinguished from both foresight and desire. Intention relates to what is aimed at, not what is believed will happen (foresight). Therefore an agent can ask of herself whether death figures in her plan, not just as a probable result, but as an objective or goal. Would the patient’s death mean success, and conversely survival represent failure? (Garcia, 1997). Philosophically, this can be described in terms of the different “direction of fit” for intention and foresight: with foresight this is from mind to world, and success is based on how well one’s belief matches what actually occurs. But with intention, the direction of fit is from world to mind, and success is based on whether what actually occurs is made to conform to the intention (Aulisio, 1995, p.341). Intention, it is argued, may also be distinguished from what might be desired. On this view, it is not necessary that death is regretted rather than welcomed. For the reasons outlined above, a patient’s death need not be seen as a bad thing in the circumstances. Sulmasy points out that one can intend to do what one does not desire, for example, out of duty, and one can desire to do what one never forms an intention of doing. He thus distinguishes intention from both foresight and desire, by the presence of a commitment to achieve something (Sulmasy, 1998).

PDE has also been criticized for placing too much emphasis on intention because, in the care of patients with reversible illness or injury but uncontrollable pain, a good intention (to relieve pain) would not justify the use of a lethal dose of analgesics (Doyal, 1999). People are generally held accountable for “all reasonably foreseeable consequences of their action, not just the intended consequences” (Quill, Dresser et al., 1997, p.1770). However, intention is only one aspect of PDE. Such a situation would not meet the criterion that the action was taken for a proportionately grave reason, since the relief of pain in the short term would not be grave enough to justify significantly shortening the life of someone who potentially had many years of healthy life ahead of them - a situation quite different from that of someone terminally ill. However this criticism does highlight the fact that the closer someone is to death (as well as the more severe and intractable their symptoms), the more justified risky doses of drugs would be, according to PDE.
PDE is certainly open to abuse. For example, it might be claimed that it justifies the type of “terminal sedation” which involves heavy sedation some weeks or months before death would be anticipated, together with the withholding of ANH. Although such a course combines two procedures which are each independently justifiable under certain circumstances, it may be considered implausible that death is not intended, as withholding ANH is not needed for symptom relief, and so can only be aimed at shortening life. In non-terminally ill patients, heavy sedation is always accompanied by ANH, to avoid shortening life (Quill, Lo et al., 1997). But according to PDE, if death is the intention, then the action is not justified. As Orentlicher argues, “(PDE) justifies only the sedation that is part of terminal sedation”. In other circumstances where food and water are refused or withheld, it can be argued that the patient’s underlying disease, through their inability to eat and drink, is the cause of death. But in some types of terminal sedation, it is the sedation which has caused the inability to eat and drink (Orentlicher, 1997, p.1237). (Thus some argue that medical acceptance of this type of terminal sedation is tantamount to acceptance of PAS/AVE and should logically be extended to it).

However, it is not clear how commonly such terminal sedation is practiced, and while some might attempt to justify it using PDE, other authors who are opposed to PAS and AVE believe it (unlike sedation of the imminently dying) cannot be so justified and should not be used. In particular, they believe that existential or psychological suffering alone, while grave, does not constitute a proportionate reason to justify a course of action which will significantly shorten life, and ought to be managed using other means, just as it would be in non-terminally ill patients. However, there is a range of cases between sedation of the imminently dying and “sedation towards death” where death is intended. PDE may offer little assistance in evaluating these (Jansen & Sulmasy, 2002).

3.5.2 An alternative to PDE: Proportionality or therapeutic ratio

Some medical authors frame their defence of terminal sedation in terms of proportionality or the “therapeutic ratio” rather than PDE: that as with any medical treatment, risks and burdens must be weighed up against the benefits it offers (Ashby & Stoffell, 1991; Cherny, 1998; Wein, 2000). As with PDE, the severity of symptoms, the magnitude of the risk of shortening life, the patient’s life expectancy and the possibility of alternative treatments must all be considered, as well as the patient’s wishes.
3.6 Why is killing morally different from at least some cases of “letting die”? 

The traditional moral distinction between killing and “letting die” has two components. The first is that it is possible to make a conceptual distinction between the two, which has been discussed above. The second is that there is an intrinsic wrongness about killing which does not apply to all cases of “letting die”. However, there is considerable disagreement among philosophers about this claim. Some argue from a consequentialist position that no action (or omission) is intrinsically wrong, and so any act of killing (or “letting die”) must be evaluated only according to the overall goodness of its consequences. Hence both the doctrine of acts and omissions and the principle of double effect are specifically opposed by the Principle of Agency, which states that “if it would be good for a state of affairs to occur ‘naturally’, then it is permissible to take action to bring it about” (Rachels, 1998, p.150). In the medical context, this means it is irrelevant in itself whether a patient’s death results from the underlying disease, an unintended side effect of treatment, or as the intended consequence of a lethal injection. Others may argue from a non-consequentialist perspective that while killing is prima facie wrong, exceptional circumstances may justify AVE/PAS, in that another moral principle (such as the obligation to relieve suffering) overrides the prohibition against killing in certain cases.

There are also consequentialist reasons for maintaining the general moral distinction that most people make between killing and “letting die”, in that preventing people killing generally is more conducive to overall welfare than preventing them “letting die” (Gillon, 1988). And specifically in the medical context, much opposition to legalizing AVE/PAS, even from those who do not believe it would always be morally wrong, arises from concerns about the so called “slippery slope”: that the practices would gradually be extended to include non-voluntary or even involuntary euthanasia, or non-terminally ill patients. There is also concern that vulnerable people, especially the disabled and chronically ill, might feel pressured to agree to kill themselves or to be killed, either by their doctors, their relatives, or a broader cultural view that some lives are “not worth living”. It is argued by some that these changes overall would be bad consequences which would outweigh the potential benefits to those patients who are currently harmed by not having legal access to AVE/PAS. Evidence for or against the empirical aspects of this claim, namely evidence of the actual consequences of legalising AVE and/or PAS, is available from the Netherlands, where AVE has been practiced under certain conditions without prosecution since 1973 and legalised in 2002,
from Oregon where PAS was legalized in 1997 and from Belgium, where AVE was legalized in 2002.

Those non-consequentialists who believe it is intrinsically wrong for doctors to kill their patients under all circumstances may do so because they believe it is generally wrong for any person to take an innocent life and/or that, because of the nature of medical practice, it is wrong for a doctor *qua* doctor to kill a patient.

### 3.7 General arguments for the wrongness of killing

From a deontological perspective, the general wrongness of killing may be framed in a number of ways, based on the intrinsic value of human life. It can be argued that the life of each individual has an equal claim to respect based on its irreducible value (Stauch, 2000). Sulmasy claims that one ought never to destroy the bearer of human dignity, which is uncompromised by disease or dependence (Sulmasy, 1998).

Oderberg claims that to kill another person, even at their request, is to commit an injustice against that person, because the right to life is inalienable, since human life is the good which is fundamental to the pursuit of all other goods, including the exercise of individual autonomy (Oderberg, 1997). The banning of dueling and of slavery are other examples of the view that we cannot waive our right to life or freedom, or give permission to anyone to kill or enslave us.

Nevertheless, as long as some exceptions to the general prohibition on killing are allowed, such as capital punishment, warfare or self-defence, it can be argued that AVE and/or PAS are also examples of exceptions to the rule against killing. Yet when the two standard arguments for these practices are examined, it is clear that each, if accepted as grounds for making an exception, would justify a much broader practice of medical killing than is usually sought by its advocates. The two arguments, respect for patient autonomy and the obligation to relieve suffering, are typically used together as a single justification, but they are logically separate. If the justification is respect for patient autonomy, then a request from a competent person is all that is required, and the practices cannot be limited to those who are “suffering” or who are terminally ill. And if the justification is the obligation to relieve suffering, it would apply equally to
incompetent as to competent patients, and would justify active non-voluntary euthanasia (Callahan, 1992).

3.8 Particular arguments against killing by doctors
Medical ethics, by which I mean the study of the moral issues which arise for medical practitioners in the course of their practice, may be conceptualised in two quite different ways. If it is an exercise in the application of general or broad based ethical theory (ies) to the particular issues which arise in medicine, then it relies on a moral authority “external” to medicine. Alternatively, clinical medicine may be understood to generate its own “internal” morality: a complex of professional role generated norms and commitments which arise from the “nature of medicine as a kind of human activity” with particular and characteristic ends (Pellegrino, 2001, p.560). Such an understanding may be derived from virtue ethics, and might provide doctors with particular reasons for believing that killing patients is wrong for doctors, and hence particular reasons for maintaining the traditional distinction between killing and “letting die” in medical practice.

Virtue ethics provides an alternative approach to consequentialism and deontology, one which focuses not on the consequences of a particular act/omission, nor on the act itself, but on the character of the moral agent. It makes central the practical wisdom (phronesis) of the person making moral decisions, and that judgment provides the standard by which the rightness or wrongness of other decisions are judged. Aristotelian virtue ethics is teleological, in that virtues are character traits required for human flourishing, which is the goal or end of human life (Oakley & Cocking, 2001). It provides a robust framework for role based and professional ethics, since professions tend to have clear, specific and widely recognized goals. A number of medical authors argue that, whether or not killing is universally wrong, or whether or not the moral distinction between killing and “letting die” has universal validity, the maintenance of the distinction and the prohibition of killing in the medical context are mandated by the goals of medicine itself, as a practice with its own “internal” morality (Gaylin, Kass, Pellegrino, & Siegler, 1988; Kass, 2002; Miles, 1995; Pellegrino, 1992).

There are two ways in which it may be argued that such an internal morality exists. The first is to point out contemporary and historical evidence for doctors having distinctive
moral norms and standards. The second is to argue philosophically for the coherence of such an internal morality.

3.8.1 Contemporary evidence for distinctive medical moral norms

There is a notable disparity between the dominant (consequentialist) view in bioethics about the moral significance of the distinction between killing and “letting die”, and that of the medical profession, at least as expressed in the official statements of medical associations worldwide. The former tends to discount the distinction, the latter to maintain it in its traditional form.

Statements of medical associations worldwide affirm a distinction between killing and “letting die” in the medical context (American Medical Association, 1994a, 1994b, 1994c; Australian Medical Association, 1997; British Medical Association, 2000; Canadian Medical Association, 1998; New Zealand Medical Association, 1996; World Medical Association, 2002). They oppose medical involvement in “euthanasia” and physician-assisted suicide, but approve the withholding or withdrawal of medical treatment, when it is declined by a competent patient, or is considered to be futile, even if this results in the patient’s death. The statements do not distinguish between withdrawing and withholding life-sustaining treatments, and one explicitly states that there is no ethical distinction between them (American Medical Association, 1994c). They also approve the provision of effective symptom management in the terminally ill, even if such treatment may foreseeably hasten death.

The Position Statement of the Australian Medical Association was formulated in 1997, when active voluntary euthanasia was a very topical issue because of the operation of the Northern Territory’s Rights of the Terminally Ill Act 1995, which legalized AVE, and the subsequent debate over of a Private member’s Bill in Federal Parliament to overturn it. Opinion polls showed overwhelming public support for AVE. In the preamble to the statement, the diversity of views in Australian society and among Australian doctors was acknowledged, as is the fact that not all suffering can be alleviated by even the best medical care. The AMA endorsed the right of patients to refuse treatment and the right of severely and terminally ill patients to have pain and suffering relieved, “even when such therapy may shorten that patient’s life”. Nevertheless, the AMA said that “Doctors should not be involved in interventions that
have as their primary goal the ending of a person’s life” (Australian Medical Association, 1997).

The BMA’s guidelines on end-of-life issues refer specifically to the contrast between their view and that of some philosophers: “Despite philosophical arguments that allowing death to occur is morally equivalent to causing it, the British Medical Association sees an important difference between intentional killing and the withdrawal of treatment in a way that will foreseeably result in the patient’s death” (British Medical Association, 2000).

Both the American and British Medical Associations draw on the concept of medicine having distinctive goals and doctors having a particular role, when they describe both “euthanasia” and physician-assisted suicide as “fundamentally incompatible with the physician’s role as healer” (American Medical Association, 1994a, 1994b) and “in tension with the fundamental role of doctors” (British Medical Association, 2000).

3.8.2 Historical evidence for distinctive medical moral norms: The Hippocratic Tradition

Perhaps the most important historical evidence for an internal morality of clinical medicine is found in the Hippocratic tradition, as exemplified by the Hippocratic Oath, said to represent the earliest known system of medical ethics. However recent scholarship has cast doubt on whether this tradition represents a genuinely medical morality. Instead it is suggested that it simply reflects the views of a particular, minority group of Pythagorean physicians.

The collection of writings associated by tradition with the name of Hippocrates is a mixed collection of about seventy works mostly written between 450 and 350 BCE. There is no uniform doctrine or literary style, except that all were written in a modified Ionic dialect (Jones, 1923). So while by the first century Hippocrates was “already famous and his medicine well established”, and “admiration for him seems to have been widespread among physicians” (Temkin, 1991, pp.5-6), it seems to have been a moot

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13 Little is known about the historical Hippocrates, thought to have lived from around 469 to 399 BCE, which made him a contemporary of Socrates. The only extant references from near the period of his life are in two passages in Plato. The first, from Protagoras (331 BCE), tells us that Hippocrates was a native of Cos, that he was very well known in his own day, and that he accepted payment for instruction in the art of medicine. The passage from Phaedrus (270 b-d) attributes (approvingly) to Hippocrates the principle that the nature of any component part or organ can be understood only through examination of the whole to which it belongs. Aristotle, writing after Hippocrates’ death, identifies him as a great physician, though apparently short in stature (Politics 1326a 15).
question even in ancient times how many of the “Hippocratic” works were actually written by him.

Rather than supposing all of the books of the Hippocratic Corpus to be written by Hippocrates or members of his school, a more plausible explanation is that “the Hippocratic collection is a library, or rather, the remains of a library… of the Hippocratic school at Cos”. It contains scholarly works of various dates and schools, along with medical notes and records and some books of “doubtful value” which had been presented to the library (Jones, 1923, pp.xxix-xxx).

There appears to have been no doubt of the authenticity of the Hippocratic Oath in ancient times. “By the first century it was accepted as the authoritative work of the great Hippocrates” (Temkin, 1991, p.21, footnote 16). Scribonius Largus, a Roman physician, ca 30CE, is the first extant author to mention the Oath and he obviously thought it was well known. According to him, Hippocrates, the “founder of our profession, placed the oath at the beginning of medical education” (epistula dedicatoria, art.5: pp.2 (l.20) -3 (l.2), cited in (Temkin, 1991, p.43)). It was also held to be genuinely Hippocratic by Erotian, a first century Greek lexicographer in the time of Nero, who listed a large number of Hippocratic writings (Temkin, 1991, p.40).

However modern scholars are more skeptical than the ancient writers about the authenticity of Hippocratic works, and many now doubt whether the Oath was written by Hippocrates or is even consistent with the Hippocratic tradition.14

The first major assault on the credibility of the Oath as an early expression of a distinctively medical morality came from Ludwig Edelstein in 1943: “I can say without hesitation that the so-called oath of Hippocrates is a document uniformly conceived and thoroughly saturated with Pythagorean philosophy. In spirit and in letter, in form and in content, it is a Pythagorean manifesto. The main features of the Oath are understandable

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14 While Nittis claims that Hippocrates himself wrote the Oath in Athens in 421 BCE (Nittis, 1940), this is denied by Carrick, partly on the basis of what he describes as a “persistent flaw” in Nittis’ analysis, namely that he “inexplicably ignores” the fact that the Oath is written in a modified Ionic dialect, rather than Attic as might be expected if it were written and used in Athens (Carrick, 1985, p.71). Yet the entire Hippocratic corpus is written in this Ionic dialect: possibly this was preferred for medical works even after koine established itself (Jones, 1923). Therefore the fact that the Oath is written in Ionic is an argument for rather than against Hippocratic authorship.
only in connection with Pythagoreanism; all its details are in complete agreement with this system of thought” (Edelstein, 1943, p.54).

Writing in 1985, Paul Carrick both critiques and builds on Edelstein’s thesis. He claims that not only is the Hippocratic Oath “now judged by very few scholars to be authored by Hippocrates”, but that it is also very doubtful that it “accurately reflects the ethical values and medical practices which the Hippocratic authors favoured and typically followed” (Carrick, 1985, p.69). Carrick is particularly concerned to demonstrate that the Oath is out of step with Graeco-Roman attitudes and practice in relation to abortion and “euthanasia”. He makes two main claims. The first is that the Hippocratic Oath is an “esoteric ethical code which is partly, though not exclusively of Pythagorean origin” (Carrick, 1985, p.69). The second claim (which had also been made previously by Edelstein (Edelstein, 1943) is that many ancient physicians chose to ignore the ethical teaching of the Oath on abortion and assisted suicide (if indeed they were even familiar with it), because of contrary ethical arguments (Carrick, 1985, p.99). If Carrick is correct and ancient medical attitudes to these issues were ethically pluralist, the claim that the Hippocratic Oath is an expression of a very early distinctively medical ethic is considerably weakened.

Carrick believes that Edelstein exaggerates the Pythagorean influence in most of the clauses of the Oath, except those concerning abortion and providing a deadly drug to a patient (Carrick, 1985, p.78). For example, Edelstein’s argument that the clause “I will apply dietetic measures for the benefit of the sick according to my ability and judgment” reflects a characteristically Pythagorean concern with diet (Edelstein, 1943, p.3) seems to overlook the fact that “Dietetics, built as it was on natural philosophy, was the speculative core of Hippocratic medicine” (Temkin, 1991, p.12). 15

Further, the proscription of sexual relations with either a patient or any member of his or her household cannot persuasively be argued to reflect an exclusively Pythagorean concern for high standards in sexual ethics, based on their concept of justice (Carrick, 1985, p.79). It is significant that this proscription is reflected in another Hippocratic work, The Physician: “Patients in fact put themselves into the hands of their physician,

15 “Rational Hippocratic therapy consisted in correcting, by diet and drugs, any imbalance in the humors…. According to Galen, this was the truly Hippocratic therapeutic principle, best known in its Latin version, Contraria contrariis curantur” (Temkin, 1991, pp.12-13).
and at every moment he meets women, maidens, and possessions very precious indeed. So, towards all these self-control must be used” (Hippocrates, 1923c, p.313). Edelstein also attempts to trace the Oath’s imperative to protect patient confidentiality to the well known value Pythagoreans placed on reticence, yet he admits that other ancient medical writings also advised reticence on the part of physicians (Edelstein, 1943).

Carrick similarly finds flaws in Edelstein’s argument about the Pythagorean basis for the Oath’s proscription of the use of the knife, “even for stone”, a notoriously difficult clause to explain on any theory. Thus, Carrick accepts Pythagoreanism as the best explanation for only two clauses in the Oath, those relating to assisted suicide and abortion:

*Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art* (Hippocrates, 1923b, p.299).

There is no doubt that these clauses are entirely consistent with the Pythagorean view that it was morally wrong to kill human or animal life, and that the foetus possessed a soul from the moment of conception (Carrick, 1985, p.111). And yet, as Carrick himself argues, the Pythagoreans are not the only plausible source of these prohibitions.

In relation to suicide and assisted suicide, it is by no means clear that the opposition of the Pythagoreans (and the Oath) was in such sharp contrast to the other philosophical schools. Plato’s attitude to suicide is difficult to ascertain and may have changed over time. In the *Phaedo* (62c4) Socrates says that one should not kill oneself “before a god had indicated some necessity to do so, like the necessity now put upon us”. Yet in the *Laws* (873c6-7), while Plato condemns suicide as morally wrong, he allows four exceptions, one of which is when one is “forced by the pressure of some excruciating and unavoidable misfortune”.

Aristotle, on the other hand, was unambiguous in his opposition to suicide, even in the face of suffering, incurable disease or disability. In *Nicomachean Ethics* he says that “to die to escape from poverty or love or anything that is painful is not the mark of a brave man, but rather of a coward” (1116a14-16), and describes suicide as acting both “in violation of right reason” and unjustly towards the state (1138a8-13).
Only the Stoics offered unqualified approval for so-called rational suicide under certain conditions. They were inspired by the example of Socrates’ courage in facing a forced death to consider suicide as noble when it was thoughtfully and willfully chosen in the face of intolerable suffering. So the Stoics Zeno and Cleanthenes suicided in response to physical pain, and Seneca did so when threatened with dishonour and execution. Therefore Carrick’s claim that “most (philosophers) eventually defended euthanasia as well (as abortion)” (Carrick, 1985, p.151) is overstated, since what they discussed was suicide, not medical AVE. Nor can Aristotle’s opposition be so summarily dismissed.

Despite its initial appeal and widespread acceptance, Edelstein’s work is today accepted by few scholars of ancient medical history (Larson & Amundsen, 1998; Nutton, 1995). His claim that the Oath is a Pythagorean manifesto is weakened by the fact that “(S)uch a group of philosopher/practitioners was never historically located” (Risse, 2003, p.110). His thesis also fails to explain why there is no proscription in the Oath of medical contraception, when the Pythagorean school had a strongly procreationist ethic, which dictated that intercourse should only be engaged in for the express purpose of procreation (Gaca, 2000). Further, the fact that the Oath is written in the Ionic dialect tells against Edelstein’s thesis, since the Pythagoreans favoured the Doric dialect (Carrick, 1985, note 56, p.267). Temkin believes that there is no need for any hypothetical philosophical affiliation to interpret the Oath, which can be explained by rivalry between groups of healers, in which “ethical standards were useful weapons in a struggle for acquiring a select clientele” (Risse, 2003, p.111). And Jouanna sees the role of the Oath in the context of the opening up of the teaching of the Asclepiads to pupils from outside the family, as a covenant which it had not been necessary to formalize within the family. (Jouanna, 1999). The Asclepiads were responsible for transmitting the medical tradition from Hippocrates of Cos, who belonged to that family.

Nevertheless, the idea that the Oath is discredited as an expression of ancient medical ethics has played an influential role in the public and medical debates about both abortion and AVE/PAS. Jack Kevorkian cites Edelstein’s work when he confidently claims that “euthanasia” and assisted suicide were widely practiced in ancient Greece in accordance with the “true Hippocratic tradition” (Kevorkian, 1998, p.273), whereas the Oath was concocted by “the tiny pagan religious sect of Pythagoreanism” (p.264). Edelstein’s view was also cited in both the Supreme Court’s opinion in Roe v Wade and
by Michigan appellate-court judge Andrew Kaufman in his “Opinion and Order Concerning the Constitutionality of the Michigan Statute Proscribing Assisted Suicide”, in order to discredit the *Oath* as “the expression of an absolute standard of medical conduct” (1993 WL 603212 (Mich. Cir. Ct), p.10). Vivian Nutton, Professor of the History of Medicine at University College London said at the Annual lecture of the Royal College of Physicians of London in 1995 that the *Oath* “is unrepresentative of Greek medical thinking; it reflects the ideas of a small group, not those of physicians and healers in general” (Nutton, 1995). Such claims, and those of Edelstein on which they are based, are not supported by recent scholarship.

Dutch scholar Van Hooff claims that the *Oath* does not in fact deal with assisted suicide but with the murder of a patient at the request of a third party (Van Hooff, 2004). He bases this interpretation on the grammar of the clause, “Neither will I administer a poison to anybody when asked to do so” (Hippocrates, 1923b, p.299). Van Hooff notes that “if asked” is in the nominative rather than the dative case, in agreement with the subject of the sentence (I) rather than the indirect object (the person to whom the poison would or would not be given). This means that the physician will not supply such drugs for any purpose, even if asked. Van Hooff argues that the focus is on murder rather than suicide. It is quite plausible that ancient physicians would want to reassure their patients that they would not murder them, as the fear of being poisoned by an unscrupulous doctor, possibly bribed by a third party, would be very understandable when the possibility of the poison being detected was low (Carrick, 1985). However, the prohibition does include assisted suicide, since it forbids the giving of poison to anyone. Van Hooff’s claim (that it does not) seems to rely not so much on the grammar of the clause, as on his view that ancient physicians did in fact assist suicides, the evidence for which will be examined below. His argument is not persuasive.

Another challenge to the credibility of the *Oath* as an historical expression of an internal medical morality comes from the claims that it is inconsistent with the Hippocratic tradition as a whole, and that the *Oath* was neither accepted nor followed as an ethical standard by physicians in antiquity, in relation to either abortion or assisted suicide. I will restrict my discussion of these claims to the arguments as they relate to assisted suicide.
Carrick claims that “the dominant medical ethical values expressed by the Hippocratic Collection as a whole do not unequivocally oppose the collaboration of physicians in abortion or voluntary euthanasia… That body of authoritative medical writings furnished no unified ideological opposition to such practices” (Carrick, 1985, p.151). However he admits that the Corpus is “not stocked with imperatives commanding doctors to assist consenting patients to end their tortured lives” (p.155). The Oath is the only Hippocratic text to mention medically assisted suicide, and that condemns it. Given that the Oath is the principal ethical text of the Hippocratic Collection, it is difficult to see how the silence of the rest of the corpus can be taken as lack of opposition, let alone endorsement of medically assisted suicide or AVE.

Suicide may have been relatively common in the ancient world, but medical involvement cannot be simply assumed in a practice which by no means always or even often required it. The extent of medical involvement cannot be accurately assessed from the limited evidence we have.

Carrick refers to “the known medical practices of those times during which the cooperation of physicians in aiding acts of suicide among the very sick was widespread” (Carrick, 1985, pp.155-156). Edelstein similarly says, “It suffices here to state that in antiquity many physicians actually gave their patients the poison for which they were asked. Apparently qua physicians they felt no compunction about doing so” (Edelstein, 1943, p.11). These are confident statements, for which we might expect to find good evidence. Edelstein supplies two ancient references, and Carrick cites a paper by Gourevitch that discusses a number of ancient references (Gourevitch, 1969). These references deserve closer examination.

In his novel The Golden Ass, Apuleius, a contemporary of Galen, describes a physician who is asked by a slave to supply poison, ostensibly for an incurably sick man who wanted a quick death, but in reality for the purpose of murder. The physician, who is described as virtuous, does not refuse to give the poison, but for reasons which are unclear suspects foul play and provides instead a harmless sedative (Temkin, 1991). Edelstein infers that the physician is not astonished at the demand, nor does he refuse it on general ethical grounds (Edelstein, 1943, p.11). Similarly, Gourevitch asserts that “it is not the request for poison which in itself alarms the virtuous physician; he knows that it is common practice … The purchase itself is recounted by the author in a very matter
of fact way… We are thus forced to believe that the custom is so well established that the mere request for poison is insufficient to compromise the requester” (Gourevitch, 1969, pp.506-507).

Since Roman law did not forbid suicide, the request for poison certainly need not compromise the requester, but in regard to the physician, against the inferences from silence which Edelstein and Gourevitch make, there is the clear evidence of the physician himself, given later, that involvement would compromise him. He states that he did not give the requested poison because “he did not believe it proper for his calling to be instrumental in bringing death to anybody, and because he had been taught that medicine had been invented not for the destruction of man but for his welfare” (*Golden Ass*, 10.11, cited in (Temkin, 1991, p.4)). This is dismissed by Gourevitch as “a romantic variation on a known theme” (Gourevitch, 1969, p.507). This theme of course is the one expressed in the Hippocratic *Oath*. It seems that this example, which in any case if fictional rather than historical, fails to support the contention that ancient physicians had no qualms about assisting suicide by providing poison. It could at least as plausibly be used to argue the opposite (Temkin, 1991, p.4).

Another, historical example of refusal to supply a lethal drug is the physician who, rather than give poison to the emperor Hadrian who wishes to commit suicide, prefers to suicide himself, as reported in *Historia Augusta*, Hadrian, XXIV (Gourevitch, 1969, p.509). This example is particularly telling in that it involves not a general objection to suicide, but only, it seems, objection to medical involvement in a patient’s suicide.

Against this evidence of physician refusal to assist patient suicide, what evidence is there for the claim that physician-assisted suicide was a well established custom in the ancient world? Gourevitch admits that “we have found no example of direct demand in a patient’s suicide”, by which she means a suicide motivated by the suffering of incurable illness, yet she continues, “it is nevertheless probable that such cases arose, for we have numerous examples of other types of rational suicide” (my italics) (Gourevitch, 1969, p.507). Gourevitch appeals to the case of Anthia in a 2nd century CE Greek romance (Xenophon of Ephesus: *Ephesiaca*, bk III, V, 5). But this forerunner of Shakespeare’s Juliet is in fact given a long lasting soporific by her physician, in order to avoid a distasteful marriage.
Yet there are other examples of ancient physicians involved to varying extents with the suicide of their patients, of which one is a clear case of giving poison. On being sentenced to death by the Emperor Nero, the Stoic Seneca appealed to his “loyal friend and skilful doctor”, Statius Annaeus, for assistance in his suicide. Having severed several blood vessels, Seneca found death painful and protracted, and his physician gave him the poison he requested, which was used for dispatching condemned prisoners. In the event, the oral poison was ineffective because “his system was closed to the action of the drug” (Tacitus, 1937, XV, LXIV). Gourevitch also refers to the physician Hermogenes, who is said to have shown his patient Hadrian the point on his chest where stabbing would ensure swift and painless death (Cassius Dio, 2003), and to the slave physician who “attended Domitius when he attempted suicide at Corfinium” (Gourevitch, 1969, p.509). However this latter reference is misleading, as the physician, when asked for poison “tempered the dose so as to do him no great harm”. His “wisdom and foresight” was rewarded by Domitius who gave him his freedom, since after taking the poison he “immediately repented and vomited it up” (Suetonius, 1989, p.214). This is not an example of physician-assisted suicide but rather of refusal to give a deadly drug, though whether from any ethical scruple or simply because he discerned that Domitius did not really wish to die, we cannot tell.

Another example is the death of Lucan, a poet who, like Seneca, fell foul of Nero and was “allowed free choice of the manner of his death”. He then “allowed a physician to open the veins in his arm” (Suetonius, 2006). Whether this suicide, or indeed that of Seneca, can truly be called voluntary, is open to question. The physician could alternatively be seen as an executioner. Nevertheless, he certainly was violating the spirit of the Hippocratic Oath, if not its letter, since poison was not involved. It is likely that the giving of poison stands for any deliberate method of killing a patient.

Finally, there is the reference to Thrasyas of Mantinea as the discoverer of a drug derived from hemlock, poppy and other herbs which would induce a painless death, and for which there was no antidote” (Theophrastus, 1916, IX, XVI,8). This passage illustrates, according to Jouanna, the blurring of the boundaries between ancient medicine and pharmacy, between the physician and the poisoner, and provides the background against which “the absolute prohibition of the oath against giving poison to a patient or third party acquired its full force and point” (Jouanna, 1999, p.130).
The ancient texts thus fail to provide compelling evidence for Gourevitch’s conclusion that “the intervention of physicians in rational suicide was common practice, particularly if motivated by reasons of health” (Gourevitch, 1969, p.509). There is no example of an illness related request for physician-assisted suicide, and only three examples of varying degrees of physician assistance in patient suicide.

While there is some evidence for physician involvement in assisted suicide, there is no evidence that it was widespread, and it is therefore problematic to conclude that the Oath was regarded as irrelevant or esoteric in ancient times. The fact that some physicians did not act according to the Oath is exactly what we would expect. As Temkin points out, “There would be little sense in solemnly forswearing murder, cooperation in suicide, abortion, and euthanasia if doctors had never been known to participate in such deeds” (Temkin, 1991, p.21). No formal education, qualifications, or state regulation of physicians existed, and the Hippocratic Law notes that “Many are physicians by repute, very few are such in reality (Hippocrates, 1923a). Some “physicians” may have been simply poison sellers.

It seems that the evidence required to assert confidently that the Hippocratic Oath did not represent the morality of ancient medicine is lacking. But it should also be noted that whether or not the Oath was observed by or agreed to by the majority of ancient physicians, it might still have reflected a genuinely medical morality. As Leon Kass says, “Even if Edelstein was right about the Pythagoreans, the Pythagoreans might have been right about medicine. And they might still be right if, as I believe, the essential activity of healing the sick is still the same, despite all the enormous changes in medical practice. That is, if to be healthy or whole still means largely what it did in ancient Greece, if the desire of the ill to be whole is no different, and if the healing relation between the physician and the one to be healed is in essence the same... Not every lost cause deserves to lose” (Kass, 1985, p.228).

Given, then, that the Oath likely represents an ethical standard which commanded respect in the ancient world though it was not universally followed, and given that the content of its ethical precepts is not exclusively Pythagorean, what then can we say of its historical significance? Verhey suggests that, even if it represented the commitments of only a minority of physicians, it had an important reformist function. It was written with the aim of correcting medical malpractices, since the reformers could find no help
in the law, convention or philosophical consensus (Verhey, 1998, p.109). But on what did they base their ethical standards, if not Pythagorean teaching?

The most plausible answer is that they based them on the nature of medicine as an art/craft (techne). The use of this term in the Oath is characteristic of the Hippocratic writings (for example, in Aphorisms we find “Life is short, the art long” (Hippocrates, 1931, p.99)), and is the more striking given that the term in Greek philosophy, especially Plato, was rather derogatory (Jones, 1923, p.296). But here the link with the Pythagoreans becomes clear. The Pythagoreans honoured technia as having moral significance. The writer/s of the Oath did not merely apply Pythagorean moral theory to a medicine conceived as morally neutral, but tried to draw out the moral significance inherent in the craft itself. Later, their reform of medicine flourished though Pythagoreanism itself waned, because their attitude to crafts became dominant. Their “convictions about the crafts allowed and required one to identify the good implicit in the craft and to articulate the standards coherent with the good of the craft” (Verhey, 1998, p.110).

Similarly, Stanley Hauerwas claims that medicine in itself represents a sectarian commitment about how to care for the ill. The Oath did not reflect the broad consensus of society but only the convictions of a group of physicians late in the 4th century BCE. Yet the prohibitions were not based on Pythagorean premises but on the standards of a practice, the telos of which is to benefit the sick. This puts limits on the use to which medical skills can be applied, in that they cannot be used for alien ends (such as the destruction of human life). “It is not that to do these things would be to fail to be a good Pythagorean, but rather to fail to be a good medical practitioner” (Hauerwas, 1986, p.8).

This review of the evidence and debate about the Hippocratic tradition suggest that it may reasonably still be regarded as an ancient expression of an internal morality of clinical medicine.

3.8.3 Philosophical argument about an internal morality of medicine

The term “internal morality” was first applied to medical ethics in 1983 by John Ladd, who adapted a concept which had been used in relation to the philosophy of law, and used it to designate the body of moral norms binding on doctors by virtue of their membership in the profession, derived from the special features of the doctor-patient
relationship (Ladd, 1983, p.209). It is generally located within the normative ethical theory of virtue ethics. Impartialist theories such as Kantianism and consequentialism have difficulty accommodating the peculiar moral demands and licences which apply to professionals, and in capturing the distinctiveness of each profession which makes appeals to professional integrity meaningful (Oakley & Cocking, 2001).

A significant influence on the development of the concept of an internal morality of medicine (and other professions) was Alasdair MacIntyre’s 1981 work *After Virtue*, in which he introduced the concept of a practice (of which medicine is cited as an example) which he defined as:

*any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended* (MacIntyre, 1984, p.187).

According to MacIntyre, being involved in a practice such as medicine involves accepting particular standards of excellence and obedience to (particular) rules, and the acquisition of certain virtues, where a virtue is:

*an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods* (MacIntyre, 1984, p.191).

MacIntyre distinguishes the internal goods of a practice from those external goods which may be attained incidentally by engaging in the practice, such as prestige or wealth. Goods are internal because they can be specified only in relation to that practice, and more controversially, “because they can only be identified and recognized by the experience of participating in the practice in question. Those who lack the relevant experience are incompetent thereby as judges of internal goods” (MacIntyre, 1984, pp.188-189). This implies not only that medicine has an internal morality, but also that medical practitioners are in a privileged position when it comes to specifying what the internal goods (sometimes also called the goals or ends) of medicine are.
When the Goals of Medicine Project of The Hastings Center was established in 1992, part of its task was to examine the relationship between medicine and society, focusing on the question of whether it makes sense to talk of goals of medicine which are universally valid, rather than determined by particular cultural and historical contexts. The authors concluded that, while medicine has both universal and particular features, “one source of the universality in medicine is our common human nature”, which entails the universal experiences of illness, suffering, pain, and aging (Allert et al., 1996a, p.S6). They described two views about the nature of medicine and its goals, which they called the inherentist position, that medicine’s goals are intrinsic, a response to the universal human experience of illness, and the social-construction view, that medicine’s goals are entirely time and culture bound, as the interpretation of illness, and the appropriate response to it vary with the social context. This is not only a debate about the actual relationship between medicine and society, but about how the two ought to relate.

The group agreed that while “medicine does have and has always had, some universal core values and is in that sense marked by inherent goals”, the expression of these values and goals may be different in different cultures (p.S8). They also emphasized that while medicine needs to have its own “inner direction and core values” in order to resist encroachments such as that of Nazi or Communist medicine, it inevitably must also be influenced to some extent by the society of which it is part. In their view, there ought to be an “open and ongoing dialogue between medicine and society”, and an openness even to a fundamental change in the values of medicine in response to new scientific knowledge, or changes in societal values (pp.S7 – S8).

In 2001 an issue of the *Journal of Medicine of Philosophy* was devoted to the question of whether there is an internal morality of medicine, and again there was disagreement. Four different views were expressed. Pellegrino put the inherentist position, and drawing on Aristotelian teleology, argued that medicine’s ends are entailed essentially in the very nature of medicine as a human activity (Pellegrino, 2001). He distinguished between the goals of medicine, or purposes to which it may be put, and the ends of medicine. The former, he said, are “defined externally by social, economic or political convention” (p.564), whereas the latter are determined by the essence of medicine. This idea can also be expressed in terms of medicine, like many other human activities and
roles, being “bounded by natural predetermined properties”, such as human anatomy, physiology and psychology (Cottingham, 1997, p.129). At the other extreme, two authors argued for a purely “external” medical morality, were Veatch and Beauchamp. Veatch concluded that the notion of a morality internal to medicine is “morally incoherent or at least morally indefensible” (Veatch, 2001). Beauchamp, a utilitarian, also argued for the dependence of medical morality on “universal moral principles that are valid independent of the perspectives of particular communities and traditions of medical practice and ethics” (Beauchamp, 2001). This view had previously also been put by Momeyer, who insisted that “the ends medicine serves are of human invention… medicine is just what we want it to be, not what nature decrees it must be” (Momeyer, 1995, p.17), and that medicine can have many, sometimes conflicting ends or purposes, but that these must come from outside itself, that is, from the more basic ends or purposes of human living derived from a common, universal (and real) morality. These three writers deny both the inherentist and social constructionist views, and represent the view, described earlier, that medical ethics consists of the application of general or broad based ethical theory (ies) to medical practice and relies solely on a moral authority external to medicine.

One of the problems with the view that the norms of medicine are derived purely from external moral principles is that there is some disagreement about the content of a common morality. The appeal to an objective external morality, apart from a particular tradition, arguably can be said to fall with the failure of the Enlightenment project to provide a universally agreed on rational basis for morality (MacIntyre, 1984). Some writers argue that, because of the seemingly intractable secular pluralism of the modern world, the morality of medical practice will inevitably be different in different social and religious traditions, so that there is no universal medical morality, only Catholic medicine, Orthodox Jewish medicine, secular medicine, and so on, building on a very small core of an internal medical morality. They claim that a rich and contentful morality (including medical morality) can only exist within a community of people with a shared moral vision (Engelhardt, 1993). This represents a mixed approach (internal and external) to the morality of medicine, with the external authority coming not from general ethical theories, but specific religious or social traditions.

Another mixed approach is the “evolutionary” perspective of the internal morality of medicine, which was the fourth view expressed in the Journal of Medicine of
Philosophy devoted to the topic (Miller & Brody, 2001). While critiquing Pellegrino’s inherentist approach, Miller and Brody pointed to the “basic facts” about medicine that call for a set of internal duties to which doctors must be bound if they are to have professional integrity: facts such as the imbalance of knowledge and power in the doctor-patient relationship, the distress of illness and the need for help in resorting health, the importance of trust. This is a mixed approach, because they argued that in liberal democratic societies, external principles such as respect for patient autonomy and justice generate ethical requirements for medical practice, and are the most important in resolving medical ethical dilemmas. They also said that the goals of medicine are not fixed, but evolve from a dialectic between the essentialist and the social constructionist views”, and denied any dichotomy between these two views (Miller & Brody, 2001). The mixed approach might be seen as seeking “some sort of happy middle ground that protects medicine against corruptive forces while allowing for external forces deemed compatible with medical practice” (Welie, 2002). But the view that medicine has both internal and external norms seems the most plausible view, and also the most helpful view when considering various medical ethical dilemmas. It is useful to distinguish between the internal norms of medicine (derived from its universal features) and external norms, such as always informing patients of their diagnosis, respecting individual patient autonomy, or the just allocation of resources, which are to a certain extent relative to the particular culture in which medicine is practiced, and may indeed sometimes conflict with its internal norms (Ladd, 1983). This approach is consistent with virtue ethics. MacIntyre argues that practices are shaped and transmitted through traditions (such as the tradition of medicine, in which beliefs and customs are passed from one generation of doctors to the next) that sustain them, and which in turn “do not exist in isolation from larger social traditions”, which are concerned with the goal or telos of a whole life and whole communities (MacIntyre, 1984).

Although disagreement about whether there is an internal morality of medicine remains, it seems reasonable to think that at least part of medical morality is derived from its internal norms. The next question to consider then, is what the goals of medicine are.

The Hippocratic work, The Art defines the goals of medicine as “to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless” (Hippocrates, 1977, p.193).
The traditional goals of medicine are generally construed as the promotion of health, and healing, which includes saving life, restoring health, and enabling patients to cope with disability and death when cure is not possible. The aphorism “To cure sometimes, to relieve often, to comfort always” is frequently cited and usually attributed to Dr. Edward Trudeau (1182-1915), founder of a tuberculosis sanatorium, although it actually derives from a 15th Century French folk saying (Anonymous, 2003b). In 1902, Sir William Osler described the goals of medicine more ambitiously as “to wrest from nature the secrets which have perplexed philosophers in all ages, to track to their sources the causes of disease, to correlate the vast stores of knowledge, that they may be quickly available for the prevention and cure of disease” (Osler, 1939). Leon Kass describes the end of medicine as “to benefit the sick by the action of healing” and, recognising that death is inevitable, “to focus on easing and enhancing the lives of those who are dying” (Kass, 2002, pp.14-15). Edmund Pellegrino conceives of the ends of medicine as “healing, helping, caring and curing”(Pellegrino, 1997, p.63).

Until recently, the goals of medicine have not been held to encompass killing, in continuity with the Hippocratic tradition. Therefore if AVE and/or PAS are to be seen as congruent with the goals of medicine, it must be argued either that killing can be in some cases a form of healing, or that the goals of medicine need to be redefined, or supplemented (Allert et al., 1996b). The argument that killing is a form of healing is generally avoided because of its associations with the Nazi justification of its “euthanasia” program as “purely a healing treatment” (Kass, 2002).

In 1991 Eric Cassell proposed that the primary goal of medicine should be expressed in terms of the relief of suffering: “The warrant for medicine in every culture is the universal existence of sickness and suffering and the need for relief… The profession of medicine must pursue the relief of suffering” (E. Cassell, 1991, pp.24, 31). In the following year, the Hastings Center Goals of Medicine Project was commenced, as a result of the perceived need to re-examine the traditional goals of medicine in light of the enormous changes in the practice and potentialities of medicine in the Modern era (Callahan, 1999). After seven years of international collaboration, the Project specified four goals of medicine: 1) the prevention of disease and injury and the promotion and maintenance of health; 2) the relief of pain and suffering caused by maladies; 3) the care
and cure of those with a malady, and the care of those who cannot be cured; and 4) the avoidance of premature death and the pursuit of a peaceful death (Allert et al., 1996b).

Not everyone would agree with these goals. Dan Brock claims that health is no longer a primary end of medicine, because, at least in developed countries, the common view is that “medicine’s goal should be to provide treatment that best enables patients to pursue successfully their own overall aims and ends, or life plans. It is the relative value of health, and of different aspects of health, as compared with other ends, that varies for different persons and circumstances” (Brock, 1993b, pp.101-2). Doctors and patients may disagree about what health is, as when a woman claims that removing a healthy breast for the sake of improving her golf swing is more significant to her conception of health than having both breasts (Simmons, 1997).

The participants in the Goals of Medicine Project (drawn from fields including medicine, law, philosophy, theology, health policy and administration) were in disagreement as to whether AVE or PAS would be compatible with the goals they proposed. A number of writers believe that the internal morality of medicine entails that doctors do not kill their patients (Kass, 2002; Lickiss, 1995; Pellegrino, 1992; Simmons, 1997; P. A. Singer & Siegler, 1990). But others argue that AVE and/or PAS are already congruent with the goals of medicine (Miller & Brody, 1995, p.12; Seay, 2001). Those who take this view include practicing clinicians (Quill et al., 1992). Others argue that, since goals of medicine are partially or wholly set by external moral standards, these should be redefined so that AVE and/or PAS may be included in medical practice (Brock, 1993b; Momeyer, 1995), or even that medicine should be replaced by another (morally better) profession which accommodates mercy killing (Rachels, 1975).

Another way that the question of whether AVE and PAS conflict with the goals of medicine as a practice is framed is in terms of a violation of the integrity of medicine as a profession. In response to the publication of a doctor’s personal account of assisting a patient to die (Anonymous, 1988), four doctors wrote in the *Journal of the American Medical Association* that “this issue touches medicine at its very moral centre… for if medicine’s power over life may be used equally to heal or to kill, the doctor is no more a moral professional but rather a morally neutered technician” (Gaylin et al., 1988, p.2139). However it has been argued that while doctors’ professional integrity grounds a *prima facie* duty to refrain from AVE or PAS, this duty may be overridden in
exceptional situations involving voluntary requests from patients with severe intractable suffering, in conformity with the medical goal of helping patients achieve a peaceful death (Miller & Brody, 1995). Momeyer similarly rejects the argument that PAS violates the integrity of medicine (Momeyer, 1995).

The corollary of medicine having specific goals is that it also has limits. These were inherent in the Hippocratic understanding of medicine as an art (techne iatrike) and of the proper relationship between medicine and nature. The word “physician” derives from the Greek physis, meaning nature, and Hippocratic physicians understood the task of medicine as working with or assisting nature to restore the “natural state of health”, where nature meant “the essential substances which make up human beings”. This also entailed setting boundaries to avoid the error of excessive confidence (Jecker, 1991). As we have seen, the Hippocratics refused “to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless” (Hippocrates, 1977, p.193). It can be argued that while “letting die” represents submission to forces beyond our control, killing may demonstrate the vice of hubris, a refusal to recognise any limits to one’s power.

3.9 Conclusion

The philosophical debate about the distinction between killing and “letting die” reflects the basic disagreement between traditional (non-consequentialist) and consequentialist morality, and is usually framed in terms of the doctrine of acts and omissions and the principle of double effect. The moral significance of the distinction for doctors depends on the claim either that killing is generally wrong, and/or that there are particular reasons why it is wrong for doctors to kill their patients, based on the internal morality of medical practice. A review of the historical and philosophical arguments about an internal morality of clinical medicine suggests that, while not uncontentious, the idea that medical morality is generated at least in part from internal norms which are derived from the goals and limits of medicine is both powerful and plausible. Yet as the traditional goals of medicine are challenged, and doctors urged to reconsider whether revised goals may encompass AVE/PAS, and whether these practices would indeed violate the integrity of the medical profession, or be incompatible with the doctor’s role as healer, perhaps the disparity between medical and non-medical attitudes to the moral significance of the distinction between killing and “letting die” is now more apparent.
than real. The official position statements of medical associations may no longer reflect
the views of practicing doctors. To explore this possibility, surveys of the views of
doctors in the late twentieth and early twenty first century will be discussed in the next
chapter.
Chapter Four  Previous studies of medical attitudes to killing and “letting die”

4.1 Introduction
In this chapter I review a number of studies of the attitudes of doctors to killing and “letting die in the medical context. I will not attempt a comprehensive review of all the findings of these studies, but instead outline the features of these studies which are relevant to distinctively medical perceptions of killing and “letting die”. Quantitative studies will be reviewed initially, followed by qualitative studies.

4.2 Quantitative studies
Australian studies will be reviewed first, followed by those from other countries.

4.2.1 Australian studies
Previous studies of Australian doctors’ attitudes to killing and “letting die” have predominantly been postal questionnaires, using yes/no answers to questions about treatment decisions at the end of life, and opinions about the legalisation of active voluntary euthanasia and/or physician-assisted suicide. These studies were conducted in a particular historical and social context, as outlined in chapters two and three. The investigators, like all researchers, had particular backgrounds, pre-suppositions, and, on occasion, “agendas” in performing their research.

Table 1 Australian postal questionnaire surveys of doctors’ attitudes

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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| Stevens and Hassan, 1994 | 298 South Australian doctors                        | 60%           | 45% support legalization of AVE  
55% say “not ever right” to “take active steps” to bring about death; 8% say this of treatment withdrawal which results in death  
19% report taking such “active steps” |
| Baume and O’Malley, 1994 | 1268 doctors in New South Wales and the Australian Capital Territory | 76%           | 58% support legalization of AVE  
52% say that their professional organization should approve it  
46% support legalization of PAS  
59% say it is “sometimes right for a doctor to take (active) steps to bring about a patient’s death”; 12% report doing so when asked by patient; 7% report providing patient with means to suicide |
<table>
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<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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<tr>
<td>Waddell et al, 1996</td>
<td>1588 Australian doctors, of whom 10% were palliative care physicians</td>
<td>73%</td>
<td>93% say would refuse request for “assisted death” by competent 56 year old man with motor neurone disease Of those who would agree to the request, more would be willing to provide PAS than AVE</td>
</tr>
<tr>
<td>Wilson et al, 1997</td>
<td>886 members of Royal Australian College of General Practice</td>
<td>80%</td>
<td>56% &quot;would not be distressed&quot; if AVE available 68% believe that “euthanasia can be an act of caring” 46% concerned about potential abuse of legalized AVE</td>
</tr>
<tr>
<td>Kuhse et al, 1997</td>
<td>1918 Australian doctors</td>
<td>64%</td>
<td>3% of 800 reported “end-of-life decisions” involved AVE or PAS, 36% treatment abatement, and 54% the use of large doses of opioids</td>
</tr>
<tr>
<td>Steinberg et al, 1996</td>
<td>486 Queenslanders from electoral roll 860 health professionals including 259 medical practitioners of whom 146 were GP’s</td>
<td>53% 76%</td>
<td>In favour of legalized AVE: 65% of community members 43% of health professionals 37% of medical specialists (41% in favour of PAS) 29% of GP’s (32% in favour of PAS) In favour of complying with competent patient’s request to switch off life support: 73% of community members 49% of medical specialists 57% of GP’s</td>
</tr>
<tr>
<td>Steinberg et al, 1997</td>
<td>535 Northern Territory (NT) community members 243 NT nurses 174 NT doctors</td>
<td>50% 59% 51%</td>
<td>Level of approval of ROTI: 79% strongly approve/ approve 65% strongly approve/ approve 35% strongly approve/ approve 1</td>
</tr>
<tr>
<td>Douglas et al, 2001</td>
<td>683 Australian general surgeons</td>
<td>69%</td>
<td>36% report having given drugs with intention of hastening death 54% agree there are circumstances in which this is morally acceptable 34% willing to hasten death by infusion but not by bolus dose 94% willing to run analgesic/sedative infusion at dose necessary to control symptoms even if this might incidentally be foreseen to hasten death If a patient were comfortable, but drowsy and with depressed respiration, 3.5% would increase the infusion rate; 43% would maintain it and 47% would reduce it to see if the patient could be kept comfortable on a lower dose 4% report giving a bolus dose of a lethal drug at patient’s request</td>
</tr>
<tr>
<td>Cartwright et al, 2002</td>
<td>405 Queensland community members</td>
<td>38% 43% 2</td>
<td>61% in favour of legalized AVE 53% in favour of legalized PAS 36% in favour of legalised AVE</td>
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1 These figures for nurses are similar to the findings of Kitchener in a 1996 postal survey of nurses in the Australian Capital Territory, 72% of whom supported AVE as ‘sometimes right’, and 69% of whom thought the law should be changed to allow it (Kitchener, 1998).
Baume and O’Malley’s study was supported by the Voluntary Euthanasia Society of New South Wales, of which one of the researchers, Peter Baume, a physician and former politician, was Patron. Written comments received from doctors in the study suggested that some terms were not adequately defined, that yes/no answers could not be given for some questions, and that the survey was “biased towards euthanasia” (Baume & O’Malley, 1994, p.140). The authors concluded from the level of support (58 percent) for the legalization of AVE, that if it were legalized, more than half of doctors would practice it “despite many who refused AVE claiming that their decision was not based on legal issues” (p.144). But there may be a difference between an abstract agreement that something may be permissible (perhaps for someone else), and a particular commitment to undertake it oneself. For example, a study of nurses’ attitudes found that although 72% of respondents thought it was sometimes right for a doctor to take ‘active steps’ to bring about the death of a patient on request, only 30 percent were willing to assist patients to give themselves a lethal dose, and only 14 percent said they would be willing to actually administer the lethal dose to a patient (Kitchener, 1998).

From 1995 to 1997 there was a great deal of public and media interest in AVE in Australia, as the Rights Of the Terminally Ill (ROTI) Bill was debated and enacted in the Northern Territory (NT). Regulated medical AVE of terminally ill patients was legal there for nine months until the Act was overturned by Federal Parliament in March 1997. This also prompted debate within the medical profession, and five studies of medical attitudes were undertaken during this period.

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2 The authors postulated that the low response rates were due to the increased complexity of the questionnaire.
The study of Waddell (an anthropologist) and Clarnette (a physician) used clinical scenarios rather than general questions, and asked doctors what they would actually do, giving them 3 options (Waddell, Clarnette, Smith, Oldham, & Kellehear, 1996). Female, Catholic, Western trained and older doctors, as well as palliative care practitioners, were least likely to say they would agree to assisted death. Analysis of the degree to which six independent variables, namely legal, ethical, religious and economic factors and patient’s and family’s wishes, were reported to influence the decision showed that only patent’s wishes, religious beliefs and ethical factors were significant in predicting responses, yet together they accounted for only seven percent of the variance. The authors concluded that their data did not support Baume and O’Malley’s speculation that it was the illegality of “assisted death” that caused doctors’ reluctance to perform it. Rather, they postulated that Australian doctors “believe that assisting a patient to die is an act that negates what they perceive to be the very essence of their profession” and that “medical practitioners may not be the most appropriate group to carry out the request” (for “some form of euthanasia”) (Waddell et al., 1996, p.544).

Another study was partly prompted by Baume and O’Malley’s finding that general practitioners were significantly more likely to have provided AVE or PAS than other doctors (I. Wilson, Kay, & Stevens, 1997). However the questions used were quite different from those in other Australian surveys, making comparison difficult. For instance, support for “voluntary euthanasia” was gauged by asking if participants would be “distressed” if this were available for others. But failing to be “distressed” (a strong term) by the prospect of something happening does not necessarily mean support for it. Nor can belief that “euthanasia can be an act of caring” necessarily be construed as support for the practice, since even strong opponents of AVE admit the caring motive of those who perform it in at least some cases. The number of respondents who expressed concern about potential abuse in relation to “euthanasia” means that it is difficult to conclude from this survey that general practitioners support a change in the law, or to assess their willingness to be involved in AVE or PAS 3.

One interesting question, which to my knowledge has not been used in other surveys, related to whether relatives should have the right to make the body of a person who has died by euthanasia available for organ donation. 40 percent agreed to this if the person was an adult, and 53 percent if the person was a child. This is remarkable, given that the euthanasia of children had never been included in any proposed or actual legislation regarding euthanasia in Australia, or indeed anywhere in the world (until recently in the Netherlands), which has been restricted to voluntary euthanasia of competent adults.
The major, and frequently cited, study of Kuhse et al. used an English version of a questionnaire developed and used by Dutch researchers (van der Maas, van Delden, Pijnenborg, & Looman, 1991; van der Maas et al., 1996). The principal researchers, Helga Kuhse and Peter Singer, were prominent advocates of AVE, and the third author was Peter Baume. The study aimed to estimate the proportion of deaths in Australia involving ‘medical end-of-life decisions’ and to compare the findings with those of the Dutch studies. “Medical end-of-life decisions” included “euthanasia” (which the authors defined as “the administration of drugs with the explicit intention of ending the patient’s life, at the patient’s request”), PAS, ending of life without the patient’s explicit request (involuntary or non voluntary euthanasia, alleviation of pain and symptoms with opioids (where the dose was large enough “so that there was a probable life shortening effect”, and a decision not to treat (withholding or withdrawal) (Kuhse et al., 1997, p.192).

There are a number of problems with this study. First, in relation to the question about the alleviation of pain and symptoms with opioids where the dose was large enough “so that there was a probable life shortening effect”, this is based on the false premise (though common belief) “that the dose of morphine (or other opioid) per se is the main determinant of whether the drug causes or hastens death”. What is more important is the size of the initial dose and the way it is subsequently increased (Ashby, 1997).

Second, one of several significant differences between the questionnaire used in the Australian study and the original Dutch version was that the Australian question concerning “actions or omissions… with the explicit intention of not prolonging life or hastening the end of life” (p.6), was, in the original Dutch version, worded “actions… with the express aim of hastening the end of that life” (Pollard, 1997). It is assumed that “not prolonging life” and hastening death are equivalent, but doctors may not see it that way. Hence it is doubtful whether the Australian data can be meaningfully compared with the Dutch results.

The way these estimates were presented could also be described as misleading. The discussion begins with the rather startling claim that “30 percent of all Australian deaths were preceded by a medical decision explicitly intended to hasten the patient’s death” (p.195). But the figure of 30 percent is derived by conflating a number of (arguably) morally distinct acts. The great majority of these deaths (24.7 percent of all Australian
deaths) involved treatment withholding or withdrawal, “with the explicit intention of not prolonging life or of hastening death” (my italics). It is not clear that “not prolonging life” and “hastening death” are equivalent, or that they mean the same thing to doctors. As Kissane notes: “actions or omissions aimed at not prolonging life… 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 Dutch [studies] meaningless” (Kissane, 2002).

Further, the authors included under the heading “intentional ending of life without the patient’s consent”, cases of treatment abatement where there had been no explicit request from the patient for this. But doctors do not require a patient request or even patient consent not to treat. Futile treatments are often not discussed with patients. The phrase “without an explicit request” is not equivalent to “without consent”, unless one assumes that every possible treatment option (and non option) must be discussed and agreed to by the patient.

The final conflation in the article occurs when, by redefining “euthanasia” as any case in which death is “intentionally accelerated by a doctor”, the authors are able to claim that 30 percent of all Australian deaths are cases of euthanasia. Kuhse and Singer are consequentialists (utilitarians) and assume (without explicitly stating the basis for it) that there is no moral distinction between taking active steps to kill and the omission of treatment, or “letting die”. The doctors who participated may not have seen it that way: the survey did not ask them.

Researchers from the Department of Social and Preventive Medicine at the University of Queensland undertook a wide-ranging investigation of the attitudes of the community and of health professionals (nurses and doctors) to medical issues at the end of life, including what they called “active and passive euthanasia” (Steinberg, Cartwright, Najman, MacDonald, & Williams, 1996). The researchers acknowledged that their sampling method meant that Aboriginal people, who were reported to represent 1.5 percent of the Australian population but 23 percent of the population in the Northern Territory (Moskowitz & Whitmore, 1997), and whose opposition to AVE is well documented (Fleming, 2000; The Select Committee on Euthanasia, 1995) were under-represented in their community sample. The questionnaires for the community members
and the health professionals were similar but not identical. Of particular interest are the differences in responses of the two groups when asked about legalizing AVE, and about complying with a competent patient’s request to turn off their life support (for example, a respirator). Although the authors did not comment on this, or compare the difference statistically, it seems that doctors were more likely to see a moral distinction between “euthanasia” and turning off a respirator than members of the community. The difference might have been even greater if the question about the respirator had been more precise, in that it did not specify that the patient was not suffering from a treatable depression, how long he/she had been on the respirator, or what were the long term chances of being able to come off it. Some doctors might have been unsure of their response or even answered no, for these reasons, and there is evidence for this in the large category of “unsure” in both medical groups compared to the community.

The same researchers also attempted to assess the level of approval in the Northern Territory of the *ROTI* legislation while it was in force (Steinberg, Cartwright, Williams, Robinson, & Tyler, 1997). Again it was recognized that the indigenous population was under-represented in the community sample, and the community figures may have therefore been less approving of the legislation than if more had been included. Even so, the authors believed that the differences between community and medical attitudes were sufficiently great to warrant their conclusion that it is “of fundamental importance to identify the factors contributing to these differences in order to develop legislation, policies and practices that are acceptable to both the community and their health practitioners” (p.577).

The principal authors of a study of Australian general surgeons were a surgical registrar and a physician/ lecturer in medical ethics, from the University of Newcastle (Douglas et al., 2001). Some of the questions related to a case vignette: a 60 year old woman with disseminated metastatic carcinoma of the colon, who five weeks post operatively, with a colonostomy, persistent pain and loss of independence and after psychiatric, stomal therapy and palliative care consultations, asks her surgeon to “help her die” (by taking active steps to hasten her death). The researchers were particularly interested in the question of intention, as it relates to the administration of analgesics or sedatives in large doses which potentially may shorten life, so they used questions “that were absolutely explicit about the agent’s intention” (Douglas et al., 2001, p.511). One of these was “Have you ever, for the purpose of relieving a patient’s suffering, given drugs
(orally or parenterally, by bolus or by infusion) in doses greater than those required to relieve symptoms, with the intention of hastening the patient’s death?” The authors considered that an intention to hasten death could be distinguished from merely foreseeing that this might happen, by these drugs being used in higher doses than required for symptom control (Gillon, 1999).

The results strongly suggest that the surgeons clearly differentiated between foreseeing that death might be hastened, and intending it through the administration of an analgesic/sedative infusion – a differentiation which is critical to the principle of double effect. Nevertheless, the authors were concerned that, by their estimates, twenty percent of the entire sample had intentionally hastened death by such means without an explicit request from the patient to do so. They concluded that surveys which only asked about administration of a bolus lethal injection were likely to have underestimated doctor’s involvement in “assisted death”. Some surgeons commented on why they would be prepared to hasten death by infusion but not by a bolus dose of lethal medication:

*It is difficult to actually administer a lethal injection, but setting up a potentially lethal system allows a degree of psychological and physical separation from the actual event.*

*I appreciate the inconsistency..... but that’s the way I feel.*

*I can’t see the ethical difference between this and a bolus injection in a fully informed patient... but simply would not be capable of the deed myself* (p.513).

The authors questioned whether those surgeons who had intentionally hastened death by overgenerous doses of sedatives or analgesics were any different from other doctors, except in the way they reported their mental state, in that they were more aware of and/or honest about their intentions, and whether their actions were substantially different “from what is widely accepted as good palliative care” (p.515).

Two commentaries on this study by palliative care physicians appeared in the same edition of the *Medical Journal of Australia*. Michael Ashby denied that intentionally hastening death through doses of analgesics/sedatives higher than those required to relieve symptoms was part of good palliative care (Ashby, 2001). Instead, he claimed that “opioids and sedative drugs can be used quite safely for symptom control without
bringing causation (of death) into question if the parameters of accepted practice are followed”, and that good palliative care is characterized by careful and progressive titration of drugs to symptom relief (p.517). He concluded that “the community does not look to the surgical workforce to fine-tune pain and symptom control in palliative care patients, and assistance from palliative-care specialists should be sought” (p.518). A different view was expressed by Roger Hunt, a supporter of legalized AVE, who said that the fact that 36 percent of surgeons admitted to behaviour for which they could be prosecuted under the law calls into question the support of medical organizations for that law (Hunt, 2001). He argued that intention is subjective, complex and ambiguous, and that a death which is foreseen cannot truly be described as unintended or incidental.

In an attempt to shed light on why health professionals were “much less in favour of legalising euthanasia and physician-assisted suicide” than community members, another survey investigated the factors that influence the attitudes of health professionals and community members to euthanasia legislation. One of the study hypotheses was that health professionals are “anti-euthanasia legislation” (but not necessarily “anti-euthanasia”) because legislation would restrict their options for treatment of patients at the end of life, and result in “paradoxically less, rather than more, activity to end life” (C. M. Cartwright, Williams, Steinberg, & Najman, 2002, p.xv).

The definition of “euthanasia” used in the questionnaire (described by the authors as an internationally accepted one) was “taking active steps to end the life of a person, at that person’s request, for what s/he sees as in her/his best interests” (p. 36). However there was still considerable diversity in what participants would describe as “euthanasia” (see table 1 above), making interpretation of some of the other questions in the survey, which simply use the term “euthanasia”, more difficult. But it is striking that doctors were significantly less likely than community members to describe the four specified “actions” of withholding or with drawing treatment, or the administration of drugs with the “secondary intention” of shortening life, as “euthanasia”. Since 36% of the doctors were in favour of legalising AVE, and some at least of those who described the actions as “euthanasia” did so because they disapproved of them and disapproved of AVE, these results indicate that the majority of doctors in the study, even those who approved of AVE, saw a morally significant difference between these examples of “letting die” and AVE, which the community members largely did not see.
To test their hypothesis that doctors are against the legalisation of euthanasia but not “anti-euthanasia” (using that general term, rather then AVE) medical respondents were asked which of four statements most closely reflected their attitude to euthanasia:

a) I am against euthanasia (anti-euthanasia) and I don’t want the law to be changed to legalise euthanasia (32 percent).

b) I am not anti-euthanasia but I don’t want the law changed to legalise euthanasia (25 percent).

c) I am in favour of euthanasia (pro-euthanasia) and would like the law to be changed to legalise euthanasia (30 percent).

d) I am neither in favour of nor against euthanasia (I am neutral or not sure) (13 percent) (p. 81).

A higher proportion of doctors were in category b) than in the general community (9 percent), and it seems almost half of doctors who oppose “euthanasia” legislation are not “anti-euthanasia” in principle. Female doctors were significantly more likely to say this than male doctors.

One of the reasons attributed to doctors for being opposed both to “euthanasia” and to its legalization included that “their medical training taught them to heal. Euthanasia goes against their medical training”, which 81 percent of community respondents agreed/strongly agreed was a reason. Similarly, 81 percent of doctors agreed/strongly agreed that “Medical professionals should heal the sick not end life” was a reason for this stance. However there were major differences between the community and medical respondents in relation to a number of the other listed possible reasons. While 27 percent of doctors strongly agreed that “withholding or withdrawing treatment is acceptable, but euthanasia is not” was a reason, only 14 percent of the community did so. And 31 percent of doctors but only 18 percent of the community strongly agreed that “it is acceptable to give pain relief even if death is hastened, but not euthanasia” was a reason for some doctors being “anti-euthanasia”.

In summary, these nine studies involve medical practitioners throughout Australia, with a response rate of between 43 and 80 percent. A low response rate introduces the possibility of bias, as those with definite views (either pro- or anti- AVE/PAS) are probably more likely to respond. Studies of non-responders have not been done in
Australia, though they have overseas (see below), so it is unclear whether the results would over- or underestimate support for AVE/PAS in Australia. It is also difficult to compare the studies to identify trends over time or differences between states or between fields of practice, since there was no standard format for questions. (However when the findings of the 2001 Queensland study were compared with one five years earlier by the same researchers, the level of support among doctors for a change in the law to allow AVE was not significantly different.)

Findings for the level of support for AVE/PAS seem to differ depending on exactly what was asked - from a figure of 7 percent who said they would provide AVE or PAS in response to a clinical vignette in one study (Waddell et al., 1996), to 59 percent who “thought that it was sometimes right to take active steps to bring about a patient’s death” in another (Baume & O'Malley, 1994). The level of support seems to decrease as the closeness of involvement in AVE asked of the individual doctor increased.

Agreement with a change in the law or that it may be right in general terms for a doctor to perform AVE is much higher than the percentage of doctors who reported having performed it. This could be partially explained by its illegality, although this is denied by many of the doctors themselves (Baume & O'Malley, 1994; Waddell et al., 1996). Among Australian nurses, there is a discrepancy between levels of support for change in the law and approval of AVE /PAS in principle, and willingness to personally be involved if it were legal (Kitchener, 1998), and this may also be so for Australian doctors.

A number of these studies indicate the large difference between medical support for withholding or withdrawal of life-prolonging treatment, and for AVE (C. M. Cartwright et al., 2002; Kuhse et al., 1997; Steinberg et al., 1996; Stevens & Hassan, 1994), and one indicates that the great majority of doctors distinguish morally between them (C. M. Cartwright et al., 2002). No study provides data on which to assess whether there is a difference in medical perceptions of the morality of the withholding of treatment as opposed to its withdrawal among Australian doctors. However one Queensland study shows that the proportion of doctors describing certain actions as “euthanasia” is higher for withdrawal of ventilation (15%) and withdrawal of PEG feeding (6%) than for withholding a treatment (CPR), although these figures are still low, especially in comparison with the corresponding percentages for community members (C. M. Cartwright et al., 2002). The earlier Queensland study shows that only 49% of
specialists and 57% of GP’s were in favour of complying with a competent patient’s request to switch off a ventilator, although, as discussed earlier, the ambiguity of the question may have contributed to this (Steinberg et al., 1996). Nevertheless, the withdrawal of ventilation and perhaps also PEG feeding may pose particular challenges for doctors, despite being considered by a majority as morally different from AVE.

In all of the studies which asked about it, there is also a very large difference in the percentage of doctors who were willing to (and did) give doses of drugs for symptom relief which potentially or even certainly would shorten life, and those who reported performing AVE/PAS (C. M. Cartwright et al., 2002; Douglas et al., 2001; Kuhse et al., 1997). In one study, only 10% of doctors describe this as “euthanasia” (C. M. Cartwright et al., 2002). Some general surgeons feel much more comfortable with giving drugs as an infusion, even if this is intended to hasten death, than as a bolus dose, and from some of their written comments, it seems experiential rather than purely logical factors are at play (Douglas et al., 2001). One might also have expected to find a higher level of support for PAS than for AVE, since there is a more active and direct role for the doctor in the latter. However, on one study doctors are less likely to report having been involved in PAS than AVE (Kuhse et al., 1997), while in another they are slightly more supportive of the law being changed to allow PAS than to allow AVE (Steinberg et al., 1996), in another there is no difference in the level of support (C. M. Cartwright et al., 2002) and in another they are less supportive (Baume & O'Malley, 1994).

One study reports that 85 percent of community members and 93 percent of doctors either strongly agreed or agreed that “their personal religious belief is that killing is wrong and euthanasia is the same as killing” was a reason some health professionals are opposed to AVE and to its legalization (C. M. Cartwright et al., 2002). However, the authors’ interpretation of this result is arguably not justified. They deduce that if a particular reason was most often strongly agreed/agreed to be a reason for some peoples’ attitudes, it is therefore believed to be the “main factor behind” (p.83) or the “thing which most impacted on” those attitudes (p.47). But religious belief is well known to influence attitudes in at least some people, so it is not surprising that they are recognized by many respondents as a reason for some people having the view they do. To strongly agree to this does not imply (although this may be the case) that one thinks
it is the main reason. The question “What do you think is the main reason people (hold the view they do)?” was not asked.

Hence the statement that medical respondents “strongly agreed that religious belief that killing is wrong and that euthanasia is the same as killing was the main factor behind attitudes of doctors who are anti-euthanasia and anti-euthanasia legislation” (C. M. Cartwright et al., 2002, p.83) is not justified by the results of this survey. Almost identical percentages similarly agreed/strongly agreed that “their personal values and beliefs include the sanctity of life” was a reason for some health professionals (and some community members) being opposed to both “euthanasia” and to its legalization. In any case, a general belief that something is the case does not make it so. There would need to be evidence of a correlation between religious beliefs and views on AVE/PAS. And there would need to be evidence of an explanatory link between them: people would need to be asked about the influence of religious beliefs on their own views.

Surveys of the Australian community show the highest percentage of those in favour of AVE among those with no religious affiliation (83 percent), and the lowest (67 percent) among Catholics (Baume, O'Malley, & Bauman, 1995, p.52-53). Several studies asked about religious affiliation. In the South Australian study, there are no significant differences in responses to the questions about whether participants had ever suggested withholding or withdrawing treatment, or about having taken “active steps” which had brought about a patient’s death, between the categories “Church of England”\(^4\), “Other Protestant”, Catholic”, “Other” and “None” (Stevens & Hassan, 1994).

By contrast, the authors of the New South Wales study conclude that “the significance of religious affiliation to attitudes to, and practice of, euthanasia was substantial” (Baume & O'Malley, 1994) and this was the subject of a separate report (Baume et al., 1995). Some 29.2 percent identified themselves as agnostic/atheist \(^5\): 55.9 percent as Christian (19.4 percent Catholic, 18.6 percent Anglican and 17.9 percent ‘other’) and less than 5 percent each of Jewish (4.8), Hindu (3.6), Buddhist (1.2), Moslem (0.9), and other religions. The survey participants were described as differing “substantially” from the population of New South Wales as a whole, which had a lower proportion of agnostic/atheist (10 percent) and Jewish (0.5 percent) and a higher proportion of

\(^4\) The Church of England has been called The Anglican Church in Australia since 1981.

\(^5\) Some respondents commented on the failure to distinguish between agnostic and atheist.
Catholics and Anglicans (p. 51). Respondents were not asked about the strength of their religious affiliation or frequency of religious observance. A small proportion of Catholics (4.4 percent), Anglicans (0.8 percent) and Jews (5 percent) identified themselves as lapsed, though they were still included in the analysis under their religious group. Religious affiliation was related to age group and type of practice, and the analysis was adjusted accordingly.

Respondents were aggregated into theists and non-theists. Theists were less likely to agree that the law should be changed to allow AVE (50.6 compared to 76.8 percent, p<0.001), to say that they had practiced AVE if they had been asked (24.7 compared to 34.6 percent of those doctors who reported having been asked, p<0.01), or to agree that they would practice AVE if it were legal (44.7 compared to 77.6 percent, p<0.001). It was also noted that of all theists, Catholics “were significantly different from other doctors in the strength and extent of their opposition to AVE” (p. 52), although 8.5 percent of Catholic doctors in the sample said they had practiced AVE.

The survey of general surgeons found that 42 percent were ‘no religion’, 17 percent Catholic, 33 percent Protestant, 4 percent Jewish, and 4 percent ‘other’ (Douglas et al., 2001). Whereas 46 percent of those with ‘no religion’ said that they had at least once given drugs either by bolus or infusion “in doses greater than those required to relieve symptoms, with the intention of hastening a patient’s death”, only 19 percent of the Catholic surgeons, 40 percent of Protestant, 33 percent of Jewish and 36 percent of surgeons classified as ‘other religion’ did so. This was a statistically significant difference (p<0.001) for both Catholics and Protestants. Similarly when asked if they believed there “are any circumstances in which it is morally acceptable” to give a terminally ill patient a slow infusion of drugs in doses greater than required to relieve symptoms, with the intention of hastening the patient’s death, only 31 percent of Catholics and 48.6 percent of Protestants agreed, compared to 70 percent of those professing ‘no religion’, 62.5 percent of Jewish surgeons, and 60 percent of those of ‘other religion’ (p. 514). On the other hand, there was no effect of religious affiliation on responses to a question about the use of an infusion aimed at symptom relief which might incidentally hasten death, with 90 percent of all respondents supporting such an action.

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6 This category included Buddhists although they are, strictly speaking, atheist.
Doctors in Australia consistently show lower levels of support for AVE and its legalization than the general community. Since there is no evidence that they are more likely to have a religious affiliation (in fact the studies above suggest the opposite) or to be more religiously devout than the general community, it seems that, while religious affiliation plays a part, there are other, more important factors influencing doctors’ attitudes.

This was confirmed by another study, which found that while Catholics were among those least willing and agnostic/atheists the most willing to engage in PAS or AVE, and that religious beliefs influenced doctors’ responses to a request for assisted death significantly, this factor together with patent’s wishes and ethical factors, only accounted for seven percent of the variance in doctors’ responses (Waddell et al., 1996).

The two Queensland surveys asked participants about the influence of their religious beliefs. In the first study, 22% of the health professionals reported no religious affiliation, 29% were Anglican, 21% Catholic and 14% Uniting Church. Half of them said that their religious belief had no influence on their attitudes to AVE/PAS, while 22 percent said they thought it had a great deal of influence, and 28 percent “some influence” (doctors’ responses were not reported separately) (Steinberg et al., 1996, p.98). In the second study, when the figures for doctors were reported separately, 53 percent said their religious views did not influence them at all, 30 percent “somewhat” and 17 percent “a great deal” (C. M. Cartwright et al., 2002, p.xxiii)

It is difficult to assess the influence of religious belief on attitudes to AVE by classifying respondents according to their religious affiliation, particularly in Australia where religious nominalism is frequent (Hilton, 2001). Generally the level of nominalism is estimated by comparing weekly service attendance with the numbers of people claiming a particular religious affiliation, and varies between denominations and religions. Only 5 percent of Australians who identified themselves in the 2001 Census as Anglican were estimated to have attended church weekly, as did 10 percent of those identifying as Uniting and 15 percent who called themselves Catholic. Some other Protestant denominations have a higher proportion, e.g. Baptists, at 36 percent. (Bellamy & Castle, 2004). It is true that weekly attendance underestimates religious commitment, since the trend is for even committed members to attend as infrequently as
once or twice monthly. Nationally it was estimated that 8.8 percent of the population attended a church weekly in 2001, compared to 18.6 percent who claimed in the 2002 Wellbeing and Security Survey to have attended a religious service at least monthly. It is also true that church attendance is only one measure of the importance of religion in a person’s decision making. Other measures, as Hilton suggests, would be the strength of their beliefs, their religious experience, the use of religious practices such as prayer and scripture reading, and their knowledge of religious doctrine (Hilton, 2001).

Nevertheless, analysis of the influence of religious affiliation on attitudes to AVE would probably underestimate the effect of religious belief or commitment, since those identifying themselves as Anglican, Uniting and Catholic in particular would include many nominal adherents, which would tend to dilute the effect of religious belief. On the other hand, the influence of early religious ethical teaching may persist after personal faith declines. Questionnaires cannot easily examine the strength or the content of religious belief, or the relationship between these factors and moral reasoning.

None of these Australian studies asked explicitly about the nature, if any, of the moral distinction between killing and “letting die” in the medical context.

4.2.2 Overseas studies
I will first review studies from Commonwealth countries (New Zealand, United Kingdom and Canada), and then a selection of studies from the United States, Europe and Asia.

Table 2 New Zealand postal questionnaire surveys of doctors’ attitudes

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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<tbody>
<tr>
<td>Mitchell and Owens, 2003</td>
<td>1255 general practitioners</td>
<td>48%</td>
<td>5.6% of 693 reported “end-of-life decisions” involved AVE/PAS, 26.9 % treatment abatement, and 53.8 % the use of large doses of opioids (similar to Australian results)</td>
</tr>
<tr>
<td>Mitchell and Owens,</td>
<td>120 general practitioners</td>
<td>40%</td>
<td>30% think both AVE and PAS would be justified in vignette</td>
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<tr>
<td></td>
<td>205 psychology</td>
<td>80%</td>
<td>62% think both AVE and PAS would be</td>
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7 This study used the same questionnaire as one of the Australian studies (Kuhse et al., 1997).
8 This study used a questionnaire with a choice of responses to a clinical vignette involving a terminally ill patient with intractable pain.
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<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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<tr>
<td>2004^g</td>
<td>students 595 &quot;Greypower&quot;^g members</td>
<td>30%</td>
<td>justified in vignette 76% think both AVE and PAS would be justified in vignette (low response rate increases likelihood of selection bias here)</td>
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Table 3 U.K. postal questionnaire surveys of doctors’ attitudes

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<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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<tr>
<td>Ward and Tate, 1994</td>
<td>312 NHS doctors in one area of England</td>
<td>74%</td>
<td>15% of GP’s and 16% of specialists report taking “active steps” to bring about death when asked 91% of all respondents prepared to consider withdrawing or withholding potentially life prolonging treatment 47% in favour of legalisation of AVE 46% would consider AVE if legal (negative responses strongly correlated with religious beliefs)</td>
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<tr>
<td>Shah et al, 1998</td>
<td>322 senior U.K. psychiatrists</td>
<td>72%</td>
<td>86% agree that suicide may be rational 38% agree that assisted suicide should be legal 20% would be willing to assist suicide 64% think psychiatric assessment necessary for assisted suicide, 35% would be willing to do this assessment 50% agree that AVE not justifiable 9% agree that withholding or withdrawal of life-sustaining medical treatment not justifiable</td>
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<tr>
<td>McGlade et al, 2000</td>
<td>400 general practice principals in Northern Ireland</td>
<td>38%</td>
<td>70% agree that “withdrawing or withholding life sustaining and life prolonging treatment” is morally acceptable 49% would be prepared to take part in it 70% believe AVE/PAS wrong and should not be legalised 1.2% report having practiced PAS/AVE 10% would be willing to participate in AVE and 12% in PAS if legalized</td>
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Table 4 Canadian questionnaire surveys of doctors’ attitudes

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<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
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<tr>
<td>Verhoef and Kinsella, 1996 Follow up mailed questionaire</td>
<td>866 Alberta doctors</td>
<td>77 %</td>
<td>Over 3 years, decrease from 44 to 42% in those agreeing it is sometimes right to practice AVE Decrease (significant) from 29% to 15% in those who would practice it if legalized Decrease from 50% to 37% in those who were in favour of legalisation of AVE</td>
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<tr>
<td>Suarez-Almazor et al, 1997 (Suarez-Almazor, Belzile, &amp; Bruera, 1997) Telephone and face to face interview</td>
<td>1,240 Alberta community members 62 terminal cancer patients 179 doctors</td>
<td>Not available</td>
<td>50% in favour of legalisation of AVE/PAS 60% in favour of legalisation of AVE/PAS More than 60% oppose legalisation of AVE/PAS Majority say they would not be willing to perform the procedures if legalized</td>
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^g Greypower is an activist organization for people aged 55 years and over.
In one of these studies, 113 doctors gave written comments on the reasons for their opinions, and the themes identified were the belief that improved pain control and palliative care would reduce the need for AVE, the fear of abuse and concerns about the “slippery slope” (Verhoef & Kinsella, 1996).

The results of these studies are similar to the Australian results in that they show:

- a lower level of support for AVE and PAS among doctors than in the general population (Suarez-Almazor et al., 1997) (Mitchell & Owens, 2004);
- a discrepancy between willingness to withhold/withdraw life-prolonging treatment and willingness to consider AVE if it were legal (Ward & Tate, 1994) (McGlade, Slaney, Bunting, & Gallagher, 2000);
- a discrepancy between agreement that treatment abatement is morally justifiable, and that AVE is morally justifiable (Shah, Warner, Blizard, & King, 1998). (In one of these studies the proportion of doctors who agreed that withdrawal or withholding of life sustaining or life prolonging treatment is morally acceptable was surprisingly low (although still 70%), and the proportion of those who would take part in it even lower (McGlade et al., 2000). However these practices were described as “passive euthanasia” in this study. Use of the term “euthanasia”, and the fact that the question did not specify whether the treatment withholding or withdrawal was justified, may explain why some respondents did not want to commit themselves to such a blanket statement, since there are many situations where treatment withholding or withdrawal is not justified.);
- a discrepancy between support for legalisation of AVE/PAS and the willingness to practice it oneself if it were legalised (Shah et al., 1998; Verhoef & Kinsella, 1996), although in one study the level of support for legalization of AVE and willingness to consider doing it were similar (Ward & Tate, 1994) – but perhaps willingness to consider and willingness to actually do are different;
- a discrepancy in two U.K. studies between the proportion of doctors who currently perform AVE and who would be willing to consider it if it were legal (McGlade et al., 2000; Ward & Tate, 1994) and a similar discrepancy in relation to PAS (McGlade et al., 2000) suggesting that for some doctors their reluctance to perform them is based on the illegality of the practices.
In relation to the effect of religious belief on attitudes to AVE/PAS, there is some evidence that religious activity rather than affiliation is important. In the Northern Ireland survey, where there was a high proportion of respondents identifying as Christian (32 percent Catholics and 49 percent Protestants), religious affiliation was found to have no significant influence on any of these attitudes, although the response rate was low (McGlade et al., 2000). In one Canadian study, both religious affiliation and religious activity were recorded 10. Religious activity was significantly related to changes in opinion on the morality of AVE, whether it should be legalized, and willingness to practice it, with physicians who were regularly religiously active being the least likely to change their disapproval. Doctors with a religious affiliation were less likely to change their willingness to practice AVE if it were legalised, but there was no significant difference for the other questions (Verhoef & Kinsella, 1996). In the other Alberta survey, the greatest level of support for legalization of AVE/PAS was found among those with no religion (Suarez-Almazor et al., 1997).

**Table 5 U.S. surveys of doctors’ attitudes**

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<th>Authors</th>
<th>Participants</th>
<th>Respond e rate</th>
<th>Main findings</th>
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<tr>
<td>Watts et al, 1992 Mailed questionnaire</td>
<td>727 geriatricians in four regions of the U.S.</td>
<td>53%</td>
<td>66% think Kevorkian’s action not morally justifiable; 14% think morally justifiable 11</td>
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<td>41% would consider suicide themselves if diagnosed with a dementing illness.</td>
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<td>57% opposed to easing restrictions on PAS for competent dementia patients.</td>
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<td>26% in favour of easing restrictions.</td>
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<td></td>
<td>21% would consider PAS for such patients if restrictions eased; 66% would not</td>
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<tr>
<td>Fried et al, 1993 Mailed questionnaire 12</td>
<td>256 Rhode Island physicians (internal medicine specialists)</td>
<td>65%</td>
<td>98% would agree to withhold ventilation on request despite worsening respiratory failure</td>
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<td></td>
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<td>59% would agree to withdraw respirator on request, once patient was intubated</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>86% would agree to give necessary pain medication, even if it could hasten death</td>
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<td></td>
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<td></td>
<td>9% would agree to PAS (prescription)</td>
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<td></td>
<td></td>
<td>1% would agree to give lethal injection</td>
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<tr>
<td></td>
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<td></td>
<td>28% would comply with requests for lethal injection more frequently if legalised.</td>
</tr>
</tbody>
</table>

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10 Participants were 54 percent Protestant, 19 percent Catholic, 5 percent Jewish (non-Orthodox) and 18 percent of no religion. 31 percent said of their religious activity that they were regularly active, 26 percent occasionally active, and 43 percent not active.

11 As previously outlined, the early 1990’s saw enormous public and medical interest in the topic of physician-assisted suicide. News of Dr. Jack Kevorkian’s assisted suicide of Janet Adkins in June 1990 made national headlines. Initiative 119, which would have legalized both practices, had been narrowly defeated (54 to 46 percent) by Washington voters in 1991.

12 The questionnaire presented five hypothetical scenarios involving a competent, elderly, terminally ill patient.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen et al, 1994</td>
<td>938 doctors in the State of Washington</td>
<td>69%</td>
<td>48% agree AVE never ethically justified; 42% disagree</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>54% think AVE should be legal in some situations; 33% would be willing to perform it if legal</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>53% agree PAS should be legal in some situations; 40% would be willing to be involved if legal.</td>
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<tr>
<td></td>
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<td></td>
<td>Haematologists and oncologists were most likely to oppose both practices, and psychiatrists to support them</td>
</tr>
<tr>
<td>Rosner, 1995</td>
<td>540 New York physicians and surgeons</td>
<td>54%</td>
<td>Physicians: 48% in favour of legalization of AVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>56% think AVE ethical</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>42% would perform if legal</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Surgeons: 38% in favour of legalization of AVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>39% think AVE ethical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>31% would perform if legal</td>
</tr>
<tr>
<td>Doukas et al, 1995</td>
<td>154 oncologists in the State of Michigan</td>
<td>62%</td>
<td>81% report having withdrawn life-sustaining therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18% report participation in PAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4% report participation in AVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21% in favour of legalization of PAS</td>
</tr>
<tr>
<td>Bachman et al, 1996</td>
<td>1119 Michigan doctors in specialties likely to involve the care of terminally ill patients</td>
<td>74%</td>
<td>56% prefer legalisation of PAS to explicit ban, but given wider choices 40% support legalisation of PAS, 37% “no law” and 17% prohibition</td>
</tr>
<tr>
<td></td>
<td>998 Michigan community members</td>
<td>76%</td>
<td>If PAS legalized 35% say might participate: 22% would consider PAS only, 13% either PAS or AVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>66% prefer legalisation to explicit ban</td>
</tr>
<tr>
<td>Ganzini et al, 1996</td>
<td>321 Oregon psychiatrists</td>
<td>77%</td>
<td>69% think PAS morally acceptable under some circumstances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>56% favour implementation of the Death with Dignity Act.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>6% very confident that they could adequately assess in a single evaluation whether the judgment of a patient requesting PAS was impaired by a psychiatric disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The majority of those opposed to the Act would refuse to perform such an evaluation</td>
</tr>
</tbody>
</table>

13 PAS was defined as “prescription of medication (e.g. narcotics or barbiturates) and or the counseling of an ill patient so he or she may use an overdose to end his or her own life” (p.89).
14 The issue of PAS was being widely debated at that time in Michigan, particularly because of the actions of Dr. Jack Kevorkian and ensuing legal cases. In December 1992 the Michigan legislature had passed a ban on assisted suicide, which was subsequently struck down by the Michigan Court of Appeals in May 1994, but then upheld as constitutional by the Michigan Supreme Court in December of that year.
15 In late 1994 the Oregon Death with Dignity Act was approved by a narrow margin of voters, making physician-assisted suicide legal for terminally ill patients. One of the required safeguards was that evaluation by a psychiatrist or psychologist should determine that “the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment” (State of Oregon, 1994).
<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
</tr>
</thead>
</table>
| Lee et al, 1996  
*Mailed questionnaire* | 2760 Oregon doctors eligible to perform PAS if the Oregon law were upheld | 70% | 60% think PAS should be legal in some cases  
46% might be willing to practice it if it were legal; 31% unwilling to do so on moral grounds  
7% report having performed PAS  
83% cite (and are concerned about) financial pressure as possible reason for a request for PAS  
Other concerns include complications of suicide attempts and doubts about ability to predict survival at six months accurately. |
| Roberts et al, 1997  
*Mailed questionnaire* | 96 residents (trainees) in the specialties of internal medicine, psychiatry and emergency medicine at the University of New Mexico School of Medicine in Albuquerque | 72% | Withdrawal of life support far more acceptable than PAS  
Were less likely to say they would assist a patient to die personally than to refer to someone else or to think it would be acceptable for other doctors to assist similar patients to die  
Were as willing to withdraw respirator themselves as to refer to another doctor or agree that it would be acceptable for physicians in general to do so |
| Howard et al, 1997  
*Interview* | 353 randomly selected U.S. oncologists | 73% | 48% could imagine a situation in which they might want AVE or PAS for themselves  
(although this often involved a non-terminal illness, which is not covered by any proposed legislation in the U.S.)  
Catholics and “more religious” were significantly less likely to do so.  
86% of those who could imagine such a situation and 42% of those who could not imagine such a situation thought AVE and/or PAS would be morally acceptable for their patients |
| Meier et al, 1998  
*Mailed questionnaire* | 1902 doctors in ten specialties expected to receive most frequent AVE/PAS requests | 61% | 11% would be willing to perform PAS under some circumstances, 36% if it became legal  
7% would provide AVE, 24% if it became legal  
18% report request for PAS  
11% report request for a lethal injection  
6% have complied with such requests at least once |
| Wolfe et al, 1999  
*Follow-up Interview* | 324 U.S. oncologists 111 oncology patients 158 members of general public | 92%  
81%  
82% | Up to one third of participants changed their attitudes  
Oncologists significantly less likely than the general public or patients to find PAS or AVE acceptable for each of the vignettes  
Oncologists significantly more likely to change from acceptance to opposition for all vignettes  
Those whose religious beliefs were less |

However the Act was declared unconstitutional in 1995 by a federal district judge. The act finally came into law in 1997, making Oregon the only U.S. state where PAS has been legalized.

The questionnaire used six clinical vignettes, with four options of possible action for each, for which respondents were asked to indicate their support.

Four clinical vignettes involving a terminally ill adult patient were used in telephone interviews 6 to 12 months apart, to investigate the stability of attitudes to PAS and AVE.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emanuel et al, 2000</td>
<td>655 American Society of Clinical Oncology members</td>
<td>51.5%</td>
<td>22.5% support PAS for terminally ill patient in unremitting pain; 6.5% support AVE 10.8% report having performed PAS and 3.7% AVE</td>
</tr>
<tr>
<td>Whitney et al, 2001</td>
<td>658 U.S. doctors from all fields of practice, including licensed allopathic and osteopathic physicians 315 members of the American Medical Association House of Delegates in 1997</td>
<td>71%</td>
<td>43% in favour of legalisation of PAS 34% opposed to legalisation of PAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>81%</td>
<td>24% in favour of legalisation of PAS 62% opposed to legalisation of PAS</td>
</tr>
<tr>
<td>Ganzini et al, 2001</td>
<td>2641 Oregon doctors eligible to perform PAS under The Oregon Death with Dignity Act (1997)</td>
<td>66%</td>
<td>51% support the Act 32% oppose it 80% had not changed their views on the law since it was first passed in 1994 Of those whose views had changed, almost twice as many had become more supportive than had become more opposed 46% unwilling to perform PAS About a third willing to perform it, but of these, 38% “not at all” or “only a little” confident of ability to determine when patient’s life expectancy less than six months 5% had received a specific request for a lethal prescription under the Act</td>
</tr>
<tr>
<td>Schwartz et al, 2001</td>
<td>2805 Connecticut doctors, including medical specialties most likely to receive a request for PAS</td>
<td>38.5%</td>
<td>3% report having practiced PAS 60% do not support AVE or PAS, and only 8% of these would perform PAS if legalized 13.9% endorse PAS only, and 56 % of these would perform if legalized 26% endorse both practices, and 75% of these would perform PAS if legalised</td>
</tr>
<tr>
<td>Dickenson 2001</td>
<td>687 U.S. doctors (physicians, surgeons and house officers) participating in courses on end of life issues</td>
<td>100%</td>
<td>93% agree/strongly agree that “sometimes it is appropriate to give pain medication to relieve suffering, even if it may hasten a patient’s death” 89% agree/strongly agree that “to allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide” 42% agree/ strongly agree that “there is no</td>
</tr>
<tr>
<td>Authors</td>
<td>Participants</td>
<td>Response rate</td>
<td>Main findings</td>
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<tr>
<td></td>
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<td></td>
<td>difference between withholding a life support measure and stopping it once it has started*</td>
</tr>
</tbody>
</table>

It is difficult to compare the data from all these studies as they used different instruments. In general, the findings are consistent with those from the studies in Australia and English speaking Commonwealth countries discussed above:

- a lower level of support for AVE and/or PAS among doctors than in the general population in the studies which measured this (Bachman et al., 1996; Wolfe, Fairclough, Clarridge, Daniels, & Emanuel, 1999);
- a discrepancy between agreement that withholding/withdrawal of life-prolonging treatment is morally justifiable, and that PAS is morally justifiable (Dickenson, 2001; Doukas, Waterhouse, Gorenflo, & Seid, 1995; Roberts et al., 1997);
- a discrepancy between support for legalisation of AVE/PAS and the willingness to practice it oneself if it were legalised (Bachman et al., 1996; Cohen, Fihn, Boyko, Jonsen, & Wood, 1994; Ganzini et al., 2001; Lee et al., 1996; Roberts et al., 1997; Rosner, 1995), although in one study there was little difference (Watts, Howell, & Priefer, 1992) and in another the discrepancy was greater among physicians than surgeons (Rosner, 1995). (In the one study which asked about it, there was no discrepancy between agreeing with withdrawal of a respirator in theory and willingness to do it oneself (Roberts et al., 1997);
- a discrepancy between the proportion of doctors who currently perform AVE or who would be willing it consider it, and who would be willing to consider it if it were legalised (Meier et al., 1998) and a similar discrepancy in relation to PAS (Lee et al., 1996; Meier et al., 1998), suggesting that for some doctors their reluctance to perform them is based on the illegality of the practices.

Some studies found differences in attitudes between medical specialties. Physicians were more supportive of AVE than surgeons (Rosner, 1995) and emergency medicine trainees were more in favour of PAS than those in internal medicine or psychiatry (Roberts et al., 1997). Doctors who frequently treated terminally ill patients (Bachman et al., 1996) and haematologists and oncologists were less likely to support legalization of PAS, while psychiatrists were more likely (Cohen et al., 1994).
Some distinctive features emerge from these U.S studies in relation to PAS. In Rhode Island and in national study, doctors were more likely to agree to perform PAS than AVE, whether it was illegal (Fried, Stein, O Sullivan, Brock, & Novack, 1993; Meier et al., 1998), or legal, when willingness increased more than three fold (Meier et al., 1998). In Connecticut, medical support for legalization of PAS was higher than for AVE (Schwartz et al., 2001), although in Washington it was about the same (Cohen et al., 1994), and it was higher in Oregon than anywhere else in the U.S. (Ganzini, Fenn, Lee, Heintz, & Bloom, 1996; Lee et al., 1996). Since the passage of the Death With Dignity Act in Oregon, 20 percent of doctors had changed their views on PAS, with almost two thirds of these becoming more supportive (Ganzini et al., 2001). PAS was also reported more frequently than AVE in Michigan (Doukas et al., 1995), where the status of a ban on the practice was unclear.

Another feature is the apparent difference between doctors’ perceptions of withholding and withdrawing ventilation. In one study, 98 percent would agree to withhold it on request, but only 59 percent to withdraw it from the same patient once intubated (Fried et al., 1993). In another study, only 42 percent agreed that “there is no difference between withholding a life support measure and stopping it one it has started”, despite the position of the American Medical Association (American Medical Association, 1994c) and the majority opinion in bioethics that there is no moral difference between them (Dickenson, 2001, p.254) \( ^{18} \). Some doctors cited the perception that they were “killing the patient” as a reason for refusing to withdraw a respirator on request (Fried et al., 1993).

Respect for patient autonomy was cited as the most important principle in complying with patient requests for PAS/AVE (Fried et al., 1993; Lee et al., 1996), while opponents of PAS cited ethical concerns (Fried et al., 1993; Lee et al., 1996), the risks of opening the door to involuntary euthanasia (Lee et al., 1996; Schwartz, Curry, Black, & Gruman, 2001), “the physician’s role in preserving life”, “the importance of allowing the natural dying process to run its course”, the “potential for distrust in the medical profession” (Lee et al., 1996) and concern about the likelihood that a depressed person

\[ ^{18} \] Medical attitudes may have been influenced by the fact that, in New York State, for example, the law prohibits the withdrawal of ventilation from an incompetent patient without written “consent” from a proxy decision maker.
if treated might change their mind (Schwartz et al., 2001). Important to all respondents in one study (irrespective of their views on PAS) were beliefs about the doctor’s role to relieve pain and suffering, experiences with the terminally ill, and personal moral convictions (Lee et al., 1996).

Some studies found a relationship between religious beliefs and attitudes to PAS. Those for whom religion was very important (Bachman et al., 1996; Whitney et al., 2001), who reported being influenced by religious beliefs in their attitudes to assisted suicide (Roberts et al., 1997), were Catholic or reported being deeply or fairly religious (Emanuel, 1994b; Schwartz et al., 2001), described themselves as fundamentalist in their beliefs, or reported that they prayed more (Schwartz et al., 2001) were less likely to be in favour of legalization of PAS. But in another study, personal religious beliefs were less influential than ethical views (Lee et al., 1996).

As in the Canadian study (Verhoef & Kinsella, 1996), those to whom religious beliefs were important had more stable attitudes to AVE and PAS, while those to whom they were less important were more likely to change their view from acceptance to opposition (Ganzini et al., 2001; Wolfe et al., 1999).

**Table 6 European surveys of doctors’ attitudes**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haverkate et al, 2001</td>
<td>405 randomly selected doctors in the Netherlands</td>
<td>89%</td>
<td>159 cases of AVE 34 cases of PAS 74 cases of “ending of life without an explicit request from the patient” 291 cases of use of high doses of opioids which were potentially life shortening Significantly lower level of discomfort after ending life without an explicit request (34%) than after performing AVE (75%) or PAS (58%) 18% report discomfort after treating symptoms with doses of medication that may have hastened death</td>
</tr>
<tr>
<td>Radulovic and Mojsilovic</td>
<td>30 Yugoslavian oncologists, 31 GP’s 31 medical students 31 lawyers</td>
<td>Not given</td>
<td>In favour of legalisation of AVE: 43% of oncologists 30% of GP’s 23% of students 61% of lawyers Lawyers twice as willing to perform “euthanasia” if legalised as students or doctors, with oncologists least willing (overall 36% would do so if legal) Only the lawyers believe that abuse of “euthanasia” could be controlled</td>
</tr>
<tr>
<td>Grassi et al, 1999</td>
<td>182 general practitioners</td>
<td>89%</td>
<td>89% agree with the use of a morphine drip for pain relief even if it might hasten death 72.5% agree with</td>
</tr>
</tbody>
</table>
These European studies suggest:

- a lower level of support for AVE and/or PAS among doctors than in the general population (lawyers) in the one study which measured this (Radulovic & Mojsilovic, 1998);
- a discrepancy between agreement that withholding/withdrawal of life-prolonging treatment is morally justifiable, and that PAS is morally justifiable (Grassi, Agostino, & Magnani, 1999; Hinkka et al., 2002). In the Italian study, slightly more doctors agreed with withholding of life prolonging treatment than its withdrawal (Grassi et al., 1999);
- a discrepancy between agreement that use of analgesics which might hasten death is morally justifiable, and that PAS is morally justifiable (Grassi et al., 1999). In the Netherlands where AVE is practiced under guidelines with both legal and official medical approval, it is noteworthy that there is still a much greater level of discomfort among doctors after having performed it, than after the alleviation of symptoms with drugs which potentially hasten death, and a slightly higher level of discomfort than after performing PAS (Haverkate, van der Heide, Onwuteaka-Philipsen, van der Maas, & van der Wal, 2001);
- no apparent discrepancy between support for legalisation of AVE/PAS and the willingness to practice it oneself if it were legalized, in the one study which measured this (Radulovic & Mojsilovic, 1998).

In the Yugoslavian study, it is difficult to separate the effect of religious belief from the effect of profession since 101 of the 123 participants were “believers” (Orthodox Christians) but a third of the lawyers were atheists, and their attitudes were significantly different from the other participants (Radulovic & Mojsilovic, 1998). Among Italian
doctors, Catholics were less likely to approve of AVE/PAS, or withdrawal of life-prolonging treatment, and 58% cited the Hippocratic *Oath* as a deterrent to performing them (Grassi et al., 1999).

**Table 7 Asian surveys of doctors’ attitudes**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morita <em>et al.</em>, 2003 <em>Secondary analysis of two surveys</em></td>
<td>697 Japanese oncologists and palliative care physicians 457 members of the general population</td>
<td>50%</td>
<td>Both groups differentiated between mild and intermittent deep sedation and standard medical care Doctors located continuous deep sedation closer to mild and intermittent deep sedation than to AVE/PAS General population located it closer to PAS/AVE</td>
</tr>
</tbody>
</table>

This study suggests that Japanese doctors distinguish more sharply between killing (PAS or AVE) and “letting die” (through the use of heavy sedation which may shorten life) than do Japanese lay people.

**Table 8 International surveys of doctors’ attitudes**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants</th>
<th>Response rate</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vincent, 1999 <em>Mailed questionaire</em></td>
<td>504 physician members of the European Society of Intensive Care Medicine, from 16 Western European countries</td>
<td>Not given</td>
<td>93% sometimes withhold treatment from patients with no hope of a meaningful life Withdrawal of treatment less common 40% would deliberately administer large doses of drugs to such patients until death ensued: those from Southern European countries less likely to do so</td>
</tr>
<tr>
<td>Willems <em>et al.</em>, 2000 <em>Face to face structured interview</em></td>
<td>152 Oregon oncologists, general physicians and family practitioners 67 Dutch physicians&lt;sup&gt;19&lt;/sup&gt;</td>
<td>80%</td>
<td>Consistently less likely to find AVE acceptable compared with PAS in vignettes 76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>76%</td>
<td>Equally likely to find AVE and PAS acceptable in vignettes Similar attitudes in both groups to increasing morphine even if it hastened death, and to PAS</td>
</tr>
<tr>
<td>Materstvedt and Kaasa, 2002 <em>Review</em></td>
<td>Doctors in Norway, Sweden and Denmark</td>
<td></td>
<td>A difference between attitudes and practice: Norwegian doctors most opposed to AVE/ PAS (17% in favour of either practice) and Swedish the most liberal (39%) But Swedish doctors appear to have practiced PAS very seldom and AVE never</td>
</tr>
<tr>
<td>van der Heide <em>et al.</em>,</td>
<td>Doctors in Belgium</td>
<td>59%</td>
<td>Estimated “doctor-assisted dying”&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>19</sup> At that time, Dutch doctors performing AVE would not be prosecuted if they acted in accordance with legal guidelines, but in Oregon although The Death With Dignity Act had been passed, it had not been implemented, so PAS remained illegal.
Two features previously identified also emerge from these studies:

- the greater acceptability to some doctors of withholding than withdrawing life-prolonging treatment (Vincent, 1999).
- the greater acceptability to U.S doctors of PAS than AVE (Willems, Daniels, van der Wal, van der Maas, & Emanuel, 2000).

The authors of a review of Scandinavian research on medical attitudes to AVE and PAS, a Norwegian team of a philosopher and a palliative care physician, noted that almost none of the studies of doctors’ attitudes and practices performed throughout the world had a common design, making comparison between countries, or even within countries such as the U.S., problematic (Materstvedt & Kaasa, 2002). In particular, they cited “inappropriate and too vague definitions of euthanasia and physician-assisted suicide” in many studies, and “the misconception that abstention from life-prolonging treatment and the use of large dose of morphine in the terminally ill may be subsumed under euthanasia” (p.18). They suggested that future research should use definitions of “euthanasia” and PAS based on the Dutch understanding [i.e. that euthanasia is “a doctor intentionally killing a person who is suffering ‘unbearably’ and ‘hopelessly’ at the latter’s voluntary, explicit, repeated , well considered and informed request…usually (but not exclusively) by administering intravenously a lethal dose of (different) quick-acting drugs/medication” (p.19) and that physician-assisted suicide is “ a doctor intentionally helping/assisting/co-operating in the suicide of a person who is suffering ‘ unbearably ’ and ‘hopelessly’ at the latter’s voluntary, explicit, repeated, well

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| 2003 Mailled Questionnaire | Denmark, Italy, Sweden, Switzerland and the Netherlands identified through analysis of 20,483 death certificates in 2001/2002 | 62% | 44% | 61% | 67% | 75% | 0.1% in Italy 1.8% in Belgium (where AVE was prohibited at the time of the study, although legalization had been discussed) 3.4% in The Netherlands Incidence of AVE: 0.21% in the Netherlands 0.3% in Belgium less than 0.3% in all other countries Incidence of PAS: 0.36% Switzerland 0.21% in The Netherlands less than 0.06% in Denmark and Belgium, No reported cases in Italy or Sweden |

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20 This study used the same postal questionnaire as previous studies (Kuhse et al., 1997; van der Maas et al., 1991; van der Maas et al., 1996).

21 Defined as “administration of drugs with the explicit intention of hastening death”.

22 In Switzerland assisted suicide is legal if altruistic. 92% of these cases involved a right-to- die organization.
considered and informed request for the doctor’s participation... usually (but not exclusively) by prescribing, preparing and giving a lethal dose of (different) drugs/medication to the person for self administration” (p.20)]. In addition, they suggested that terms such as ‘ending life without an explicit request’ should be replaced with the terms non-voluntary and involuntary medicalised killing.

Despite these criticisms, a study of medical end-of-life decision making in six European countries (van der Heide et al., 2003) used the same ambiguous postal questionnaire as previous studies (Kuhse et al., 1997; van der Maas et al., 1991; van der Maas et al., 1996). “Doctor-assisted dying”, defined as “the administration of drugs with the explicit intention of hastening death” (p. 347), and thus including the administration of pain relieving drugs or sedatives for symptom relief which may have hastened death (see discussion of the Australian study of Khuse et al., 1997, above) was reported in all countries but varied in frequency. What the authors classified as “ending of life without the patient’s specific request” occurred more frequently than AVE in all countries except the Netherlands, but as noted in the discussion of the study of Khuse and her colleagues, this included cases of treatment withholding or withdrawal where the intention was not to prolong life.

4.2.3 Comparison between studies in Australia and overseas
Although the differences in survey design make comparison difficult, the foregoing studies suggest that:

- Australian doctors generally do not share the view of many U.S doctors that PAS is morally different to or morally more acceptable than AVE;
- The illegality of AVE/PAS is an important deterrent to its practice in the U.K. and the U.S., although this has not been demonstrated in Australian studies;
- Australian doctors do not seem to distinguish between withholding/withdrawal of ventilation in the way that some U.S. doctors do 23, although the withdrawal of ventilation is more problematic for them than its withholding, and than the withdrawal of other treatments.

23 Although the percentage of doctors who would not comply with a competent patient’s request to withdraw ventilation is similar in one Australian study (Steinberg et al., 1996) to that in one of the U.S. studies (Fried et al., 1993), they cannot meaningfully be compared. As previously discussed, the question in the Australian study was broad and many respondents were uncertain, whereas in the U.S. study, there can be no such uncertainty about the patient’s mental state or the appropriateness of the treatment in relation to prognosis, since 98% of the group were willing to withhold ventilation on request in the same patient.
4.2.4 The limitations of survey data

Empirical research in medical ethics often aims (as in many of the studies above) to inform public policy. Both supporters and opponents of AVE/PAS may use such studies to support their arguments. While not stated explicitly, it is sometimes implied by advocates of AVE/PAS, whether researchers or commentators, that if the law is inconsistent with the attitudes and practices of doctors, the law ought to be changed (Baume & O'Malley, 1994; Hunt, 2001; Mitchell & Owens, 2003; Steinberg et al., 1996) and suggested that if certain illegal practices (such as AVE or PAS as well as non-voluntary and involuntary euthanasia) are occurring, the best way to regulate them and prevent abuses is through legislation, with strict guidelines (Baume, 1998; Bilsen, Stichele, Mortier, Bernheim, & Deliens, 2004; C. M. Cartwright et al., 2002; Deliens et al., 2000; Kuhse et al., 1997). On the other hand, some opponents of AVE/PAS suggest that a decrease in support for AVE among doctors may be the result of increased knowledge and education (Verhoef & Kinsella, 1996; Wolfe et al., 1999).

Perhaps empirical research is especially attractive to doctors in the age of ‘evidence-based medicine’. But while empirical data on doctors’ opinions can legitimately be used to explain and clarify the issues around end-of-life decision making, they cannot be used to justify or formulate public policy unless one believes that majority opinion determines what is ethical. As Pellegrino points out, this is to confuse the descriptive, the analytical-metaethical, and the normative domains of ethics (Pellegrino, 1995). Empirical studies can shed light on the descriptive domain (how people make decisions and how they behave), and on the analytical-meta-ethical domain (what moral presuppositions they have), but cannot establish what is morally right. Some researchers acknowledge this: “No survey can tell us whether physician-assisted suicide is ever a valid moral choice or whether its legalization would be wise public policy” (Whitney et al., 2001). Arguments from data to support public policy also require premises about normative ethical theory, which are sometimes smuggled into the discussion without being openly declared, for instance, Kuhse and Singer’s utilitarianism (Kuhse et al., 1997). As Nilstun and colleagues argue, “The value premises or ethical theory used or presupposed in such arguments should be made explicit and assessed critically” (Nilstun, Melltorp, & Hermeren, 2000).
4.3 Qualitative studies of doctors’ attitudes to killing and “letting die”
A small number of qualitative studies which have been undertaken in Australia and overseas countries will now be reviewed.

4.3.1 Australian Studies
The 1993 study of NSW and ACT doctors (Baume & O'Malley, 1994) included some open-ended questions about AVE and PAS, the answers to which were analysed thematically (Baume, 1998). One question invited participants to explain the morally relevant difference between AVE and PAS. Forty eight percent of those who responded referred to recognising patient autonomy, 28 percent to concern about medical control or medical responsibility, 10 percent thought AVE was always wrong and 3 percent found suicide unacceptable.

University of Sydney academic lawyer Roger Magnusson published his study of the attitudes of forty nine health professionals who worked mainly with HIV/AIDS patients in Melbourne, Sydney and San Francisco, as Angels of Death: Exploring the Euthanasia Underground (Magnusson, 2002). As a group they had extensive experience with both AVE and PAS, which was described in detail. But the question of their attitude to whether there is a moral distinction between killing and “letting die” was not explicitly addressed.

Of the nineteen doctors in the study, sixteen held what Magnusson calls a “revisionist” view, and were “articulate, vocal, even militant proponents of the right to die” (p.104). While not necessarily working for a change in the law, as some believed this would restrict their exercise of clinical judgment, they believed the understanding of the role of the medical profession ought to be revised to include these practices as part of good medical care. Magnusson concludes that support for “euthanasia” involves a “re-imagining of the collective professional ethos” and “what it means to be a doctor”(p.101). On the other hand, attitudes towards the medical profession in this group also included rejection of “the whole notion of professionalism” by one gay doctor who described as cute the idea that “there is a line (between professional and personal) that you actually cross” (p.11). She said that her involvement with “euthanasia” reflected her personal philosophy, and that “the notion of a professional role, or of wider professional standards” had little influence. Another doctor expressed contempt for the Medical Board: “they’re all frumps, and they’re not operating in the
real world” (p.8). According to Magnusson, “at one extreme… some revisionists display… an almost reckless individualism” (p.105), but the whole group displayed, in their practice of AVE and PAS, a cynicism towards the law and professional standards. He concludes that they “have little respect for the standards of bodies such as the Australian Medical Association (to which they don’t belong anyway). Magnusson speaks of “an all pervasive culture of deception” which was part of “an absence of professionalism which could even be described as “anti-professionalism”(p.201).

At least one “revisionist” doctor was clear that he would provide PAS but not AVE, on the grounds of respect for patient autonomy. His view was that “People should always be able to make their own decisions and I think it makes a stronger society when people have to assume that responsibility… Early on I let it be known that I myself will only provide the tools and that I will not be involved in doing the actual procedure” (p.14). On the other hand, others argued that it is much better for the doctor to be present right up to the time of death (which does not usually happen, for legal reasons) to ensure death occurs”.

Of the three doctors in the study described by Magnusson as “traditionalists”, one opposed “euthanasia” on religious grounds, but also emphasized the function of professional standards to prevent doctors acting like “loose cannons” (p.102). Paradoxically, he favoured legalisation in order to regulate the practice. In contrast, another doctor was not morally opposed but doubted that any law could be framed to adequately protect vulnerable groups. All three thought that palliative care, in particular deep sedation, obviated the need for AVE or PAS.

4.3.2. Overseas studies
In a study of seventeen English general practitioners and eighteen geriatricians, five clinical vignettes were used to explore the reasoning behind decisions to withhold treatment which would probably be life-prolonging, in terms of transfer from a nursing home to hospital (Sayers & Perera, 2002). Participants were largely in agreement in relation to the five vignettes, and most used medical reasons, (such as the specific diagnosis and prognosis of the patient) to explain their decisions, although they all said they would be influenced by relatives’ wishes. The authors were critical of the doctors for failing, as they thought, to recognize the ethical significance of their decisions, or to make use of concepts like “best interests” or personhood. Only one doctor considered
the vignette to be an ethical dilemma. The authors concluded that “by cloaking their reasoning in medical terms they avoided having to justify the outcome or death of the patient”, and thus that they were guilty of self deception (p. 351). However, this conclusion was based on their explicit assumption that withholding or withdrawing life-prolonging treatment is morally equivalent to action taken with the purpose of ending the patient’s life.

As part of the 1991 Alberta survey, doctors were invited to add written comments about AVE, and the 40 percent who did so were similar to the whole survey group in demographic characteristics, area of medical specialty, and views about AVE (Verhoef, Kinsella, & Page, 1996). Those who supported AVE cited the ethical principles of the doctor’s duty to relieve pain and suffering and of respect for patient autonomy; those who opposed it cited the Hippocratic Oath, the duty to “Do no harm”, and the sanctity of life. Many doctors distinguished between “active” and “passive” euthanasia on the basis of the commission/omission distinction, but some did not make a clear distinction. Many also distinguished between AVE and alleviation of symptoms even if this was foreseen as shortening life, on the basis of a difference in intention.

Some doctors said they opposed AVE because of the fear of possible abuse, or its use to free up hospital beds or avoid expensive treatment. Many commented on the potentially destructive psychological effect it might have on doctors themselves who carried it out, and the possible loss of trust in and respect for the profession. Some referred to the possibility that AVE would pre-empt the possibility of spontaneous recovery or a cure being found. The authors concluded that there was “a continuum of beliefs about euthanasia rather than a simple pro/con dichotomy” (p.71), and that while some doctors support various actions in principle, many are not willing to carry them out in practice.

The way that doctors assessed and responded to requests for PAS was studied using focused ethnography with a group of U.S. AIDS physicians, oncologists and one hospice physician (Kohlwes, 2001). Participants had to have received at least one request for PAS and were identified as experienced in responding to such requests. They distinguished between requests occurring early in the disease process related to fear and uncertainty about the dying process, and regarded as exploratory rather than serious, and requests occurring in the last few months of life, which were almost always serious. Reasons for such late requests fell into three broad groups: physical symptoms,
psychological issues such as depression or dementia, and existential suffering. All of the physicians used the request as a “warning flag” to aggressively address physical symptoms, but they believed existential suffering was the most common cause of serious, persistent requests, and was also the most difficult to deal with. This led to feelings of powerlessness in some, but others found it an opportunity to improve their relationship with the patient. Eleven (69 percent) of the patients described as having received PAS had experienced primarily existential suffering. Ten of the study group of twenty had complied with a request for PAS.

Another qualitative U.S. study involved 75 physicians from high technology workplaces and analysed their narratives concerning the deaths of patients in their care, with particular emphasis on factors which make for what is popularly called a “good” or “bad death” (DelVecchio Good et al., 2004). The physicians did not use these terms, but the major themes which emerged in relation to positive and negative characteristics of patient death were whether death was expected or unexpected, peaceful, chaotic or prolonged, whether medical care was rational and appropriate, facilitating a gentle death, or futile and aggressive, and whether there was effective communication with patient and family, compared to misunderstandings and conflict.

In a Finnish study, 32 patients with incurable cancer, 13 of their family members, 13 nurses and 13 doctors were interviewed about their attitudes to AVE (Kuupelomaki, 2000). More than half of all participants (mostly family members and nurses) thought AVE could be justified ethically. Those who did not spoke of there being no right to decide the death of another, potential abuse, uncertainty about diagnosis and prognosis, the effectiveness of good palliative care in alleviating symptoms, and the potential negative effects on medical staff.

4.3.3 Summary of qualitative studies
The findings which emerge from these qualitative studies of doctors’ attitudes to “killing and letting die” (some of which were also raised in the quantitative studies) include:

- reference to medical professional ethics as expressed in the Hippocratic Oath or other Codes of Ethics (Verhoef et al., 1996) as reasons to oppose AVE/PAS. On the other hand, some supporters see the need for these to be revised in order to
accommodate PAS/AVE, and others reject the concept altogether (Magnusson, 2002);

- the use of ethical principles to justify acceptance or rejection of AVE/PAS, including the duty to relieve pain and suffering, respect for patient autonomy, and the duty to “Do no harm” and the sanctity of life (Verhoef et al., 1996);
- the use of clinical rather than ethical concepts in describing reasons for withholding life-prolonging treatment (Sayers & Perera, 2002);
- a distinction between “active” and “passive” euthanasia on the basis of the commission/omission distinction, although some do not make a clear distinction (Verhoef et al., 1996);
- a distinction between AVE and alleviation of symptoms even if this was foreseen as shortening life, on the basis of a difference in intention (Verhoef et al., 1996);
- concerns about the legalisation of AVE/PAS including loss of trust in the medical profession (Magnusson, 2002; Verhoef et al., 1996), the need to protect the vulnerable (Magnusson, 2002), possible negative effect on doctors who perform it and the risk of inaccurate diagnosis or prognosis (Verhoef et al., 1996) (Kuuppelomaki, 2000);
- greater support for AVE among lay people than doctors (Kuuppelomaki, 2000);
- the lack of necessary connection between views on the morality of AVE/PAS and on whether they ought to be legalized (Magnusson, 2002);
- a discrepancy between agreement in principle with PAS and willingness to carry it out personally (Verhoef et al., 1996);
- possible differences in medical perceptions of AVE and PAS (Baume, 1998) (Magnusson, 2002);
- the importance of existential rather than physical suffering in serious requests for PAS (Kohlwes, 2001);
- the role of palliative care in obviating the need for AVE/PAS (Kuuppelomaki, 2000; Magnusson, 2002);
- the importance of withdrawing futile aggressive treatment at the end of life (DelVecchio Good et al., 2004).
4.3.4 A qualitative study of attitudes of Australian nurses

One study which specifically addressed the difference between killing and “letting die” was a 1995 grounded theory study of ten Tasmanian nurses. Audio-taped interviews were used to explore their understandings of what was called “active” and “passive euthanasia” (McInerney & Seibold, 1995). The study was prompted by dissatisfaction with the design of previous surveys of nurses’ attitudes. Fifty three codes were developed, from which seven categories finally emerged, including “passive/active distinction”, and “shortening life or prolonging death”. The majority of nurses defined “euthanasia” exclusively in active terms, although two saw no difference between actively “assisting to die” and treatment withholding/withdrawal that might result in death, and one of these was a supporter of AVE. In rejecting the concept of “passive euthanasia”, participants spoke of events that did not involve technology, or were related to the withdrawal of technological intervention as “ordinary” or “natural”. Participants were more often disturbed ethically by the continuation of what they perceived as unnecessary and cruel life-prolonging treatment, or an inability of doctors to “let go”, than by early withdrawal of treatment. The researchers acknowledged that the Catholic affiliation of the majority of the participants may have influenced their results.

4.4 Conclusion

The results of these studies suggest that many doctors think differently from lay people (including philosophers and ethicists) about killing and “letting die” in the medical context. This difference is seen in their views on the moral permissibility of AVE/PAS and whether one or both of these practices should be legalized, as well as their views on the permissibility of “letting die” (by withholding/withdrawal of life-prolonging treatment and/or the use of drugs at the end of life which may foreseeably hasten death) and in the comparison between the two. The difference is also seen in their reasons for holding those views, especially in relation to medical professional ethics. But none of these studies, quantitative or qualitative, either Australian or overseas, has specifically or in detail addressed the question of the moral significance, if any, of the distinction between killing and “letting die” for doctors in their particular context.
Chapter Five  Rationale for present research

The views of philosophers on the moral significance of the distinction between killing and “letting die” remain sharply divided. At the same time, while “letting die” is generally acceptable under certain conditions to the public and the medical profession in Australia (with the possible exception of the withdrawal of PEG feeding for patients in a persistent vegetative state), active voluntary euthanasia and physician assisted suicide remain highly controversial issues, as in other Western societies. Attempts to legalise AVE and/or PAS occur from time to time and the campaigns of advocacy groups such as the Voluntary Euthanasia Societies (now called Dying with Dignity in Victoria) and Exit International, founded by Australian Dr. Philip Nitschke, continue. Public opinion polls in Australia and other Western nations consistently show majority support for the legalisation of one or both practices.

Yet while legalized AVE or PAS is usually envisaged as involving the medical profession, the majority of doctors remain opposed to the practices, and even more would be unwilling to perform it even if it were legalized. Medical practitioners, both as individuals and officially as a profession see a significant moral distinction between killing and “letting die” in the medical context, that is, between AVE/PAS on the one hand, and both the withholding or withdrawal of life-sustaining medical treatment, and the administration of necessary symptom relieving medication which might possibly shorten life, on the other. This distinction is not as clearly perceived by the general public, and some (mainly consequentialist) philosophers find it incoherent. The reasons for both these discrepancies have not been thoroughly explored with those medical practitioners who are untrained in philosophy or law and do not contribute to the bioethics discourse.

The arguments about killing and “letting die” will no doubt continue in the philosophical, bioethics and public arena. Rational argument requires a thorough understanding of the views and reasoning of those with whom we disagree. Philosophers and bioethicists are expert in reasoning and moral argument, and some of them have tended to be dismissive of the views of doctors who are untrained in philosophy. Yet according to MacIntyrean virtue theory, medical voices ought to be given careful attention as those who are best placed to identify and recognize the
internal goods or ends (goals) of their practice, and discern whether killing and “letting die” may be congruent with them. As members of a practice with a long tradition of distinguishing between killing and some forms of “letting die”, doctors, especially those whose daily practice is with the dying, might be expected to have a particular and important contribution to the debate.

5.1 Research Aim
The aim of this study is to explore doctors’ modes of reasoning in relation to the nature of the distinction between killing and “letting die” in the clinical context. I wish to understand what doctors who routinely work with dying patients mean when they use these terms, and if they distinguish morally between them. My research questions are:

- do these doctors make a distinction between killing and “letting die”?
- how do they make a distinction?
- why do they believe that killing is wrong for doctors (if they do)?
Chapter Six Methodology

In this chapter I explore potential methodologies and explain which best suits the purpose of my study.

6.1 Choosing qualitative research

The question of why doctors think that there is a moral difference between killing and “letting die” in the medical context (if they do) could be addressed either quantitatively or qualitatively. Although quantitative surveys of doctor’s opinions about AVE or PAS do not often reveal the reasoning they use in forming those opinions (Verhoef et al., 1996), one of the Queensland studies already described did attempt to do so (C. M. Cartwright et al., 2002). An example of a quantitative approach to my research question would be an anonymous survey of a randomized sample of medical practitioners in general, or of members of medical specialties who might be expected to have frequent dealings with terminally ill or severely disabled patients. Such a survey could ask participants to quantify how significant they think the moral difference between killing and “letting die” is, and/or ask them to choose, from a list of factors, their explanation for the moral difference. The list would include concepts such as the distinction between acts and omissions, causation, intention, the principle of double effect, liberty and entitlement rights, the difference between patient request and refusal, positive and negative duties and whether killing is compatible with the goals of medicine. Participants could be asked to rank these factors in order of importance, or to indicate a combination of one or more factors which they find most important.

In light of previous surveys of doctors’ attitudes, it would be necessary to define unambiguously both killing and “letting die” in the medical context, in order to be sure that participants were all answering the same question. In addition, the factors listed would need to be defined clearly, as doctors might not be familiar with them, or might understand them differently to each other, or to the way they are used in philosophical/bioethics literature. In view of the complexity of these concepts and the philosophical disagreement about them, it would be difficult to frame them succinctly, and especially to do so without reflecting the researcher’s own views, with the resulting danger of “leading” participants into choosing the most plausible sounding option/s.
In addition, and perhaps most significantly, a “multiple choice” questionnaire would require participants to reduce their moral reasoning to a small number of predefined categories, none of which may capture it well, if at all. Since there is the possibility that doctors have particular and distinctive ways of thinking about the issue, ways which have not received much attention in the bioethics literature, it is appropriate to employ a research method which allows doctors to speak with their own voice, to explain their reasoning without coaching or prompting. It has been said that, if the purpose of research is to “see the subject anew” and be open to surprises, as well as to make sense of complex data without destroying its complexity, qualitative methods are necessary (Morse & Richards, 2002, p.27). Questionnaires and statistical analysis do not capture the richness of actual clinical experience or the interplay of professional, moral, legal, cultural, psychological and religious factors in moral reasoning.

The justification of a particular research methodology requires consideration not only of the purpose of the research, but also of the theory of knowledge or epistemology (“a way of understanding and explaining how we know what we know”) embedded in that methodology (Crotty, 1998, p.3). I use the term “methodology” to mean “the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of particular methods to the desired outcomes” (Crotty, 1998, p.3). Examples of qualitative methodologies include ethnography, phenomenological research, grounded theory, heuristic theory, action research, and discourse analysis, although some writers describe these as methods (Morse & Richards, 2002, p.43). I will use the term “methods” to refer to “the techniques or procedures used to gather and analyse data related to some research question or hypothesis” (Crotty, 1998, p.3), which are sometimes called “strategies”, and include procedures such as sampling, audio-taped interviews, observation, focus groups, case study, data reduction, theme identification, comparative analysis, cognitive mapping and content analysis.

The epistemological stance behind qualitative research is a form of constructionism (Crotty, 1998, p.4). Constructionism denies both objectivism, which holds that meaning and therefore meaningful reality is intrinsic to objects, “exist(ing) as such apart from the operation of any consciousness” and subjectivism, which claims that “the object as such makes no contribution to the meaning”, which is imported from human consciousness. Instead it holds that “truth or meaning comes into existence in and out of our
engagement with the realities in our world” (Crotty, 1998, pp.8-9). Meaning is neither discovered (objectivism) nor solely imposed on the object by the subject, but constructed, in the interaction between object and subject. It is a social activity mediated through the various institutions in which all of us are embedded. Hence people in different cultures may construct the meaning of the same object differently.

The adoption of a constructionist epistemological stance does not necessarily exclude realism as an ontological stance. Ontology is concerned with the “nature of existence, the structure of reality as such”, and realism asserts that realities exist outside the mind: that the world is there whether it is observed or not. However the meaning of that reality is not independent of human consciousness (Crotty, 1998, pp.10-11).

In relation to my research question, a constructionist epistemological stance recognizes that the meaning of the way some doctors at least distinguish morally between killing and “letting die” is not an objective truth that can be identified with precision and certitude (such as weight or blood pressure), but neither is it entirely arbitrary, depending solely on my own individual interpretation. Though the outcome of the research must be suggestive rather than conclusive, it ought to be plausible, even convincing, to other observers who inhabit the same cultural institutions, while recognizing that with different cultural beliefs and assumptions they might interpret it differently.

6.2 What type of qualitative research?

6.2.1 Theoretical perspective

A constructionist epistemological stance informs a number of theoretical perspectives, which in turn inform particular qualitative methodologies. Crotty defines theoretical perspective as “the philosophical stance informing the methodology and thus providing a context for the process and grounding of its logic” (Crotty, 1998, p.3). Theoretical perspectives include interpretivism, Critical Inquiry, Feminism, and Postmodernism.

Since the focus of my research is understanding rather than critiquing the moral reasoning of doctors, it is apparent that it is informed by an interpretivist theoretical perspective, which is generally oriented toward “an uncritical exploration of cultural meaning”, as distinct from critical theory and most feminist and postmodern approaches
Within interpretivism, there are three broad strands: hermeneutics, phenomenology and symbolic interactionism. While the first two focus on humans as individuals, the latter focuses on collective behaviours, attitudes and understandings. It stems from the understanding that “we owe to society our very being as conscious and self-conscious entities” and that being arises through the process of symbolic interaction, that is, interaction through the shared symbols of words and other means of communication, in order to interpret their meanings. Taking the role of others and adopting their standpoint is central, and meaning is “the subjective meaning actors impute to their actions” (Coser, 1971, p.40). Culture is explored rather than called into question or criticized by an outsider (Crotty, 1998, p.74-76).

Since my research question concerns the way doctors qua doctors rather than as individuals understand a particular moral question, and since my initial task at least is to describe and elucidate that understanding rather than to critique it, symbolic interactionism seemed to be the appropriate theoretical perspective for my study. Interpretivism was developed in reaction to attempts in social research to find “allegedly value-free, detached observation” and to “identify universal features of humanity and society” which could lead to explanations and prediction of human behaviour, analogous to empirical research in the natural world. Instead, interpretivism informs the search for “culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998, p.67).

When first reflecting on this project, I considered phenomenology as a theoretical perspective, and phenomenological research as a methodology, since this focuses on “lived experience” (Morse & Richards, 2002), and I was interested in subjects who had actual experience of making killing and /or “letting die” decisions, rather then those who considered the possible moral difference between them from a purely theoretical perspective. However I subsequently rejected this approach for a number of reasons. First, lying behind phenomenology as a theoretical perspective are both a “deeply rooted suspicion of culture and the understandings it imposes on us”, and an attempt to access immediate experience (Crotty, 1998, p. 81). But my study is concerned with medical perceptions of killing and “letting die”, that is, the shared understandings of these concepts which doctors have, which is by necessity socially constructed, and perhaps differently socially constructed by the medical profession than by other groups. Second, and even more importantly, after the data were collected it became apparent
that I did not have any material dealing with the medical experience of killing (though a
great deal on doctors’ experience of “letting die”), and on further consideration I
realized that I was not so much interested in a comparison of doctors’ immediate
experience of these phenomena, but on their reflections, attitudes, beliefs and moral
reasoning about them.

6.2.2 Methodology
The methodology chosen for this study is focused ethnography.

Ethnography is a qualitative methodology which explores particular cultural groups,
seeking to uncover participants’ understandings in the context of their overall
worldview or culture. The aim of ethnography is to get inside the way the study group
sees the world; to see things from their perspective (the emic perspective). As culture
consists of “the beliefs, behaviors, norms, attitudes, social arrangements and forms of
expression that form describable patterns in the lives of members of a community or
institution” (Le Compte & Schensul, 1999, p.21), researchers have extended
ethnographic enquiry from broad cultures such as ethnic groups to smaller subcultural
units such as hospitals or prisons and occupational or professional groups (Morse &
Richards, 2002, p. 49). Subsections of the medical profession have been the subject of a
number of ethnographic research projects, including studies of surgeons (J. Cassell,
1987; Pope, 2002), cardiologists and cardiac surgeons(Hughes & Griffiths, 1996),
anaesthetists (A. F. Smith, Pope, Goodwin, & Mort, 2003) and surgeons and intensivists
in intensive care units (J. Cassell, Buchman, Streat, & Stewart, 2003).

The goal of ethnographic research is a “thick” (rich and detailed) description of the
features a particular culture or subculture (Geertz, 1973). While traditional ethnography
produces a broad description of a culture unfamiliar to the researcher and uses multiple
types of data, such as field notes, photographs and diary notes as well as interviews,
focused ethnography seeks information on a specific topic that may be identified prior
to the study, may be conducted with a subcultural group that is not completely
unfamiliar to the researcher, and the data obtained may consist of interviews alone
(Morse & Richards, 2002, pp. 52-53).

Ethnography is said to be best conducted by researchers who are not part of the cultural
group under study, that is from the etic perspective. As a medical graduate, I might be
considered an insider to the group, yet as someone who no longer practices medicine, and who has never engaged in a medical specialty which deals particularly with severely or terminally ill patients, I am an outsider. In particular, in view of the critical stance bioethics as a discipline takes towards medical practice and medical practitioners as a “bioethicist” I might be, and might be perceived to be, an outsider in relation to doctors. I considered that my medical background would have at least two advantages for the study. First, it would be similar to having learnt the language of the group under study in traditional ethnography, and would facilitate communication, in that participants would not need to explain technical terms or to translate their thoughts into “lay” language, which might interfere with the spontaneity of their thinking aloud. Second, I thought that it might facilitate access by tending to counter any mistrust or hostility either participants or gatekeepers in the institutions where they worked might feel toward me as a bioethicist. The potential disadvantage was that I might not have sufficient distance from the participants to be able to identify their medical beliefs and values as distinct from my own. I will indicate in the next chapter how the methods I chose were designed to limit the effects of this disadvantage and enhance the authenticity of the study.

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39 The birth of bioethics as an academic discipline in the 1960’s marked a new era of critical scrutiny of medical practice, including the exposure of many morally questionable research projects, and the ideological commitment to emphasise respect for patient autonomy, thus attempting to limit what was/is perceived as illegitimate medical power.
Chapter Seven Methods

In this chapter I explain the choice of methods used in relation to the aim of my study.

7.1 Sampling
Unlike quantitative research, which typically uses large randomly selected samples which ought to be representative of a larger population so that the results are generalisable to that population, the aim of sampling in qualitative research is information-richness, rather than generalisability (Kuzel, 1999). Therefore sampling needs to be both appropriate, in that participants should be those who can best answer the questions posed by the study, and adequate, in that information sources are chosen to give as full a picture as possible of what is being studied (Fossey, Harvey, McDermott, & Davidson, 2002).

7.1.1 Participants
In considering the appropriateness of my sampling, I decided to recruit doctors who were most likely to have seriously wrestled with the question of the moral distinction, if any, between killing and “letting die”, to have made “letting die” decisions, and perhaps also to have practiced AVE or PAS. I decided to interview only reasonably senior clinicians (those who had completed post-graduate training), who would have had sufficient time and experience to work through the issues for themselves and perhaps had read about or discussed the topic with colleagues. Thus the sampling was purposeful in targeting participants with certain characteristics who would most likely be good informants. Further, during the course of the study, the issue of particular difficulties that doctors have with patients with debilitating neurological conditions arose, and from within the pool of doctors within which I had already planned to recruit, I deliberately sought out those who worked with such patients, by emphasizing the particular contribution they could make to the study when I telephoned them.

I could have chosen to recruit from only one group of medical specialists who routinely deal with terminally or seriously ill patients, but in the interests of the adequacy of my sample, I chose to recruit from three specialties: palliative care physicians, oncologists and intensive care physicians. Palliative care physicians look after patients who are terminally ill (usually with cancer) and very frequently make “letting die” decisions of
both types: treatment abatement and use of drugs which potentially shorten life (including terminal sedation). They also might be expected to receive requests for AVE/PAS. Yet palliative care as a discipline is perceived as opposed to AVE/PAS, and according to the WHO Definition, it “intends neither to hasten or (sic) postpone death” (WHO), although there are some palliative care physicians who support AVE/PAS (Hunt, 2001). Therefore, in order to access a potentially wider range of views, and address the consideration of sampling adequacy, I decided to include oncologists, who also, though possibly less frequently, make both types of “letting die” decisions, and also would be expected to receive some requests for AVE/PAS. I decided also to include intensive care physicians, because they regularly face decisions about commencing and continuing or discontinuing ventilatory support: the so-called “switching off a ventilator” which to some represents the paradigm case of an “active” treatment withdrawal that they find indistinguishable from killing. Practitioners in each specialty could therefore be described as expert, but the fact that each group operates in a different context made the sampling more comprehensive (Kuzel, 1999).

Although other doctors, particularly general practitioners and geriatricians, also work with the dying and make “end of life” decisions, I focused on three groups of doctors who would be expected to make such decisions most frequently, and who in addition are affiliated with hospitals, and so could be recruited through these institutions. The other group who meet these criteria would be paediatricians who work with neonates. However I decided not to include them in this study as the ethical questions involved would be complicated by the issues of surrogate decision making, evaluation of quality of life in the disabled, and the moral status of the infant, including debate about the concept of “personhood” (when does a human become a “person”?). Admittedly, some of these issues, may also arise in consideration of end of life decision making in adults, but not in all, so that they may be separated from the question of the distinction between killing and “letting die” as such, in a way which is much more difficult when decisions involve neonates.

I chose to recruit through hospitals rather than, say, though membership lists of colleges or professional associations because I considered it likely that I would be able to stimulate more interest in my project through presenting it at departmental meetings and

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40 However, as previously noted, one U.S. study showed that haematologists and oncologists were less likely than other doctors to support the legalization of PAS (Cohen et al., 1994).
offering potential participants the opportunity to meet me and ask any questions they had, rather than simply sending a letter, which might be ignored, forgotten or not even read. Initially, I selected a convenience sample of five medium to large Melbourne hospitals, including four which had intensive care units, four of which were public hospitals, and all of which had palliative care units. Three were affiliated with Catholic healthcare providers.

In a further attempt to ensure adequacy of sampling, I aimed to ensure that I canvassed the views of at least some clinicians who were both in favour of, and had practiced, PAS. Therefore I recruited from the group of seven doctors who had publicly reported having “helped a patient (who requested assistance in suicide) to die”, in an open letter to the State Premier of Victoria, and had urged the premier to follow the example of the Northern Territory and bring in a bill to legalise PAS. Extracts of the letter were published in the Melbourne newspaper The Age on March 25th, 1995, and subsequently appeared on the website of the Voluntary Euthanasia Society of Victoria (Syme et al., 1995). The inclusion of these doctors is an example of extreme case sampling, because their experience is atypical or unusual. While other doctors may have practiced PAS or AVE and even admitted to it anonymously, these doctors felt sufficiently strongly about advocating for the legalization of PAS that they were prepared to risk possible criminal investigation and prosecution, as well as investigation by the Medical Board of Victoria, by going public. It might also be seen as an example of negative case sampling, or sampling for disconfirming evidence, since these doctors were very likely to think and argue that there is no morally significant difference between killing and “letting die” (Fossey et al., 2002).

7.1.2 Sample size

Sample size in qualitative research is typically small (5 to 20), with no fixed minimum number of participants required in order for the research to be sound. I aimed to recruit between 30 and 40 participants, roughly equally distributed between the four target groups, hoping that there would be at least five in each group. However, since the group of advocates of PAS was small (only seven individuals), I realized that this group would probably be underrepresented in the final sample. In the other groups, I planned to continue recruiting until I achieved a range of views, particularly a range of religious affiliations among participants, and until the themes which emerged were fully developed, a point often called saturation in qualitative research. I expected that a
sample size of ten in each of these groups would be more than adequate, since the scope of the study was narrow, the topic was clear and I expected to obtain the required information easily, and the quality of the data should be good as participants were intelligent and articulate, would have reflected on the topic, and would have sufficient time to cover the material (Morse, 2000).

7.1.3 Selection of research instrument
The aim of ethnography is a thick description based on getting inside the way study participants see the world, and in focused ethnography such information is sought on a specific, pre-defined topic. Potential sources of data for this study included observation of clinical settings where killing/“letting die” decisions were being made, such as in a hospice or intensive care unit, or of settings where such decisions are discussed, for example clinical case conferences or ward meetings, as well as interviews of doctors. An ethnographic study in Quebec, Canada involving 90 participants, including chronically ill patients, family members and health care workers, of whom five were doctors, in two long term care centres, prospectively examined decisions to undertake life-prolonging treatment (admission to an acute care hospital, and in one case the use of CPR). Eight patients were confronted with such a decision, and data collection consisted of semi-structured interviews, direct observation of patient-staff interactions, and examination of medical files and nursing notes (Shidler, 1998). However such an approach is more suitable for an investigation of interactions between health care staff, patients and family members in the decision making process, than for an investigation of doctors’ moral reasoning. It would also have been very intrusive for the patients and family members involved, especially in the intensive care context (and this would probably have made it much more difficult to obtain ethics approval). Similarly, case conferences and ward meetings would typically be multidisciplinary (including nurses, social workers and perhaps chaplains), and involve junior as well as senior clinicians. Observation of these groups would shed light on professional interactions and different contributions to decision making, but would fail to address my research question in depth. My focus was on the moral reasoning of experienced doctors, and I considered that the most appropriate way to sample this was to ask them to explain it to me, using an audio-taped semi-structured in depth interview. I needed to know not only what decisions doctors made, but even more importantly, why they made them. As has previously been noted, data collection in focused ethnographic studies is often confined to interviews, with field work omitted.
I chose a semi-structured interview in order to allow a great deal of flexibility for participants to talk about the issues which were important to them, and as much as possible to let them raise concepts, rather then introduce them myself. I planned that generally, questions would flow from what the participant had said, as in a normal dialogue, with questions of clarification and probing for further explanation, as well as questions which followed up cues, to lead to related topics. Questions were to be as much as possible open ended, and not presented in any set order or standardized format. Within the parameters of the research question, I wished to allow participants to take the lead, rather than being directed by the interviewer. In this way, I sought neither to introduce nor to impose on the participants any terms, concepts or modes of reasoning that I might have expected them to use. I wished to ensure “sensitivity to participants’ language” and to privilege their knowledge and experience, rather than forcing them to fit their perceptions and reasoning into pre-existing frameworks (Fossey et al., 2002).

Yet because I wished to focus on a specific topic, the interview was to be semi-structured, using an interview guide. The interview guide was a list of questions and topics which would guide the interview while still allowing it to be flexible and conversational (Fossey et al., 2002):

A. Definitions of “killing” and of “letting die” in the medical context.
B. Nature of moral difference between them, if any.
C. Attitudes to active voluntary euthanasia.
D. If AVE were legalized, should it be practiced by doctors?
E. What are the goals of medicine?
F. How do you understand suffering and death?
G. Difference between “sedation of the terminally ill” and AVE, if any.
H. Difference between AVE and PAS, if any.
I. Influence of religion or spirituality on thinking in this area.
J. Attitudes to philosophy and bioethics.

Each interview would be conducted by the same person (myself) and was to commence in the same way, with a similar (though not precisely identical) invitation to discuss a case. Medical cases are particular and formulaic stories. Outlining a case history is a very familiar task for clinicians, and one which I hoped would put them at ease initially,
before I asked them to engage in what may have been, for some of them, less familiar
tasks, namely, exploring their personal reactions to the people and events they described
and articulating their moral reasoning. The interviews were to be for up to one hour,
sufficiently long (I hoped) to cover the issues in depth, but of a fixed duration to enable
timetabling into medical schedules. These elements introduced a basic structure to the
interviews. Interviews were to be face to face (rather than by telephone), in order to
facilitate the development of rapport, the perception by the interviewer of non-verbal
cues, and the use of silence, if necessary, to allow reflection and facilitate spontaneous
ideas rather than answers to specific questions.

I chose to audio-tape the interviews rather than make notes, both because of the
complexity of the topic and because of the need to have an accurate record of the exact
form of words that were used.

### 7.2 Ethics approval process

I required approval from each of four hospital Human Research Ethics Committees
(HREC’s), as well as from the University of Melbourne HREC. In response to my letter,
the Clinical Director of the other hospital stated that as I was wishing to interview
senior clinicians, I did not require ethics approval from that organization for the
research, as “it would actually be up to the individual clinician and whether they are
willing to participate”. The project was covered at this hospital under the approval of
the University of Melbourne HREC.

A number of difficulties arose in obtaining approval from three of the hospital HREC’s,
not all of which I had anticipated.

Because of the sensitive nature of the material to be covered and potential legal issues,
including the possibility of research records and audiotapes being taken by the police or
required by the courts, specific steps were taken in the original project design to protect
the identity of participants. There is a tension between the need to maintain accurate and
verifiable records, and the need to maintain confidentiality and provide reasonable
protection from the risk of prosecution. I assessed this risk as slight, since no individual
criminal charges have ever been brought in Australia against a doctor or other health
professional who has admitted in general terms to “helping patients die”, whether
through involvement in research, or by a public statement. The specific steps I took in my original project proposal to protect participants were:

- There should be no written record of participants’ names.
- Consent was verbal, not written, and recorded at the beginning of the interview.
- All transcripts and tapes were labeled with synonyms.
- No master list linking names with pseudonyms was to be kept once data collection was completed.
- Participants were advised in the participant information and consent form of the risks of revealing potentially incriminating information, and advised to recount their experience without revealing identifying details.
- Participants were advised that the research records including tapes would be kept for seven years but in a secure location, to which only the principal researcher had access.
- Participants were encouraged to discuss any legal concerns with their medical defence organisation.

Before granting approval, one hospital required (among other conditions) that I “assure the HREC that (the hospital and its parent organization and related companies) will not be identified in the research records or in any publications or presentations”. The issue, as expressed to me by the HREC secretary, was the reputation of the hospital, which did not wish to be associated with any morally or legally questionable activity I might uncover. As a result of this requirement, and in order to treat all participating hospitals equally in this regard, I removed all references to the names of all the hospitals at which I intended to recruit from all documentation, including the participant information and consent forms for all participants.

At a meeting which I attended of the HREC at another hospital, and in their subsequent letter declining to approve the project without significant revision, it was clear that the committee was very concerned to protect participating doctors from the possibility of criminal charges. It was pointed out that participants could be identified by their voice on the audio-tape, and that “there is a real risk that the researcher may be interviewed intensively by the Homicide Squad. She could face a charge of concealing information regarding one or more criminal deaths. There is a real risk that the researcher, under
pressure from the Homicide squad, may identify individual doctors, or those doctors may be contextually identified.” It was stated that most doctors would not understand the adverse inferences which might be drawn from their remarks, and that police could identify individual patients through search warrants and record review. The committee considered that “there is a high risk of seriously incriminating admissions being made, particularly from doctors who feel a mixture of satisfaction from assisting a patient, coupled with feelings of moral guilt and culpability.” I was required to amend the project so that “each doctor obtains specific approval from their medical defence organisation, in writing, before participating.” In view of the extra time and trouble this would involve to potential participants, and the likelihood that medical defence organisations would be unwilling to give written permission when it was uncertain what this implied, I decided that this requirement made the project unfeasible at this site, and decided not to pursue the application any further. I also sent a copy of the letter to all the other HREC’s involved in the project.

Because this was a large hospital with a large intensive care unit, I was concerned that I would not be able to recruit a reasonable number of intensive care physicians, and considered recruiting through the Australian and New Zealand Intensive Care Society. In the event, this was not necessary. The failure to gain approval at this hospital also meant that, of the four hospitals where I was eventually able to recruit, three were affiliated with Catholic health care providers.

The HREC at another hospital stipulated a number of conditions which had to be met before the project could be approved. One of these was that I should “include in all the materials a declaration of your own position … in the interests of ‘transparency of bias’”. I therefore stated on the Participant Information and Consent form for this hospital that my own position was that there is a moral distinction “between active euthanasia and the appropriate withholding or withdrawal of treatment, even when this results in death”.

This hospital then granted approval, but with several more conditions, one of which was very significant, and related to concerns about the reputation of the hospital being damaged by association with illegal activity. I was required to agree in writing “to permit (the hospital) review of your proposed presentation or publication of your research at the appropriate time for the sole purpose of assessment of risk to the
organization”. I sought clarification of this, and it was stated that this review would be limited to: “a determination that appropriate de-identification has occurred such that neither (the hospital) nor specific members of its staff can be identified by a person with general knowledge of the health care industry in Victoria”, and that the assessment would be made only prior to the initial presentation or publication of the data, by both a representative of the hospital HREC and a representative of senior management at the hospital.

Another important condition was that the analysis should not distinguish between religiously affiliated and non religiously affiliated hospitals. I agreed to these conditions, and approval was then granted on June 2, 2004.

However, permission to proceed with the project at this hospital was subsequently withdrawn on June 15, pending external legal advice to the Hospital Board. This advice imposed new conditions, including that the audiotapes be destroyed after the transcripts was made and verified, that the master list be destroyed as soon as possible after data collection, and that I should stop the interview and wipe the tape if any incriminating details were revealed. After discussion with a member of the University of Melbourne HREC, I agreed to these additional conditions and approval was reinstated on July 20. These new conditions were also subsequently imposed by another hospital, with the result that each transcript from both these hospitals had to be checked for accuracy by the interviewee before I could include it in the analysis. This proved time consuming, and required repeated prompting in some cases.

7.3 Recruitment
Final versions of the participant information forms for Hospitals 1, 2 and 3, and that used at hospital 4 and for the seven advocates of PAS (authorised by the University of Melbourne HREC) are found in Appendices A to D. References to specific hospitals and their staff members have been removed.

At Hospital 1, I contacted the heads of the palliative care, oncology and intensive care to discuss how I might recruit members of their departments. I sent the participant information and consent form by email using an email address list of palliative care physicians supplied by the head of the department, and seven palliative care physicians
responded and were interviewed. I was invited to hospital oncology and intensive care departmental meetings to give a brief presentation of my project and invitation to be involved, as well as to answer questions about it. Two oncologists and two intensive care physicians responded and were interviewed.

At Hospital 2, I also contacted departmental heads and was invited to a palliative care meeting and a meeting of oncologists, where I presented the project. In addition, an email was sent to other potential participants. I was able to recruit and interview 3 palliative care physicians, nine oncologists and one intensive care physician.

At Hospital 3, address labels for more than 30 oncologists and palliative care physicians were given to me by the medical director. Even with follow up phone calls, there was only one response, from a palliative care physician. However I was able to attend the intensive care departmental meeting and recruited 3 participants.

Hospital 4 did not have oncology or intensive care departments. The names of palliative care physicians were given to me by the medical director, and after contacting each by phone, I was able to recruit four of them. Although I already had more palliative care physicians than other specialists, I was keen to recruit at this hospital because it cared for a number of patients with motor neurone disease, and the issues in managing patients with this disease had arisen in previous interviews, as being possibly distinct from those involved in managing cancer patients.

The letter to *The Age* which seven doctors had signed included their practice addresses, and I posted the participant information and consent form to each. I received replies from two who were willing to participate.

### 7.4 Data collection

I conducted 34 interviews between July 3, 2004 and July 28, 2005. Interviews were audio-taped and took place in a site of the interviewee’s choosing, in most cases the doctor’s own office or a convenient room at their place of work. Four interviews were conducted in my office, two in the participant’s home, and one in a rather noisy cafeteria. I first asked each subject his or her age and where he/she had undertaken undergraduate and postgraduate medical training. I then switched on the tape-recorder
and obtained formal verbal consent to participation in the project. The interview proper then commenced with an invitation to discuss a recent difficult end-of-life decision, which “raised the question for you the question of the difference if any between killing and ‘letting die’”. Apart from questions of clarification, interviewees were encouraged to continue talking without interruption. Topics were explored as they arose naturally rather than in a predetermined order, but after these had been dealt with, relevant areas not yet touched on were raised with specific questions.

All but three of the interviews (where the recording was of too poor a quality) were transcribed by the researcher. At Hospitals 1 and 2, the transcript was emailed or mailed (if the participant requested this) to be checked for accuracy. Participants were advised to delete these emails, and the researcher did likewise once notified that the participant agreed that the transcript was accurate. The audio-tapes were then destroyed. One participant (at hospital 2) failed to respond to repeated requests to verify the transcript, and was not included in the study. This audio-tape was also destroyed. For other participants, audio-tapes were retained, and each interviewee received a follow up telephone call to ask if they had any concerns, and if there were portions of the tape they wished to be deleted, or additional comments they wished to make. These audio-tapes were labeled only with the date of the interview. Transcripts were identified only by number, and a pseudonym assigned to each participant.

When all interviews had been conducted, and all transcripts (but one) verified, the master list of names of participants was destroyed.

7.5 Data analysis
Transcripts were imported and stored as text documents in the computer package, ATLAS.ti 5 (Scientific Software Development, Berlin, 2004), a program designed to assist data handling in qualitative analysis by enabling multiple coding of a large volume of data and searching for both words in text and patterns of codes.

7.5.1 Initial code list
Each transcript was divided into many meaning units and each meaning unit coded initially using a code list I had prepared based on both my interview guide and literature review. This included both descriptive and topic coding (Morse & Richards, 2002,
Descriptive codes were age, gender, specialty, hospital or recruitment group, religious/spiritual view and definition (of killing versus “letting die”).

Topic codes were act/omission, intention, double effect, causation, terminal sedation, futility, wrongness of killing, trust (in the medical profession, importance of), withholding versus withdrawing of treatment, PAS versus AVE, goals of medicine, limits of medicine, and attitudes to philosophy and bioethics.

An iterative process of open coding was used, in that the data generated many new, often unexpected ideas and concepts which were then assigned a new code. Additional descriptive codes were introduced, such as “story”, which indicated a case history or an event in the participant’s own life, and “example” and “counter-example” were used of cases from current events or literature which were either illustrated or provided an exception to a general argument. A “key experience” was an event which was self-reported as having a major or decisive influence on the participant’s attitudes to the research question. “Policy” was a statement of how the participant generally proceeded under certain circumstances (Jordens & Little, 2004).

Further codes were generated by subdividing codes into narrower and more specific ones. For example, there were different types of stories: an initial story (the first case recounted in the interview, in response to opening invitation), a personal story (involving a family member or close friend) or an early story (an event experienced as a medical student or junior doctor). Similarly, the withholding or withdrawal of artificial ventilation and of ANH were given separate codes. Once a new code emerged, previous transcripts were rechecked for that code. In this way, a final list of 151 codes was generated. Thus, many meaning units were associated with multiple codes.

### 7.5.2 Conceptual framework

The initial list of codes derived as part of the data reduction process was used to construct an index or conceptual framework by combining certain codes, identifying links between them and organizing them into a hierarchy (Ritchie, Spencer, & O'Connor, 2003, p.222). At this stage, the terms used were as close as possible to those used by the participants.
7.5.3 Development of themes

Some of the codes created were (to a certain extent) unexpected, as they had not been prominent in the literature review of the topic. The most important of these, in terms of thinking about the moral distinction between killing and “letting die,” were “certainty versus uncertainty” (that the level of certainty of the outcome was a key difference between killing and “letting die”), “intervention” (that the difference between killing and “letting die” was the difference between intervening and not intervening, medically), “immediacy” (of the connection between the doctor’s action and the patient’s death), “reluctance to kill” (the reluctance doctors, even those who may be in
favour of AVE, feel about killing a patient) and “theoretical versus personal” (the
difference between a theoretical view that an action is morally permissible and being
willing to perform it).

Other topic codes were related to the research question indirectly, such as the obligation
to relieve suffering, conditions under which “letting die” was morally permissible,
recognition of when a patient has entered the dying process, the importance of
respecting doctor’s own moral autonomy, the view that good palliative care obviates the
need for the legalization of AVE, the morality of abortion, capital punishment and
warfare, the dangers of legalising AVE, the experience of legalized AVE/PAS in
Holland and the Northern Territory, the Nazi “euthanasia” programme, the concepts of
“good” and “bad” deaths, and “dignity” in dying, the importance of recognising and
treating depression in patients who wish either to be killed or to forego potentially life-
saving or life-prolonging treatment, the roles of doctor and patient in the decision-
making process, the role and influence of family members in end-of-life decisions,
reference to the Hippocratic tradition, possible differences in relation to the need for
AVE between cancer and patients and patients with debilitating neurological disease
such as motor neurone disease, the difficulties of medical practice, especially caring for
the dying, a personal change of attitude in relation to AVE/PAS, and the doctor’s own
wishes should he or she be dying. Space constraints do not allow all of these topics to
be explored in this thesis.

Some topic codes represented moral reasoning. Examples include the use of or
repudiation of consequentialism, reference to the importance of respect for patient
autonomy and beneficence, the invocation of rights language, reference to doctors’
duties or obligations, the use of the slippery slope concept, and reference to the sanctity
of life.

Further analysis and reflection on these categories using immersion/crystallization
(Borkan, 1999) led to the development of two major themes: “taking control”, and
“killing and the role of the doctor”.

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7.6 Criteria of trustworthiness and authenticity

Although qualitative research arises from a constructionist rather than objectivist epistemological stance, the question of rigour, that is, what constitutes good research practice, is still relevant. Rigour is often expressed in terms of reliability and validity (Davies & Dodd, 2002; Morse & Richards, 2002), though these terms do not have the same meaning in qualitative inquiry as in quantitative research. Reliability is problematic in qualitative research, as it requires that the same results would be obtained if the study were replicated in another time or context and by a different researcher, but a qualitative study is difficult or even impossible to replicate as the data are richly context-dependent. Similarly, validity requires that the results accurately reflect objective reality, yet qualitative research sees reality as constructed rather than discovered (Morse & Richards, 2002). For these reasons some authors do not think they should be used in the former context. Instead they use the concepts of trustworthiness, which includes credibility, applicability and consistency (Lincoln & Guba, 1985). Central to all these concepts is whether “the subjective meaning, actions and social context of those being researched is illuminated and represented faithfully” (Fossey et al., 2002, p.731). Trustworthiness and authenticity may be more appropriate terms than reliability and validity.

7.6.1 Steps taken to ensure trustworthiness

Trustworthiness is an irreducibly ethical quality which therefore relies on the researcher’s good faith, but can to some extent be assessed by the reader, through the researcher practicing accountability by making the research process as visible and as transparent as possible (Davies & Dodd, 2002). Transparency can also be achieved by discussion and justification of the research design, and the processes of data collection and analysis with supervisors (Spencer, Ritchie, & O'Connor, 2003).

Specific steps were taken in this study to ensure the trustworthiness of the results. In relation to the management of the primary data, all transcripts were available to supervisors, and will be available for seven years after completion of the study for verification by a University audit, if required. In addition, those audiotapes which were not destroyed after transcription in accordance with the conditions of HREC approval were retained and will similarly be available for university audit if required. Where the audiotape was to be destroyed, participants checked the transcript of their interview and verified its accuracy or corrected it if necessary.
In relation to the interpretation of the primary data, an initial draft of the results chapter, which was sent to all supervisors, included lengthy extracts from transcripts to justify the researcher’s analysis. Ideally, two or three researchers would have analysed the data and confirmed or challenged each other’s coding and theme choices. However this is not possible in a Ph.D thesis. In addition, “negative cases”, that is those which were atypical and did not fit within the final themes, were searched for and highlighted.

7.6.2 Steps taken to ensure authenticity
In the design phase of the project, the first step taken to ensure authenticity was the familiarization of the researcher with the relevant literature, as outlined in the first three chapters, on the philosophical arguments about the distinction between killing and “letting die”, the history of medical professional attitudes to them in the medical context, and the recent studies on doctors’ attitudes to these in the medical context. This informed the research question and the interview guide. The second step was ensuring congruence of the research purpose with the methodology, so that the results address the question asked. I have explained the rationale for my choice of methodology in terms of the underlying epistemology and theoretical stance, and the particular question I was asking in relation to this particular study group. Finally, in relation to methods, the use of open questions and a semi-structured interview allowed participants to shape the interview and introduce new topics which they considered relevant to the question, but which the researcher may not have anticipated. In this way I attempted to discover the fullest possible picture of the moral reasoning of the participants in relation to killing and “letting die”, not just the features previously identified or for which I was looking.

During conduct of the project, the first step taken to ensure authenticity was an appropriate and adequate sampling strategy, including extreme case sampling, as outlined above, so that I obtained material from those who might be expected to be experts and included as much as possible a diversity of views concerning the morality of active voluntary euthanasia and physician-assisted suicide (and by implication, on the moral difference between these and instances of medical “letting die”). The second step was the bracketing of the information obtained in the literature review, in order to allow the researcher to work inductively and learn from the data. Codes were developed for material which was unexpected, or which may have appeared irrelevant initially. Themes emerged from the data rather than being imposed on it.
The third step was the process of reflexivity: the researcher attempted to reflect on how her own beliefs and opinions might influence the findings, and especially, the interpretation of them (Borkan, 1999, p.194). My own view is that there is a morally relevant difference between killing and “letting die” in the medical context. However, during the interviews, I frequently challenged participants who held this view to defend it or to provide clarification of the way they understood it, so that some of them (as they reported to me afterwards) thought I had a different view, and some revised their position to some extent. In this way, I did not merely accept the standard explanations for the distinction which doctors often provide. I also allowed as full an exploration and explanation as possible in the time available of views with which I disagreed. During the analysis, being wary of my own understanding and the way it might shape my interpretations, I allowed for the possibility of, and searched for alternative explanations of the data. These were discussed with supervisors, and several explanations and themes were explored before the analysis was completed (Borkan, 1999, p.194).

The final step to ensure authenticity was the comparison of my findings with the relevant theoretical and empirical literature, and the process of fitting them logically and credibly into it, as will be seen in the discussion chapter.
Chapter Eight  Participants

8.1 Introduction
This chapter first outlines the demographic features of the study group, including medical discipline, source of recruitment, current religious belief and attitudes to AVE, and provides a brief profile of each participant. The content of initial stories (stories offered in response to the initial invitation to think of a case which raised the question for them of the difference between killing and “letting die”) as well as of personal and early stories and “key experiences” which shaped their views, are summarized.

8.2 Sample characteristics
Thirty four doctors were interviewed. No interview had to be terminated because of potentially incriminating material revealed by a participant. Three tapes could not be transcribed due to technical problems with the recording. One participant failed after many requests to confirm the transcript and so could not be included. Thirty transcripts were thus available for analysis, from eighteen male and twelve female participants, with an age range from thirty one to seventy seven, and median age of forty nine years. All were Melbourne trained except for three who trained in the United Kingdom and one each in New Zealand, Sydney and Perth. All but five had Anglo Saxon or Anglo Celtic ancestry; three were from Jewish and two from Mediterranean ethnic backgrounds.

In accordance with the requests of two of the HREC’s, characteristics of the hospitals are not described, so that they may not be identified. And in accordance with the advice of the HREC of one hospital, the presentation of results does not distinguish between religiously affiliated and non-religiously affiliated hospitals.
Table 9 Source of participants by medical discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Source of participants</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hospital 1</td>
<td>Hospital 2</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Oncology</td>
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<td>7</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

8.2.1 Current Religious belief

Exactly half of the participants identified themselves as atheist or agnostic, and half as having some religious belief, as follows:

Table 10 Current religious belief of participants

<table>
<thead>
<tr>
<th>Religious Belief</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>5 (17%)</td>
</tr>
<tr>
<td>Catholic (non practicing)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Orthodox</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Anglican</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Other Protestant</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Agnostic</td>
<td>10 (33%)</td>
</tr>
<tr>
<td>Atheist</td>
<td>5 (17%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30</td>
</tr>
</tbody>
</table>

These percentages may be compared with those from the Australian Census, 2001^42:

---

^41 This group comprised seven doctors who had publicly reported having “helped a patient (who requested assistance in suicide) to die”, in an open letter to the Melbourne Age in 1995, and advocated the legalization of PAS.

Table 11 Religious affiliation of Australians

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>26.6%</td>
</tr>
<tr>
<td>Anglican</td>
<td>20.7%</td>
</tr>
<tr>
<td>Other Protestant</td>
<td>20.7%</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.4%</td>
</tr>
<tr>
<td>Orthodox</td>
<td>2.8%</td>
</tr>
<tr>
<td>No religion</td>
<td>15.5%</td>
</tr>
<tr>
<td>Did not reply</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Compared to the general Australian population, the percentage of Catholics appears to be the same, the percentage of atheist/agnostic and Jews much higher, and the percentage of Protestants much lower.

The findings may also be compared with the recorded religious affiliation in previous studies of Australian doctors:

Table 12 Religious affiliation of Australian doctors in previous studies

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>19.4%</td>
<td>17%</td>
<td>45%</td>
</tr>
<tr>
<td>Anglican/Protestant</td>
<td>36.5%</td>
<td>33.3%</td>
<td>15% other religions</td>
</tr>
<tr>
<td>Orthodox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>4.8%</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>No religion</td>
<td>29.2%</td>
<td>42.4%</td>
<td>40%</td>
</tr>
</tbody>
</table>

The percentage of participants identifying themselves as Catholic, Jewish and atheist/agnostic medical participants is higher in this study while the percentage identifying as Anglican or Protestant Christian is much lower.
Table 13 Current religious belief by source of participants

<table>
<thead>
<tr>
<th>Current religious belief</th>
<th>Source</th>
<th>Hospital 1</th>
<th>Hospital 2</th>
<th>Hospital 3</th>
<th>Hospital 4</th>
<th>PAS advocates</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>Hospital 1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Catholic (non practicing)</td>
<td>Hospital 2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Orthodox</td>
<td>Hospital 3</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Jewish</td>
<td>Hospital 4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Anglican</td>
<td>PAS advocates</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Protestant</td>
<td>Total</td>
<td>9</td>
<td>11</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 14 Current religious belief by medical discipline

<table>
<thead>
<tr>
<th>Current religious belief</th>
<th>Discipline</th>
<th>Palliative Care</th>
<th>Oncology</th>
<th>Intensive Care</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>Hospital 1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Catholic (non practicing)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Orthodox</td>
<td>Hospital 3</td>
<td>2</td>
<td>2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jewish</td>
<td>Hospital 4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Anglican</td>
<td>Total</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>30</td>
</tr>
</tbody>
</table>

8.2.2 Attitudes to AVE

Seventy three percent of the sample believed AVE to be morally wrong. Seventeen of these twenty two doctors also expressed their opposition to its legalization, four expressed no opinion about it, and one was neutral about it, in that he thought it was a matter for society to decide. Eight doctors (27 percent) believed AVE would be morally permissible under some circumstances. Nevertheless, three of these did not support its legalization, while five did.
### Table 15 Attitudes to AVE by religion

<table>
<thead>
<tr>
<th>Current religious belief</th>
<th>Attitude to AVE</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVE wrong</td>
<td>AVE sometimes permissible, oppose legalisation</td>
<td>AVE sometimes permissible, support legalization</td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Catholic (non practicing)</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Orthodox</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Anglican</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Protestant</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Jewish</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Agnostic</td>
<td>6</td>
<td>2</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>3</strong></td>
<td><strong>5</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

### Table 16 Attitudes to AVE by discipline

<table>
<thead>
<tr>
<th>Medical discipline</th>
<th>Attitude to AVE</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVE wrong</td>
<td>AVE sometimes permissible, oppose legalisation</td>
<td>AVE sometimes permissible, support legalization</td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td>11</td>
<td>2</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Oncology</td>
<td>7</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Intensive care</td>
<td>4</td>
<td>1</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>3</strong></td>
<td><strong>5</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

### Table 17 Attitudes to AVE by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Attitude to AVE</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVE wrong</td>
<td>AVE sometimes permissible, oppose legalisation</td>
<td>AVE sometimes permissible, support legalization</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
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<td>Female</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>3</strong></td>
<td><strong>5</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

### Table 18 Attitudes to AVE by participant source

<table>
<thead>
<tr>
<th>Source</th>
<th>Attitude to AVE</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVE wrong</td>
<td>AVE sometimes permissible, oppose legalisation</td>
<td>AVE sometimes permissible, support legalization</td>
<td></td>
</tr>
<tr>
<td>Hospital 1</td>
<td>8</td>
<td>1</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>7</td>
<td>2</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>3</td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Hospital 4</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>PAS advocates</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>3</strong></td>
<td><strong>5</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>
8.3 Profiles of participants
These profiles were constructed entirely from the information given in the taped interviews. Names were changed and some details omitted or changed (including gender) in some cases, in order to prevent the identification of participants.

8.3.1 Palliative care physicians
Dot is in her seventies, and has retired from clinical practice. She is an active member of the Uniting Church, but she also says, “I think if I were to ditch it all (Christian faith), I’d still have the same view, yet it’s basic to my point of view on everything”. She thinks AVE is morally wrong and is opposed to its legalisation.

Hilary is also retired, and had a Christian upbringing but is now “not religious”, an agnostic. Hilary believes AVE is morally wrong and is opposed to its legalisation.

Richard is 41 and an agnostic: “I am more of a free thinker. I don’t have a traditional Christian view, it would be more of a new age collective consciousness type view”. He thinks AVE is morally wrong and is opposed to its legalisation.

Nathan is 48 and a strict Jew who says, “This is the way we were brought up, and this is what we were taught… And it makes sense to me within my value system, my philosophy and beliefs. I think that these other philosophies and laws are wrong”. He thinks AVE is morally wrong.

Alison is 47 and a practicing Catholic who says this “has a lot to do with my fundamental approach”. She thinks AVE is morally wrong.

Kerry is 35 and agnostic: “I know that some religions consider it extremely wrong. But it’s not part of where my thinking’s coming from”. She does not think AVE is always wrong, but is not in favour of its legalisation: “I don’t have a problem with euthanasia with someone in their last week of life. But what about their last month of life? Or their last three months of life? And who makes that decision? All the standard arguments… I probably think it’s better off being left illegal… I think it’s probably just easier for us if we don’t have to address the issue. It gets done quietly 43, in appropriate circumstances, and that’s fine… But the mind boggles at what would happen if it was made legal”.

43 Throughout, underlining in excerpts from transcripts indicates the participant’s original emphasis.
When asked if she would be willing to perform AVE if it were legal, she said “I just don’t know… I suspect not”.

Michelle is 34 year and agnostic: “I’m not religious. My upbringing was Church of England. I probably wouldn’t call myself an atheist, but I suppose I do not believe in God… I don’t believe in heaven and hell. But I believe in good versus evil… Now why something should be good and why something should be evil, and where that comes from, I don’t know!”. She does not think AVE is always wrong, but is opposed to its legalisation: “I’m not against euthanasia, as a concept. I am against it in the sense of making it available because I worry for all the vulnerable people, and it’s just not that simple... I guess legislation’s there to try and protect the greater proportion of people, and you’re never going to get it right for everybody, but if you’re trying to look after the majority, rather than the minority, to make something like euthanasia legal, I think would not be for the greater good… I wouldn’t want to be involved in it”.

Margaret is a 55 year old practicing Catholic who justifies her position on killing “in terms of the Christian belief about, you don’t have the right to kill somebody. The Ten Commandments”. She thinks AVE is morally wrong and is opposed to its legalisation.

Bill is 69 and also trained in oncology. He was brought up as a Christian but no longer attends church: “It may have influenced the way I grew up… But my ethics of caring for people is secular. It’s not religious”. He thinks AVE is morally wrong and opposes its legalisation.

Annette is 45 and agnostic: “Some of my moral values have come just from who I am as a person. But certainly not from a religious point of view. I didn’t have a religious upbringing”. However she says, “I feel that working in the field has probably made me more spiritually aware”. She does not believe in a “life hereafter”. She believes AVE to be morally wrong and is opposed to its legalisation.

Vivienne is a 48 year old Anglican who says, “Although I would say that I’m a Christian, I’m a little less sure about my faith than I used to be. It’s not primarily my religious beliefs that drive me in this area, although that is definitely one aspect of who I am, and I’ve lived for so long with the respect for the gift of life and the spirit that is in
us, and perhaps what you might call God’s supervision of everything”. She thinks AVE is morally wrong and opposes its legalisation.

Natalie is a 50 year old agnostic who says her views come “not specifically because of any religious point of view”. Her practice focuses on patients with chronic neurological disorders. She believes AVE to be morally wrong and is opposed to its legalisation.

Forty three year old Mark also trained in oncology and like Natalie, his current practice includes many patients with chronic neurological disease. He has an Orthodox faith: “I’m not a particularly religious person. I don’t go round trying to convert people. But I’m a Christian, and I believe in God”. He is not a church goer, but says, “that doesn’t seem to be the point to me. To me the point seems to be what do you believe”. His views on killing and “letting die” are “99.99 percent my own thinking (rather than church teaching)”. He thinks AVE is morally wrong and opposes its legalisation.

8.3.2 Oncologists

James is 47 and “grew up within Christian ethics”, but now describes himself as an atheist, whose views are “not anything that comes from religious doctrine… I don’t believe in afterlife, or rebirth, or those sorts of things”. He thinks AVE is morally wrong but is neutral about its legalisation: “That is a matter for society (to decide)”. 

Craig is 31 and says, “I’m an atheist, so that doesn’t influence my position on the issue”, and that “humanists don’t think that people should suffer, and medicine has the ability in most situations to prevent pain and suffering, and so that should be used to its full extent to do that”. He is not opposed to AVE or its legalization, although he said it was rarely an issue in oncology patients. “I would be open to it. But I would be looking for other options as well… It’s not something I would want to do”. But he added, “I would be more comfortable with active euthanasia in patients who requested it, and it seemed appropriate and they’d been properly assessed, and that was legal avenue that could be taken… I would be comfortable with that, if society accepted that as well… I would (be in favour of legalization) in appropriate circumstances. I have been surprised how rarely the issue’s come up in oncology practice, but I think there are other areas where it may be justified. And I guess there is the odd oncology patient who does have pain that is extremely difficult to manage, and who does have appalling quality of life…”
where maybe euthanasia is a reasonable option, when other options have been exhausted”.

Paul is a 37 year old agnostic: “I’m not a religious person at all”. Like Craig, he is not opposed to AVE or its legalization, although he thinks it is not appropriate for cancer patients. “I think there are actually situations where euthanasia is not a big no, but I don’t think it’s appropriate in cancers. For instance, motor neurone disease. I think that is one of the most dreadful diseases around. If someone is completely dependent, and they’re basically going to suffocate… Or people who have quadriplegia, who, after they’ve lived with it for a couple of years, and don’t have a clinical depression… They’re the situations, that’s where I think the discussion of euthanasia should be. For terminal cancers, I don’t think it’s appropriate, because it’s always aimed at problems that are treatable. It’s really the situation where you get desperate and sad people who have got the prospect of living for years with a terrible incapacity. And they feel they have no quality of life. Where you feel you have time to nut it through, and perhaps go through a legal system… So, I’m not completely against euthanasia”.

Tom is a 50 year old practicing Catholic, who says, “There’s no doubt that it drives some of my philosophies on life”, but also that, “I certainly wouldn’t use my religious background to justify a position, because in contemporary Australian society that’s not necessarily appropriate… One of the things that sustains the beliefs that I have is that I think that they are right, they are based on the principles I think are important”. He believes AVE to be morally wrong and is opposed to its legalisation.

Judith is 44 and was raised as a Catholic: “Whilst I’m not what you would consider a practicing, believing, all-believing Catholic, I suppose there’s still a lot of that that you carry with you”. She thinks AVE is morally wrong and is opposed to its legalisation.

Oliver is 34 year old Catholic who describes himself as “a religious person” and says this may affect his views on death and dying “a little bit, in the sense that I have the belief that there may be something else out there, rather than just life ends”. However he says, “I use religion in the sense of trying to use it to deal with people better… more than if the Pope says you can’t believe in abortion, you can’t believe in euthanasia, therefore you don’t believe in euthanasia and abortion. It’s a little bit more complicated than that”. He believes AVE to be morally wrong.
Kate is 42 and was raised a Catholic but is no longer practicing: “I’m not a very religious person, although I’ve been brought up with that background. I don’t actively go to church, but I suppose I have that philosophy. Some of it, but not all of it. And I suppose it stems from that, that there is another force, beyond us, and that we have to respect that. Well, I would respect it”. She thinks AVE is morally wrong and is opposed to its legalisation.

Desmond is a 58 year old liberal Jew, but says this influences his thinking about end of life decision making “only at an exceptionally basic level, like the injunction not to kill. The fact that my views are more related to individuals rather than the community, reflects a slightly different standard to what an Orthodox Jew might espouse”. He thinks AVE is morally wrong and is opposed to its legalisation.

Harry is 55 and Jewish: “I come from a group of people who believe that it is absolutely wrong to shift the balance of things away from God’s hand. But I’m a physician as well, and my own beliefs should not impair my response to somebody else’s belief system or their wishes… I think that’s why we have a relatively independent formulation for ethics, to try and resolve some of these issues... I’m not fundamental about it. If religion rules a person to the point that they will do whatever the religious organization says, I think they’ve lost autonomy”. He thinks AVE is morally wrong.

8.3.3 Intensive care physicians

Gordon is a 58 year old atheist, with a strong sense of professional duty: “I grew up in a medical family, with a large degree of noblesse oblige, and I remember being laughed at by one of my junior colleagues, (when I explained an action by saying) ‘It’s my duty’... I think there are probably still important elements (of that) within the profession, but I’m not sure how rife it is, amongst the modern generation”. He does not think that AVE is always morally wrong, but is opposed to its legalisation: “You can make out that very rare occasion, where it (a lethal injection) might well be worthwhile, under extreme circumstances, where the quality of existence and the symptoms are such that it would be, on balance a kindness to fall in with the patient’s wishes”. But he went on to say, “I think that societies have very short memories. What is instituted, maybe with the best possible motives, can ultimately be twisted and turned by a change of social climate, by governments… and used inappropriately... I’m just always aware of slippery slopes.”
And what I have reservations about is formalizing any of these situations... If you formalize it (a lethal injection) and make it legal, and encourage that sort of activity, ultimately it can be misused, abused... and the **extreme** example is what the Nazis did”.

Brian is 39 and describes himself as a humanist. While no longer a practising Catholic, he says, “I’m sure that that’s had an influence in the way I’ve formulated my ethics... in a large way perhaps, that’s why I believe that (killing is wrong)... I can’t say that I know I’m right. I’m not a religious zealot”. He thinks AVE is morally wrong and is opposed to its legalisation.

Andrew is a 52 year old practicing Catholic for whom church teaching is authoritative: “What dictates what I do comes down to what Catholic teaching is”. He thinks AVE is morally wrong and is opposed to its legalisation.

Ken is 63 and an atheist: “Some people live in a sort of spiritual framework. That’s not something I find myself attracted to, or involved in, or thinking about... So it doesn’t affect how I think about anything. It doesn’t affect any aspect of my life”. He does not think that AVE is morally wrong and is not opposed to its legalization. “If I was on a desert island, I’d be very happy to do it... If I felt that this was burdensome treatment that wasn’t going anywhere, I wouldn’t form major distinctions between the mode of death. Wouldn’t think about it for a microsecond... What I have said would provide some sort of support for the idea of freeing up the law about euthanasia. I wouldn’t be uncomfortable with that”.

Ruth is 52 and describes herself as agnostic, although “I was confirmed, I went to a Presbyterian school. I’m the sort of person who goes to church two or three times a year (for weddings, christenings and funerals)”. She says her views are not influenced by any religious or spiritual considerations. She thinks AVE is morally wrong and is opposed to its legalisation.

Ian is 55 and an Anglican, but says this doesn’t influence his views: “I would go to church I suppose once a month. I’m not over the top. I read a little bit about things, but I don’t have any fanatical views, and I suppose I’m a little ambivalent still, about my religion”. He thinks AVE is morally wrong and is opposed to its legalisation.
8.3.4 Advocates of PAS

Robert is retired and was brought up as a Christian, but says “I don’t know if I’d call myself an atheist or an agnostic”, although “I guess one is shaped by various things. The Christian ethic is delightful”. The main reason for his view is that, “I as an individual, would choose to have control, for myself. So I am a very strong believer in the individual’s choice”. He does not think AVE is morally wrong and is an advocate for its legalization under strict controls. “If you believe that to speed that event (death) would be a kindness then that’s the decision which I would make… there are so many individual features which ought to be considered. That’s why any laws which we make, to make it legal (would have to be quite restrictive)... So if the law was changed, people would have less problems, but there would still be problems”.

Walter is also retired, and an atheist, though he had a Christian upbringing: “The concept of God is no longer part of my thinking… we make of life what we can, and most people want to do something useful and good, that I suppose is my ethics. But because of a Christian upbringing, and beginning from a Christian based society, I can’t help but have ethics which are really strongly based on that. I sometimes call myself a Christian humanist. A Christian atheist. I have a sort of humanist spirituality, and to me the most important thing of all is respect for other human beings. And that would lead you to respect their autonomy… that’s the key thing for me”. He does not think AVE is morally wrong, and is comfortable with its legalization, as in Holland, although he believes the emphasis in Australia should be on the legalization of PAS: “I really think that the Dutch, much as they’ve been extremely valuable in conducting a very sophisticated debate, unfortunately they’ve skewed the debate in terms of lethal injections... To my mind, that’s a great shame, because it’s really the exception”.

In summary, eight of the participants with religious beliefs (five Catholics, one Orthodox Christian, two Protestants and two Jews) indicated that this shaped their moral code, and two non-practicing Catholics also indicated that their Christian religious upbringing had contributed to their opposition to AVE. In addition, the two advocates of PAS (one atheist and one agnostic) said their religious upbringing had influenced their thinking about ethics to some extent.
8.4 Stories
Bill and Mark told no stories at all, and ten participants told only one (Kerry, James, Craig, Gordon, Michelle, Judith, Annette, Walter, Ruth and Natalie), but sixteen told multiple stories, with the most being told by Paul (eleven) Margaret (nine) and Ian (seven). All of these were of first hand experiences and mostly told in the first person, and while most related to clinical experiences, some were more personal, relating to family members. Some of them (told by Richard, Alison, Nathan, Brian, Kate, Paul, Margaret and Ian) were very rich, detailed and vividly told, and described the participant’s emotional responses.

8.4.1 Initial stories
Seventeen of the participants told a story in response to the initial invitation to recount a case which had raised for them the issue of the difference, if any between killing and “letting die”. Of the thirteen palliative care physicians, eight told such an initial story: three were of sedation in the terminally ill, one of the use of opiates in such patients, two of withholding or withdrawing treatment, and two of sedation plus the withholding or withdrawal of treatment. Richard and Alison each recounted three cases initially, and all of these four additional cases concerned sedation.

Bill said that he could not remember such a case because he had never found himself thinking the distinction was unclear, and Annette said that she could not think of any case where “it came into my train of thought” that she was killing a patient rather than “not doing anything active” or alternatively administering medications that “might be hastening things”. Vivienne said, “I’ve been in palliative care for twenty years, and it often crosses my mind that there’s a big difference between them”. Mark said he could not think of any cases where it had troubled him, though it often came up in relatives’ minds, so that he had to explain the distinction to them. And Natalie spoke in general terms of patients with advanced neurological disease who would prefer to be dead, some of whom requested “help to achieve that”.

Of the nine oncologists, seven recounted an initial story, of which two concerned sedation of the terminally ill, two the use of opiates and one the withdrawal of a feeding tube. Tom told of a patient whom he suspected wanted a laparotomy to relieve bowel obstruction associated with disseminated malignancy because he wanted to die under the anaesthetic, and Craig of a Dutch patient whose request for AVE disappeared after
adequate symptom control was achieved. Harry recounted three initial stories of patients who had requested AVE, one of whom was treated with an infusion of opioids and diazepam, “so that he was asleep until he died”. In another case, such a course of action was decided upon but the patient died after being told that would happen but before it could be set up, and in the final case such an infusion was not used on the grounds that the patient was “not about to die”.

Oliver began with the statement “I don’t agree with the concept of actively killing the patient”, then spoke of the typical situation in which he might withhold treatment in the terminally ill. Desmond said, “I don’t subscribe to killing patients”, but “I do subscribe to striving aggressively to control symptoms. And if that shortens their life, that’s not a moral issue, as far as I’m concerned”.

Of the six intensivists, only two told an initial story, Ian one of treatment withdrawal, and Gordon one of sedation which probably shortened life. Ian also told two more stories of treatment withdrawal. Brian said that he couldn’t think of a case, because he doesn’t think that what he does in the intensive care unit (ICU) “comes close to a decision about ‘Am I killing or letting people die?’” He said patients were never killed in his unit, but frequently allowed to die, either by treatment withholding or withdrawal. Andrew also said that no case had stood out or bothered him, though decisions were frequently made either to withdraw or to limit therapy. Ruth also referred to these frequent decisions, but said that killing “doesn’t come into my consciousness”. Ken said that he couldn’t recall a situation ever raising the question in his mind of the difference.

Of the two doctors who were advocates of PAS, Walter said he could not think of such a case because “I don’t accept the validity of the term ‘killing’ in this respect”. He then told me of a patient where antibiotics were withheld at the request of the patients’ guardian, and sedation and opiates administered “which in all probability did hasten his death”. Robert described killing (“taking active steps”) as “equivalent to passively letting go, since there is no difference in final outcome, which is death. In each case a person decides to (act or not act) to achieve the outcome, but “one has agreed to make it easier, or more pleasant, and one has not”.

Thus while doctors in all groups thought of the issue of the difference between killing and “letting die” in terms of both the administration of sedatives/analgesics which might
hasten death and treatment withholding and/or withdrawal, the palliative care physicians and oncologists tended to focus on the former, and the intensivists on the latter, as might be expected from the nature of their clinical work.

8.4.2 Early stories
Several doctors told stories from early in their medical career which had left a lasting impression or challenged them in some way.

Paul told a story from his time as an intern (first year after graduation), about “one of the very first patients that I looked after”. Late at night he went to see an elderly woman with metastatic cancer who was severely short of breath and told him, “I don’t mind being dead, but it’s the dying thing that I’m pissed off with.” As he said, laughing, “I was 23, and no one had told me how to deal with this sort of thing, so I sat down and we had a chat”. She was discharged, and he later saw in the death notices that she had died. About a month later he was told that she had had a big party, then “took a bit much morphine and just didn’t wake up the next morning”. He remembers thinking that that was good, although “we’ll never know if she intentionally took a bit much morphine, or whether it was just the way things happened”.

Michelle’s initial story, from her time as a registrar, was of a man with end stage ischaemic heart disease, who was very distressed and agitated despite reasonable control of his physical symptoms, had “had enough of life”, and wanted to be sedated. She asked herself “Why was that particular case a problem for me?” and concluded it was because he was not a cancer patient and it was not obvious that he was dying. She said, “I didn’t feel concerned, because I had complete faith in my consultant… but I suppose I wondered if I would have been able to make that decision”.

Craig’s initial story was also an early one, from his time as an oncology registrar (see above), as was Judith’s, from her time as a junior doctor on a country rotation, which was “the only case, that I recall that it (the distinction between killing and ‘letting die’) came up in my mind”. It involved a woman dying from an uncontrolled malignancy, with rapidly enlarging glands in her neck that obstructed her breathing, whose distress was both physical and existential. The only way to relieve her distress was with a morphine infusion at a level which put her to sleep. “I remember wondering at the time,
not having been involved in a similar case, whether that could hasten their death… And I suppose that was the one case where it sort of seemed close”.

Kate’s story from her time as a registrar was of being questioned about the dose of morphine she prescribed. She had been called in after hours to the emergency department to see a man who was in respiratory distress and obviously dying. “He was very, very distressed, and had no one to be with him. And I asked for some morphine to be given to the patient, and the nurse questioned the dose, because it might lead to his death”.

Mark’s story from his time as an oncology registrar also concerned a distressing death. “I remember looking after a woman who had the worst case of locally advanced breast cancer. She was physically well. Yet she had this fungating, awful, pussy, messy, disgusting, painful lesion, which was getting bigger and invading the brachial plexus, and she was getting so much pain, it was just unbearable.” He was sure that she would have seriously considered a lethal injection if it had been offered to her, but she did not ask for one. He added “But things have changed in palliative care quite significantly since then (twenty years ago)”.

8.4.3 Personal Stories
Richard spoke of a very disabled friend of his, who had not been expected to live, and reflected that many people would have thought his life “not worth living”: “He’s faced all those challenges and yet kind of inspires people. But his journey’s pretty tough. And I wonder what disadvantage pragmatism would stop. I guess it’s a slippery slope argument. I don’t think there’s any end to it, so I don’t think you should start it (AVE)”.

Other personal stories concerned the deaths of family members. Paul spoke of the misperceptions that family members can have of dying patients being in pain and recounted how his brother in law had died with a “fairly nasty cancer”, inability to swallow and persistent vomiting, which was “very distressing and very awful for everyone”. While other relatives said that he died “in terrible pain”, Paul’s own perception was that he was in no pain, and in fact required no analgesia.
Richard spoke of the recent death of his father in law, who chose not to be investigated for serious symptoms as he hated hospital, and died at home: “I respected that he lived, and he died, as he wished”.

Brian said, “The only time that I’ve watched someone die that I felt I couldn’t control his suffering, was when I was watching my uncle die, and I had no drugs to give him, because he was at home. But in a hospital, or even in a home setting, if you’ve got the appropriate drugs, there’s no one you can’t make comfortable”. And Oliver spoke of the death of his grandfather, who was unable to eat or drink, but had not been given intravenous (IV) fluids. Oliver had thought IV fluids were necessary in such patients, but changed his mind, “when I saw a family member who I cared about, and he was looked after very, very well, and they kept him very comfortable in his last days”.

Harry told me, “My grandparents both died at home, in considerable pain because doctors were afraid of them becoming addicted to morphine”.

Robert had seen two close relatives die, one over six months with cancer, and one over a few hours from a heart attack. He also had a relative who had a stroke at around 80, and after several days with no signs of recovery, a large dose of sedatives was administered at Robert’s request and the patient died some time later.

At the end of his interview, Ian said, “You might say, what do you know about it? I’ve been up close and personal with it. I had a wife die of breast cancer, at home… You don’t have to commit suicide. You can manage pretty much everything”.

8.4.4 Key experiences
Several participants described experiences which they said had significantly influenced their thinking about AVE and/or PAS. All but one of these (Hilary’s) occurred early in their medical careers. Two were from supporters of AVE:

From his time as a resident, Robert remembered a patient with lung cancer, who was very distressed from breathlessness and asked to be helped to die. The patient was given such assistance, and Robert said that he did not think it unusual: “Euthanasia was probably easier in those days because there was less scrutiny, especially of drugs”.

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Paul’s key experience was from his time as a registrar, of a patient with motor neurone disease. “Unfortunately for him, someone just happened to drop by after he took this huge overdose. And he came in to the emergency department, and after a lot of discussion, we got him on his side and put some oxygen on, so he wouldn’t choke on his vomit, and just saw what happened. And as it was, he recovered. We’d said, let’s not actively let him die from vomiting and choking on it, but we didn’t actually give him any antidotes to the drugs that he’d taken. And I suppose that’s the case that sticks in my mind. I spoke earlier about euthanasia not being objectionable in some conditions, motor neurone’s one... I suppose that’s partly because of this case”.

Though not supporters of AVE, Harry, Desmond and Hilary ascribed their desire to relieve suffering to a particular experience. Harry said, “I suspect that I’m driven by seeing the absolutely unsatisfactory palliation of cancer in close family members, from a long time ago, and that’s something which seems to be unjustifiable, still. And I would challenge all my palliative physician colleagues (who say that) all pain can be controlled and all forms of suffering can be controlled, because in fact it’s not true. And, some people, I suspect, still ask for this (death to be hastened)”. Desmond said, “The first job I had when I was an intern, was on a Head and Neck unit, where there was this woman dying this most terrible death. And I had a great deal of difficulty dealing with that. And I guess, in a sense, that’s driven me to try to help people avoid that”.

Hilary spoke of his determination to help relieve the distress of patients who want to die, and his distress over one such patient he was unable to help: “There was a woman who had a cerebral tumour which affected her speech, so she was unable to speak sensibly. And she got the message across to me by drawing her finger across her throat, that she wanted to die. After a time of trying to get through and communicate with her, even with the help of speech therapists, it was very difficult to get rational communication. It was really awful, and she committed suicide. She was the only suicide that ever happened at that hospital. But I always felt that it would have been good if we could have done better. I regretted that I didn’t do better… maybe we could have done things differently”.

Margaret told of a summer job as a student working in a hospital with long staying mental patients: “A lot of them had very advanced dementia, and all they were doing was lying in their beds, being fed and having their bottoms washed. And this was thirty
years ago, I remember thinking at the time, that to me it was almost a slippery slope. That once you started thinking that someone else’s life wasn’t worth living, it would be very difficult to know OK, why this life, why not that one? I guess that was probably the time, about thinking about life and death decisions”.

Alison’s key experience left her with a conviction of the value of human life: “It came into focus for me when I went to India, and did some voluntary work in Calcutta, in the home for the dying. I just found that these people clung to life in a way that I couldn’t really explain. They were people that were being picked up off the street, and, obviously in a miserable state, and yet they seemed to have this life force that just defied all explanation to me, and it was quite confronting… And also the nuns were particularly frightened of anything that might shorten life. To the extent, I think, of not allowing adequate relief of suffering. But by being so extreme, it challenged what I really thought was of value... It’s just something about the value of life... it was nothing to do with life being comfortable, or having enough to eat, and having a lot of material things. It was just a very fundamental belief that life was life, and you had to do all you can to maintain it. So I think that was a bit of a key experience, for me”.

8.4.5 Examples
A number of participants used examples other than from their personal experience to illustrate either the distinction (or lack of it) between killing and “letting die”, or their concerns about AVE/PAS. Most of these were of clinical cases from Australia or overseas which had appeared in the media, or well known legal cases of withdrawal of treatment.

Some cited examples of patients who had received AVE during the period when it was legal in the Northern Territory. Three doctors expressed doubts that particular patients had received appropriate palliative care (Hilary) or all the appropriate treatment (James). Paul said, “One of the first cases… was a man who had metastatic prostate cancer and he was having terrible pain and nothing was working… and he was killed. And I believe that he’d never seen a radiation oncologist, and radiotherapy can significantly improve pain for bony metastases in 80 to 90 percent of cases. He didn’t actually receive the full care that we are able to give”.
Brian spoke of a woman who had traveled to the Northern Territory to receive AVE, and become dehydrated: “What did Phillip Nitchzke do? He rehydrated her, so he could kill her. I mean, it was insane. He could have just left her alone, given her some morphine, and she would have died. From dehydration, not a bad way to die. But instead of that, he resuscitated her so that she could die at the time she wanted”.

Others referred to the case of Nancy Crick, a 69 Queensland woman said to be suffering from terminal bowel cancer who suicided by means of a drug overdose on May 22, 2002, in the presence of 21 witnesses. Her case was widely publicized by Dr. Philip Nitschke and Exit Australia as indicating the need for liberalization of laws on assisted suicide (Anonymous, 2002). However it subsequently emerged that both Mrs. Crick and Dr. Nitschke had been told she was cancer free two months before her death. Dr. Nitschke acknowledged that in hindsight it was a mistake not to have revealed this but said that “euthanasia” should be available not only to terminally ill cancer patients but also to chronic pain sufferers (Jackson, 2002). A postmortem revealed that she was indeed cancer free when she died (Anonymous, 2004).

Dot expressed doubts about how free Mrs. Crick’s decision to suicide had been, and to what extent it had been orchestrated by Dr. Nitschke. James said that one of his major concerns was that “one of the strong proponents of the euthanasia lobby just doesn’t have much experience looking after terminally ill people”. Both he and Tom, who described it as a “terrible situation”, thought that she had not received adequate care and was probably seriously depressed.

Gordon also referred to the mistaken diagnosis, as did Annette: “I guess that concerns me a bit”. However Paul felt that in her case “(there) is a stronger argument for euthanasia than saying ‘I’ve got cancer and I’m going to die from it’… ‘I’ve suffered terribly from this and I’m going to live another twenty years with this awful short gut syndrome’… That’s the sort of case where (legalized AVE might be appropriate)”.

Bill cited another case of mistaken diagnosis from Holland: “There are some terrible stories. There was the guy with terminal lung cancer, who was euthanased, without being asked. Postmortem showed he had TB. Bit of a worry isn’t it?”
Several participants also referred to legal cases. The 2003 Victorian case of BWV was mentioned by Alison and Walter, and discussed in some detail by Andrew, Judith and Vivienne, who were in basic agreement with the opinion that PEG feeding is a medical treatment which maybe withheld or withdrawn. Harry referred to a very recent Victorian case of attempted murder which left the victim apparently in a permanent vegetative state, and where the decision to remove PEG feeding had been made by her legal guardian, the Public Advocate.

Both Hilary and Andrew used the example of Karen Quinlan to illustrate the uncertainty of the result of taking someone off a ventilator, and the fact that doctors may be wrong in their prediction of the outcome. Nathan used the case to illustrate that people can be maintained on a ventilator for years, and Andrew that they can be maintained on PEG feeding for many years.

Andrew referred to the case of Terry Schiavo, who died during the period in which interviews were conducted, saying he thought there was some (though slight) possibility of being surprised by patients like her (in PVS) waking up, even after many years. But both Robert and Walter though that “allowing her to die” by removing her PEG feeding was unacceptable. Robert found it unpleasant and “offensive”, and thought that the process should have been speeded up by a lethal injection. Walter said that he could see no place for a lethal injection in such cases, but that he was not convinced people in PVS would not suffer during the process: “If you look at these patients, they have episodes where their body stiffens, they grimace and go very red in the face, they’re responding to some stimulus which seems to be disturbing them”. He said reports suggested this was the case with Terry Schiavo, and that if there was any doubt that such patients were suffering, maximum palliation with deep sedation should be given, which would shorten the dying process.

Nathan was the only one to use a non clinical examples of the distinction between killing and “letting die”. Nathan referred to people in Darfur and Bangladesh being killed in warfare or natural disasters, “and we’re not doing anything about it ... We’re “letting them die”, as it were. That’s quite distinct from me going out and shooting somebody”.

8.5 Common Ground

Whatever their views on the morality of AVE or the nature of the distinction between killing and “letting die”, there were four things on which all participants agreed. The first was that it is permissible and sometimes obligatory to withhold and/or withdraw life-saving or life prolonging medical treatment under certain circumstances. The second was that doctors have a moral obligation to relieve suffering. The third was that doctors are very unwilling to kill a patient directly (as with a lethal injection), and the fourth the conviction that, if AVE legalized, doctors should not be forced by law, and would not be morally obliged, to perform it.

8.5.1 Permissibility of, or obligation to, withhold or withdraw treatment

A number of doctors stated their obligation to respect patient refusal of treatment, including Richard, Brian, Margaret and Vivienne. Oliver, Andrew and Annette said that this applied even when they disagreed with the decision on medical grounds: “If the patient’s competent, and they don’t want that, then I think that’s their choice, and I think that’s fine. I might try very hard to convince them otherwise, if I don’t agree with it, but if that’s what they chose, I’d support them in that” (Annette).

But some doctors recounted how difficult they found it to accept a competent patient’s refusal of potentially curative or significantly life prolonging or beneficial treatment (Nathan, Tom, Paul and Oliver). Bill put it the most strongly: “It distresses me greatly, to see patients with curable cancers who wander off into Laetrileville 44 or wherever, and die. And where I am personally involved with those people, I will invest as much time as I can to try and help them see that there is a genuine chance of cure (if they) go down the orthodox road”.

Some doctors referred to withholding of withdrawing treatment because it was futile, and the concept of futility was used in three ways. The first was to indicate treatments which had very little or no possibility of changing the course of the illness in any way (Andrew, Ruth, Ian, Harry and Michelle). Bill referred to futile treatments as “physiologically impossible”.

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44 Laetrile is an alternative, unproven anticancer therapy, the active ingredient of which is thought to be cyanide.
Futility was also associated with treatments which might prolong life, but by an amount insufficient to justify the treatment (Bill). As Desmond put it: “Sometimes we don’t treat things that are treatable, because there’s no net gain from them. I mean, that patient might die a day before they would otherwise have died”. And the term “futile” was also used of treatments (particularly ventilation and tube feeding) which might significantly prolong life, but could not reverse the underlying pathology or improve “quality of life” (Hilary, Craig, Margaret, Bill and Annette).

Brian said, “The other way (that we ‘let people die’ in intensive care), which perhaps is more common, is that we withdraw treatments. We turn off certain drugs, take people off the ventilator. Again, because in our clinical assessment, those treatments have become futile for that patient. They’ve become burdensome. They’re not achieving a goal of cure, or restoring the patient back to a function, there’s no prospect of that person returning to a level where they would have a good outcome, in terms of function, or what they would see as having a good outcome”.

Brian’s comment illustrates that assessment of futility can involve balancing the cost or burden of treatment to the patient with the magnitude and/or likelihood of benefit. Ian also associated futility with assessment of the burdensomeness of the treatment: “If they’ve got a belly full of tumour and you know they’re not going to survive, there’s no point in subjecting them to the hardship of an intensive care unit. We do pretty awful things to people, down there, and they’re painful and uncomfortable, and if they’re futile, then there’s no point”.

Others also spoke of weighing the burden of treatment against potential benefit (Alison, Craig, Andrew, Paul, Oliver, Ken and Desmond). Dot put it most succinctly: “If treatment at the end of life becomes intolerable it must be withdrawn”.

At the end of life, even simple treatments were sometimes withheld by doctors as prolonging life was not judged to be of any benefit (Paul, Margaret, Vivienne and Ian). As Desmond put it: “You might decide not to give them another course of antibiotics when they’ve had three or four courses, and they’ve all resulted in minimal improvement. Just to prolong things when nobody wanted it prolonged”. 
Some doctors referred to situations where they believed medical treatment which postponed death would not be in the patient’s best interests (Brian, Bill, Ian). As Tom said, of an unconscious patient on a ventilator with no hope of recovery, “Maintaining life for maintaining life’s sake as a long term phenomenon is not appropriate. Nor do I think it’s in the patient’s best interests, or respects their dignity or autonomy”.

In some cases, treatments judged to be inappropriate were either not offered or withdrawn despite the wish of the patient (or family) to begin or continue them (Tom, Kate, Oliver and Ian). Examples included surgery, chemotherapy and admission to intensive care. Ruth said, “When there has been a decision made not to offer things, that is more problematic, when you’ve got a family who insist that something be done that is not being done… but I wouldn’t agree to do something that I really believed was not in the patient’s interests, just ’cos we were pushed by someone”.

The specification of certain conditions under which treatment withholding or withdrawal is permissible implies that there are other situations where it is not, and such situations were mentioned explicitly by some participants. Ian indicated that, generally in medical practice, “letting die” is not permissible: “Taking lives is not what we’re about at all. And “letting people die” is not what we’re about at all. But sometimes, in the patient’s interests, that’s probably the best outcome”. Dot mentioned a specific example of where “letting die” would be culpable (she later called it “reprehensible”): “In some cases, I think you’re culpable for withholding treatment, say if you’ve got a person who’s bleeding to death and you don’t stop the bleeding and transfuse them”. Both Alison and Judith spoke of the conditions under which they would considered it wrong to turn off a ventilator, and Vivienne of when it would be wrong to discontinue PEG feeding. Some doctors indicated that it would be wrong to accept a patient’s refusal of potentially life saving treatment which they believed to be in the patient’s best interests (and so fail to treat) without ensuring that the patient was competent to make the decision and that they fully informed, and without reasonable attempts to persuade them to change their mind (Nathan, Paul, Margaret, Oliver and Bill).

8.5.2 The obligation to relieve suffering
The moral obligation of doctors to attempt to relieve pain and suffering was implicit in the responses of all participants and explicit in those of many. It was also agreed that this obligation obtained even if it sometimes required the administration of analgesia
and/or sedation in doses which might hasten death (Tom, Gordon, Kate, Paul, Judith, Bill, Annette, Walter, Natalie, Ian, and Desmond). As Mark said, “If palliating means that they might die a little bit faster, or might become unconscious a little bit sooner, or develop pneumonia as a consequence a bit sooner, well so be it. I would not withhold a dose of medication that could potentially be lethal, just because it could potentially be lethal. I would administer the dose, if I thought it was necessary to alleviate pain, or suffering”.

8.5.3 Medical unwillingness to kill
Clearly those doctors who believed it was wrong to kill a patient were not willing to do so, but some participants expressed this in very strong terms:

Hilary spoke of his “antipathy towards killing people”, and James said it was “not something that I would ever consider”. Mark said it was something he disagreed with because he “personally couldn’t do it”, while Bill described it as “undoable” and Ian as “anathema”.

This unwillingness was felt even by those who agreed that AVE could sometimes be morally justified in principle, and could not explain their reluctance to perform it (Kerry, who also described it as “anathema”, Craig, Gordon and Paul).

Michelle said, “I’m not against euthanasia... But I still just, myself would not feel comfortable actually carrying the act out... I myself would not ever want to be involved in shortening someone’s life, but... I believe in people being able to make their own choices in life... I wouldn’t have an objection to someone making that choice to shorten their life... So why is it that I wouldn’t want to be involved? I almost don’t know other than to say, it would just feel wrong. And it would go against something very deep seated inside of me, it wouldn’t feel right to do it”.

This unwillingness was also felt by Harry, who had some doubts about whether there was a significant moral difference between their practice of sedation which probably hastened death, and a lethal injection. “I think (the objection to) being the proximate cause of death.. is deeply imbedded. I’m not prepared to do it, let me put it that way.... Well I wouldn’t inject somebody with... I’m definitely not going to try and do that, to a person, I find that really quite difficult”.

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And this unwillingness was also recognized and experienced to some extent by the two doctors who were on the public record as being in favour of the law being changed to allow doctors to “assist patients to die” and as having themselves done this. These doctors did not think that there was a necessary moral difference between a lethal injection and medical forms of “letting die”:

Robert said, “It is a significant and fairly traumatising thing… which nobody chooses to do… No caring individual chooses to end life, unless they really believe that that is a kind act, which they can justify to themselves… I mean, you would choose not to kill somebody. It’s not an easy decision to have your pet put down, is it? It is a much greater decision to have your mum put down. It is sometimes appropriate for your pet, and is sometimes appropriate for your mum. But it is more difficult, the closer you are to somebody. But I don’t think it’s any more wrong to assist your mother”.

And Walter: “It’s an emotional response, as much as anything. In that I as a doctor, and most human beings have the greatest reluctance to directly end somebody’s life. You may think that that’s odd, since you know that I’m an advocate of voluntary euthanasia, but I regard the delivery of a lethal injection by the doctor as an absolute last resort. Absolute last resort... I think that’s just asking, in most circumstances, just far too much of the doctor”.

Alison also commented on the unwillingness of a high profile AVE/PAS advocate to actually perform AVE: “I was always fascinated by (Dr. Philip) Nitschke coming up with some machine. Even Nitschke couldn’t quite bring himself to be the one to actually give the injection”.

8.5.4 The doctor’s moral autonomy
Many participants stressed the importance of doctors making and acting on their own moral decisions, whatever their views on the morality of AVE and PAS, and whether these practices should be legalized.

Nathan spoke of executing “my moral imperative, what I felt was the correct thing to do”, and Oliver of “sticking with what I believe”, and not “compromising myself, for the patient”. Both Paul and Ian felt doctors had a professional obligation to make
judgments and take moral responsibility for them: “We’re not, although a lot of people see us as glorified shopkeepers… part of the job is to use your judgment and to give your input on what you feel is the right thing. That’s what I do for a living, and so, I’ve got to have some part in the judgment” (Paul).

In particular, participants stressed that doctors should not be obliged legally or morally to perform AVE or PAS against their own moral judgment (James, Tom, Michelle, Oliver, Ian and Desmond). Andrew described the situation where a doctor was morally obligated to perform AVE, if it were legalized, as “your Nazi sort of scenario” and said, “You eventually have to be guided by conscience”. Mark also spoke of the importance of a clear conscience, and Kate of the doctor’s own values and beliefs being considered.

Brian said he would only be willing to provide what he believed was a valid treatment option: “Suicide is not on my list of valid treatment options for you”. He implicitly repudiated the model of the doctor-patient relationship which sees the doctor as a service provider and the patient as a consumer whose values take priority over those of the doctor: “The medical profession in some ways has relinquished too much control to the consumer”.

Alison and Tom said they knew that they might be accused of paternalism: “It’s almost shouted down that doctors have any say in influencing that decision, because it’s seen as paternalistic, and so forth: if the patient feels that they want to have euthanasia then that should be enough, almost… But we would reserve the right to be allowed to practice within our given medical framework” (Alison). Tom said, “I may be accused of paternalism, in that I’m making a decision that’s contrary to what the patient wants, but at the end of the day I have to do what I feel is appropriate, what’s morally correct.. That’s why we can go to bed at night”.

The two participants who were advocates of AVE and PAS agreed that no doctor should be obliged to perform them against their moral judgment:

“I would like every doctor to feel comfortable with it... But again, I am pro-choice. If a doctor doesn’t feel comfortable with it, they mustn’t be compelled to do it” (Robert). And Walter said, “I think all proponents of legislation would accept that a physician has got a right to say no…. If you have an intense Christian belief that doing that is morally
wrong, then there’s no way you should be forced to do that. Because who’s making the moral judgment that it should be done? The patient may be saying they think this is a moral act, other doctors may think so, but it's the doctor who is involved… You can’t force somebody to do what they consider to be an immoral act”.

The exercise of medical moral autonomy in relation to AVE and PAS related not only to the freedom to decline to be involved at all, but also included, for doctors who would or might be willing to be involved, the doctor making his or her own independent assessment of whether a request should be acceded to:

“I wouldn’t feel comfortable prescribing euthanasia for someone who still had other options which were potentially going to make them feel better or improve their quality of life” (Craig). “I’ve got autonomy too. There’s a balance of autonomies. I respect your autonomy, you might want to die, but… I’ve got to be convinced that your suffering is sufficient. There’s an element of judgment on my part… At the end of the day, you are the only person who can really judge your suffering. But at the same time, you’ve got to convince me that it’s real and genuine, and that there is nothing that can be done, to alter that” (Walter).
Chapter Nine  Theme 1: “Taking control”

9.1 Introduction
In this chapter I describe the way that participants distinguished conceptually and morally between killing and “letting die”, as the first theme to emerge from the data, that of “taking control”. This phrase seems to capture the essence of the way that participants thought about the distinction. I describe the seven criteria used to make the conceptual distinction, and whether participants also made a moral distinction. The three doctors who denied that there is any moral significance to the distinction did so on the basis of consequentialist reasoning, but most rejected such reasoning. I also describe the way participants thought about “terminal sedation” and physician-assisted suicide, in relation to whether they would describe these as “killing” or as “letting die”

9.2 Criteria which distinguish killing from “letting die”
Medical decisions and actions which were described by participants as “letting die” fell into two broad categories: the withholding or withdrawal of life-prolonging or potentially life saving treatment (which I shall call category 1), and the administration of drugs for symptom relief in the dying patient, which potentially hastened death (category 2). In addition, some discussed the distinction between physician-assisted suicide by means of providing a prescription for a lethal quantity of drugs, and the use by a patient of prescribed drugs to suicide, without the knowledge of the doctor (category 3). Participants discussed seven criteria in total, which they used to make a conceptual distinction between killing and “letting die”.

9.2.1 Criterion 1: That it involves an act, not an omission
The difference between a lethal injection and the withholding or withdrawal of potentially life-saving or life prolonging medical treatment was frequently described in terms of the distinction between an act and an omission (Hilary, Nathan, Alison, Kerry, Gordon, Paul, Vivienne, Ruth, Mark and Harry). “Not treating someone is certainly different to actively shortening someone’s life… It’s easier to let someone die quicker by omission, and also easier on my conscience” (Craig). Craig was the only participant to note a difference between acts and omissions in the medical context in terms of the difference between patient requests and patient refusals: “This is also a different thing, between requesting euthanasia or requesting not to have
active treatment. I would be complicit in not doing active things, if that was the patient’s wishes”.

Robert, who did not think there was a necessary moral difference between killing and “letting die”, nevertheless spoke of the difference between them in terms of one being active and the other not: “I suppose ‘killing’ is a way of expressing active participation, but in reality, of course, ‘letting go’, while it appears inactive, is in fact taking no steps, and so that’s an equivalent decision, in my mind”.

But Walter did not allow that such a distinction makes sense, and described as simply different “actions” all of the following: “not treating and letting die, or withdrawing treatment and letting die, usually with some palliation, or giving medication that the patient might take, or giving medication which actually specifically might hasten their death in quite a clear manner, they’re all just points on a spectrum, of palliating that particular patient. So to describe one as “killing”, and the others as not being killing, I think is misleading, just a use of words. And I don’t see a distinction, to me they’re all essentially palliative acts”.

Sometimes the withdrawal of medical treatment (such as ventilation, artificial feeding or an external cardiac pacemaker) involves a bodily action (switching a switch or removing a tube) whereas withholding such treatment does not. The withdrawal of such treatments was often perceived as an act or as more ‘active’ than withholding them, or than withdrawing other medical treatments. In relation to other treatments (such as dialysis or antibiotics), participants did not see a morally significant difference between withholding and withdrawing treatment, although many said that the two are often emotionally different for the patient, the family and the doctor. Often it was felt to be more difficult for the doctor and the family to withdraw treatment once started, and participants thought it was better if possible not to begin a treatment that would later have to be withdrawn, while recognising that uncertainty about the diagnosis or prognosis often means this is not possible (Dot, Richard, Kerry, James, Gordon, Kate, and Vivienne).

On the other hand, some thought decisions to withdraw treatment may be easier, in that they are made with greater knowledge of the patient’s condition and prognosis, and after
treatment has been tried and judged to be burdensome or inappropriate (Hilary, Richard, Kerry, Andrew, Ruth and Desmond).

Most participants did not see any distinction between withholding and withdrawing ventilation, as they considered the important question in both cases was the same: whether the treatment was appropriate (James, Brian and Annette). As for other treatments, withdrawal could be an easier decision to make because it was thought to be better informed (Margaret). But it was also thought that the greater emotional difficulty in withdrawing treatment was particularly acute in the case of ventilation, because of the ‘active’ nature of the withdrawal. Richard described it as “more confronting”, and Craig said, “I think it’s harder for families to agree to switch off a ventilator as an active measure. It’s harder to actively switch off a switch than it is to passively not resuscitate them once they’ve arrested. So I think there is a difference... A moral difference? No, where it’s been assessed that there is no hope of recovery, I don’t think that there’s a moral problem with turning off a ventilator”.

Three of the intensive care physicians (Ruth, Andrew and Ian) pointed out that withdrawal of ventilation need not involve “switching off the ventilator” or “pulling out a tube” and so need not be an act: “Turning off a ventilator is a very uncommon event. What we would actually do, is we would wean the person off the ventilator. We would let them breathe oxygen, and then, on occasions we would extubate the patient. So, it’s not turning it off, it’s weaning” (Andrew). “By just reducing the pressures and reducing the oxygen, you’re not actually turning off the ventilator, the bellows still work, but the support’s no longer there and they simply die of hypoxia and underventilation… And so it’s an act of omission, rather then the act of commission, which is taking the tube out. It’s uncommon to pull out a tube” (Ian).

However some non-intensivists, who rarely were involved in decisions to remove ventilation, found the idea more difficult. While having no moral problem with withdrawing ventilation from an unconscious patient unlikely to recover, Dot (palliative care) and Tom (oncologist) both found the idea of withdrawing ventilation at the request of a conscious, competent patient so confronting that they thought they wouldn’t do it, although they stopped short of calling it “killing”. “I doubt if I would do that. If the patient’s otherwise aware and competent. Because I do think it’s similar to, but not the same as giving a lethal injection” (Dot). Similarly, Tom said, “That person, they’re
asking me to be their agent, and I’m not prepared to do it. I’d see that as much closer to killing”.

Palliative care physician Nathan was the only participant who made a clear moral distinction between withholding and withdrawing of ventilation, and classified all withdrawal of ventilation (unless the patient was actually brain dead) as killing rather than “letting die”. For him, the act/omission distinction was strictly one of whether bodily movement was involved, and this determined whether it was morally permissible: “Some cultures have the idea that if somebody’s on a life support system (and this is in the Jewish culture, or religion), you are not allowed to disconnect the life support system on the basis that that would be doing something active that would kill them. However, if there were an interruption to the electricity supply, you’re not obligated to reconnect them. You can’t do anything active to shorten life… But what they do sometimes is that they have these ventilating machines on automatic switches, that every 24 hours will stop for one minute. And then you don’t have to restart it”. He went on, “If the patient had not been intubated in the first place that’s a different thing. But once one has partaken of a course to maintain life, I think actively doing something to stop that, is like killing” Asked to clarify, he said, “I think it’s killing”.

Oncologist Harry, who is also Jewish, was not as definite. He spoke of whether there was a difference between killing and turning off a ventilator as an “extremely difficult question”, but while Desmond (oncologist and also Jewish) said of the distinction between killing and “letting die”, “It’s a fairly simplistic case of the difference between omission and commission”, he denied that turning off a ventilator was killing because it involved action (“That argument doesn’t have any attraction to me”).

Other participants stated explicitly that they did not regard the removal of ventilation as active, even though it involved (or might involve) bodily action (Tom, Brian). While Craig had previously described switching off a ventilator as “active”, it seems that to him it is not “active” in the same way as a lethal injection: “Administer a lethal injection? That’s stepping over that boundary of withdrawing something active (as in switching off ventilator) versus doing something actively”.
Michelle acknowledged the activity of switching off a ventilator and at the same time denied it was killing: “I don’t see stopping something which is artificially keeping someone alive, as actively killing them. I think that’s actively letting them die”.

Hilary, Richard and Kate told of having made decisions to withdraw artificial feeding. As with removal of ventilation, even when withdrawal of feeding was not seen as morally different from withholding, it was perceived by those who were faced with the decision in their practice as a more difficult emotional decision for both family and doctor (Natalie). “While I don’t think they’re different, I don’t think that lay people see it that way... I’ve never had a family agree to cease them. Patients have usually died with PEG feeds running” (Kerry).

Gordon and Kate said that they did not regard the removal of artificial feeding as “active”, even though it might involve bodily action. But for Mark, the active nature of withdrawing artificial feeding made him very reluctant to do it: “If you made a decision from the outset not to implement PEG feeding, then you weren’t putting yourself in a position where you have to actually actively remove something… It becomes very difficult to actually make a decision to stop it... It’s a lot easier to say, we won’t start it, because at least that way we’re not doing anything, actively, to hasten death”.

Desmond called the withdrawal of artificial nutrition and hydration killing rather than “letting die” despite his disquiet about it: “If in fact her wish had been stated that she didn’t want to be in that state, then I think you’re basically letting them die, not necessarily killing. But it’s a very fine line. I don’t feel comfortable about it… I don’t have a strong feeling one way or the other, I just have some disquiet”.

While comfortable with the withdrawal of ventilation, intensive care physician Ian initially struggled with the idea of disconnecting pacemaker wires, because it involved a bodily action: “I guess it’s more the act of commission, rather than the act of omission. I’m comfortable to omit doing things, because then it’s the natural history of the disease, which the patient dies from. But if I do something positive, which results in the patient’s death, then that’s an act of commission”.

Participants often formulated this criterion in terms of (medical) intervention versus non-intervention. They spoke of killing as a medical intervention (Kate, Oliver, Robert
and Mark), and “letting die” by treatment abatement as a decision not to undertake or continue with a medical intervention (Ruth, Desmond). As Andrew said, when asked if he thought he was shortening a patient’s life by removing artificial ventilation, “Well the person would have been dead already. I have prolonged the life, so am I then shortening it? … To me, in ICU all we’re doing is we’re propping up things, until we know what’s going to happen. And, so they’re temporary supports, they’re never really meant to be permanent supports… the natural history of their illness would have been that they would have died, which I have already modified”. James explicitly contrasted killing as intervention and “letting die” as non-intervention.

Harry spoke of the Jewish proscription of intervening either to cause death or delay it: “They’re not supposed to lift a finger one way or the other. Nothing which might make them die sooner, and nothing to interfere with their death”.

Sedation at the end of life clearly involves an act rather than an omission, as was pointed out by Nathan: “If you want to have a meaty conflict between the two (killing and “letting die”), it seems to me, the point of medical intervention that raises this most acutely would be sedation at the end of life. Because there you’re actively doing something, yet trying to retain a certain passivity that you’re not interfering with the dying process”.

Therefore it seems that while most participants would describe all omissions (non-actions) as “letting die”, they would not necessarily describe all medical acts which might precede or contribute in some way to the death of a patient as “killing”.

9.2.2 Criterion 2: That it is artificial, not natural

Another way some participants distinguished between killing and “letting die” was in terms of the artificial and the natural. “Artificial” and “intervention” were linked explicitly by Judith, Alison, Brian, Andrew, Kate and Michelle, and “natural” and “non-intervention” by Margaret and Kerry: “‘Letting die’ is just allowing natural processes to act and not intervening in them”.

Withholding or withdrawing treatment was described by several participants as “letting nature take its course” (Kerry, Michelle, Margaret, Judith, Ruth and Ian), including two who were in favour of AVE under some circumstances (Craig and Robert).
A number of medical treatments, including ventilation and PEG feeding, were described as artificial, so that “letting die” was seen as refraining from doing something artificial (Richard, Kerry, James, Brian, Michelle, Oliver, Annette and Natalie), although Ken used the term “abnormal” rather than artificial. Vivienne expressed it very vividly: “If there’s a zero chance of recovery, and you are, I do think, artificially, invasively, prolonging that life, I do think you can make a case for removing the artificial, invasive thing… Just because a treatment exists, doesn’t mean we’re duty bound to assault people with it”.

Ian resolved his difficulty in disconnecting a pacemaker wire by appeal to this criterion: “What’s the difference between that (a lethal injection), and removing a pacemaker wire? The difference is to me quite clear cut. The pacemaker wire is an artificial medical support, of an ailing heart”.

While Mark spoke of disease terminating a patient’s life naturally, Michelle described killing as “interfering with that natural process” and Brian as “artificial”, and Kate contrasted the two: “(Lethal injection) is in some ways artificial, it’s putting something into somebody’s body that’s not part of the natural process. And that’s where I see the distinction. By withdrawing nutrition, etcetera, the natural process is what’s leading to the person’s death, rather than putting something artificial... or actively altering the natural process”.

Michelle found it hard to explain why a distinction between the natural and the artificial should be important: “I see that as wrong, to give them a single injection because I think we’re playing God in doing that.. You know, we’re playing with nature but we do that anyway as doctors, so, oh God! I’m talking myself into corners left right and centre… Maybe I need to go away and think about it more”.

Several participants spoke of the need to acknowledge that because death is the natural and inevitable end to life, there comes a time when this should be recognized and interventions aimed at prolonging life withheld or withdrawn. Otherwise, death is being inappropriately postponed (Kate, Alison, Oliver and Bill). As Kerry put it, “When people have accumulated illness after illness after illness, that keep getting interrupted, then you haven’t let nature take its course, but there comes a point where you say,
enough. This person is so miserable, is so disabled, let’s just let this accumulation of illnesses do what they’ve been trying to do for so many years. And so you let all their illnesses kill them. Paul and Oliver spoke of the person’s own body “making a decision” or “trying” to die, and medicine either “not propping it up any longer” (Paul) or “trying to stop the process” (Oliver).

Though it clearly involves a medical intervention with an artificial substance, four doctors described the administration of analgesia or sedation at the end of life in terms of allowing nature to take its course (Michelle) or not changing the natural course of the illness (Nathan, Richard and Bill). Harry described it as allowing “some other natural processes to intervene, and bring about the death”.

9.2.3 Criterion 3: That the doctor causes death, not the underlying disease

Many doctors distinguished between killing and “letting die” by withholding or withdrawal of treatment on the basis of whether the doctor or the underlying disease causes the death (Dot, Hilary, Richard, Nathan, Alison, Kerry, James, Tom, Brian, Andrew, Kate, Vivienne, Ruth and Desmond). Ruth said, “Even though the end result might in some, in most circumstances be the same, it’s just who’s the person that’s doing it. That’s taking the person’s life. If I inject something, then it’s me that takes the person’s life”. Alison referred twice to the doctor being the agent of death in AVE.

For these doctors, causation was relevant to the moral distinction between killing and “letting die”, as they believed it was wrong to cause death. “It’s ethically wrong to cause people’s death. It’s wrong to go and push someone in front of a train. And it’s wrong to kill someone who’s on a ventilator with a terminal illness. I can’t find a clear line of distinction between causing death by any means, whereas I can find a clear line of distinction between withdrawing inappropriate treatment and intentionally causing death” (James). “I was willing to assist her to die comfortably if she was dying herself, but I didn’t want to be the sole cause of her death (Judith).

Neither of the PAS advocates attached any moral significance to this criterion, but for different reasons. While Robert agreed that when a feeding tube is removed the patient dies of the disease, whereas in administering a lethal injection the doctor causes death, he did not believe it was wrong for a doctor to cause death, and thought both decisions could be described as a decision to end life: “This is just a matter of timing, if you, as
the doctor, have decided that a patient is going to die, in the next day or week, but to
make that exit from life most comfortable”. Walter, however, found the distinction
completely unconvincing because he thought that, at least in the case of withdrawal of
ventilation, the doctor did cause the death: “It’s said that it’s not the withdrawal of
treatment that kills the patient, it’s the original disease. That’s sophistry really. The
patient would go on living if the respirator was still there, so the act of removing it does
in fact end the patient’s life. And it’s a decision to end life. I just see the distinction is of
method”.

Nathan implied that removing mechanical ventilation causes death: “That would be
doing something active that would kill them… You can’t do anything active to shorten
life”. Both Kate and Margaret initially thought of withdrawal of ventilation as causing
death, but, on further reflection, each decided that it was in fact the underlying disease
which caused death. No other participant thought of withdrawal of ventilation as
causing death: As Michelle put it: “The difference for me, is that you’re just removing
an artificially life-prolonging treatment, allowing death to happen naturally… Rather
than actually being the person who actually causes the death by a direct action. You’re
not actually killing them by taking them off. What you’re doing is removing a life-
prolonging treatment”. Despite her reservations about switching off a ventilator in some
circumstances, Dot did not see it as killing because she did not see it as causing death:
“It is similar to, but not the same as giving a lethal injection, because here again it’s the
disease that will kill the person, the fact that they couldn’t breathe”.

Similarly, despite the emotional difficulty he felt, Mark classified withdrawing PEG
feeding as “letting die” rather than killing, and as something he would do, though
reluctantly, on the basis that it was the underlying disease which caused death: “I think
the moral difference is that when you give them a lethal injection, they’re dying from a
lethal injection. When you stop their feeding, they die from their disease, which was
there in the first instance. Given that without this device they would succumb to their
illness, I don’t see it as euthanasia to withdraw that device. But it does play very much
on one’s conscience when they do participate in that. And, participate in that is as far as
I dare go. Unwillingly. Kicking and screaming”.

Andrew used the criterion of causation to explain his opposition to removing PEG
feeding from someone in unresponsive coma: “What kills them is not that they’ve got a
disease that will kill them, because they can stay alive for years and years, as evidenced by Karen Quinlan”. However he was not opposed to removing PEG feeding from people with other diseases which would be lethal in themselves, “People with other diseases, like worsening heart failure or declining brain function from a progressive sort of disorder, that is what’s actually going to terminate the person. Their inability to eat and drink isn’t the only thing”. However, while saying that he would abide by Catholic teaching, he also admitted that “Personally, I still think that, in an unresponsive coma, using PEG tubes and things is pushing us to the limit”, and that “ I might debate in my mind that a Terry Schiavo sort of case might be reasonable not to have a PEG in. I still think that PEGs are a very intrusive sort of thing. And I worry about their complications. I don’t think they’re as harmless as everybody says”.

Nathan regarded the withdrawal of food and fluids as killing on the basis of causation: “Let’s say stopping food and fluids, well that’s the same as killing, isn’t it, if somebody otherwise can’t eat? If you didn’t feed a child that was newborn, you’d be charged with killing, not just passive ‘letting die’”, and Harry suggested the same thing, at least for patients who could perhaps survive for years with artificial feeding. In referring to the case of Maria Korp, he said “They’re actually causing her death... the process is going to be terminated, that has kept her alive. We’re all dependent on this life line of water and food, if someone cuts it off, they kill us. Whether it’s children in Africa being starved because the food lines don’t get to them, or whether it’s because we pull out a nasogastric tube”.

Ian also used the criterion of causation to justify removal of pacemaker wires, despite his initial reservations: “I’m comfortable to omit doing things, because then it’s the natural history of the disease, which the patient dies from”. When he was asked if the patient also died of the underlying disease when pacemaker wires were disconnected, he replied, “Sure. That’s why it’s inconsistent. And I recognize that”.

Two palliative care physicians (Nathan and Hilary) thought that the way they used analgesics and sedatives, and the way they ought to be used, meant there could be certainty that they did not contribute in any way to causing or hastening death. Hilary said, “For many years it was believed that it might be necessary to poison the patient to get adequate pain relief. There was a poor understanding of the methods of relieving pain, and the drugs that could do it and the doses of those drugs. I don’t believe for a
moment that you take a risk of killing them. And I think that not enough doctors know a way of managing pain without using analgesics in a way that kills people”. Neither did he think that sedation, properly used, would hasten death: “it’s a matter of monitoring how much drug you use and how things go. And it can be done in a sensible way, that doesn’t kill people”.

Three palliative care physicians (Nathan, Alison and Bill) referred to studies which had shown that there was no evidence that either analgesia or sedation hastened death. “There was an article in *Lancet Oncology* which showed that there was no evidence that the use of drugs in the terminal phase shortened life” (Bill).

Although he said this was a “grey area”, Harry distinguished between sedation which he thought would definitely hasten death, and a lethal injection, on the basis of whether the doctor or natural processes (such as pneumonia) actually caused the death: “One allows some other natural processes to intervene, and bring about the death, the other one immediately causes the death”.

**9.2.4. Criterion 4: That death is certain to result**

The distinction between killing and “letting die” was also expressed in terms of how certain the doctor could be that death would in fact occur after a decision to intervene, to cease intervention or not to intervene had been implemented.

Many participants noted that the outcome of withholding or withdrawing treatment was uncertain, since the doctor could not know whether the underlying disease would cause death, and the patient may not in fact die. This was compared to giving a lethal injection, where the outcome was certain (Kerry, Ruth and Vivienne). “A lethal injection is an absolute, whereas not participating in a treatment reduces their chances of survival, but it’s not an absolute. I suppose that’s the distinction I have” (Alison).

Several referred to this uncertainty even in the case of withdrawal of ventilation, where it is often assumed that death is sure to result (Tom, Andrew and Judith). “You can take some people off a ventilator, and they do survive. So you don’t know for certain that somebody’s going to die if they come off the ventilator. It’s extremely likely, in that situation, but it’s not certain” (James). Hilary and Andrew referred to Karen Quinlan and intensivists Ian and Brian recounted examples from their personal experience of
patients unexpectedly surviving the withdrawal of ventilation: “I can remember a woman, some years ago, with some sort of chronic neuropathy, and she’d been on a ventilator for weeks without improvement. She was completely lucid, and she made the decision that she no longer wanted to have that treatment. We discussed it with her family present… What actually happened is, she got better. She actually didn’t die. She looked like she was going to die for twelve or twenty four hours, and then she just rallied. And she went home, and actually got back to playing golf again. That’s an unusual case, but…” (Brian).

In relation to “letting die” by the use of sedation or analgesia which potentially hastens death, the question of certainty related not to whether the patient would die or not (as this was generally only envisaged being used for terminally ill patients), but whether death would be caused, directly or indirectly by this treatment, and thereby hastened. There was some disagreement about this.

As reported in the previous section on causation, two of the palliative care physicians (Nathan and Hilary) thought that the way they used these drugs, and the way they ought to be used, meant they could be certain that they did not contribute in any way to causing or hastening death. Alison and Bill stated that there was no evidence that the use of sedation/analgesia shortened life, although in some cases this might be a possibility.

A number of other participants, particularly palliative care physicians, were confident that analgesia at least could be used effectively without shortening life (Dot and Margaret). “People talk as though opioids are hastening death, and I really haven’t seen any great proof to back that up. Not if you’re actually using them in the way that we do. Certainly if you suddenly whack someone on massive doses, you’d be hastening them, which is not really the way that we go about it. I think it’s not well understood” (Annette).

Although less confident about it, some of these doctors, and others, expressed doubt about whether effective sedation does necessarily contribute to causing death (Dot, Richard, Margaret, Natalie and Desmond). “I’ve never actually been convinced that the use of sedation, or the side effects of sedation has actually hastened death” (Vivienne).
A number of doctors stressed the difficulty of knowing for certain in many cases whether death had been hastened by medical treatment, given that the time of a patient’s death cannot be predicted with certainty (Kerry, Michelle and Harry). “There’s no way of proving whether it’s shortened their life or not. I don’t think it does make a particular difference to the duration of someone’s life, particularly if they’re in the last few days” (Craig).

The uncertainty of the results of therapeutic administration of analgesia or sedation was sometimes contrasted explicitly with the certainty of death following a lethal injection properly administered (Dot, Michelle and Judith). “Although you might be applying the same sort of drug recipes, dying’s something that does happen in its own good time, even with medical intervention, with sedation, it can be very variable… ‘Cos some people are very resistant to drugs… But your framework is that you’re using them therapeutically. When you’re killing somebody, you’re presumably escalating the dose to a level that you are quite certain will have the effect of killing the person, quickly. Which is very different” (Natalie).

Robert agreed that a lethal injection produced a more certain outcome than sedation, but did not think this made any moral difference, only serving to make doctors who used the latter feel less uneasy: “They find that comforting. Potassium is more speedy, and you are more certain of the outcome. I think they are choosing to comfort themselves”.

Others referred to situations where analgesia or sedation most likely did sometimes shorten life, either directly through respiratory depression, and/or indirectly through a complication of a reduced level of consciousness such as pneumonia (Kerry, Tom, Gordon, Kate, P17: 098; Paul, Judith, Annette, Mark and Ian). “In that situation where high doses are given, a side effect of that may be to cause reduced levels of consciousness, and that can lead to complications, such as pneumonia, or other things which may cause death” (James).

Both Harry and Walter referred to the use of heavy sedation so that the patient remained asleep as definitely life shortening. Harry recounted a case where “we set up an opioid drip and diazepam. Now that’s definitely life shortening, there’s no doubt in my mind, that setting that process up shortened his potential life”. Despite his unwillingness to
give a lethal injection, Harry found it difficult to distinguish between this and the practice he had just described: “I think that it is intellectually difficult to separate the two… they both coincide at the end of the day, with the same outcome. And there is a grey area there and I think it’s an irreducible grey area”.

And Walter said “If you’ve got a person who may be going to die in two weeks, and you provide them with terminal sedation, that puts them to sleep and keeps them asleep, because of their severe suffering, if you do that it’s highly likely that it will hasten their death”. He did not distinguish morally between this and a lethal injection: “They’re all just points on a spectrum, of palliating that particular patient. So to describe one as ‘killing’, and the others as not being killing, is misleading”.

The concept of certainty is related to that of irreversibility. Four doctors used the question of whether the decision could be reversed if the patient’s situation improved or if they changed their mind, to make the distinction between killing and “letting die” by either treatment abatement (Oliver), use of drugs which might shorten life (Nathan, Desmond) or both (Dot). Mark also emphasized the irreversibility of killing, and Alison said that this was her fundamental objection to it. All these doctors had a religious faith. However Richard, who did not, also referred to as “comforting” the fact that several patients who had been deeply sedated were able to wake again following gradual withdrawal of the drugs, suggesting that he also was using this criterion.

The certainty of the result of a lethal injection was also compared with the uncertainty of medical diagnosis and prognosis, in terms of the possibility of being wrong in predicting that a patient will die soon, or even die at all of the diagnosed disease, with or without treatment. Bill referred to a Dutch patient who had been “euthanased” and subsequently found to have been misdiagnosed with terminal lung cancer. Desmond said, “I don’t know that we want to go round shortening it (human life) for reasons that may or may not be accurate in retrospect. There’s an article in the MJA analysing the deaths of patients (in the Northern Territory) who were supposedly euthanased. And most of those cases there was considerable doubt about the legitimacy of the diagnosis on which that decision was made. And I find that very disturbing”. As Paul said, “Even though medically you think there’s no chance of this person recovering, the thought that’s in the back of my mind, even with all my training is ‘What would happen just in
case we were wrong, in case there was something that was reversible?”. Nathan also referred to the possibility of an unexpected cure being found.

9.2.5 Criterion 5: That death is intended, not merely foreseen

The criterion mentioned by most participants, in relation to the distinction between a lethal injection and “letting die” by withholding or withdrawing treatment and/or use of potentially life-shortening medication in the terminally ill, was the intention of the doctor. Some also spoke of the “deliberateness” of a lethal injection (Richard, Nathan, Alison, James, Tom, Kate, Michelle, Bill and Ruth).

In relation to the distinction between a lethal injection and withholding or withdrawal of medical treatment, seventeen of the doctors referred to the doctor’s intention or aim being different in the two cases, with the intention being to cause the death of the patient in the former, but not in the latter (Dot, Hilary, Richard, Alison, James, Tom, Brian, Andrew, Michelle, Margaret, Judith, Oliver, Bill and Annette). And having said that switching off a ventilator was killing because it was active, Nathan nevertheless seemed to distinguish it in some way from a lethal injection on the basis of intention.

The intention in treatment withholding or withdrawal was usually not specified, but Hilary said it was to “see how it goes”, Richard to “respect that death is part of life’s experience”, Andrew to let the illness take its course, Michelle “to allow the patient to die naturally”, Brian to “remove futile treatment”, and Ken to discontinue a treatment (ventilation) which “would have no good consequence in terms of a useful and fruitful life. It’s as simple as that”. However, Gordon, Michelle and Alison thought some doctors could intend the patient’s death in withdrawing treatment.

In relation to the distinction between a lethal injection and the use of medication which might potentially shorten life, whether they were confident that analgesia/sedation did not shorten life, or were uncertain about it, or were convinced that sometimes it did, the majority of participants thought that the distinction lay in intention. This was also expressed as the doctor’s aim, purpose or goal, what the treatment is designed to do, what the doctor is trying to achieve or was focusing on, and what is done deliberately. The intention of a lethal injection was to cause death, the intention of analgesia/sedation the relief of symptoms (Dot, Richard, Nathan, Alison, Kerry, James, Craig, Tom, Gordon, Kate, Michelle, Paul, Bill, Annette, Vivienne, Natalie, Mark and Desmond).
“As long as the primary intent is that you’re trying to relieve symptoms, and that you think about it, and weigh the risks up, informed by the patient’s values as best you can, then to me that is not killing” (Richard).

Although he did not use the word “intention”, Ian also implied a significant difference between foreseeing and intending death when using symptom relieving medication: “I’m quite comfortable giving people plenty of morphine to keep them comfortable, and I don’t see that as a soft cop, and I don’t see it as... splitting hairs. It’s just keeping somebody comfortable, and if the natural process is that they die from hypostatic pneumonia, well so be it. But I think giving somebody, an elderly lady, 20 or 40 mg of morphine, that’s a serious act of commission”.

Harry thought that bringing about earlier death might be at least part of the intention in some cases of sedation: “If what they give you means that you’re going to get pneumonia within the next twenty four hours, because that’s what usually happens, is the intention that you’re going to die? Probably. It’s probably there as part of the intention”. However, he described his own intention in the one such case he recounted as “quite purposefully to reduce the patient’s awareness of the dying process”.

When asked if he would see possible hastening of death through analgesia/sedation as the same as a lethal injection of potassium, at first Walter did distinguish them on the basis of intention: “The injection of potassium is aimed at one purpose, and that’s to end the life. The injection of morphine or a sedative, or whatever it is, is designed to palliate”. However, later in the interview he claimed that the intention of a lethal injection as a method of AVE is not to kill, but to palliate: “I think the idea that the doctor giving euthanasia has an intention to kill is really bizarre. His intention is to relieve that patient’s suffering. There’s no intention to kill the patient!... He recognizes yes, this is going to end this patient’s life, and it’s going to do so quickly, but that is what the patient has asked for”.

Later, Walter said that what was important was not the intention of the doctor, but that of the patient: “The doctor is secondary. That’s why I think it’s really the intention of the patient, which we should be focusing on. If you want your suffering to end, then it’s your intention that you should die. The doctor, in a sense, if he delivers a lethal
injection, he’s an agent to your intention. It’s wrong to focus on the intention of the doctor… the fundamental thing is the intention of the patient”.

Six participants specifically mentioned the principle of double effect, in relation to foreseen but unintended side effects of medication:

Kerry included it in her definition of “letting die” as distinguished from killing: “With the doctrine of double effect. Appropriate increases in medication can potentially shorten someone’s life. But because that’s not the purpose, then it’s considered permissible. Whereas killing is giving someone medication that you well and truly know is going to end their life. With the sole purpose that outcome”.

When asked about palliative care physicians who are in favour of AVE, Annette said, “Yes, and they’re arguing that we’re fooling ourselves by... the principle of double effect”, and when asked if she ever found the distinction between killing and “letting die” a bit blurry, Vivienne replied “Only in the sense of the principle of double effect”.

Because of the study be cited that showed no evidence that the use of drugs in the terminal phase shortened life, Bill concluded, “In truth, we may not have to think about double effect”.

Nathan raised doubts about the principle, on the basis of the difficulty of knowing one’s intention: “There’s a concept of the double effect… And that’s based on the intention, so it obviously raises extreme difficulties. What’s in a person’s mind and heart? I don’t know what is in anybody else’s mind and heart, and half the time I don’t know what’s in mine own…. So, double effect is not bad except for this big problem of what intention is”. On the other hand, Nathan also argued that the principle of double effect was simply part of ordinary medical practice, where risks and side effects are weighed up against benefit: “Whilst it’s couched in a very high sounding moral thing, I suspect it’s just part of life, that we can’t fully know the future, and part of our day to day practice where we take risks, but where the intention is good. So I tend not to labour the point invoking this sort of moral principle, and I tend to teach and practice it like that: this is something that has to be done to relieve terrible suffering, which cannot be relieved in any other way”. Michelle made a similar point: “None of us can say that some of the decisions we make in medicine, and that’s in any field of medicine, don’t shorten people’s lives”.

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Walter did not accept the principle, on the basis that the way it is formulated assumes that death is a bad effect (unintended but foreseen): “Those people usually take succour from the doctrine of double effect, don’t they? And of course that doctrine has been criticized, largely on the basis that it takes the position that hastening of death is a bad thing. There are a lot of people, who would regard hastening of death as a good thing. So I don’t accept that. I think that is an extreme position based, really on a religious position. That there can be no circumstance where hastening death is a good thing”.

Harry did not mention the principle by name, but implied that the Jewish tradition did not subscribe to it: “I’m not sure about notions of intention. I don’t know whether if you do something with the intention of x, and it will bring about y, if you’re aware of y, rather than that being the intention, it’s a sort of side effect, if you like, is that really any different? See, in Jewish law, we would say, ‘No, it’s not. If you’re aware that giving persons morphine and midazolam will shorten their lives, you should refuse to do it. They should suffer’… That’s my religious view, I shouldn’t put that on other people”.

Richard and Mark thought one could know one’s own intention: “That’s actually one of the easier questions for me. I ask myself why am I doing it” (Richard). “You know damn well what your intention is. I think you do. I think you should do, otherwise you shouldn’t be practicing medicine. I think you should know, before you do anything, you should be very clear about what you’re intending, what your anticipated and desired outcome should be. In other words, what you’re trying to achieve. If you’re doing something, without knowing what you’re trying to achieve, you should not be doing it” (Mark).

However Walter thought that though the primary intention in sedation might be relief of symptoms, there could be a secondary intention to hasten death “Intention exists on a number of layers, and there’s no doubt that the intention of the doctor is to palliate the suffering. That’s his primary intention. He may say that’s his only intention. Another doctor may say that’s my primary intention, but if this results in the hastening of death, I don’t see that as a bad thing. So the secondary intention may be at least an acceptance that if death is hastened it is not a bad thing”.
Paul said he thought it might be difficult to distinguish a doctor’s intention from the perspective of an observer, but he said that, from his own perspective, the aim of medication would be reflected in the way he administered medication, by increasing dosage gradually.

Others thought that intention could also be inferred from the way that drugs were given (Richard, Alison, Mark and Desmond). “The intention of killing someone is to stop it there and then. And whatever you do, it’s going to make it happen. You know, it’s going to be bold enough, in order to do it” (Michelle). And although he expressed doubts about intention, Nathan also used this criterion to distinguish sedation at the end of life from killing: “The aim of sedating at the end of life is that a person would be rendered less conscious to the extent that they are not suffering, but without the express aim of shortening the life. In fact, with the express aim of not changing the natural outcome of the illness”. He also said, “I think mostly it (the intention) is fairly clear, what’s going on becomes apparent”.

9.2.6 Criterion 6: That death occurs immediately
Whether or not they thought there was a moral difference between killing and “letting die”, many participants associated killing by lethal injection with immediacy, in terms of the time interval between the doctor’s action and death. Richard and Michelle spoke of death occurring “there and then”. Some contrasted this immediacy with “letting die” by analgesia/sedation at the end of life (Judith, Robert, Walter, Natalie, Mark and Harry) and some with treatment abatement (Gordon, Andrew and Michelle). “That (a patient dying from untreated pneumonia) is quite different from the director going into the movie and going ‘Cut!’ Suddenly, you don’t get the sort of tapering off of what by rights is their story” (Vivienne).

For two participants, it was at least partly this immediacy which made the idea of giving a lethal injection emotionally very difficult: “I have a real problem with saying, I’m going to sit down now and give you this injection and goodbye” (Annette). “I would find performing euthanasia undoable. To walk into someone’s room, put the tourniquet on, whack the needle in the vein and go squirt. To kill them” (Bill).
However Ian recognized that some “letting die” decisions, such as turning off a pacemaker, could also result in immediate death, and this made the decision more emotionally difficult for the doctor, but did not mean that it was killing.

9.2.7 Criterion 7: That death is caused directly
Killing by a lethal injection was sometimes described as a direct action or decision (Richard, Michelle, Walter and Ruth), and the death as being directly caused (Ruth and Harry) by the doctor. “It’s known at the outset that the patient will die as a direct result, and it’s how they die, as a direct result of what you’ve done” (Ruth).

For Harry, this made the difference between what he was and was not prepared to do: “I won’t actually kill someone directly, myself. I will bring about circumstances which may make them less aware of it, and hence may, I suppose, indirectly bring about their death”. He thought these two actions were “qualitatively different”.

9.3 “The end of the needle”
The certainty, irreversibility, intention, immediacy and directness of a lethal injection was captured vividly in the phrase “on the end of the needle”, which was used by Tom, Gordon, Andrew, Desmond and Natalie: “Killing’ to me, in medical terms, is something that’s fairly abrupt, with one aim only. So, you’re taking steps, to end a person’s life, on the end of a needle essentially” (Natalie).

9.4 Taking control versus refusing to take control
The distinction between killing and “letting die” was framed in terms of taking control or refusing to take control by some participants, mostly doctors who were morally opposed to medical killing.

In relation to distinguishing a lethal injection from treatment abatement, Richard spoke of “interceding your control on that life, as opposed to nature’s or what ever you want to call it”, Alison of whether or not the doctor dictates the time or manner of death, Tom of whether the doctor determines when death occurs. Ian said, “I think when we stop doing things, and let nature take its course, then it’s not us deciding whether the patient lives or dies”, and Nathan, “it’s different killing somebody, than if they’re dying, for reasons not in my control. I don’t find that a difficult distinction, at all”.

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In relation to distinguishing a lethal injection from analgesia or sedation which might shorten life, Kate said, “I’m not comfortable taking that kind of control over somebody’s life”, Judith spoke of being “the one to take what time there is left”, and Ruth contrasted this with the situation where death occurs “at a time not of your choosing”.

Four participants said that they did not believe it was up to doctors (or anyone) to take such control (Andrew, Kate and Mark), but that they should leave it to other forces to determine if and when a patient dies: “We haven’t had the arrogance to say you’re going to die now. Here’s your injection. We’ve said, we’re taking away these treatments, and it’s up to your body, it’s up to your God, it’s up to whatever you as an individual believe in, and whatever you as an individual are, you will determine your time of death, not us. Not me. I’m not God. I don’t know. And that’s what I tell people, I say, I don’t know… And, to me that’s the difference” (Brian).

Bill said, “Nobody has the right to dictate who’s going to live and when they’re going to die”, and Michelle referred to playing God: “I see that as wrong, to give them a single injection because I think, we’re playing God in doing that. I say that, and I don’t actually believe in God, but anyway… I think that that is actually making a conscious choice rather than allowing what’s a natural process to take place”. Vivienne, who did believe in God, said, “I guess I’ve lived for so long with the respect for.. what you might call God’s supervision of everything, that could be one reason why I would hold back, from taking over that role”.

Harry also referred to the Jewish belief that it is wrong to “shift the balance of things away from God’s hand”. And Craig (who was not opposed to AVE) thought the public might fear its legalization, because doctors already have a lot of power and to give them “the power of euthanasia” might be seen as giving them “the power of God, to choose life and death”.

9.5 Distinguishing killing from “letting die” in general
Ten doctors used some of the criteria above to describe killing without an explicit contrast with any particular category of “letting die”. The criteria used in this way were
directness (Richard, Michelle, Ruth, Walter), certainty/uncertainty (Alison, Mark), immediacy (Bill, Annette) and intention (Ruth). Several participants also described killing in general terms as “taking control” (Harry, Andrew, Mark, Vivienne and Craig).

Of the 21 doctors who gave a definition of killing and “letting die”, nine did so in relation to treatment abatement (Hilary, Nathan, Kate, Margaret, Judith, Oliver, P22:209; Vivienne, Mark and Desmond), six did so in relation to potentially life shortening medication at the end of life (Alison, Gordon, Michelle, Bill, Annette and Natalie).

Six participants defined killing and “letting die” in general terms which combined the two types of “letting die” (Dot, Richard, Kerry, James, Craig and Ruth). Two examples of this are:

“‘Letting die’ is just, allowing natural processes to act and not intervening in them. Killing in a medical sense, is actively administering doses of medications such as you know is going to end their life early. Without the intent of relieving suffering. Killing is actively giving medication with the sole purpose of ending someone’s life” (Kerry).

“Active killing is not just the provision of adequate analgesia to control pain, but the administration of either medication or suicide to end life. I see “letting die” being not doing investigations or prescribing medication, which may result in hastening of death” (Craig).

9.6 Whether the distinction between killing and “letting die” is conceptually clear

Overall, participants were clear about the conceptual distinction between killing (of which the paradigmatic case is a lethal injection) and “letting die”.

In relation to category 1 “letting die”, only Walter did not make a conceptual distinction between this and killing, and only two participants were unable to classify any particular action as killing or “letting die”. Judith was uncertain about whether sometimes switching off a ventilator would actually be killing: “I think it would depend on the circumstances... I don’t know whether I’d call it killing or ‘letting die’, but probably the doctor in their mind, might think that they were letting die”. And Harry thought the
question of the difference between switching off a ventilator and giving a lethal injection was “extremely difficult”. Despite calling it “a really grey zone”, Mark was definite that he would be willing to remove a PEG tube, but never to give a lethal injection.

Participants also thought that there was a clear and significant distinction between killing and category 2 “letting die”, although it might be a fine one. Gordon said it was a “very fine line”, Alison, “a fine distinction, perhaps, but it’s still a distinction”, Tom a “difficult distinction to make”, but still “a significant distinction”, and Paul “often a very fuzzy line”, but also “a very big difference. Vivienne said, “I agree that there’s a blurring between the two, but in my mind, I think there’s a huge ethical distinction between the two”. While admitting “it’s still always going to be a bit of a grey area”, Annette said, “To me there is that difference… and I guess that the difference is fairly small, really, but it’s what I feel comfortable with”. And while Harry said, “I found that very difficult to distinguish… I don’t think that you can, the only thing is that nothing was given in the acute sense, to kill him”, he continued, “but there would be a fine line, I believe, philosophically”. And while Craig described the distinction between killing and category 3 “letting die” as “a very blurry line”, he also made the distinction on the basis of intention.

That the distinction was clear to participants is also apparent in the fact that there was almost complete agreement about what was killing and what was “letting die” among those who distinguished between them. The only exceptions were Nathan’s classification of the withdrawal of artificial ventilation as killing, and Nathan and Harry’s classification of the withdrawal of artificial nutrition and hydration as killing.

9.7 Summary of criteria of “taking control” used to distinguish between killing and “letting die”

The criteria used by each participant were identified from the definitions of the difference between killing and “letting die”, if one was given, plus other places in the interview where a criterion was used. For example, Ruth’s definition was: “Killing, it’s an active thing, it’s deliberate. And it’s known at the outset that the patient will die as a direct result of what you’ve done… “Letting die” is not doing something that would prolong life… so it’s passive as opposed to active, it’s not doing, it’s omission rather than commission. ‘Letting die’ does imply that the patient will die as result, but I think
they are the main differences. And thinking about it, myself, I feel that the second circumstance is really letting nature take its course”, which included the criteria of act/omission, certainty/uncertainty, causation and natural/artificial, and she also used the criteria of intervention/nonintervention, intention and directness.

Table 19 Criteria used to distinguish between killing and “letting die”

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Doctors who maintained the distinction between killing and “letting die” in its traditional form, that is, that while killing the innocent person is always wrong, some cases of “letting die” are also morally wrong, but some are not (Sulmasy, 1998).

+ used to distinguish lethal injection from treatment abatement (category 1).
# used to distinguish lethal injection from sedation/analgesia at the end of life (category 2).
~ used to distinguish PAS from patient using hoarded drugs to suicide (category 3).
ά used to distinguish killing, from “letting die” in general
* These participants only discussed the difference between killing and “letting die” in relation to treatment abatement.
Θ This total represents all doctors who used this criterion in relation to any category of “letting die”, or to “letting die” in general, and is not always the sum of these groups, because some doctors used criteria in relation to more than one of these.

Of the doctors who distinguished conceptually between killing and treatment abatement (all except Walter), only three did so on the basis of a single criterion. These were Bill (intention), Paul (act/omission), and Natalie (artificial/natural). The others used more than one criteria: six used two, six used three, eight used four, five used five and one, six criteria. However in relation to distinguishing killing from category 2 “letting die”, nine of the 25 doctors who discussed it did so on the basis of a single criterion (eight used intention and one causation), but the rest used multiple criteria: nine used two, five used three, one used four and one used five criteria. Intention was the only criterion used by the six participants who distinguished killing from category 3 “letting die”.

9.8 Whether the distinction between killing and “letting die” has any moral significance

Twenty two doctors maintained the traditional moral distinction between killing and “letting die”. Five of the doctors who did not think AVE was necessarily wrong in all circumstances, and therefore did not maintain the traditional moral distinction between killing and “letting die”, nevertheless thought that the distinction between killing and “letting die” has some moral significance in the medical context. Both Kerry and Michelle, despite a lack of in principle opposition to AVE, were convinced that it would be wrong for them to perform it, especially as a doctor. Although he said he would be open (but reluctant) to performing AVE if it were legal, Craig thought an important moral difference between treatment withholding and AVE was that the former decision could be taken by the doctor alone, without patient involvement. Gordon spoke of the
“moral abhorrence of converting a passive action into an active action”, and said of symptom relieving medication which might shorten life, “I don’t think it’s the same” as a lethal injection, which he described as “the bastardization of our profession”. And Paul said of the difference in intention between a lethal injection and the use of symptom relieving medication which might shorten life, “that’s where the moral difference is”.

Three doctors did not consider the distinction between killing and “letting die” to have any necessary moral significance. Ken said that if there were no legal issue, “I wouldn’t think about it (performing AVE) for a microsecond”. Robert said, “That’s an equivalent decision, in my mind. So that I don’t really see any difference. In the final outcome, which is death. And so the person who decides either to participate or to inertly stand by has made the same decision as regards the outcome”. In fact, Robert thought in some situations killing was morally preferable to “letting die”: “One has agreed to make it easier, or more pleasant, and one has not”. Walter said that both “letting die” and “giving them medication which will hasten their death” (he did not want to use the word “killing’) were “making a decision which is designed that they will be relieved of their suffering... they’re all just points on a spectrum, of palliating that particular patient”.

9.9 The moral distinction and consequentialism
In their discussion of the distinction between killing and “letting die”, many participants explicitly repudiated the idea that the morality of an act (or omission) depends only on its consequences (or the consequences to which it can reasonably be expected to lead). Of those who maintained the traditional distinction, Richard said, “If I had to do my clinical work with only outcome as a measure, I wouldn’t make any decisions. I have to ask ‘What is the intent of giving this dose in this manner?’... Goals of care for us are very important. And that’s very much matter of intent, it’s not about just outcome”. James said, “I don’t quite understand the ethical viewpoint that there’s no difference because the outcome is the same. I mean, if a child’s hit by a car, it matters a great deal to me whether the intention of the driver was to drive with care, and this was an accident, or whether they were deliberately trying to run someone down. The fact that the outcome is the same, doesn’t mean the intention isn’t important… the intent of the agent made a difference”.

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Ruth did not think outcome was the only significant factor in decision making in distinguishing between killing and “letting die”: “I can see the similarity, in that something that you do or don’t do results in the death of the patient… But they are morally different, to me. Even though the end result might in most circumstances be the same. It’s just who’s the person that’s doing it. That’s taking the person’s life. If I inject something, then it’s me that takes the person’s life. And in the second situation, I’ve been struggling to save a person’s life, well they would have been long dead if I hadn’t intervened. So I’ve been struggling, and not been successful. It’s the bad person and the good person, who wasn’t good enough, that’s the difference”.

Alison thought that even if the intention and outcome were both the same, “As being the agent that causes, that is doing, it feels different”. Kate said, “I accept that death may be a better outcome, if you’re suffering. But I still don’t think, and I guess it comes down to a way of thinking and a philosophy, that I would actively take part in hastening it”.

Four of the five participants who made some moral distinction between killing and “letting die” though they did not think killing was necessarily always wrong for doctors, also rejected consequentialist reasoning:

“I don’t know whether you feel really pragmatic about it and say well, it doesn’t matter which route you go by to get that particular outcome, therefore those things are identical, but I would actually argue differently, that the route is important and that, both from the patient’s, the patient’s family and the doctor’s point of view, that it’s easier to let someone die quicker by omission, and also… easier on my conscience. And also possibly on the patient’s family’s conscience. Letting nature take its course is a different thing to hastening death” (Craig).

“The institution of symptom control, even though the outcome would be the shortening of their existence, I don’t think it’s the same as actually taking a syringe of potassium or insulin, and executing somebody” (Gordon).

Michelle agreed at first that if death is considered a good thing, the means by which it is achieved is irrelevant: “I think that is a good argument”, then went on: “But I see the intention as different, in the sense of allowing someone to die naturally versus taking their life”. She also thought that the consequences of treatment withdrawal could not
(always) be described as the same as those of a lethal injection: “You take someone off a ventilator and would that be perceived differently by the grandkids as giving a lethal injection? Would that time, if it took time, would that be important time? You would deprive them of that time with the lethal injection... And so maybe you can’t distinguish between intent but perhaps the actual consequences of what you do are going to be different. And maybe that’s where I feel it’s different”.

“If you draw up a big syringe of morphine and give it, then although the effect is the same, your intent is very different... We’ll often give treatments in the knowledge that someone may very well die earlier but in my point of view, it is a very big difference, and I think my intrinsic morality tells me that there is a difference, and that’s what I hang my hat on” (Paul).

On the other hand, the three participants who thought that there is no necessary morally relevant distinction between killing and “letting die” all used consequentialist reasoning to explain their view:

“That’s an equivalent decision, in my mind. So that I don’t really see any difference... in the final outcome, which is death. And so the person who decides either to participate or to inertly stand by has made the same decision as regards the outcome” (Robert).

“If I was on a desert island, without all these people around me, and I felt that this was burdensome treatment that wasn’t going anywhere, I wouldn’t form major distinctions between the mode of death” (Ken).

“It’s an extremely common clinical experience when somebody has been dying an extremely bad death, and they do die, everybody says “I’m glad that’s over”… As though the fact that that suffering has come to an end, is a good thing. And if it’s a good thing that that suffering has come to an end you could say it might even have been a better thing if it had come to an end sooner” (Walter).

9.10 “Taking control” and two other medical practices
Participants discussed the distinction between “letting die” and killing in terms of AVE, using the paradigmatic case of a medically administered lethal injection. However they
also talked about two other medical practices which raise the question of whether these were also thought to be killing or rather, “letting die”.

9.10.1 “Terminal Sedation”

Only six participants, five of whom were palliative care physicians, used the expression “terminal sedation”, and they meant slightly different things by it. Nathan, Bill and Vivienne said they would not practice what they called “terminal sedation”. Nathan distinguished between this, which he said was aimed at death, and “sedation in the imminently dying”, which he would perform, believing it did not shorten life, even if the patient was rendered unconscious for a few days. Bill contrasted his practice of light sedation, which he did not think hastened death, with what he called “terminal sedation”, that is the practice of heavy sedation to the point of unconsciousness, which he believed was intended to cause death, as did Vivienne: “I myself am very uncomfortable with this new trend in palliative medicine, particularly by the newer people, to have this area of practice called terminal sedation… I don’t have a problem with using a level of sedation to treat symptoms, which won’t put the patient into a stupor or make them unconscious, and still relieve those symptoms, and not hasten death. Or, not definitively hasten death… But if somebody says, ‘I don’t want to live like this any more… and I wish that euthanasia were legal, so that I could be killed’, then I think if someone offers them, ‘Look we can’t do euthanasia, but we can instead give you a heavy bomb of sedation which is like an anaesthetic, so that you won’t wake up’… I would never offer that”.

Kerry also used “terminal sedation” to mean putting the patient into a coma, and said she had done that on one occasion, but that she did not think it significantly shortened life, if at all: “I relieved his suffering, but I didn’t kill him. I suspect that my relieving his suffering would hasten his death by a day or two, well I don’t know by how much actually, because he may have got a chest infection or whatever. He died quite quickly”.

Walter was quite comfortable with providing “terminal sedation” which he described as putting someone to sleep who was close to death (within 24 hours) in order to relieve their suffering where it was highly likely that this would hasten their death.

Natalie distinguished her practice of “terminal sedation” from giving a lethal injection on the basis of its intent: “People use that argument, that terminal sedation is the same
as euthanasia, but just slower, but I would say that there is a big difference in my own
mind, when I am doing that, that it isn’t the same as a lethal injection, and quite clearly
it’s not the same as a lethal injection. If one wanted to kill a patient, then one would use
the most appropriate means of doing it. Presumably by intravenous high dose of
potassium or something that would stop their heart immediately. And that has a very
different intent to controlling symptoms”.

Two other participants referred to the use of heavy sedation in the terminally ill which
would definitely shorten life, but without using the expression “terminal sedation”.
Harry was comfortable to provide such sedation and recalled one occasion when he had
done so, not for relief of symptoms, but “to reduce the patient’s awareness of the dying
process”. He said “There would be a fine line, I believe, philosophically, between
giving something which keeps somebody asleep so they can’t say, drink or eat, or
whatever, and giving them something that over a few seconds, instead of over a few
days... The whole process actually still took days, but he was no longer aware of it”.

Although never having been asked for or done it, Craig thought that giving an ambulant
patient sedation so that they would not eat and drink and eventually die was “on the
borderline of what I’d be comfortable with”.

Four of the palliative care physicians said they would always use the lightest form of
sedation possible, and would not go beyond making the patient sleepy (Natalie) to
“putting them into a stupor” (Vivienne). Bill said “What I might do for my patient is
give them something oral or mild, and sedate them without rendering them unconscious.
Whereas, some of these other people, you got the impression that they were going from
fully conscious and fully suffering to anaesthetized. Which is something I’ve never
done”. Annette said that heavy sedation should only be used as a last resort for
refractory symptoms.

In general, sedation was only practiced when patients were close to death, and the
further they were from death, the more problematic it became (Nathan and Alison).
Although she had sometimes put a person to sleep for a few days, until they died, Kerry
spoke of another patient who wanted “euthanasia”, but where she would not use
terminal sedation: “We’re not going to do it. She potentially has months to live”. And
Alison spoke of occasionally pulling back on the drugs “just to be sure that we aren’t
unnecessarily or inappropriately over-sedating. If there’s a concern when it goes on too long and therefore maybe the patient wasn’t as near death as we thought, or if the family really express a concern that it’s the medication rather than the disease that’s causing the lowered consciousness... and either the patient’s become uncomfortable and distressed again... or they can see that it makes no difference, that the person really is deeply unconscious, as a result of their disease”.

On the other hand, Mark said, “I don’t think it’s an issue, how close they are to death, it’s an issue how much they need it”.

Participants also addressed the issue of what kind of symptoms might warrant sedation. Walter claimed that, while “terminal sedation” was introduced for the management of terminal restlessness, it was now commonly used for other symptoms including psychological and existential suffering. However some of the palliative care physicians said they would not feel comfortable sedating for reasons other than physical symptoms. Nathan thought that the most controversial indication for sedation at the end of life was “extreme existential distress”. Annette agreed that this was controversial, and indeed raised the “conflict around are you killing them or ‘letting them die’?” She said she had only sedated people “who’ve been sort of thrashing around, and hurting themselves, or actually harming others, quite violent... rather than just wanting to die and being sedated until that happens.

Vivienne was similarly very uncomfortable with sedation for existential distress. Mark said he might sedate for existential distress, but also, “I think someone like that may not necessarily need the degree of sedation that you’ve described. I think it’s a bit of an extreme... I think one would titrate the dose to their requirements. And it’s very important that you have a psychiatrist involved in the management. Because you have time. I don’t think that you can make any choice as extreme as that, without having explored your options”.

Natalie was comfortable to sedate for mental anguish, but only in the end stage, and to the extent of the patient being sleepy, not comatose: “We’re all duty bound to treat symptoms. Both physical symptoms and mental anguish... And sometimes that means sedating patients in the end stages of their lives, and I think it is bad medicine to undertreat people under those circumstances, and not control their symptoms,
particularly when they’re asking for help. That’s something that one would try to
discuss with the patients - how sleepy are they happy to be? And most of them in those
last days of life are happy to be sleepy”. Similarly, Harry would sedate not just for
physical symptoms, but also simply so that the patient was unaware of the dying
process, but only when the patient was close to death, not early in the disease process:
“Once you’ve run out of things to do, once the cancer sort of has the patient, and there is
no chance of improving the situation, I think the existential question for the patient
becomes, ‘What is there for me to see through? There’s nothing left”.

Vivienne said that if sedation was instituted for the purpose of the patient dying through
not eating or drinking, it would be killing and therefore impermissible. Mark described
it as no different to giving a “slow poison”, Judith as a “slow form of killing” and
Margaret as “effectively euthanasia”. Desmond said, “I think the critical thing there is
what is the degree of level of consciousness that you achieve. To put somebody to sleep
for a week so they starve to death I don’t think is any different to just giving them the
same amount of sedation so that they’re getting it in one shot. I don’t know that there’s
a real difference there”.

On the other hand, if the intention was not to terminate life but to control symptoms,
Natalie said that “terminal sedation” could not be called killing. Asked if she thought
putting the patient into a coma could be seen as a form of “slow euthanasia”, Kerry said,
“Yeah, I could see that. I guess you would have to say the legality and the doctrine of
double effect (made the difference”.

9.10.2 Physician-assisted suicide
Participants’ objection to PAS was not usually associated with an objection to suicide as
such. Most of those who discussed the issue, including those with religious beliefs, had
no moral objection to people committing suicide (Nathan, Tom, Oliver, Ian, Desmond,
Brian, Judith, Michelle, James, Paul, Annette, Natalie and Ken). As Bill said, “It’s
usually a terrible tragedy. No (I have no moral objection), I have a sadness. I feel sorry
if somebody commits suicide”.

However five doctors did have some moral objection to suicide, at least in some
situations. In four cases this was not a religious objection. Kate said she thought suicide
was “a very selfish thing to do”, although “I think when somebody’s got a terminal
illness, I don’t have as strong an objection”. Mark said, “They don’t have to live with it”. Vivienne said “While I would never judge the person who suicided, I think it’s a kick in the guts for the people around them, and Ruth that “I think it’s morally wrong, but it’s certainly understandable”. Harry said his objection was religious rather than moral, but he also described the suicide of a relative as “the most selfish thing I’d ever come across”.

Several pointed out the need to assess patients who express the desire to die for depression (Nathan, Vivienne, Judith, Michelle and Paul). “I would ask, as a doctor, why are they committing suicide? What’s wrong with them, that they want to die? Why are they in such a state of hopelessness, or despair?” (Brian). And Tom and Vivienne said that suicide was an indication of the failure of society in some way. But some also said they thought that suicide could be a completely rational decision (Oliver, Desmond and Paul), and Walter was a strong advocate of the right to suicide: “If she cares to make that decision, I think she’s got an absolute right to do so”.

Several doctors strongly maintained that, while they had no objection to people suiciding (provided they were not suffering from treatable depression) they had a strong objection to assisting the suicide of such people (Nathan, James, Michelle, Judith, Natalie, Mark, Ian and Desmond).

The difference, as some expressed it, was the agency of the doctor. As Nathan said, “But you’re asking if I, as my own moral agent (would assist suicide), I would not”. Oliver said, “You are then asking me, will I kill somebody? I’m taking an active step. It’s no longer the patient. The patient may say I want it, but the person doing the killing would be me… The problem is that I’m doing it. And that’s a different question”. When Desmond was asked, “If you think that a person has a moral right to commit suicide, why would you object to helping them?”, he replied, “Then it’s not suicide”. Mark said, “It affects me… You’re asking a great deal of someone to ask them to participate in that. If you want to do it yourself, that’s fine… But when you’re implicating someone else it’s very different”. Brian also thought it was asking too much of a doctor, and showed “a certain selfishness, of those individuals who want someone else to be involved in killing them”.

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Several claimed that medical assistance was not necessary for successful suicide (Nathan, Oliver and Harry and Brian). Asked about patients who because of disability could not commit suicide alone, Desmond replied, “They don’t actually need a doctor, they just need some other pair of hands, to replace their own”.

Given this, Nathan argued that the request for medical assistance in a suicide might indicate some ambivalence about wanting to die: “The fact that they think it’s important that doctors are involved, to me tends to imply that there are other emotional and psychological issues, influencing the decision of that person, that should therefore be analysed and explored”, and Brian that it indicated a desire to justify the decision: “If there really is this group of rational people who want to kill themselves, why do they have to enlist our help? Why do we need to medicalise their suicides? Why do we need to justify or condone or legalise the suicides of this very small group of people?” Harry argued that if the patient wasn’t willing to kill themselves, why should a doctor (or anyone else) be willing to do it?: “He said, ‘I want you to do something. My wife won’t put the plastic bag over my head’. And I said, ‘Well you wouldn’t put it over your head, and neither will I… If you’re not prepared to do it, why should I be prepared to do it? Or your wife?’.”

Most participants thought there was no moral difference between AVE and PAS (Hilary, James, Tom, Bill, Ruth, Mark, Ken and Desmond). Paul said, “I don’t think there’s a demarcation between them, really. I think it’s different names for the same thing… It’s a case of semantics”. Robert, an advocate of the legalisation of PAS and AVE, agreed: “I don’t see a difference. They’re both (the doctor deciding to provide the means). It might feel easier, but if you’re going to do it, you should do it”.

Richard said that there might be very little practical difference between PAS and AVE. Referring to devices such as the one set up by Dr. Phillip Nitcheske, which enabled patients to begin a lethal infusion by pressing a computer key, he asked, “Where do you draw that line between the whole thing you set up, and all they’ve got to do is tilt their head?… I can’t respect it if he says, ‘One’s killing and I could never do that, the other isn’t’. That’s nonsense”.

Robert and Natalie indicated that sometimes patients are unable to commit suicide, even with prescribed drugs, and therefore would require AVE. Walter said, “It’s only in rare
circumstances, where a person is either totally paralysed, and can’t help themselves, or they can’t ingest or absorb medication that the question of lethal injection becomes possible”.

Alison and Ruth thought PAS would perhaps be psychologically easier for the doctor, and Michelle said, “Somehow that feels easier, just when you’re talking about it, to write a prescription, and say, go away and you make the choice to take it or not, that feels different to actually carrying out the act yourself because they then carry the act out themselves, and it’s quite definitely a personal choice and a personal action”.

Walter thought there was very large psychological difference: “Certainly emotionally it’s a different matter altogether. I’m happy to advise somebody, to have a dialogue with them… and if I can help them to find the peaceful death that they want, well that’s OK, I’ll help them with the medication, but the delivery of a lethal injection is just another level, and it’s a big step up for me”. He also thought that there was an ethical difference, based on who takes responsibility for the final act: “There is clearly a very significant practical difference. On the one hand, the patient takes the responsibility, in injection, it’s shared with the doctor. The other factor about physician-assisted suicide, is that it’s got a really intrinsically powerful safety element to it, because the patient is totally in control, if they take the medication. So they can arrange with the doctor to have a lethal injection and he comes to give it, and there’s a certain pressure there. I think they’re different. Whether it’s a moral difference, I think there is personally, that’s how I feel… The level of involvement, the responsibility just puts it on a different level to me”.

Despite being opposed to both practices, Dot agreed that there was some moral difference between them, in terms of the patients’ autonomy, the possibility of the patient feeling pressured, and the possibility for them to change their mind: “If you give them tablets that they can take themselves, they can change their mind. So they have the absolute final say, whereas if you give them an injection, for one thing they feel that they’re committed to it. And they have more autonomy in a way, because they can take or not take the thing you provide”. And Gordon said, “At least you’re then giving the patient the means, but leaving the choice to the patient. So that, in some ways, I don’t think it’s a copout to say that, if you give the means and wherewithal, but don’t actively participate beyond that, you’re then giving the individual the choice. And people might change their minds”.
However others thought PAS might be morally worse than AVE, because in both cases, the intention of the doctor is that the patient should die, but the former shows a lack of courage and willingness to take the responsibility to ensure that it happens in the easiest way for the patient. Richard described it as “a bit of a wimp out or a cop out” and an “abrogation of a sense of responsibility”, Alison as “a bit of an abandonment”, and Margaret said it was worse because “you’re not having the courage to do it yourself”. Kerry thought it was worse because it might involve a patient who was reasonably well, “whereas usually, if you’re giving an injection, it would be in the context of the last few days of life.

Natalie said, “I don’t think it’s a very fair thing for a doctor to do to give a prescription to a patient and say, ‘Off you go. Take these pills, it’ll probably work’. That’s not caring for a patient. If you feel a person has got every right to die comfortably, well why not do it yourself? You might as well go the whole hog, and help the person die. At least you’re then controlling the death, and making sure the person is safe. Those horrific tales of people trying to overdose by themselves and it not working, but leaving them distressed or even more disabled. It’s a shocking thing for any doctor to assist at something like that. You either do it properly or you don’t do it at all, I reckon”.

Several said that there was no difference between PAS and AVE because there is no difference in the intention of the doctor (Andrew, Kate, Oliver and Vivienne). Richard said, “If your intent is to kill but you haven’t got the gumption to actually do it… I don’t see any difference. I can’t understand the person who disagrees with euthanasia but agrees with physician-assisted suicide. I can’t get my head around that”.

Intention was also the criterion used to distinguish between physician-assisted suicide and the situation where a patient hoarded prescribed drugs and used them to commit suicide, without the doctor’s knowledge (Kate, Michelle, Vivienne and Harry). As James said, “To me, it comes back to the intention. If the intention is to prescribe them so that they can take the painkillers and have a good quality of life, then I don’t have a problem with writing that prescription. But if I knew that they were likely to commit suicide, if they told me that, I’d probably prescribe them a smaller amount”. Craig agreed that there was a difference in intent and responsibility between PAS and a patient using prescribed drugs to suicide: “There it’s the patient taking the responsibility, rather
than anything I’ve done or said. I haven’t done anything out of my usual practice, to cause that death. I may have written a prescription, but I didn’t do it with the intent of hastening death”.
Chapter Ten  Theme 2: Killing and the role of the doctor

10.1 Introduction
In this chapter I discuss the second theme to emerge from the data, which concerns the place of killing in the medical role. In many cases unwillingness to perform AVE was associated with a belief that killing an innocent person is generally morally wrong, derived from a moral authority external to medicine. Such a belief was held by those with or without a religious commitment. However participants who thought killing was not part of the medical role included three doctors who did not believe that killing was necessarily wrong on general moral grounds. Many doctors spoke of killing as being in opposition to what medicine is all about, thus appealing to the internal morality of clinical medicine. Participants also discussed whether killing could be seen as congruent with two particular goals of medical practice, achieving a good death and the relief of suffering. And they discussed the difference that being in the medical role made to the way that they thought about medical killing.

10.2 Is it wrong for doctors to kill their patients?
Central to the traditional distinction between killing and “letting die” is the idea that killing the innocent is always wrong, but “letting die” may sometimes be permissible.

Eight doctors (Robert, Walter, Kerry, Michelle, Craig, Gordon, Paul and Ken) thought that AVE could be morally justified in some cases, although Michelle, Gordon and Ken did not think that they would ever practice it themselves, even if it were legal, and Paul said he did not think it was not appropriate in his (oncology) practice.

10.3 Reasons for believing it is wrong for doctors to kill their patients
In most cases, the reluctance to administer a lethal injection was associated with the belief that killing an innocent person is morally wrong in itself, that is, intrinsically wrong. This belief was held by those with or without a religious commitment.

10.3.1 Illegality of killing
For three participants, however, the wrongness of killing was said to be related solely to its illegality (Craig, Ken). Kerry said, “I just follow the rules too much. I just wouldn’t break the law. I’m too rule-bound, I just can’t do it”.

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10.3.2 Reasons which rely on a moral authority external to medicine

Some of the Christian participants who thought it was wrong for doctors to kill a patient based this on their religious beliefs (Alison, Tom, Margaret, Oliver, Vivienne and Mark). Dot said, “I don’t say I follow any text in the Bible or any command - well there’s the commandment ‘Thou shalt not kill’, which is basic - but religion’s at the back of it”. Of the Jewish doctors, Harry and Desmond linked their attitude to AVE explicitly with their religion, though Desmond said that this influenced him “only at an exceptionally basic level, like the injunction not to kill, I guess”, but Nathan implied a moral rule against killing: “We’re not permitted, I believe, to shorten their life”.

Religious participants also gave reasons not directly related to their faith, including the intrinsic value of human life (Alison, Tom, Nathan and Desmond) and the universal proscription of murder (Dot, Tom, Andrew and Ian). As Ian said, “It’s (anathema) from a human point of view, I think… it’s a whole environment in which we currently exist, and I feel comfortable with the current environment”. None used the term “sanctity of life”, although Ian said, “I hate the term life is sacred”. Margaret and Oliver said no one had the right to take human life. Several of these participants were also opposed to capital punishment, and some to warfare (Dot, Tom, Margaret, Oliver and Desmond). Ian and Harry were not opposed to these practices.

Some of the doctors who had no current religious beliefs or commitment and did not express their reasons in religious terms, nevertheless attributed their personal belief in the intrinsic wrongness of killing at least partly to values derived from their religious upbringing (Hilary, Kate and Judith). Brian said, “I have a belief, which is based on my childhood, my religious upbringing, my interaction with people, what I’m doing now. And I have this irrational belief that it’s wrong to kill people”.

James, Michelle and Ruth simply stated their belief that it is wrong for someone to kill another person. Brian spoke of the “fundamental law” of the importance of human life, and the need to maintain the taboo on taking it in order to avoid attacking the very fabric of society. Brian referred to the sanctity of life, and Annette to life being sacred.

Several spoke of not having a right to kill another person (Hilary, Brian, Kate, Annette, and Natalie). Bill said, “I believe that life is a wonderful thing, and that nobody has the
right to dictate who’s going to live and when they’re going to die”. Natalie also said she did not believe anyone had the right to ask someone else to kill them.

Hilary referred obliquely to the lack of “informed consent” when someone is killed: “When we kill them we don’t know what we do”, and Richard to humans not having the necessary wisdom to decide who lives and who dies.

Some were opposed to capital punishment (Richard, Brian and Annette), but others were ambivalent towards or supportive of state sanctioned killing as in capital punishment and/or warfare (Hilary, Bill and Natalie).

10.3.3 Reasons based on the internal morality of clinical medicine

Some doctors who distinguished morally between killing and “letting die” nevertheless were not completely opposed to AVE, and yet none of them could see themselves being involved in it, in their medical practice. The key questions here seemed to be: “What is the role of a doctor?”, and “Is killing patients compatible with it?”

Many doctors said that the medical role was to heal, to care, to help patients or to act in their best interests, and to save life, and did not include killing (Richard, Nathan, Tom, Brian, Andrew, Judith, Oliver, Mark, Ian and Desmond). As James put it: “All that we do, as a doctor, is about keeping people alive, maintaining their quality of life, but it’s always to me it’s sacrosanct that you wouldn’t shorten someone’s life”. And Annette: “I don’t think that’s why I’m here, as a doctor, to administer something that’s going to kill them… It’s not part of what I do. I personally, as a doctor, I think we’re there to help people, and that doesn’t encompass killing them”. Ian said, Basically, my job, my training is to save lives”, and Bill put it this way:“I believe that the doctor’s job is to serve in the patient’s best interests, medically. And I can never see euthanasia as being that”. Brian expressed this view in terms of suicide not being a “valid treatment option”.

Vivienne spoke of doctors having a different perspective: “I do think about this differently because I am a doctor. And particularly because I work in palliative care. Because you would think if we saw such dreadful suffering, that we couldn’t help, whether it’s physical or other aspects, we would, out of sheer necessity, be saying we’ve got to have euthanasia. But the push isn’t coming from palliative care. So I think doctors have a different perspective”.
Participants who thought killing was not part of the medical role included four doctors who did not believe that killing was intrinsically wrong:

“I’m in the business of helping people’s symptoms, and helping them die peacefully and comfortably, but I’m not in the business of hastening that or actively killing people” (Craig). “I don’t think it’s the same as actually taking a syringe of potassium, or insulin, and executing somebody, which I think is ‘the bastardization of our profession’” (Gordon). “We spend our whole training in how to help people, so it’s kind of anathema to actually kill someone, I guess” (Kerry). “That’s not what I perceive my role to be. My role as a palliative care physician is to try and improve quality and relieve suffering... not to intentionally shorten people’s lives... I don’t actually disagree with euthanasia in principle. It’s more the fact that I don’t want to be doing it as a palliative care physician” (Michelle).

Mark and Ian stated explicitly that in contrast, “letting die” could be compatible with the medical role.

Many doctors spoke of killing as being in opposition to what medicine is all about, using such expressions as “going against” (Natalie), “flies against” (Hilary), “flies in the face of” (Alison), “switching” (from the caring role) (James, Vivienne)“conflict of interests” (Brian), “a volte face” (Gordon), “doing the opposite” and “a bit foreign” (Kate), “clash with” and “pull against”, and “screams against the intention of palliative care” (Michelle), “against the grain” (Paul, Judith), “splitting” (Vivienne) and “the opposite of what we do all the rest of the time” (Judith).

Margaret spoke of how her experience in medicine had shaped her understanding of her role and of killing as being opposed to it: “You spend so much of your time, learning how to keep people alive... trying to save lives, and to maintain lives”, and Kerry of how this had changed her attitude to AVE: “It was a lot easier back in my early twenties, to say, this sounds like a good and sensible idea, but having spent eleven years treating people, now it’s different”.

Vivienne spoke of the incompatibility of the practice of AVE with good palliative care: “There is no way in the world you could offer both... How can you spend all this
tireless energy working meticulously on peoples’ quality of life and their mental health, and their spiritual health, encouraging them, even in these last few weeks, to blossom as a person as they reminisce on their life and make sense of things, and meticulously work on symptoms to get that balance right, and give beautiful nursing care, so that they’re fresh and comfortable… and they’ve got crisp sheets and a palatable meal that they can manage, how could you then in the next room, be saying, ‘OK this is the one we’re going to kill today’. I mean you just can’t, philosophically, do both. You can’t practice that’.

Ken put it in an unusual way. Despite having said that he could see a role for AVE as part of medical practice, he said he would not be interested in performing it, as it goes against the rules of the “game” of medicine: “It’s not part of the game. It’s the antithesis of the game… It’s just a mad game we play. Or this is the way I see it anyway. Engaging, in that it’s quite a complex game, just like a chess game or a board game. There are rules to it and you have to understand them. And there are ways to play it well and ways to play it badly. And the main thing about that would be that it’s contrary to the rules of the game… The rules of the game are to try and ensure the patient’s survival, by getting all the technology right.. And so the euthanasia part of it is just uninteresting because it’s easy. It doesn’t require any intellectual capability, at all. So that’s the sense in which I would not wish to find myself involved in it”.

And Robert said that medical killing was not easy, because “we’ve been brought up to care, in every case”, but then went on to say that a lethal injection may also be the caring thing to do, when it is necessary and a “kindness” to hasten death.

10.4 The goals of medicine
Another way of thinking about whether AVE/PAS could be part of the role of a doctor is to ask what are the goals of medicine. Most participants were asked this question, and their answers included curing disease (Vivienne, James, Paul, and Desmond), prolonging life (Richard, Annette, James and Paul), improving quality of life (Richard, Michelle, Margaret, Annette, James, Paul and Brian), control of symptoms and suffering (Hilary, Kate, Paul and Brian), supporting the sick and dying and promoting health and well being (Richard), helping terminally ill patients with decision making (Natalie) and controlling disease (Kate).
Several said that medicine’s goals did not necessarily include prolonging life (Michelle, Annette), at least not at all costs (Margaret, Paul). Dot, Vivienne and James referred to the adage “To cure sometimes, to relieve often, and to comfort always”.

10.4.1 Reference to the Hippocratic tradition
Only four participants mentioned the Hippocratic tradition. Hilary and Andrew referred to the Oath’s proscription of killing by doctors. Desmond, in discussing the role of a doctor, talked of “Do no harm”, which he (mistakenly) attributed to Hippocrates, and Ian (also mistakenly) thought that “somewhere in the Hippocratic Oath, it says that we are under no obligation to strive officiously to prolong life”.

10.4.2 Can AVE/PAS be subsumed under the goals of medicine?
Dot said, “Letting die would be part of relieving and comforting but a lethal injection “would be destroying a person, relieving their pain by finishing their life. And I don’t think that’s what medicine is about”. Vivienne expressed the goal of medicine as “healing in the sense of bringing wholeness to the person… within the limits of their physical problem”, but when it was suggested that “euthanasia” might be a form of healing, she said, “That’s obscene. How can that be healing?”. On the other hand, Robert thought that while medicine is about health, “if you can maintain it”, it also needs to recognize that death is part of life, “and we might as well optimize that, as well as the birth and the life”.

10.4.3 “Good death” as a goal of medicine
Alison, Kate, James, Craig, Brian, Paul, Annette, Ruth and Desmond all spoke specifically of a “good death” as one of the goals of their practice, although this could not always be achieved, and some deaths were “bad deaths” (James, Craig, Kate and Margaret).

Elements associated with a good death included not only good symptom control and comfort (Alison, Robert, Craig, Brian, Kate, Michelle, Vivienne, Walter and Natalie), relief of psychological suffering (Kate), and death being easy and pleasant (Robert), but also dignity (Richard, James, Tom, Michelle, Paul and Walter), presence of family (Craig, Brian, Andrew, Paul and Margaret), having had time with family to work through issues (Craig, Margaret), a natural death from the family’s point of view (Kerry,
Craig and Robert), and control over the manner and time of death (Robert, Walter). Natalie and Desmond also said control over their death was important was to some patients.

Annette admitted that it could be argued that a lethal injection was a means to a good death, but said, “morally I feel that that’s not the right thing to do”, but Desmond said, “I don’t think that the euthanasia advocates have a monopoly on achieving a good death… I don’t know that euthanasia is the mechanism that is required to achieve that”.

Walter thought that a good death could only be achieved in some cases by heavy sedation: “People want certainty that (the drugs) are going to work, and they want dignity in the way they die. It really means just going peacefully and calmly to sleep”. And Robert thought that making death “easier or more pleasant” justified AVE.

10.4.4 Killing as relief of suffering
Michelle recognized that AVE could be seen as aimed at the relief of suffering, and so found it difficult to explain her opposition to doing it herself. But of the seven other doctors who thought AVE could sometimes be morally justified, five argued for it as a means of achieving the goal of relief of suffering. Craig used a “humanist” argument that people should not suffer to justify AVE, and Paul said that, though he was not sure he would be brave enough to perform AVE (at least while it remains illegal), “in the ideal world I’d like to prevent anyone I care for from suffering, and anyone in all cases, from suffering”.

Gordon referred to people rendered quadriplegic in an accident: “I can well imagine responding, under those circumstances in a way that might fall in with the wishes of somebody suffering that”. Robert said, “It all depends upon the suffering that the individual patient is undergoing at that time… If it would appear that there is suffering involved, then I think active intervention (is justified)”. Walter described both AVE and PAS as a means of relieving suffering, an “act of palliation”.

10.4.5 Killing and respect for patient autonomy
Only Robert and Walter used respect for patient autonomy as part of their argument for AVE/PAS. Robert said, “I believe that the individual should have that choice... The individual really would like a choice, in the management of their death”. Walter said,
“That’s (respect for autonomy) the key thing for me. I don’t think there’s any way in the world we should be telling other people what they should do with their lives. They’re the ones living the experience… and it’s arrogant in the extreme to tell people how they must behave and the decision they must make. We need to explore their decision very carefully, but at the end of the day, it’s their life and their decision”. However, he also said that respect for patient autonomy alone could not justify AVE/PAS, since the doctor would also need to be convinced that it was necessary in order to relieve suffering: “The two go together. You respect their autonomy, but if there’s no suffering, or minimal suffering, then there’s not a very strong argument for helping somebody”.

**10.4.6 Limits to the goals of medicine**

Richard spoke of the need for humility in medicine, and said that in the dying process “we can do so much... I think we have to recognise our limits, and we’re not as good as what we should be. But I don’t see death as the enemy, and I accept our limitations in how much we influence the dying process. There’s things that are well beyond our control that might mean you might not have the dignified death you wished for”.

Desmond also admitted that medicine could not alleviate all suffering, although he thought it could generally control physical symptoms, and Bill said, “I don’t pretend that 100 percent of the patients I see have no suffering. There are some that you can never fix. There is the patient who’s going to die in pain, because he knows that his wife and children are going to get thrown out of the house as soon as he dies. And they will have nowhere to go. You can’t fix his pain. But you can be there with him”.

Natalie spoke of patients with mental anguish who were unable to take their own lives “That’s a terrible situation and one would pity them… There are lots of things that doctors can fix. It doesn’t mean to say that we need to take the negative approach that we can’t do it, therefore we’ll tidy this whole thing up for us all, we’ll let you have euthanasia”. She felt that deciding to agree to kill such people would entail making value judgments which were beyond the scope of medicine: “I just think that it’s a situation that medicine doesn’t have an answer for. We just have to accept that it’s not a medical… And that we haven’t got any tool to measure, a healthy person who just doesn’t want to live any more… We haven’t got a tool to say this person deserves euthanasia and that person doesn’t deserve it, so medicine shouldn’t step in and try to arbitrate the situation”.

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Desmond similarly agreed that some suffering and some problems are beyond the scope of medicine: “Doctors aren’t omnipotent, and they can’t, they don’t provide for all the patient’s needs and desires”. In relation to people who wish to choose the manner and time of their death through AVE or PAS, he said, “Well that goes back to individuals having control over their destiny. I don’t think that’s a medical problem, that’s a philosophical problem, I suspect”.

And Vivienne spoke of the need for both patients and doctors to recognize that there are some problems which can’t be solved: “I think one of life’s lessons is to learn to let go of the urge to control. And the anxiety that comes through trying to constantly problem solve when the problems can’t always be solved. When control is an illusion”.

However Robert thought that the recognition that doctors cannot cure everything should lead them to be willing to practice AVE: “We have been taught that medicine ought to be able to cure everyone… We’re not realists if we don’t recognize that there is a terminus to all life. And we’ve got to recognize that we can’t prevent it… There is nothing they can do to prolong the life of that patient. There is something they can do to make that life more comfortable”.

10.4.7 Would legalised AVE undermine trust in the medical profession?
Dot, Paul, Judith and Bill said that AVE should not be part of the medical role because it would change the nature of the doctor-patient relationship by removing or reducing the trust of the patient in the doctor. Paul and Dot spoke of the reported anxiety of elderly patients in Holland about being admitted to hospital because they feared being pressured to undergo AVE, or even involuntary euthanasia. And Richard referred to aboriginal peoples’ fear of doctors in the Northern Territory when AVE was legal there. Annette said, “If we had that right to administer the lethal injection, how would that affect other patients? It would change the relationship between doctor and patient. That always concerns me a bit, that there’d always be that query. The patient could be a bit vulnerable here, rather than thinking that my doctor’s going to do everything in their power to help me, to relieve my symptoms and to manage my medical problems”.

Andrew said that medical foreswearing of killing patients, as in the Hippocratic Oath “has a history because... the public wanted some reassurance that doctors with their
knowledge of how they could bump off people, weren’t going to do it”, and Craig said, “I think the public has a fear that if euthanasia’s legalized, that doctors will be euthanasing patients willy-nilly, against patients’ wishes, or against families’ wishes or if a patient’s too difficult or a bit of a nuisance or whatever, well let’s euthanase them”.

10.5 Why might the medical role lead to support for legalised AVE?
Several doctors offered suggestions as to why being a doctor might lead to support for AVE: These included witnessing unpleasant deaths or unrelievable suffering (Hilary, Dot, Kerry, Paul and Mark), compassion (Richard) and humaneness (Alison).

Nathan thought it could relate to the need to be a hero: “People need to be heroes… And I think for some doctors, this need to be a hero is overplayed, because they actually have the ability to control life and death in other people… I think it can happen with people who want to practise euthanasia. That they have a perverse sense of the need to be a hero, and in point of fact, what they’re doing is, maybe possibly compromising other people’s lives for their own needs”. Richard also thought doctors might practice AVE because they were uncomfortable with suffering, and out of their own need to resolve their sense of powerlessness.

10.6 If AVE were legalised, should another profession undertake it?
Of those participants who were opposed to AVE, Dot, Nathan, Brian, Judith, Natalie and Desmond also said that if it were legalized, it should not be conducted by doctors, but by another profession. As Brian said, “I’m opposed to it completely, and, if it was there, and I wasn’t opposed to it completely, I don’t think it’s something we (doctors) should be involved in”.

On the other hand, some who were opposed to AVE recognized that doctors must be involved in the process, at least to the extent of making an accurate diagnosis and prognosis, and excluding treatable depression (James, Tom) and Bill thought that doctors might need to be involved to ensure that it was carried out effectively.

Of those who were not opposed to AVE in principle, Michelle and Paul were nevertheless opposed to doctors actually performing it. Paul said, “There obviously needs to be medical input (in relation to diagnosis and prognosis). But I think it needs to
be taken out of the medical sphere as such, and be treated as something separate”.
Michelle argued that medical expertise was not required for the actual administration of a lethal injection, “I don’t think you need a doctor to do it. You may need someone at some stage, to design the way of their death, which has already been done. But to press a button or do something like that, you don’t need a doctor”.

However Kerry thought that if AVE became legal, the necessary medical involvement in assessment of patients would mean that they were morally involved in the decision to conduct it: “I don’t think it matters who gives the injection. I think if you’ve said that it’s appropriate to go ahead, it’s your decision”.

Craig said that “doctors need to be an integral part of the decision making process, to say that medical options have been exhausted. I still think doctors are probably in the best position to assist with making those decisions and probably to assist in the process of euthanasia”. Gordon also thought that “the doctor is the person with the training, the skills and presumably the access”.

10.7 Separating one’s self from one’s role
When asked if they would think differently about AVE if they were not a doctor, a number of participants said they could not answer this question as they could not separate themselves as a person from their professional role (Michelle, Nathan and Kate). Paul, Mark and Desmond expressed it in very similar way: “This is what I do for a living. It’s what I spend most of my waking hours doing. So it’s very hard to separate your person from your profession… I don’t have my doctor box and my person box… I like to think that what I do professionally is an extension of what I do privately. And that I’m the same person, that I don’t don one hat and don another, ’cos I’m me” (Paul).

“I think one’s personal views are inextricable from one’s professional views. That’s why as professional you can’t behave differently to what you behave as a person. I mean, it’s still you who’s doing this” (Mark). “Unfortunately, I can’t divorce the two. I think that’s very difficult, for a doctor, to do... I don’t think you actually have the luxury of having two personalities” (Desmond).
However two doctors (who did not think AVE was always wrong but opposed its legalization) said they could imagine wanting it as a patient, but not being involved in it as a doctor: “I suppose I can think theoretically that, I can imagine, if I were in certain situations myself, that I would want out. If I became quadriplegic, I’m not sure that I would enjoy that sort of existence” (Gordon). And Michelle said “If I was suffering with some dreadful illness, and really felt that there was absolutely no quality left, and that nothing anyone could do… I personally would want the choice to be able to end it. But I just, I wouldn’t want to be the person doing it. And I guess I just can’t explain that”.

10.8 Attitudes to bioethics

Both Gordon and Desmond had positive things to say about the role of ethics in clinical medicine: “There’s some papers… from the States, about an ethical clinical review group… that carries out a review of the patient after six hours in intensive care, with a view then to making a decision about whether to carry on with treatment or to withdraw treatment. And I think that is probably the way I would want to be going forward” (Gordon). “I actually believe that clinicians should spend a lot of time arguing about ethics, in general. If you don’t, then on a day to day basis you just keep doing what you’ve always done, without actually re-examining what and why you’re doing it” (Desmond).

Although some participants were familiar with the literature of bioethics (Dot, Alison, Kerry), others commented on the lack of ethics teaching in both undergraduate and postgraduate medical training (Andrew, Kate), and admitted their lack of expertise in philosophy (Brian, Ken, Mark, Harry). Most participants did not refer to any of the “four principles of biomedical ethics” (Beauchamp & Childress, 1994), but Richard referred to all four, and seven others referred to respect for (patient) autonomy (Dot, Nathan, Alison, Craig, Bill, Harry and Walter).

Three participants acknowledged the difficulty they had in explaining the moral distinction they saw between killing and “letting die”: “That distinction makes a lot of sense to me. If the question is why does it make a lot of sense, I don’t know… I guess that’s what I’ve been trying to say. But, I’m not explaining it terribly well” (James). Michelle said, “It doesn’t sit very comfortably with me. But I feel myself going round in circles here, and I can see why this is such a… difficult thing to explain… Maybe I need
to go away and think about it more”. Tom said, “There is a difference there, I think. Perhaps I’m not articulating it very well… That’s probably more wooly thinking by clinicians, rather than those who sit and think about things all day long… I don’t think I can explain it any better. I haven’t explained it very well at all, I suppose, but I just don’t think that I can explain it any different”. When I said that some philosophers accuse doctors of being illogical in this area, he said “They may well be right. But that doesn’t make it any easier”.

Judith and Hilary also acknowledged that their position could be seen as illogical: “It’s possible that we are being illogical, but probably, for most of us, it goes so much against the grain of what we are trained to do that… there is a distinction in their mind, that’s reasonably clear in most cases… It may be, to them that we are being illogical, but my sense is probably the majority of the medical profession view it as a distinction, even though lay people may not!” (Judith). “I don’t know why. It is hard to reason why. You’ve got me squirming in my chair at the moment. There’s no apparent good reason to not give a quick injection… No, you’ve got me over a barrel… it would have been easier, wouldn’t it? It’s probably a coward’s way out. But…”(Hilary).

However Nathan, Robert, Brian and Bill said they did not regard philosophers or bioethicists to be more expert than doctors in recognising a distinction or lack of it between killing and “letting die”. Desmond said, “I think (professional ethicists telling doctors how to behave) is a recipe for failure. I think that the answer, would be better one of dialogue and discussion, rather than direction. And I’m interested in how doctors change their practice, and clinicians need to have buy-in, and be convinced that something’s right, rather than be told that something is right”.

Walter said, in relation to arguments he had had with ethicists about whether there is a moral distinction between AVE and PAS, “They say there’s no difference, I defer to their skills in ethics and philosophy but I, personally, there is clearly a practical difference, a very significant practical difference… The ethicists tell me there’s no moral difference, but I just feel that there is”.

“Quill will tell you that there is no difference between him giving a lethal injection… and my padding around, holding their hand, treating their symptoms, and allowing death to occur when it was going to naturally occur. It’s black and white in my brain and the
way I work… they repeatedly make the argument, if you really think about it properly,
there’s no difference. And I’m an experienced clinician, and there’s a canyon of
difference. To me.” (Bill).

Kerry said, “Maybe for some of them, it’s more like ivory tower and stuff, looking at it
on paper… But the finite lines, when you’re on the ground with a patient they’re often
quite significantly different… To be honest, the practical day to day stuff is a lot more
in your face than mumbling about words. Is there money to pay for my patient’s
treatment, can my patient stay in hospital long enough to get well enough to go home?
These are all real questions. Talking about the semantics of killing and “letting die”…
If you’re employing ten ethicists to talk about that, I’d rather the money went into the
ward. It would achieve a lot more”.

Brian was the most scathing: “It bothers me that these people who claim to be ethicists,
can be so obtuse in their use of logic, to make something which is absurd, sound
sensible… Peter Singer, and Savulescu, they’re very intelligent people, and they can put
up very cogent arguments as to why it’s exactly the same, but you sit back and you say,
‘Yes, but they’re not the same’. And it does trouble me that these people who are
supposedly very bright, can argue that”. He also recognized that he did not have the
skills to argue with philosophers: “I think they’ve confused doctors by making some
people believe that there is no difference, when I think, fundamentally, it’s not rocket
science, they’re two different things. They can’t be the same. You know, one’s an apple,
one’s an orange and you can argue that they’re the same thing. And I have trouble with
those guys, because I’m not smart enough to argue against them. These guys can go
through long and convoluted arguments… and they’re logically very sound, but it boils
down to the fact that they’re trying to make something which is superficially and
actually different, look the same through clever argument… when I think that most of
us, our gut feeling is that, no, they aren’t the same. But the clever people are telling us
that they are the same, therefore we should be allowed to kill people”.

Several said that, for philosophers, the discussion is theoretical, as they neither deal with
dying patients nor have to make decisions about killing and/or “letting die” and carry
them out. Richard said, “I can see how somebody can make a very good argument for
euthanasia in a philosophical, intellectual way, but I think the reality for me both
morally, and the consequences would be enormous… particularly as a health
professional... It’s very easy to argue about euthanasia at that intellectual, academic, philosophical level. I think at the coal face, it would be quite a different thing”. Mark put it the most bluntly: “Now these philosophers, it’s all right for them, they live at Monash. They drink coffee and read the internet... The difference is like watching Federer play, and actually being Federer 45. There’s a big difference. You can comment as much as you like about what he should have done, but you can’t do it yourself.”

And Harry put it the most starkly: “I’m aware (that some philosophers say if one is prepared to let die one ought to be prepared to kill), I’m aware that it’s dishonest, and I challenge those people to come in and cut somebody’s throat instead of giving them morphine and midazolam”. Even Robert said that being the person asked to actually carry out something might make a difference to one’s views: “They (doctors) are the ones that are being asked to do it. And so this may be a slight degree of hesitation… “A ought to do something”, as opposed to “I ought to”.

Richard, Kerry, Andrew, Bill, Vivienne and Ken argued that clinical experience made them see things differently, and that some experience of the medical situation might also lead philosophers to see things differently. “Well, they can come and work here and see that there is a distinction. For all the reasons that we’ve discussed. I think we need to maintain that distinction for the safety and welfare of patients” (Vivienne). “I think professional bioethicists should be on ward rounds. I think they just need to be there. And they should be asked to be on call. They should be asked to deal with families. It’s very easy to come up with scenarios and so forth, and say x y and z must be the case. But they need to be there. They need to look in the patient’s eye, and see what’s going on, the dynamics of the family, what the person has been suffering” (Andrew).

Desmond wondered whether it was time for philosophers to begin to listen to the medical perspective: “If they’ve been saying that (that there is no moral distinction between killing and ‘letting die’) for thirty years, and doctors don’t agree, maybe they should be reassessing whether that’s the right way of putting it”.

45 Swiss tennis player Roger Federer was the 2004 men’s singles champion at the Australian Open.
Chapter Eleven  Discussion

11.1 Introduction
In this chapter I will discuss my findings in three parts. Part 1 concerns the relevant features of the study group, including the common ground they shared. The second and third parts relate to the aim of the study and the specific research questions. The aim of this study was to explore doctors’ modes of reasoning in relation to the nature of the distinction between killing and “letting die” in the clinical context, and the research questions were:

- do these doctors make a distinction between killing and “letting die”?
- how do they make a distinction?
- why do they believe that killing is wrong for doctors (if they do)?

Part 2 concerns whether and how participants made a distinction, in terms of the theme of “taking control”, and Part 3 is about why they believed that killing is wrong for doctors (if they did), which was significantly related to their understanding of the internal morality of medicine.

In the course of the study, I also found that participants had views about bioethics as a discipline, and discussion of these is included in Part 3, as it relates to their perceptions that the particular perspective and experience of doctors, in relation to thinking about killing and “letting die” in the medical role, is not sufficiently taken into account in bioethics.

Part 1: Participants

11.2 Sample characteristics
The study group was atypical of the general population of Australian medical practitioners in a number of ways, as might be expected with a non random, targeted sample. No quantitative conclusions are drawn from the data.

As previously noted, the percentage of Catholic, Jewish and atheist/agnostic participants is higher in this study than in previous studies of Australian doctors’ attitudes to end of life decision making, while the percentage of Anglicans and other Protestants is much
lower. It is possible that the respondents who self identified as agnostic but indicated that they had a Christian background would have indicated an Anglican or other Protestant church affiliation if asked about religious affiliation rather then beliefs and practices. (As previously indicated, religious nominalism is frequent in Australia (Hilton, 2001)). This would have changed the percentages for Anglican/ Protestant and ‘No religion’ to 20% and 40% respectively, more in line with the other studies.

The higher percentage of Catholics in the sample may be related to the fact that three of the four hospitals from which they were recruited had a Catholic affiliation, although there were no Catholic participants from two of these hospitals. It may also be that the higher percentage of Catholic and Jewish respondents reflects a greater interest in, and stronger opinions on, the topic of the study. A European study of doctors’ attitudes and experiences in end-of-life decision making concluded that non-participation causes an overestimation of support for both life-shortening, and life-prolonging actions, as non-responders more often have ambivalent attitudes than responders (Fischer et al., 2006). As part of a larger survey (Miccinesi et al., 2005), non-responders in Denmark, the Netherlands, Sweden and Switzerland were surveyed to determine the direction and magnitude of participation bias. There were no significant differences in socio-demographic characteristics between responders and non responders, but non-responders more frequently gave neutral answers to questions about AVE and life-preserving treatment. If this is true in relation to a mailed questionnaire, one might expect an even greater effect in relation to a one hour face to face interview, which requires greater effort on the part of the doctor than returning a questionnaire. Several participants in this study had very definite opinions about AVE/PAS, with Walter and Robert arguing strongly for their legalisation, and Brian and Bill arguing equally strongly against it. These interviews seemed to take the form of an attempt to persuade me of their position, rather than a dialogue or exploration of ideas.

Forty percent of the study group were female, which is higher than the 4.3 percent of Australian surgeons (Douglas et al., 2001), 24 percent of general practitioners in New South Wales and the Australian Capital Territory (Baume & O'Malley, 1994) and 28 percent of Queensland doctors (C. M. Cartwright et al., 2002), but similar to the 41 percent of Australian general practitioners (I. Wilson et al., 1997), in previous Australian studies where this information is available. In 2004, thirty two percent of clinicians in the Australian medical labour force were female, including 20.3 percent of
specialists, and 49 percent of primary care doctors (Australian Institute of Health and Welfare, 2006, p.6). The fairly high percentage of female participants in this study group as a whole is due to the very high percentage (61.5 percent or 8 of 13) among the palliative care physicians. The proportion of females in the Victorian members of the Australian Chapter of Palliative Medicine of the Royal Australian College of Physicians is 44 percent ⁴⁶, which is higher than for medical specialists in general, but still lower than in this study group.

The levels of approval of AVE are surprisingly low in this study. Twenty seven percent of the study group did not believe AVE was morally wrong, compared to 45 percent (Stevens & Hassan, 1994) and 59 percent (Baume & O'Malley, 1994) in previous studies, and 17 percent either supported or were not opposed to its legalization, compared to 45 percent (Stevens & Hassan, 1994) 58 percent (Baume & O'Malley, 1994), 37 percent of medical specialists and 29 percent of general practitioners (Steinberg et al., 1996), 35 percent (Steinberg et al., 1997) and 36 percent (C. M. Cartwright et al., 2002), in previous studies. The 10 percent who were not morally opposed to AVE but were opposed to its legalization compares with 25 percent in another study (C. M. Cartwright et al., 2002).

The low level of approval of AVE could be related to a number of factors, the first of which is the higher than expected numbers of Catholic participants. However the relatively high proportion of the sample (50 percent) who were agnostic or atheist might have been expected to increase the level of approval of AVE. In the general Australian community, the highest levels of support for AVE are found in those with no religious affiliation (83 percent) and the lowest (67 percent) in Catholics (Baume et al., 1995, pp. 52-53), and studies of Australian doctors have found the same trend (Baume et al., 1995; Douglas et al., 2001; Waddell et al., 1996), as well as two U.S. studies (Emanuel et al., 2000; Schwartz et al., 2001) and one in Italy (Grassi et al., 1999). In this study, no Catholic (active or non-practicing) believed AVE to be morally permissible or supported its legalization. Neither did any participant with any religious beliefs: but 53 percent of atheist or agnostic participants believed AVE to be morally permissible. Eight of the twelve participants who had current religious beliefs indicated that this influenced their thinking on moral issues, and two non-practicing Catholics also said

⁴⁶ Statistic provided by Administrative Officer of the Adult Medicine Division of the RACP, per email.
that their Christian religious upbringing had contributed to their opposition to AVE/PAS.

The second possible contributing factor to the low level of support for AVE in this study is the large proportion of palliative care physicians (43 percent) and oncologists (30 percent) among the participants. In U.S. studies, doctors who frequently treated terminally ill patients were less likely to support the legalization of PAS (Bachman et al., 1996), and haematologists and oncologists were less likely to do so than other doctors (Cohen et al., 1994). A Swiss study using an anonymous questionnaire with hypothetical scenarios sent to 726 palliative care specialists, 148 oncology health care professionals, and 140 medical students, found that the oncology health professionals were more in favor of AVE and PAS than the palliative care specialists, but less in favor than the medical students. The authors concluded that familiarity with the care of severely ill and dying patients is important in explaining variance in medical attitudes (Marini, Neuenschwander, & Stiefel, 2006).

The third possible contributing factor to the low level of approval of AVE is the higher number of women in the sample than in most previous studies. Three studies have demonstrated an influence of gender on medical attitudes to AVE, although most have not. One Australian study revealed that female doctors were significantly less likely to agree to “assisted death” (Waddell et al., 1996), and in a Finnish study, females agreed more strongly than males that “active euthanasia is reprehensible” (Hinkka et al., 2002). Another Australian study showed that female doctors were significantly more likely to say that they were not morally opposed to AVE but were opposed to its legalization. In this study, two of the three doctors who took this position were female, but there was no apparent difference in the proportion of male and female doctors who were morally opposed to AVE and its legalization (72 and 75 percent, respectively).

In addition, the risk of possible criminal charges being brought against a participant who revealed having participated in AVE or PAS, which was emphasized in the participant information and consent forms, and the warning (at two sites) that if any potentially incriminating material was revealed the interview would be abandoned and the audio-tape wiped, might have deterred some doctors who had performed AVE or PAS from participating in the study.
11.3 Stories

Initial stories were told by doctors to illustrate how they had struggled with whether there was a difference between killing and “letting die” (with the exception of Craig’s story, which dealt simply with a request for AVE). Participants who thought the issue was straightforward did not tell such a story: Bill, Annette, Vivienne, Mark, Natalie, Oliver, Desmond, Brian, Andrew and Ruth because they thought that both the conceptual and moral difference is clear, and Walter and Robert because they did not believe there is a moral difference. Ken could not recall a situation which raised the issue of the conceptual difference between them (which he thought is clear), although he said he did not believe that the difference is morally significant.

Events described in stories from early in the doctors’ career clearly had a significant impact, to be singled out from so many clinical encounters, remembered and recounted. Three early stories were also initial stories, but the other three emerged spontaneously during the interview. These were stories of distress in dying patients, which also seem to have to distressed the doctor. They may also have influenced the doctors’ attitudes to killing and “letting die” issues. Paul remembered thinking that it was good that a patient should die of a morphine overdose (perhaps suicide) after giving a party to say good bye to her friends. Kate was convinced of the need to give adequate doses of analgesia, even if potentially risky, for patients in severe distress. And Mark recognized that dying patients can suffer unbearably, and may well prefer a quick death, although he is opposed to AVE, and believes modern palliative care can manage such suffering much better than it used to.

Some stories were of events that participants explicitly said had significantly influenced their thinking about AVE and/or PAS (key experiences). All but one of these occurred early in their medical careers. Two were from supporters of AVE: Robert recounted the first instance of AVE he observed as a resident, and his view that this was not unusual, while Paul explained that his view, that AVE might be justified for patients with severe chronic neurological disorders such as motor neurone disease, related to his experience with such a patient, who had attempted suicide.

Harry, Desmond and Hilary ascribed their desire to relieve suffering to particular, distressing experiences with the dying where suffering was not relieved, although they did not support AVE. Both Margaret and Alison, who are practicing Catholics, told of
experiences which occurred early in their lives, when they were dealing with patients, although not in the role of a doctor. Margaret recalled becoming aware of the dangers of the “slippery slope”, when a life is deemed not worth living. And Alison described how a fundamental belief about the value of human life was renewed in her, after this had been “dulled” during her postgraduate medical training. These “key experiences” are similar to the “turning points” described in a qualitative study of palliative care physicians in Wellington, New Zealand, which were “deep emotional experiences” some of which happened very early in the doctor’s career, which gave them a new perspective, in this case, on the notion of caring for dying patients (MacLeod, 2001, p.1725).

Stories involving close friends or family members revealed that these doctors did not tightly compartmentalize their professional and personal lives. Some of these events also seemed to have directly influenced participants’ attitudes to killing and/or “letting die”. Richard’s experience with a disabled friend made him wary of the dangers of the “slippery slope”, and whether legalized AVE might be extended to non-voluntary or involuntary euthanasia (where the patient is incompetent, or competent but makes no request, respectively). Harry was convinced of the need to provide adequate analgesia, and the experience of his wife’s death at home convinced Ian that the suffering of a dying patient could be managed without AVE or PAS.

11.4 Common ground
The finding of a substantial core of common beliefs among participants of different gender and from different specialties, age groups, religious beliefs and attitudes to AVE suggests that these beliefs may arise from participation in the practice of medicine, which was one thing all participants had in common, despite their differences in other respects.

11.4.1 Permissibility of, or obligation to, withhold or withdraw treatment

It is not surprising that there was general agreement among all participants on this issue, as it is in accordance with standard medical practice and the position statements of Medical Associations. The obligation to respect a patient’s refusal of treatment arises from the ethical principle of respect for patient autonomy, as well as the law of trespass.
Participants recognized this obligation even when they did not agree with the patient’s decision and found it distressing, although in the case of discontinuation of artificial ventilation, three participants (who did not face this decision personally) said they would not personally be prepared to do it, if the patient was conscious (Dot and Tom) or under any circumstances (Nathan).

Apart from the situation of refusal of treatment, participants thought of the decision to withhold or withdraw treatment as primarily a medical decision, based on judgments of futility, and on balancing the burdens and risks of treatment against its potential benefits. These concepts are not independent, but closely interrelated. Medical futility refers to “interventions that are unlikely to produce any significant benefit for the patient” (Jecker, 1998). The balancing of burdens and risks against benefit is expressed in the ancient Hippocratic tradition in the Oath: “I will follow that system of regimen, which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous” (Adams, 1959), and the concept of futility is expressed in The Art, which advocates: “refusing to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless” (Amundsen, 1989, p.251).

Decisions to withhold or withdraw treatment would sometimes be informed by the patient’s (or possibly surrogate’s) views and values, although in the case of withholding treatments, the decision might not even be discussed with the patient or family at all, and a number of doctors spoke of withholding or even withdrawing treatment against the wishes of the patient or their family if the treatment was not appropriate in the judgment of the doctor. These views and practices are in contrast with the views of bioethicist Robert Veatch, who argues that the patient, not the doctor, should determine what is a good or a harm for them, what is futile for them, and how the relative weights of burdens/risks and benefits of treatment are assessed in their own individual case (Veatch, 1995).

Some bioethicists distinguish between physiological futility, referred to by a number of participants, where treatment cannot have the desired effect, and normative futility. They agree that doctors ought to withhold physiologically futile treatments and refuse to give them even if asked (Brody, 1998; Veatch, 2005; B. E. Wilson, 1996). But participants alluded to two senses in which a treatment might be considered futile. The
first was what has been called “quantitative” futility, where the probability of an intervention resulting in benefit is extremely low, and the second, “qualitative” futility, where the intervention will produce a benefit, but one of “exceedingly poor” quality, or where there are questions about the value or purpose of this “benefit” (Gampel, 2006). Assessments of both quantitative and qualitative futility involve a value judgment of what constitutes benefit, rather than simply an assessment of whether a treatment will produce a physiological effect (Jecker, 1998). The concept of quantitative futility raises the difficult questions of how the probability of success is determined, and exactly how low is “extremely low”? Qualitative futility is most frequently invoked where life can be sustained but only for a short time, or in a severely damaged state, such as the permanent vegetative state (Gampel, 2006).

Veatch argues that such judgments, of quantitative and qualitative futility, should not be made by doctors, as there is no medical basis for them (Veatch, 2005). He says that doctors cannot know what is in the patient’s “best interests”, even in the narrow sense of what is good for them in terms of their health, because as experts and professionals, doctors’ value judgments are atypical of the general population. Further, while, for example, life in a persistent vegetative state might not be considered a benefit to the majority of the population, or the medical profession as a whole, it is so considered by some people, and this is not an issue which can be settled by medicine or science (Veatch, 1995).

It may also be argued that, in Western liberal individualist societies, in which the doctor and the patient have no shared vision of human flourishing, there is no account of what is good to give content to beneficence other than the patient’s (or their surrogate’s) conception of what is good for him or her (Engelhardt & Wildes, 1994). Thus there ought to be “a priority or precedence of the values and views of patients” so that doctors “allow people to live, die and practice according to their personal view and value systems” (Neuberger, 2003, p.6). As another philosopher puts it, “It is the patient’s life that is at stake, and it should be the patient who decides” (Gampel, 2006).

Against this, it may be argued that doctors are not obliged to offer treatments which are inconsistent with professional standards of care, but that it is the profession as a whole, not the individual doctor, which has the ethical authority to determine these standards (Jecker, 1998).
11.4.2 The obligation to relieve suffering

The emphasis placed by participants on the medical duty to relieve pain and suffering is not unexpected, given that this is an internationally accepted goal of medical practice in general (Allert et al., 1996b), and of palliative care in particular (Hurst & Mauron, 2006; National Consensus Project for quality palliative care, 2004). However, it is sometimes claimed that some religious opposition to euthanasia comes from the belief that “suffering is part of the divine plan for the good of man's soul, and must therefore be accepted” (Fletcher, 1950, p.10). None of the participants expressed this view, nor does it reflect current Catholic doctrine: “Suffering is a fact of human life, and has special significance for the Christian as an opportunity to share in Christ's redemptive suffering. Nevertheless there is nothing wrong in trying to relieve someone's suffering; in fact it is a positive good to do so, as long as one does not intentionally cause death or interfere with other moral and religious duties” (United States Catholic Conference, 1971).

11.4.3 Medical unwillingness to kill

I did not find any evidence in this study of what many people suspect to be the frequent practice of AVE and/or PAS by doctors.

The strength of language used to describe medical killing by participants who were opposed to it is striking. Such language was used both by doctors who had religious beliefs, and those who were atheist or agnostic. What is especially noteworthy is that the personal reluctance to perform AVE was expressed by five of the eight doctors who were not in principle morally opposed to it, including, surprisingly, three of the five who were not opposed to its legalization, two of whom were advocates of AVE. This finding is consistent with the discrepancy between support for legalisation of AVE/PAS and the willingness to practice it oneself if it were legalized, that has been observed in previous studies in the United Kingdom (Shah et al., 1998), Canada (Verhoef & Kinsella, 1996) and the United States (Bachman et al., 1996; Cohen et al., 1994; Ganzini et al., 2001; Lee et al., 1996; Roberts et al., 1997; Rosner, 1995). The unwillingness to administer a lethal injection was also expressed by one participant who had some doubts about whether it was morally much different from his practice of sedation in the terminally ill, which accords with the comments of Australian surgeons who were prepared to hasten death by an infusion but not with a bolus dose (Douglas et al., 2001).
Whatever their attitudes to the moral difference between killing and “letting die” in the medical context, participants agreed that there is an emotional or psychological difference between them from the doctor’s perspective, and a great reluctance to kill a patient, although both PAS advocates thought this reluctance might and should be overcome if there was a sufficient moral justification, or as a “last resort”.

The view that the psychological effect on doctors of killing would be very different to that of “letting die” was expressed as long ago as 1884 in an editorial in *The Boston Medical and Surgical Journal*: “Perhaps logically it is difficult to justify a passive more than an active attempt at euthanasia, but certainly it is less abhorrent to our feelings” (cited in (Fye, 1978, p. 501-2)), and more recently by an American family medicine physician: “Regardless of the technical arguments, the two practices would be emotionally very different for most practicing physicians” (Gates, 1997, p.2438).

The emotional impact of being involved in AVE or PAS is not often discussed in the bioethics literature. Yet a prominent Australian advocate of both practices, Dr. Philip Nitschke is reported as saying of his involvement in the death of Bob Dent, the first patient to die under the *ROTI* legislation of the Northern Territory, “I was dreading the actual event. That’s when I put all this effort into building the machine. I didn’t want to sit there alongside him and give him a lethal injection. I’m not suggesting it took away my responsibility. But it was bad enough feeling like some sort of executioner, which haunted me; I’d have felt worse if I’d been sitting there, delivering the injection” (Cosic, 2003, p.19).

Similarly, Magnusson’s study of health professionals involved in the “euthanasia underground” in Australia and San Francisco described the high personal cost of involvement. One participant said, “I hate it” and another that it was “emotionally demanding and draining… there’s only a finite amount of times you can do it” and “I think I’ve almost reached the expiry date”. Involvement in AVE was probably especially stressful for these health professionals because they were “frequently killing their friends”, often acting in a personal rather then professional capacity, and because of the illegality and necessary secrecy of their actions” (Magnusson, 2002, p.242-243).
However repeated involvement in AVE might be expected to decrease the reluctance to be involved and lessen the emotional impact. Some participants in Magnusson’s study said that their stress levels declined with experience. One said, “I feel very comfortable. I have no problems sleeping at night” and another, “After doing several, you get over it quicker… I suppose that could be an argument for the thin end of the wedge… that maybe now it’s just a short step to me actually enjoying this, but I think that’s going too far” (Magnusson, 2002, p.242).

11.4.4 The doctor’s moral autonomy
Irrespective of their views on the morality of AVE and PAS, no participant thought that doctors would be morally obliged to provide AVE and/or PAS if they were legalized, and many said that there would be no such moral obligation, and should be no legal obligation, to do so. They spoke of their personal moral values, of doctors necessarily making moral judgments, and acting according to conscience. This might seem non-controversial. However, the prominent Australian bioethicist Julian Savulescu argued in an article in the *BMJ* in early 2006 that “a doctor’s conscience should not be allowed to interfere with medical care”, that, at least in the public health system, “all doctors and medical students should be aware of their responsibility to provide all legal and beneficial care’, and that “conscientious objectors who compromise the care of their patients must be disciplined”, although he ceded that “conscientious objection may be permissible if sufficient doctors are willing to provide the service” but that “conscientious objectors must ensure that their patients are aware of the care they are entitled to and refer them to another professional”. He claimed that the determinants of medical care are the law, the just distribution of finite resources, and the patient’s informed desires, not the doctor’s values (Savulescu, 2006, p.296). The abstract read, “Deeply held religious beliefs may conflict with some aspects of medical practice. But doctors cannot make moral judgments on behalf of patients” (p.294).

Savulescu’s article provoked a flood of outraged responses to the *BMJ* from doctors in the U.K., as well as the U.S., Greece, the Czech Republic, Australia, New Zealand and Hong Kong(Various, 2007). It was described as illogical and muddled, “catastrophically wrong”, outrageous, and reflective of a bleak world where doctors are “mere technical functionaries”. One writer, an English general practitioner whose letter was published said that after thirty years of reading the *BMJ*, this article was the “first one to make me feel physically sick” (V. Smith, 2006), and another withdrew his membership of the
BMA and subscription to the *BMJ*. The editors of the *BMJ* were criticized for publishing the article without any qualification, disclaimer or balancing argument. Common themes in the responses were the need to respect the autonomy and freedom of choice of doctors as well as patients, that doctors who practice without values or a conscience would be dangerous, that Savulescu himself was guilty of doing what he accused others of, that is, attempting to impose his own values on others, and the view that conscientious objection to practices such as abortion and euthanasia is not necessarily related to religious belief.

Savulescu also came in for criticism from fellow bioethicists. Another response published in the *BMJ*, from a clinician and a philosopher, said that Savulescu had violated the standards of argument based ethics in failing to provide any reasons for his “contentious claim” that the law and the just management of resources are the ethically authoritative sources of the moral obligations of doctors (Chervenak & McCullough, 2006). A U.S. bioethicist said that even when disagreeing with their moral stance, “I respect professionals who sometimes decide they should not deliver the service they are asked to perform… We should encourage practitioners to draw upon their own moral convictions. To do otherwise would treat medical professionals as automatons instead of moral agents… society should not require people to behave in ways that go against deeply held convictions” (Asch, 2006, p. 11).

**Part 2 “Taking control”**

**11.5 Features of doctors’ reasoning about the distinction between killing and “letting die”**

**11.5.1 From the perspective of the doctor as moral agent**

There are two aspects to the perspective of a doctor in relation to killing and “letting die”. The first is that it is the perspective of the killer/”letting die”, rather than that of the one killed/”let die”, or the one who observes killing/”letting die”. As one doctor put it, “The person doing the killing would be me… The problem is that I’m doing it. And that’s a different question”, and another, “If I inject something, then it’s me that takes the person’s life”.
Several participants commented on the difference between agreement with an action in theory, and actually being willing to carry it out oneself, in terms of the difference between “A ought to do something”, as opposed to “I ought to” (Robert), or the difference between “watching Federer play, and actually being Federer” (Mark).

The agent’s perspective is also apparent in two of the criteria used in this study to distinguish killing from “letting die”: certainty/uncertainty and intention. From an impartial perspective, certainty/uncertainty may be dismissed simply as a matter of probability, and intention may be difficult to discern, but from the perspective of the one acting, it seems that is very different to be in doubt about the outcome than to be absolutely sure, and that one has access to one’s own intention that observers do not have. These criteria, and the relationship between them, will be discussed further below.

The agent’s perspective is also apparent in the way that half the participants described medical killing in terms of “taking control”. AVE is often framed as giving the patient control over their death (and Robert described it this way), but from the perspective of the one acting, some of the doctors described it as themselves taking control, determining or deciding on death, or playing God.

Another example of the difference that perspective makes is the finding that all but one of the doctors in this study either did not distinguish morally between AVE and PAS, or thought that PAS could be morally worse than AVE. They classified both as killing from the perspective of the person actually performing either action. This is despite the fact that there is a more active and direct role for the doctor in AVE than in PAS, and is consistent with findings in previous Australian studies (Baume & O'Malley, 1994; C. M. Cartwright et al., 2002; Kuhse et al., 1997). But AVE and PAS might well be seen as morally different by a patient, as was recognized by four participants, because the patient makes the final decision and performs the final action, and may in fact decide not to proceed. On the other hand, participants did distinguish clearly between PAS and other types of suicide, and between PAS and the situation where a patient suicides using drugs a doctor has prescribed, but not for that purpose. Yet there need be little if any morally significant difference, from the perspective of the patient, between suicide by means procured oneself, and suicide using drugs prescribed by a doctor, with or without the doctor’s intention that the patient use them for that purpose.
The argument from a patient perspective that PAS is morally different from AVE, and so ought to be legalized while AVE should not, is based on the greater exercise of patient autonomy in PAS, and the claim that it involves less potential for coercion and abuse (Meier, 1992; Quill et al., 1992; Watts & Howell, 1992). Some supporters of both practices argue that PAS is preferable for the patient for psychological reasons, in that the patient can choose their own time to take the medication or even change their mind, and that they and their family and/or friends may prefer privacy rather than a medical presence at the time of death (Brody, 1992; Glover, 1977). On the other hand, as recognised by some of the participants, PAS might be psychologically worse than AVE from a patient perspective because of the sometimes lengthy period, which may be stressful and frightening, between the ingestion of oral drugs and death, and even the possibility of failure of the drugs to ensure death (Mitchell & Owens, 2004).

From an impartial perspective, PAS and AVE differ simply because in the former, the patient kills herself, while in the latter the doctor kills the patient (Thomson, 1999). Beauchamp argues that PAS is not (medical) killing at all, because the doctor “is not the cause (the proximate cause)” of the patient’s death (nor is it “letting” die) (Beauchamp, 2004, p.127).

But when the practices are compared from the perspective of the doctor as agent, “in each, the physician plays an active and necessary causal role”. In each case there is a partnership between doctor and patient, who “together kill the patient”; the only difference is who acts last (Brock, 1993a, p.204). As Dixon says, “their moral similarity derives from the similar roles of the physician” (Dixon, 1998). Many participants said that their reason for regarding the two practices as morally equivalent was that the intention of the doctor was the same in each case. Likewise, from a medical perspective, PAS was distinguished from the situation where a patient suicides by any other means, including the use of drugs prescribed by a doctor but not for that purpose, by the involvement of the doctor in intending death. So PAS is considered to be killing, at least morally equivalent to AVE. Some thought it was possibly worse from a medical perspective, because it represents an abandonment of the patient, “not caring”, and a failure of courage, because it is easier for a doctor to maintain a distance between their action which is intended to cause death (writing a lethal prescription), and the result of that action. It is easier not to be present and not to have to overcome the reluctance to
actually administer a lethal injection. This view was also expressed by participants in a previous qualitative Australian study (Magnusson, 2002).

However, it is not only doctors who might perform AVE or assisted suicide. Other health professionals, particularly nurses, and relatives or friends of people who wish to die would also need to consider the distinction between killing and “letting die” from the perspective of a potential killer/“letter die”. So the second aspect of the distinctive medical perspective is that the question for doctors is more specifically framed as, “Is it different (and how) if I kill a patient as a doctor, as opposed to if I allow that patient to die?”

The difference that a medical perspective makes is perhaps most clearly seen in the prominence given by participants to reasons for the wrongness of killing based on the role of a doctor, which will be discussed further below. A number of participants stated explicitly that they could not consider the morality of AVE as if they were not a doctor, because they could not separate their person from their profession. However, it is interesting that when two participants contrasted their attitudes as doctors with how they might see things as a patient, there was a discrepancy. They said they could imagine wanting AVE as a patient, but could not imagine doing it as a doctor. Similarly, for five of the eight doctors who were not in principle morally opposed to AVE, including three of the five who were not opposed to its legalization, there was a discrepancy between theoretical or general approval of AVE and willingness to be involved in it oneself, even if it were legalized.

Several participants pointed out that, for some philosophers, the discussion about killing and “letting die”, is theoretical, as they neither make such decisions, nor carry them out. A number of them thought that clinical experience made doctors see things differently to other people, and that some experience of the medical situation might also lead philosophers to see things differently.

11.5.2 Concrete and particular
While they are able to generalize about killing and “letting die”, for example in giving definitions of these terms, the second feature of how the doctors in this study think about the distinction between them is that they also make extensive use of particular, concrete clinical examples, usually from their own experience. And while the criteria
they use to make the distinction are similar to those found in philosophical discussion of
the issue, there is relatively little use of abstract philosophical principles or doctrines.
For example, although four participants mentioned the PDE in passing, only three
(without explicitly naming it) described it, and either did not find it useful or rejected it
altogether. One said he preferred to speak about it in terms of ordinary medical practice
“It’s just … part of our day to day practice where we take risks”, and another also did
this: “None of us can say that some of the decisions we make… don’t shorten people’s
lives”. This way of framing treatment decisions accords with the concept of
proportionality or “therapeutic ratio” (Ashby & Stoffell, 1991).

The concrete and case based aspect of doctors’ moral reasoning is illustrated by the
extensive use of stories by many participants, with sixteen telling multiple stories.
Stories were of the doctors’ own experiences, mostly told in the first person, and some
of these were very personal and rich in detail, including the teller’s emotional responses
in the situation. Almost all stories were of clinical situations, though the participant was
not always the clinician involved (as in the personal stories of friends or family
members). Stories locate the doctor and her moral reasoning in particular places and
times, and the distinction between killing and “letting die” in relation to real, individual
doctors and patients, rather than hypothetical or generalised situations.

All twenty one doctors who gave definitions of killing and “letting die” did so
specifically in relation to the medical context. In terms of examples used to illustrate
their argument, the great majority were from their own clinical experience, and a
number were from current or well known legal cases of clinical situations in Australia
and overseas. Only two non-clinical examples were used by any participants and these
were examples from everyday life: the difference between a driver killing a child
intentionally or accidentally, and the difference between “letting people die” overseas in
warfare and natural disasters by doing nothing about it, and actively killing them. (This
latter example is also often used in philosophical arguments about the distinction
(Gibson, 1998)).

The use of particular and concrete examples may be compared with some of the
philosophical debate about killing and “letting die”, which is framed in terms of abstract
and generalized, universal concepts. The direction of these arguments about any
distinction between them, and of any moral significance in that distinction, is from the
universal to the particular, from the abstract to the concrete, and so if there is no conceptual or moral difference at this universal and abstract level, it is argued that there can be none at the particular, concrete level of real life situations of killing and “letting die”, such as occur in medical practice. And in contrast with medical thinking about the issue, the examples used to test the logic of a particular definition of the distinction or of its moral significance are often (though not always) hypothetical and fanciful, posing dilemmas which are unlikely to be faced in the real world. Such an approach will necessarily be adopted by those working within the framework of an impartial normative ethical theory, such as consequentialism.

A virtue ethics approach, however, with its focus on the moral agent rather than exclusively on the act performed or its consequences, recognizes that moral judgments are made by particular people in particular concrete situations and contexts. Virtue ethicist Martha Nussbaum suggests that “immersed particular judgments may have a moral value that reflective and general judgments, of whatever level of generality, cannot capture” (Nussbaum, 1987, p.69). Fellow virtue ethicist (and practicing neurosurgeon) Grant Gillett suggests that the judgments of those who are immersed in the dying situation should be given special weight, since it may be that “general and abstract arguments fail to take account of the complex and particular situations which are found in the care of those with terminal illness” (Gillett, 1994, p.312), but that these “elusive aspects” of moral reasoning are often neglected in philosophical discussions, which tend to use “simplified and under-described or imaginary cases” (p.319).

Gillett claims that it is in particular and complex situations that there are “perceptions and intuitions available that do not easily find propositional form but lead most of those whose practice is in the care of the dying to resist active euthanasia” (p.312). While conceding that there is a legitimate role for the notion of moral intuition, Gillett’s fellow New Zealand philosopher Jim Thornton counters that “the reason why ‘intuitive’ ethical decisions in particular situations often deserve to be taken seriously, especially when made by experienced, sensitive and morally perceptive agents, is because good reasons and arguments can be produced in support of those decisions, though not necessarily by the agents who made them... If there is no way in which such intuitions can be given rational support, there is no way in which we can distinguish sound intuitions from judgments founded on ignorance and prejudice” (Thornton, 1999, p.418).
As a consequentialist, Thornton claims that medical intuitions about the moral distinction between killing and “letting die” are not supported by good reasons and arguments, and implies that there is only one possible rational (philosophical) answer to the question (his own and that of his fellow consequentialists). However the disagreement among philosophers on the issue suggests rather that “philosophy as such delivers no verdict on moral issues; there is no unique set of moral principles which philosophy as such underwrites” and so when consequentialist bioethicists speak, “it is their voice we hear and not the voice of reason or rationality”, since there is no single uniquely rational answer to moral questions (Maclean, 1993). Different normative ethical theories begin from different premises, and while some proponents may claim that the premises of their favoured theory are more rational than those of the alternatives, “the rival premises are such that we possess no rational way of weighing the claims of one as against the other” (MacIntyre, 1984, p.8).

11.5.3 An inclusive understanding of “letting die”
Philosophical debate treats the distinction between killing and “letting die” by treatment withholding or withdrawal (category 1), and the distinction between killing and the use of symptom relieving drugs which might foreseeably hasten death (category 2) as two separate though related questions, the first involving the doctrine of acts and omissions (DAO), and the second the principle of double effect (PDE). Indeed, as noted in chapter two, the terms “letting die” or “allowing to die” are usually used by philosophers in the medical context only in relation to treatment abatement. However in this study, all but five participants (four of the six intensive care physicians, and one oncologist) included the use of analgesia and/or sedation at the end of life under the heading “letting die”. And while nine of the twenty one participants who defined killing and “letting die” did so in relation to treatment abatement, six did so solely in relation to potentially life shortening medication at the end of life.

Several criteria were used by participants to distinguish killing from both category 1 and 2 “letting die”, with intention and certainty/uncertainty the criteria most often used in relation to both, but also the natural/artificial and causation criteria. Six participants gave a definition of killing and “letting die” in general terms which combined the two categories of “letting die”. In practice, the two categories can occur together. In palliative care, curative treatment for the underlying terminal condition is no longer being provided and even treatable illnesses such as infections may not be treated if this
is regarded as futile, while analgesia/sedation is used where necessary to treat symptoms (although, for example, infections may be treated if that is appropriate to address symptoms). And sometimes patients who have treatment such as mechanical ventilation or artificial nutrition and hydration withdrawn require opioids or sedation to alleviate symptoms of respiratory distress or hunger and thirst, respectively.

In addition, six doctors discussed the distinction between physician-assisted suicide by the writing of a lethal prescription, and the situation where a patient uses hoarded prescribed drugs to suicide without this being the intention of the doctor in providing the prescription (category 3), a distinction which is not included in the usual philosophical treatments of the killing/“letting die” distinction. There were no cases of a doctor making a conceptual (or moral) distinction between killing and one category of “letting die” but not the others, when more than one category was discussed.

These observations suggest that the fundamental and important distinction for doctors is not so much between killing and specific categories of “letting die”, but between medical practices which are killing and those which are “not killing” from the doctor’s perspective.

11.5.4 A clear conceptual distinction between killing and “letting die”
However difficult it may be to distinguish killing from “letting die” in non medical contexts and hypothetical situations, especially those involving a conflict situation where one is forced to choose between killing or saving different individuals, in the medical situations discussed by participants in this study, the conceptual distinction was generally unproblematic. Despite acknowledging that the distinction could sometimes be very fine, small or subtle, and that it could be difficult to make, grey or blurry, all but Walter drew a clear and important conceptual distinction between killing and each of the categories of “letting die” that they discussed, although Judith was uncertain whether in some circumstances withdrawal of ventilation could be called “killing”. The distinction was sufficiently clear for there to be agreement amongst all those who made it about what was killing and what was letting “die”, with the exception of two of the Jewish doctors, who considered the withdrawal of artificial ventilation and/or of artificial nutrition and hydration as “killing”47.

47 There is no one, unified Jewish view on the withdrawal of life-prolonging treatment. One view is that it is forbidden on the grounds that health professionals must prolong life, as long as there is some form of
Participants would generally agree with those philosophers who accept the conceptual distinction, but say that what is important is whether there is any moral significance in the distinction: “There is no question that letting someone die and killing someone are different acts, distinguishable one from the other. But it is unclear that these acts result from distinct moral choices” (Kary, 1980, p.326). Or as another author puts it: “The dispute is not over whether some distinction between killing and letting die exists. No one argues that acts of killing are ‘acts’ of letting die. It is rather over the relevance of the distinction to our moral assessment of the action or agent in question” (Pinches, 1987, p.193) ⁴⁸.

Likewise, in relation to the use of analgesia/sedation at the end of life which might possibly shorten life, all participants distinguished this conceptually from a lethal injection, if only on the criterion of immediacy. What was at issue is whether the distinction has any moral significance.

11.5.5 A combination distinction
Another feature of participants’ reasoning about the distinction is that it involved a combination of criteria. Meeting any one criterion for killing was a necessary but not sufficient condition for calling a particular medical action “killing”. This is seen most clearly in relation to the distinction between killing and category 1 “letting die”. If they were unsure on the basis of one criterion, they turned to another to make the judgment. So, what some participants thought of as an act, such as withdrawal of ventilation (Dot), withdrawal of PEG feeding (Mark) or of a pacemaker wire (Ian) was not called “killing” because it did not meet the criterion of causation. Conversely, Andrew did not call the withdrawal of PEG feeding “killing”, although he considered it as causing death in certain circumstances, because he saw that it did not meet the criterion of being an act, instead being a medical omission, and the removal of an artificial intervention. In a similar way, using a combination distinction it can be argued that though the criterion of independent life, which today is determined by the presence of brain activity on EEG. Another is that artificial nutrition and hydration may be ceased, but without removing intravenous or feeding tubes, thus avoiding a direct action which might be seen to hasten death, rather than to allow a natural death(Ross, 1998). Nathan used similar reasoning to this in relation to the impermissibility of withdrawing (but not withholding) artificial ventilation. Another view is that one is permitted (but not obliged) to remove artificial means of prolonging life because this is not considered a positive action (Sherwin, 1974). ⁴⁸ In fact, it has been argued that when withdrawal of ventilation is not justified by the refusal of the treatment by the patient or their proxy, it is “killing by letting die”, since it causes the death of the patient (Beauchamp, 2004, p.127). It has also been claimed that that all treatment withholding or withdrawal causes death and is “killing by letting die” (Gruzalski, 1981).
certainty is met when failing to resuscitate a patient who has suffered a cardiac arrest, or withdrawing PEG feeding from someone unable to swallow, neither of these is “killing” because they are omissions not acts, and they do not cause death. Similarly it may be argued that intention to bring about death is not sufficient to call treatment abatement “killing”, even when the outcome is certain, because treatment abatement is an omission, it does not cause death, and it is natural.

In contrast, some philosophical discussion of the distinction between killing and category 1 “letting die” attempts to reduce the conceptual distinction to a single criterion, such as bodily movement (Isaacs, 1995), causation (Dinello, 1980; Green, 1980; Stauch, 2000) or intention (Quinn, 1997). When a single criterion is used to make the distinction between killing and category 1 “letting die”, the clarity of the distinction may be attacked by the use of counterexamples which seem to show that some examples of “letting die” are in fact killing using that criterion. The strength of a combination distinction is that if one says a particular act/omission must meet all the criteria in order to be classified as ‘killing” and not only one or even two particular criteria, such proposed counterexamples can then be reasonably described as “letting die”, even if they meet one or more criteria of killing.

The use of a combination distinction is less obvious in participants’ discussion of category 2 “letting die”, but still implicit. For some, the distinction was clear in certain situations because of confidence that there was no causation of death and therefore no alteration of the natural course of the illness. But if causation of death was a possibility, some then asked about how certain one could be about this causation. And if one could be certain, then the question of intention arose. So in some cases of category 2 and all cases of category 3 “letting die”, the distinction eventually depends on a single criterion, intention, but this is because all the other criteria for killing have already been met (act, artificial, causation and certainty). Intention alone does not make an action killing. For example, it is possible that a doctor administers drugs, which he intends to cause death and believes will cause death, but perhaps due to inexperience and lack of expertise in palliative care, he is mistaken in this belief (Ashby, 1997).

Whatever the semantic difficulties of defining acts and omissions in non medical settings, the distinction between them was clear to all but four participants in the medical setting, and this was based on whether an action represented a medical
intervention or the failure to intervene/cessation of an intervention (even where cessation involves a bodily act). This has also been helpfully framed in terms of the difference between a patient requesting treatment and a patient refusing treatment. “A request cannot be paraphrased as ‘Leave me alone’… This distinction between a request and a refusal is not a sophisticated philosophical distinction, but one that is commonly made, both legally and in actual medical practice, where death is not an issue” (Gert et al., 1994, p.14). Even when the patient does not refuse treatment and the doctor makes the decision for treatment abatement, it is clear that the patient is being “left alone”.

However there is an increasing tendency to blur the distinction between patient request and patient refusal, related to an emphasis on respect for patient autonomy and patient choices. For example, the agreement of patients (or more usually their relatives) to discontinuing treatment (such as ventilation or ANH) or not instituting treatment (such as a “Do not resuscitate” order) is often framed as “giving consent” to these decisions. While it is good practice to involve patients and their relatives/surrogates in such decisions, it is not strictly correct to say that “consent” must be obtained to a non-treatment decision. Nor is a doctor morally obligated to commence or continue treatment that is medically inappropriate or to which she has a moral objection, simply because it is requested (or even demanded) 49. The fact that hospitals have sometimes felt obliged to obtain court approval to discontinue treatment in the face of disagreement by relatives is not evidence of doctors’ obligation to treat on request. Rather it indicates ongoing disagreement in the community about when it is medically proper not to treat, and the seeking of court approval is a precautionary measures to avoid future litigation. When doctors proceed with treatment withdrawal in the face of disagreement from relatives, they may face charges of negligence, but not of assault (as they would if they treated without consent).

An implied equivalence of refusal and request is the basis for Beauchamp and Childress’s argument for PAS and AVE: “If competent patients have a legal and moral right to refuse treatment that involves health professionals in implementing their decision and bringing about their deaths, we have a reason to suppose that they have a similar right to request the assistance of willing physicians to help them control the

49 However, in some U.S. states, for example New York, there is a legal obligation to commence DNR unless the patient has refused it, and a legal obligation not to discontinue ventilation in an incompetent patient, without written approval from a proxy decision maker.
conditions under which they die. If the omission of treatment is justified by respect for
patient autonomy and non-maleficence, cannot the same form of justification be
extended to physicians prescribing barbiturates needed by seriously ill patients, and
possibly to physician-administered lethal injections?” (Beauchamp & Childress, 1994,
p. 226).

Claiming such an equivalence ignores the fact that a doctor is morally obliged to respect
a competent patient’s valid refusal of treatment (or that of their authorised surrogate)
and so to withhold or withdraw such treatment, whether or not the decision accords with
their own clinical or even moral judgment. But doctors are not generally held to be
morally obliged to accede to a competent patient’s request for treatment; they must
make their own judgment about its appropriateness (Gert et al., 1994). If a morally
significant distinction between patient requests and patient refusals is not maintained
(corresponding to the distinction between killing and “letting die” through treatment
withholding or withdrawal), it arguably follows that doctors would not only be
permitted but morally obliged to accede to a competent patient’s request for AVE or
PAS. In other words, just as they have the right to refuse treatment and to demand that
their doctor respects this refusal, patients would have the right not only to request but to
expect or demand the assistance of doctors, willing or not, in providing a lethal
prescription or a lethal injection.

One of the most influential criticisms of the moral significance of the act/omission
distinction relied on the demonstration that some of even the clearest cases of omissions
(where the agent literally does nothing) may be just as wrong as acts (Rachels, 1975).
Glover says, “It may well be because of tacit acceptance of the acts and omissions
doctrine that we acquiesce in the worst evils in the world” (Glover, 1977, p.112). If the
DAO said that “there is always a morally relevant difference between an act and an
omission, where the consequences of the act and the omission are identical”, this would
indeed be a powerful criticism. But it does not address the form of the DAO which
states that “there is, or is sometimes, a morally relevant difference between an act and an
omission, where the consequences of the act and the omission are identical”(Gibson,
1998, p. 23), nor the traditional distinction between killing and “letting die”, which
clearly acknowledges that omissions may be as bad as acts (J. Boyle, 1977; Sulmasy,
1998). As McCormick says of Rachels’ examples, “to say that their actions are equally
‘reprehensible’ is to say only that we have responsibility for our acts and our
omissions... no one to my knowledge has ever denied this... But to conclude from this
that commission and omission are morally equivalent is to assume that all cases of
saving patients are situations wherein the physician could have and should have saved
the patient. But this is not the case; there are many instances where one cannot save the
patient, or, all things considered, has no obligation to do so” (McCormick, 1997, p.8).

Further, the argument that there is no intrinsic distinction between an act and omission,
so that failing to save a life is morally equivalent, other things being equal, to killing a
person, is deeply counterintuitive. It is also “intolerably demanding” (McMahan, 1998,
p.416), given that, at least according to one of its exponents, Jonathan Bennett, it means
that we are not permitted to allow any one to be harmed or to die in circumstances
where we would not be allowed to harm or kill them, even to protect our own (lesser)
interests (Bennett, 1995). So demanding in fact, that Bennett admits that “there seems to
be no way out of the difficulty except either to accord fundamental weight to the
making/allowing distinction or to accept the tremendously exigent morality’s
condemnation of our conduct”. He admits, “I am unwilling to hold myself to such a
standard” (Bennett, 1995, p.162-3).

The concept of nature has a long association with medicine, and is closely related to the
concept of intervention. Hippocratic medicine was concerned to establish when
intervention was and was not appropriate, by understanding its task as working with or
assisting nature to restore the “natural order”.

In contrast to Hippocratic medicine, Baconian science which developed in the
seventeenth century could be seen as aimed at conquering and control of nature. When
medicine became scientific during the nineteenth century, it took on the goal of
bending nature to one’s will (Jecker, 1991). Modern medicine might be seen as
constantly intervening in natural processes, including the process of dying. So it may be
surprising that so many study participants seemed to attach moral significance to
whether death occurs naturally or as the consequence of artificial medical intervention.
In this way, their attitudes are similar to those of Australian nurses in a previous
qualitative study, who described the withholding or withdrawing of technological
intervention as “natural” (McInerney & Seibold, 1995).
While, in most respects, modern medicine is thoroughly scientific, the medical distinction between killing and “letting die” may represent a partial persistence of the Hippocratic tradition. The World Medical Association’s Resolution on Euthanasia speaks of "respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness (World Medical Association, 2002). Those who distinguish between “hastening death” and “not prolonging death” imply that there is an appropriate or natural time for death to occur, which should neither be brought forward nor postponed by medical intervention.

“Letting nature take its course” did not necessarily imply complete lack of any medical intervention. Four participants used the term for death when analgesia/sedation was used, believing it did not alter the natural history of the illness, or that it was uncertain if it did. One ascribed significance to the fact that death was due to “natural processes” (usually pneumonia) even when these natural processes would probably not have occurred at that time without the use of sedation.

Daniel Callahan argues that a pattern of “technological monism” has emerged in modern medicine, whereby nature disappears, to be “replaced by what humans do and do not do”(Callahan, 1993, p.67), so that “no death is ‘natural’ any longer… and “no pathology fatal unless failure to deploy a technology makes it so” (p.68).

Why should one attach moral significance to whether a person dies naturally or as the result of human agency? Many philosophers do not. Hopkins argues that just as we are free to liberate patients from the “trap of technology” (by turning off a machine), we ought to “set aside our prejudices against the artificial and set aside our myths of the natural death and extend the option of good killing to those trapped by nature”(Hopkins, 1997, p.37). Rachels’ Principle of Agency states that “if it would be good for a state of affairs to occur ‘naturally’, then it is permissible to take action to bring it about” (Rachels, 1998, p.150). Rachels thinks that any moral distinction between what nature does and what we do is a vestigial religious notion. Nevertheless, doctors (And others) of varying religious beliefs, or none at all, continue to attach significance to whether death occurs by means of a natural process or by a human decision and action. As Carl Elliott puts it: “There is a difference between thinking it best that something should happen and thinking that you should do it- between thinking that it would be best for a person to die and thinking that you ought to kill him or her” (Elliott, 1996, p.1088).
Many participants argued that in killing the doctor causes death, whereas in “letting die” through omission it is the underlying disease which causes death. But if this is the only criterion used to differentiate between killing and “letting die”, it may be argued, using the “but for” test, that some cases of omission or non-intervention in fact do cause death. It has been claimed that withdrawal of ventilation causes death and so is killing (Persson & Savulescu, 2005). (Walter and Nathan agreed with this, and Nathan, Harry and presumably Walter also thought the same of the removal of artificial nutrition and hydration). It has even been claimed that all withholding or withdrawal of treatment in patients with a treatable illness causes death, and so is “killing by letting die” (Gruzalski, 1981). Beauchamp argues that killing is causing death through intentional interventions or non-interventions. Using the example of a doctor discontinuing ventilation of a conscious and competent patient who has not refused the treatment, he argues that “patient authorization” is what makes an instance of treatment withdrawal “letting die” rather than killing because causation is not then attributed legally, whereas if there is no patient authorization, then the doctor would be deemed to be causally responsible for the patient’s death (if they did die) and thus have killed the patient (Beauchamp, 2004, p.127). This is misleading in three ways. First, it confuses patient refusals with patient requests through the use of the term “authorization”. As previously discussed, patient authorization is strictly required only for treatment, not failure to begin or continue treatment. Second, it exploits the ambiguity of the term “killing” which results from the different way that it is used in the law and in general usage (which includes some cases of “letting die”, as discussed in 2.2 above) and the way the term is used in the traditional distinction. Third, it fails to recognise the complex and specialized way that causation is used in the law.

The withdrawal of life prolonging treatment is a situation of multiple causation, in which only one of the causes, the underlying disease, such as respiratory failure, is a sufficient cause of death. The other cause involved, cessation of treatment, is not a sufficient cause, but “the courts could still hold the latter to be a cause for the purpose of the law (a contributing cause) and will do so when (the discontinuation of treatment, such as turning off a ventilator) constitutes an illegal act”(Somerville, 1997, p.564 - 565). Whether a doctor omits treatment properly (because it is futile or burdensome or has been refused by the patient) or improperly (negligently or even maliciously), this omission is not a sufficient cause of death. Even an interloper who illegally disconnects
a mechanical ventilator does not cause the death in terms of their act being a sufficient cause of death. These are all cases of “letting die”, although the doctor’s improper omission/non-intervention and the interloper’s illegal act/intervention are wrong, and would be deemed for the purposes of the law to be a cause of death.

Only two participants addressed the question of whether they would distinguish between wrongful and permissible withdrawal of life-prolonging treatment by calling the former “killing”. Andrew thought removal of PEG feeding wrong in the case of a patient in PVS on the basis that it causes death, but did not call it “killing”. Judith was unsure about whether unjustified removal by a doctor should be called “killing” or “letting die”.

If the use of drugs at the end of life does not actually cause or contribute to an earlier death, then clearly it cannot be called “killing”. Some participants were convinced that symptoms could be controlled without causing death in all or most cases, and although contrary to public and legal opinion, this has been confirmed by a number of studies which have shown no influence of analgesic or sedative use on survival (Morita et al., 2001; Stone et al., 1997; Thorns & Sykes, 2000; Ventafredda et al., 1990). The authors of one such study conducted at Newcastle Mercy Hospice in Australia concluded that “the reality of palliative care (and hopefully medicine in general) is that it is rarely necessary to use the principle of double effect as a justification for the administration of opioids and sedatives” (Good, Ravenscroft, & Cavenagh, 2005, p.516). But what of those cases where there is doubt about causation, or even certainty that the drugs do contribute to death?

The criterion that death is certain to result was one of two criteria most commonly used by participants to distinguish between killing and both category 1 and 2 “letting die”. This was surprising, as it is not a criterion which is often mentioned in the philosophical literature, nor does it generally find favour among bioethicists. However it seems to be important for doctors. Certainty includes two elements: whether there is any doubt about death occurring as a result of one’s act/omission, and whether the act/omission is irreversible (or irrevocable). These two elements usually, though not always, coincide.

One reference to the criterion of certainty/uncertainty in the literature is in the BMA Report on Euthanasia where it was used to distinguish treatment withdrawal from AVE:
“Action to terminate a person’s life is irrevocable and allows no respite for re-evaluation, whereas a decision not to prolong life is often capable of reappraisal once the patient experiences the true implications of the step he has taken” (BMA, 1998, section 92.3).

In responding to the Report, Nowell-Smith denies this, citing the example of a decision not to resuscitate in the event of a cardiac arrest (Nowell-Smith, 1989). Once an arrest has occurred, and if the decision not to resuscitate has been taken because the patient has refused resuscitation, the decision is irrevocable, he says, because at that point the patient cannot change his mind. This is true, although it is by no means certain that the patient will suffer a cardiac arrest. A decision not to resuscitate does not ensure that the patient dies, except after the patient has arrested. Nowell Smith also argues that a decision to comply with a patient’s request for AVE is revocable, because there may be a cooling off period during which the patient can change his mind. But Nowell-Smith is not actually comparing killing and “letting die”. If the injection is never given, then the doctor cannot be said to have killed.

A distinction based on certainty/uncertainty has also been criticised on the grounds that “it is nonsense to talk of letting someone die if in fact they do not die” (Dines, 1995, p.915). But is it? Perhaps from an impartial, third person perspective after the event. But at the point of deciding to withhold or withdraw treatment the decision maker generally does not and cannot know what the outcome will be. (Nowell-Smith’s example above may seem to contradict this, but the decision not to resuscitate because of patient refusal is made before the patient arrests, and thus before it is certain that the patient will arrest.) Even if the patient does not die, from the perspective of the decision maker they have been “let die”, because the doctor has not intervened to prevent death. Whether death actually occurs is not the decision of, and is beyond the control of, the doctor. Morally, the decision is the same whatever the outcome. So killing only happens when the patient dies, but “letting die” may happen whether the patient lives or dies.

Perhaps the view that “letting die” only happens when the patient dies results from too simple an equation between treatment and outcome, the assumption that the patients will die if not treated but live if he is treated. In reality, as some participants pointed out, in many cases patients die even if they are treated and attempts made to save their life. And conversely, as some participants also noted, patients do not always die even if
treatment is withheld or withdrawn, even if that treatment is mechanical ventilation. So in “letting die” there is no simple choice between treat/live and not treat/die as any combination may occur: treat/live, treat/die, not treat/live and not treat/die.

The moral significance of certainty/uncertainty in relation to treatment withholding or withdrawal has been discussed in terms of the Optionality Principle, a factor which is said to underlie the distinction between positive and negative duties. Some actions, such as killing, both destroy a good and make it impossible for anyone else to realize that good. So, it is argued, a “negative duty is a duty not to do an action that closes all options, not only for oneself but for everyone else, to realize a certain good that would (or might) have been realized if one had done nothing. A positive duty is the duty to do an action to bring about a certain good, which someone else might also have the option to bring about” (Trammell, 1980, p.169). A treatment abatement decision leaves the option open that the patient may recover spontaneously, or that the agent (or another agent) may in the future institute or reinstitute treatment, and so there is a possibility that the patient will live. With a lethal injection, however, there is no such possibility: the outcome is assured and indeed irreversible.

Nevertheless, some “letting die” decisions, such as deciding not to resuscitate once a patient has arrested, and the withdrawal of PEG feeding when a patient is unable to swallow, do meet the criterion of certainty. Yet they are not killing, because they do not meet the other criteria (they are not acts, not artificial, do not cause death and are not necessarily intended to result in death).

In line with the growing evidence from the literature (as discussed in the previous section), several participants said there was uncertainty about whether the use of symptom relieving drugs at the end of life might hasten death. Four also referred to the reversibility of sedation, which was an indication that they could be reasonably sure it was not contributing to death. Uncertainty related both to the different effects that the same dose of medication has on a particular patient, and the unpredictability of the dying process. Although from an objective or third person perspective one might say that either the medication caused or contributed to death or it didn’t, and that this alone

50 In one U.S. study 11% of patients survived terminal weaning (where the endotracheal tube is left in place but the pressure and/or concentration of oxygen delivered is gradually reduced) and were discharged from hospital (Carlson, Campbell, & Frank, 1996).
should determine whether the doctor killed or let die, this fails to recognise the inherent uncertainties in medical practice. The significance participants attached to uncertainty in both category 1 and category 2 “letting die” can be attributed to the subjective difference between certainty and uncertainty; it is an example of the difference that the first person perspective makes.

It may be objected that PAS does not always meet the criterion of certainty. It is true that when a doctor writes a prescription for a lethal quantity of drugs in response to a patient’s request for assistance to die, the doctor cannot be certain that the patient will in fact take the medication in the prescribed way. Or if they do take it, perhaps they will be discovered and given treatment so that they survive. This uncertainty might be considered analogous to the uncertainty of the outcome in treatment abatement or the use of analgesia/sedatives. However the crucial difference from the perspective of the doctor is that, in the case of PAS, she has done everything she can to make certain that the patient dies. In the second case, she has not.

On the other hand, there are rare cases where a doctor is reasonably certain that symptom relieving medication will shorten life. But in order to be called “killing”, one further criterion, that of being intended to cause death, would also need to be met.

That death is intended, not merely foreseen, is the other criterion which was very widely used to distinguish killing from both category 1 and category 2 “letting die”, and also used in relation to category 3 “letting die”. Only Robert and Walter (who thought there was no moral distinction), did not use it at all. Seventeen used it in relation to category 1 “letting die”, and every participant who discussed sedation distinguished it from killing by the criterion of intention except Robert, Walter and Hilary (for whom it wasn’t relevant since he did not believe it shortened life). Twelve participants used it in relation to both categories. This finding tends to confirm the view that “If there is a difference (morally significant or not) between attempting to kill a person and pursuing a course of action where the death is foreseen but only incidental to what one is attempting to do, there is a similar difference between withholding or withdrawing support in order that someone might die and doing so knowing that the person is likely to die as a result but without attempting to bring about that death” (Atkinson, 1983), and that “What distinguishes voluntary active euthanasia from either passive or direct euthanasia is the intention of the physician. In the former case, the physician intends to end the life of the
patient, while in the latter two cases the physician intends something else, such as relieving pain or withdrawing intrusive medical interventions” (Emanuel, 1994a, p.1890).

The meaning of intention should be carefully specified. The doctors in this study used intention in a particular way, to mean intention to cause death, and not in the way that some authors do, when they use phrases such as “intentional termination of life” or “intentional causation of death” to mean an intentional (as opposed to accidental or unintentional) act/omission which may be foreseen to, and does in fact, result in death (Kuhse, 1984; P. Singer, 1995).

It is generally agreed that giving a lethal injection “reveals a clear intention to end the patient’s life” (Hunt, 2001, p.516), although Walter was ambivalent about this, and attempted to throw it into doubt, by saying that the intention of a lethal injection was only to relieve suffering, and that in any case, the intention of the doctor was not important, because he acted as an agent of the patient’s intention. (Against this it may be argued that intention relates both to the end of an action (relief of suffering) and to the means chosen to achieve that end (the death of the patient)).

In relation to “letting die”, it is often disputed whether the intention of the doctor can be sufficiently clearly known to constitute the basis of a significant conceptual or moral distinction from killing. As previously noted, it is sometimes argued that “Intention is inherently subjective, it can be complex, ambiguous and paradoxical. The clinician’s intention may also be difficult to infer, for example when the method of hastening death involves a separation (in time) between the initiation of an infusion of drugs and the patient’s death (Hunt, 2001, p.516). Quill similarly claims that clinical intentions are so inherently ambiguous that they cannot be used in evaluating the morality of actions (Quill, 1993a).

It may sometimes be difficult to judge another’s intention, yet this does not prevent it from being a critical consideration in the law: “Common sense and the law place important weight on intentions in evaluating the morality of human actions, and properly so” (Sulmasy & Pellegrino, 1999, p.547).And a number of participants thought that an intention to kill could be deduced from behaviour, in terms of the dosages of drugs used and how they were administered.
The importance that doctors attach to intention is another instance of the difference that the first person perspective makes. One has access to one’s own intentions that one does not necessarily have to others’. This also highlights an important difference between morality as a way of evaluating other’s actions, and as a guide to one’s own decision making. Bioethicists may be concerned to evaluate the actions of others, doctors are generally concerned with actually making the moral decisions.

As previously noted, the principle of double effect was not formally invoked in participants’ moral reasoning. As we have seen, the PDE is probably irrelevant in most instances of symptom relief at the end of life in the hands of skilled palliative care physicians. But where there was some doubt about possible foreseen shortening of life, participants relied on the criteria of intention and/or uncertainty rather than PDE, and some spoke of analgesia/sedation at the end of life being guided by the same principles that guide ordinary medical practice. This finding accords with the view that “The morality of everyday clinical practice depends heavily on the concept of intention, and clinicians have an unarticulated, intuitive grasp of the rule of double effect in almost all their therapeutic interventions. This is because the whole notion of a side effect is totally dependent on the rule of double effect and the concept of intention” (Sulmasy & Pellegrino, 1999, p.547). Almost all medical treatments have foreseen side effects or risks, which are by no means intended by the doctor. Whether the treatment is justified depends on the “therapeutic ratio” between likely benefits and side effects/risks (Ashby & Stoffell, 1991).

Intention is an important criterion in distinguishing killing from all three categories of “letting die”. However, it has frequently been pointed out that medical omissions as well as acts may sometimes have the intention of killing the patient (Brock, 1999) (Begley, 1998; Rachels, 1975; Weithman, 1999).

11.5.6 Only five of the seven criteria are used consistently to make the distinction
We have seen that all of the criteria above were used consistently to distinguish between killing and “letting die”, in that all of them needed to be met in order for an action to be classified as “killing”. However, this was not true of the criteria of immediacy and directness, as is apparent when we examine participants’ discussion of terminal sedation on the one hand, and physician-assisted suicide on the other.
No participant advocated or described performing the type of “terminal sedation” which involved sedating a patient to the point of unconsciousness, perhaps weeks or months from death, together with the withholding of artificial hydration and nutrition, which was intended to shorten life. Some would only sedate patients in the terminal phase if they could be sure it would not shorten life. In cases of sedation where there was uncertainty, many sought to decrease the risk of causing hastened death by limiting sedation to the lightest form possible, using it only close to the time of anticipated death, and only for severe refractory symptoms. These findings are consistent with previous studies of the attitudes and practices of palliative care physicians (Chater et al., 1998; Cowan & Walsh, 2001). Harry was the only participant who would use heavy sedation for non physical symptoms, and then only when the patient was dying or close to dying. None described sedating patients with the intention of causing or hastening death.

Those who distinguished between some types of terminal sedation and killing did so on the basis of the criteria of causation (if it did not shorten life it was not killing), uncertainty (if there was reasonable doubt about whether it would shorten life it was not killing) and intention (if the intention was to shorten life rather than relieve symptoms it was killing).

The administration of sufficiently large doses of opioids or sedatives can kill patients directly, but they may also hasten death indirectly, when administered in lower doses over several days or weeks, either through dehydration if fluids are withheld or through the effects of immobility and inhibition of coughing, producing sputum retention and hypostatic pneumonia. The fact that several doctors described such use of sedation as killing when the intention was to cause death, although death did not occur immediately and was not the direct result of the sedation, indicates that they did not consistently use the criteria of immediacy or directness to distinguish between killing and “letting die”.

In relation to physician-assisted suicide, only one participant (Walter, who admitted the distinction might only be an emotional one) distinguished, from the perspective of the doctor involved, between giving a lethal injection on request and writing a prescription for a lethal dose of medication at the request of a patient who wished to commit suicide.
PAS is regarded as killing by these doctors, even though it may not meet the criterion of immediacy.

Thus, the criteria of immediacy and directness, though used by some participants to distinguish between “letting die” and AVE by a single lethal injection, appear not to have been used consistently to make the distinction between killing and “letting die”, when participants’ reasoning in relation to terminal sedation and physician assisted suicide is examined. While the vivid image of a patient dying on “the end of the needle” represents the most acute felt expression of “taking control” by the doctor, immediacy and directness were not necessary for an action to be called “killing”. This means that doctors actually used only five criteria to distinguish between killing and “letting die” in the medical context.

11.5.7 A morally significant distinction

Participants in this study could be divided into three groups on the basis of their understanding of the nature of the moral distinction between killing and the three categories of medical “letting die” they discussed. Group 1 (22 doctors) maintained the traditional version of the distinction, that while killing is always wrong (at least for doctors in their medical practice), “letting die” may be (but is not always) permissible. Group 2 (5 doctors) distinguished morally in some respects between killing and “letting die”, but did not think that medical killing (AVE or PAS) is necessarily wrong. Group 3 (3 doctors) distinguished conceptually between killing and at least one category of “letting die”, but did not attach any moral significance to the distinction.

None of the doctors maintained the version of the distinction which is sometimes assumed in critiques of it 51, that killing is always morally wrong but all “letting die” is morally permissible. The conditions under which participants thought “letting die” is permissible or even obligatory are discussed in section 11.4.1 above. Several participants also mentioned specific situations where “letting die” would not be permissible.

The finding of a group of doctors who do not think medical killing is necessarily always morally wrong, yet distinguish morally between it and “letting die”, is consistent with

51 For example, Rachels (Rachels, 1975).
the findings in a previous Australian study, which showed that even those who approved of AVE, saw a morally significant difference between it and both treatment abatement and the use of symptom relieving medication which might hasten death (C. M. Cartwright et al., 2002). The version of the distinction held by those in Group 2 also appears in the bioethics literature. Gillon does not believe that AVE and PAS are always morally wrong (although he thinks that legalising either practice might overall do more harm than good), yet argues that foreseeing but not intending death is experientially, conceptually, legally and morally different from foreseeing and intending death (Gillon, 1999). He also rejects what he calls “spurious philosophical claims or suggestions that when doctors forgo life prolonging treatment their omissions are necessarily morally equivalent to killing their patients” (Gillon, 1988). Similarly, Miller et al., for whom “substantial moral differences remain between refusal of treatment and assisted suicide”, also say, “it does not follow that assisted suicide is never morally justified. The understanding of the line that separates forgoing life-sustaining treatment from assisted suicide in terms of refusals and requests leaves the moral justifiability of acts of assisted suicide open” (Miller, Fins, & J, 2000, p.472). They believe that the line must be maintained because they do not accept the logical implications of not holding it: “if there is no valid distinction between assisted suicide and refusal of life-sustaining treatment, then a legal option of assisted suicide should be just as broad in scope as the right to refuse treatment” (p.472), which would mean that PAS (and AVE) could not be confined to the terminally ill, or to competent patients (since surrogate decision makers can legally refuse treatment). Nor could safeguards such as mandatory waiting periods and palliative care or psychiatric consultations be enforced for AVE/PAS in situations where they would not be required for refusal of treatment.

Two of the doctors who were in Group 3 nevertheless acknowledged one moral difference between killing and category 1 “letting die”. Both Robert and Walter were convinced of a doctor’s right not to comply with a request for AVE/PAS (as indeed were all participants), whereas doctors may not (morally or legally) fail to honour a competent patient’s refusal of treatment (including artificial ventilation and feeding).

11.5.8 Non-consequentialist
Another feature of doctor’s moral reasoning in relation to killing and “letting die” is that, in making the traditional distinction between them, which involves the view that all cases of directly killing the innocent (such as in the case of AVE ) are morally wrong”
(J. Boyle, 1977, p.435), participants implicitly rejected consequentialism. Five of the doctors who made the traditional distinction also explicitly repudiated the idea that the morality of an action (or inaction) is determined not by the nature of the action itself nor the character of the agent who performs it, but only by consideration of its consequences (or the consequences to which it can reasonably be expected to lead). They insisted that the intent of the agent, and the means by which the outcome was determined, namely through a human agent, and even more specifically, “me”, makes a significant moral difference. Harry drew the distinction in terms of the directness of the connection between the actions of the agent and the consequences.

In addition, four of the five participants who made some moral distinction between killing and “letting die”, though they did not think killing was necessarily always wrong for doctors, also explicitly rejected consequentialist reasoning, arguing that the route by which the outcome is achieved, and the intention of the doctor are morally significant. Michelle also reasoned that although the outcome of death might be the same in both killing and “letting die”, the broader consequences were not always identical, for example in terms of the time taken to die. Saying that the outcome is the same, because in each case the patient dies, ignores all the features and implications of how the patient dies and by what means.

On the other hand, all three doctors who denied any moral significance in the killing/“letting die” distinction did so on the basis of consequentialist reasoning, that the outcome (death), not the mode of death is what is important. Walter’s statement, “if it’s a good thing that that suffering has come to an end you could say it might even have been a better thing if it had come to an end sooner” echoes consequentialist philosopher Rachels’ Principle of Agency: “if it would be good for a state of affairs to occur ‘naturally’, then it is permissible to take action to bring it about” (Rachels, 1998, p.150).

There are philosophers, like Judith Jarvis Thomson, who deny the moral significance of the distinction between killing and “letting die” in the medical context and who are not consequentialists, and Thomson argues that to say that intentions are irrelevant to the assessment of the morality of an action does not mean “we must become consequentialists” (Thomson, 1999, p.517). However the medical participants in this

52 However, Robert and Walter also placed great emphasis on the principle of respect for autonomy (both that of the patient and the doctor).
study linked acceptance or rejection of the view that there is at least some morally significant difference between killing and “letting die” with either rejection or acceptance of consequentialist reasoning, respectively.

11.5.9 The moral significance of the distinction is not reducible to any single criterion
The final feature of participants’ reasoning in making the moral distinction between killing and both category 1 and 2 “letting die” is that, again in contrast to some philosophical argument about the distinction, they did not attempt to attribute moral significance to the distinction by demonstrating the moral significance of any one criterion by which they may be distinguished conceptually.

These observations tend to support the suggestions (made in relation to “letting die” by omission), that “Part of the explanation (for the intuition that there is a moral asymmetry between killing and letting die) may be that the difference between making and allowing is not reducible to a single factor… It might instead be that, while we are indeed responding to somewhat different factors in different cases, we are also right in detecting an asymmetry... for the distinction between making and allowing might be internally complex, compounded from the various factors that engage our intuitions” (McMahan, 1998, p.399), and that “there is a holistic particularity to dying situations that does not admit piecemeal reduction to a series of factors, each of which can be shown to be morally irrelevant” (Gillett, 1994, p.323).

The way that participants framed the traditional moral distinction was not “Killing is morally different to ‘letting die’ on the basis of criterion x, and x is wrong for the following reasons”, but rather, “Killing is conceptually different from ‘letting die’ on the basis of a complex of reasons, and killing is wrong (in general and/or for doctors in particular) for the following reasons”. Bennett has challenged defenders of the distinction to find an empirical distinction in which the moral significance of the distinction uncontroversially resides (Bennett, 1980). But no such distinction exists which will convince consequentialists, who by definition do not attach moral significance to any criterion except the goodness of the consequences of any act/omission and so do not believe that killing is wrong in itself. Most non-consequentialists, however, do believe that killing is generally wrong, and therefore the only necessary distinction for them to make is an empirical or conceptual one: is this killing or not, and are there clear and consistent ways of making the distinction?
As Sulmasy (who does not make the distinction on the basis of a single criterion 53) claims, “the (traditional) distinction is defensible if one holds certain views about the nature of intentions and about the role of intention and causation in the moral evaluation of human acts” (Sulmasy, 1998, p.56). But absent a belief that it is generally wrong to act with the intention of causing someone’s death, the demonstration of a difference between killing and “letting die” in terms of act/omission, causation or intention (or other related criteria) will not be evidence of a necessary moral distinction between them. Rachels, for example, thinks that intention is irrelevant in “assessing whether the act is right or wrong, but instead is relevant to assessing the character of the person who does it, which is another thing entirely” (Rachels, 1986, p.93). Non-consequentialists do not agree.

What, then, of those five doctors (group 2) who did not make the traditional distinction and did not believe that killing is always wrong for doctors, yet thought there was some moral distinction between killing and “letting die”? They belong to that group of non-consequentialists, who believe that while killing the innocent is generally wrong, AVE and PAS may constitute, under certain circumstances, rare exceptions to the general rule against killing. For some, their attitudes may also reflect genuine ambivalence, in that their approval of medical killing is more hypothetical than real, given their personal reluctance to perform it.

11.6 Is it morally permissible to “take control”?
To intend to cause someone’s death and then to act in such a way as to ensure that this happens was often seen as “taking control” of that person’s death. But why should this be necessarily wrong? Here is where the real disagreement about the morality of AVE and PAS lies. On the one hand, there are those who think that taking such control is morally legitimate, and would agree that “if it would be good for a state of affairs to occur ‘naturally’, then it is permissible to take action to bring it about” (Rachels, 1998, p.150). On the other, there are those who do not believe that taking such control is morally legitimate, and would agree that with the view that “When we decide with a

53 As noted in chapter 3, Sulmasy makes the distinction between killing and “letting die” by treatment abatement in terms of a combination of the distinction between acts, causation and intention (Sulmasy, 1998, p.57-58).
patient or family that the time has come to withdraw life-support measures and allow a patient to die, it represents a humble recognition of the limits of medicine and a submission to forces beyond our control. By contrast, in administering a lethal injection, even to a consenting patient, we seem to overstep our bounds, as though wresting from nature something that is not properly ours” (Gates, 1997, p.2438).

Part 3 Killing and the role of the doctor

11.7 Introduction: General and particular arguments for the wrongness of killing
There are two broad ways in which the argument that killing the innocent is wrong may be formulated. The first is that it is wrong in general, and the second is that there are particular reasons why people engaged in particular roles should not kill. Doctors might explain their moral objection to killing in either or both of these ways. In the first case, they would be applying general moral theory to medical practice, and relying on a moral authority “external” to medicine. Twenty one of the study participants, both religious and non religious, expressed their belief in the general wrongness of killing in this way. In the second case, they would be relying on an internal morality of clinical medicine; those norms and commitments generated by the medical role itself.

11.7.1 Is killing compatible with the medical role?
Twenty five participants (all except Dot, Ruth, Harry, Robert and Walter) said either that killing a patient is not part of the medical role or that it is actually antithetical to it. Expressions such as “flies in the face of”, “the bastardization of our profession”, “doing the opposite” and “against the grain” were used. The participants who thought this way included six of the eight doctors (all of whom were agnostic or atheist) who did not believe that killing was intrinsically wrong and were not opposed to AVE or PAS in principle, though three were opposed to their legalization. This suggests that for these doctors the internal morality of medicine was as important and in some cases more important than external standards in determining the moral norms of medicine.

54 A Dutch doctor who had performed euthanasia is reported to have told the British Medical Association Working Party on Euthanasia in 1987: “You feel a bit Judas-like” and “it goes against the grain” (Gillett, 1994, p. 325).
What moral weight should doctors attach to their strong feeling that killing is not part of, or is even opposed to, the medical role? Is this a sufficient reason for them to refuse to do it?

Support for AVE and PAS is sometimes associated with weak identification with the medical role. In one study, AIDS physicians who supported and practiced AVE and PAS, were almost all “revisionists”, who challenged traditional perceptions of the doctor’s professional role, and were characterised by cynicism about the medical “establishment”. According to the author of the study, they often did not attempt to separate their professional from their personal life, or even rejected the whole notion of professionalism. For those who were themselves gay, their primary identification was with the gay community rather than medical community. Involvement in AVE/PAS, because of its illegality, necessarily included other breaches of traditional medical ethics: stealing drugs, falsifying clinical notes, drug charts, death certificates and cremation certificates, which would also indicate a level of unconcern or even disdain for professional standards (Magnusson, 2002).

Although only four mentioned the Hippocratic tradition, it seems that participants in this study mostly stand within that tradition, a tradition that is an example of applied virtue ethics, understanding medicine as a techne with its own proper ends or goals (Carrick, 1985). Contemporary virtue ethics speaks in terms of practices and their internal goods (MacIntyre, 1984), or of professional roles which “create peculiar moral demands on the individuals who occupy them” (Oakley & Cocking, 2001, p.1).

Why then should medical killing be incompatible with the medical role? Professions such as medicine have specific goals which are “clearer, more specific and more widely recognised than… the characteristic functions and ends of human beings generally” (Oakley & Cocking, 2001, p. 3). In relation to the medical profession then, the critical questions are whether killing a patient can be understood as fulfilling one of the goals of medicine, whether it is simply beyond the scope of medical goals or whether it runs counter to, or would frustrate the achievement of these goals.
11.7.2 The goals of medicine

AVE/PAS might be understood as achieving one or more of three of the goals of medicine identified by participants: healing, achieving a good death, and the relief of suffering.

The chair of the Dutch Health Council is reported to have claimed that “there are situations in which the best way to heal the patient is to help him die peacefully, and the doctor who in such a situation grants the patient’s request acts as the healer par excellence” (Capron, 1992, p.32). There was no support for this view among participants, with one describing it as “obscene” 55.

In relation to the goal of a good death, it has been claimed that “one of medicine’s most important purposes is to allow hopelessly ill persons to die with as much comfort, control and dignity as possible” (by which the authors actually meant PAS rather than “letting die”) (Quill et al., 1992, p.1380). Miller and Brody argue that “when no healing interventions are appropriate for the condition of a patient who resolutely requests aid in ending his or her life because of intolerable suffering (in spite of careful consideration of comfort care alternatives) then resort to physician-assisted death may become, unfortunately, the best among the limited options available to achieve this important goal of medicine for the patient” (Miller & Brody, 1995, p.12).

However while many participants agreed that achieving a good death was a goal of medical practice, only Walter and Robert spoke of it as justifying AVE/PAS.

It can also be argued that AVE and PAS are permissible under the goal of relief of suffering (Snyder & Sulmasy, 2001). All participants agreed that doctors are obliged to relieve symptoms and suffering, although only seven said explicitly that relief of suffering is a goal of medicine, and five said that it provided a moral justification for AVE/PAS.

In the bioethics literature, arguments for AVE/PAS based on respect for patient autonomy are prominent (Brock, 1992; Crisp, 1994; Mayo & Gunderson, 2003; Ognall, 55 As Capron points out, it is difficult to equate killing with healing, which is defined in the Oxford English Dictionary as “making whole or sound in bodily condition; freeing from disease or ailment; restoring to health or soundness; or curing” (Capron, 1992).
Beauchamp describes the right to die as the “triumph of autonomy” (Beauchamp, 2006). In a previous qualitative Canadian study, doctors cited the duty to relieve pain and suffering and the principle of respect for patient autonomy as reasons for supporting AVE (Verhoef et al., 1996). However, in this study, only two of the eight doctors who thought these were sometimes morally permissible used this argument, and one of these did not take what has been called “The Pure Autonomy View”, that “the justification for euthanasia rests solely on the principle of respect for autonomy”, but rather held what has been called “The Joint View”, that “the principle of respect for autonomy and the principle of beneficence morally justify euthanasia together” (de Haan, 2002, p.154). This finding accords with the claim that “For medical doctors… respect for autonomy is not a decisive motive for action. The most important consideration for medical doctors, and the main moral justification for euthanasia, is relief of suffering” (Ten Have, 2001, p.509), and also with the view that “The Pure Autonomy View” is “unable to give a doctor a reason for performing euthanasia that appeals to her in her capacity as a doctor, such as the relief of suffering” (de Haan, 2002, p.509). Respect for patient autonomy is not a goal of medicine, but rather a constraint which sometimes limits the achievement of those goals.

In relation to the relief of suffering, some palliative care physicians claim that physical pain can always be relieved, although it sometimes requires sedation, and that universally available palliative care of a high standard would eliminate virtually all requests for AVE/PAS. But suffering includes emotional, social, psychological, existential and spiritual as well as physical dimensions. Psychological or existential suffering, which may be less amenable than physical suffering to palliative interventions, is considered a valid reason for AVE or PAS by some of its advocates, although this remains controversial (Hurst & Mauron, 2006, pp.107-108). It has been observed that in the first fifty six cases of PAS under Oregon’s assisted suicide law, the patient’s motivation was more often to do with concerns about loss of autonomy and control than fear of pain or suffering. Similarly, in the Netherlands, patients’ reasons for requesting AVE were more commonly loss of control and “tiredness of life” than the relief of pain (Snyder & Sulmasy, 2001).
11.7.3 Limits to the goals of medicine

Concerns about loss of control may well lead to emotional existential suffering, but it is open to question whether it is appropriate for medicine to aim at the relief of all human suffering. The Hippocratic tradition recognized the limits of medicine, and a passage in *The Art* warns that, “if a man demand from an art a power over what does not belong to the art… his ignorance is more allied to madness than to lack of knowledge... Whenever therefore a man suffers from an ill which is too strong for the means at the disposal of medicine, he surely must not even expect that it can be overcome by medicine” (Hippocrates, 1977, pp.204-205). Daniel Callahan argues that medicine needs to resist the temptation to move beyond its health related goals to address general human well being: “Medicine should try to relieve human suffering, but not that suffering which comes from anguish or despair at the human condition” (Callahan, 1992).

The idea that there are some kinds of suffering which medicine cannot and should not seek to relieve was expressed by a number of participants, as well as the need for medicine to recognize its limitations, the things that are beyond the scope of medicine, or “beyond our control”. Theologist and bioethicist Paul Ramsey once rhetorically inquired whether “the purpose of modern medicine is to relieve the human condition of the human condition?”. Not every human problem is susceptible to medical resolution, and to suppose that it is or ought to be reflects what the ancients called *hubris*, a pretension to unbridled control and unlimited knowledge (Campbell, 1990, p.S8).

11.7.4 Would legalised AVE/PAS frustrate the goals of medicine?

The belief that killing is not part of the medical role is related to whether it fits within the goals of medicine. However the belief that it is actually antithetical to the medical role suggests that for doctors to be engaged in killing would work against or frustrate the goals of medicine. Several participants expressed this in terms of the detrimental effect it would have on the doctor-patient relationship by undermining trust in the medical profession, and in individual doctors. Trust in medical practitioners is necessary because of the imbalance of power between doctors and their patients, and as one participant noted, to greatly increase medical power by giving doctors what might be thought of as the power of life and death might erode trust and lead instead to fear.

Alexander Morgan Capron also links the possible loss of trust in the medical profession with the perception of the greatly increased power that being authorized to kill patients,
even under strictly specified conditions, would put into the hands of doctors. He says that, while treatment abatement represents an acknowledgment “of the limited power (and wisdom) of health care professionals”, by contrast “the decision to perform active euthanasia is one that proclaims the omnipotence (and omniscience) of health care professionals. The power of the latter is already great; increasing the imbalance with patients seems uncalled for”. He argues that the risks of increasing the imbalance would not be limited to interactions where AVE or PAS was discussed, but would also extend to every doctor-patient interaction when the possibility of “physician killing… hangs unspoken in the air” (Capron, 1992, p32).

A public policy argument against legalising AVE and /or PAS based on the loss of trust in the medical profession that might result is sometimes made on consequentialist grounds. If patients fear being persuaded to have their death hastened, they may not seek medical attention at all, or they may fail to disclose the extent of their suffering or explore their feelings of wanting to die. One author, who believes that PAS is morally permissible in some circumstances, nevertheless says “in terms of the general role and purpose of medicine, and not just as a patient’s rights issue, proclaiming physician administered killing -merciful as it may be- public policy, significantly clouds if not transfigures the public image of the doctor as one who seeks to cure and heal… There is already a rather extensive suspicion and distrust of doctors in our land… Empowering them, in effect, to be beneficent executioners is hardly apt to generate a deeper sense of trust from the body public” (McKinney, 1989). However this argument does not require an absolute moral prohibition on doctors killing their patients, only a legal prohibition in order to maintain public confidence in the medical profession in general.

But an argument against medical killing related to concerns about medical power and the trust which is necessary in the doctor-patient relationship need not be consequentialist. A virtue ethics approach asks which virtues or character traits doctors need to cultivate in order to enable them to achieve the goals of medicine (MacIntyre, 1984, p.191). This approach has been used by one writer to argue that “doctors should cultivate a virtue centered on an absolute prohibition: a prohibition on acting from the intention of killing their patients” (Weithman, 1999, p.544) 56. Weithmann argues by analogy with another Hippocratic prohibition - that of seducing one’s patients- saying

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56 Weithmann’s formulation does not maintain the distinction that Aristotle made between prohibitions and qualities of character (virtues and vices).
that the reasons for doctors observing both prohibitions are quite similar. In both cases, the vulnerability of patients mean doctors face powerful temptations, either to have sexual relations with, or to kill their patients, respectively. Doctors may be tempted to end the lives of their terminally ill patients because they grow tired of treating patients who are not going to recover, who may be regarded as failures, or reminders of medicine’s limitations. The temptation may be increased by the fact that it is relatively easy for doctors (compared with the general population) to obtain or prescribe lethal drugs.

In both cases, it is argued, there are legitimate doubts about the validity or genuineness of the patient’s consent or request. There is a danger that when the topic of AVE or PAS is raised and discussed, “patients who choose to end their own lives are doing what they believe their doctor wants them to do, rather than acting from a genuine desire of their own” (Weithman, 1999, p.560). There are special grounds for concern if the patient thinks of these procedures as legitimate medical care, and when the doctor reinforces this by discussing them in those terms. Further, the doctor’s assessment of the genuineness of a request will be impaired, since “rationalization and self-deception tend to cloud judgment in the face of strong temptation to perform an action that may be done in some circumstances but not in others” (p.555-556). Cultivating a disposition to honour an absolute prohibition (against either sexual relations with patients or medical killing) better protects both patient and doctor from the dangers of these situations than doctors making complex judgments on an individual case by case basis.

This is a teleological but not a consequentialist argument, based not on the overall consequences of a particular policy, but on whether a certain disposition enables or impedes the achievement of the goals of medicine. Knowing that medical killing is off limits (not just legally but morally) impacts not only on the patient’s trust in the doctor, but on the doctor’s ability to care for the patient. On the one hand, “the patient is allowed to say personal and private things to the doctor within an environment known to be safe, and that will contain the patient’s fears and impulses” (Varghese & Kelly, 2001, p.250). On the other, the existence of what has been called a “constructive taboo” enhances the therapeutic relationship between a doctor and terminally ill patient because it prevents actions that are based on the doctor’s own fears and motivations (Miles, 1994). This enables the doctor to develop a better understanding of the patient’s
suffering, which leads to better care, and so facilitates the achievement of the goals of medicine (Varghese & Kelly, 2001, p.251).

11.7.5 Why might the medical role lead to support for legalised AVE?
Some of the reasons that doctors *qua* doctors might kill their patients have already been explored. These are complex and often ambiguous. Participants mentioned compassion and humaneness, but also how personally difficult it is for doctors to witness suffering and distress in dying patients. It is understandable and well recognized that doctors find death and caring for the dying very stressful and draining (Varghese & Kelly, 2001, p.244), and one author has described the “emotional disorientation” of doctors (Miles, 1994).

But there may be more than compassion for the patient involved in acceding to a patient’s request for PAS or AVE. Two participants thought it might also involve meeting the doctor’s own emotional needs. Fear of death or even disgust with disease may be powerful unconscious motivators in the attitudes and behaviour of doctors towards the terminally ill (Gabbard, 1985), as may feelings of impotence, guilt, and a sense of failure (Varghese & Kelly, 2001, p.244).

Cassell argues that the medicalisation of suffering leaves doctors ill equipped to address the psychological needs of patients or to understand their suffering. Hence they may resort to purely biological or physical treatment, and when confronted with the failure of such treatment to address the patient’s real needs, withdraw from the patient psychologically in reaction. This withdrawal only accentuates the patient’s feelings of hopelessness and abandonment, and possibly a wish to die. But the patient’s anger and disappointment may only serve to further “fuel the doctor’s retreat from the patient… or stimulate the development of intense negative feelings toward the patient” (E. Cassell, 1982, p.10). Hence the claim that “compassion can become maleficent unless it is constrained by principle” (Pellegrino, 1993). This resonates with the Thai Buddhist belief that acts of killing are always acts of hatred or ill will, and that even “mercy killing” may be due to the doctor’s repugnance towards the patient’s pain and suffering being transferred to hatred of the patient who embodies it (Ratanakul, 1990).

Willingness to practice AVE/PAS may also be related to doctors’ need to be in control. Feelings of futility and helplessness are often recognised in dying patients, but may also
distress those caring for them. “Patients are not alone in their inability to tolerate situations they cannot control... By deciding when patients die, by making death a medical decision, the physician has the illusion of mastery over the disease and the accompanying feelings of helplessness” (Hendin, 1994, p.129). The desire to be in control is a natural human desire, but may be exacerbated in doctors by a culture that encourages medical action (and) “therapeutic omnipotence” (Varghese & Kelly, 2001, p. 248).

11.7.6 If AVE were legalised, should another profession undertake it?

The observation that participants who thought medical killing was not part of or actually antithetical to the medical role included the five doctors who said they were not opposed to AVE in principle, raises the question of whether doctors ought to be involved, if AVE and or assisted suicide were legalised. Particular, role based arguments against medical killing would suggest that even if the practice were legalized, doctors ought not to engage in it. This was the position of several participants, including some who were and were not opposed to its legalisation.

Some felt that doctors were best qualified to carry out AVE, but others thought that simply giving an injection did not require medical skill. However, the provision of drugs, no matter who actually administers them (doctor, nurse, technician or patient) requires, at least currently, medical authorization in the form of a prescription.

Therefore, a moral decision by the doctor to “take control” of the patient’s death is required, and as one participant pointed out, and as is seen in the doctors’ view that there is no moral difference between AVE and PAS, a doctor morally opposed to the practice would not be likely to give such an authorization, no matter who was responsible for its administration.

The view that legalized AVE ought not to involve doctors at all, but rather, for example, involve an initial assessment by two lawyers and then be performed by suitably trained technician (Randall, 1993) or “certified providers of suicide assistance who are not physicians or other health care workers” (Menken, 1997, p.328), fails to recognize what some participants pointed out: that there would still need to be some medical involvement in the process, if only to ensure that any specified diagnostic and prognostic criteria were met. Doctors who had moral objections to AVE/PAS might
well refuse to be involved even to the extent of providing the necessary documentation to enable either procedure to be carried out.

Another argument why doctors ought not to be involved in AVE/PAS is based on concerns about “the serious effect on the physician’s own psyche of premeditated, socially sanctioned killing”. Presumably this would apply to all people (including non medical “euthanasia” technicians) but the particular issue for doctors is whether, if they are already necessarily desensitised to death and suffering to a certain extent, AVE and PAS might “further reinforce this objectification of death and dying, and further desensitize (doctors) to killing” (Pellegrino, 1992, p.99).

There seems to be no way out of the dilemma that doctors must necessarily be involved in the assessment and care of terminally ill patients, which would be a necessary part of any responsible legalised practice of AVE or PAS, and yet most doctors in this study have a strong conviction that involvement in these practices is incompatible with the role of a doctor.

**11.8 Medical attitudes to bioethics**

Participants in this study belong to a generation that had little or no exposure to ethics teaching in either undergraduate or postgraduate medical training. The negative attitudes to bioethics and philosophy expressed by some seem to reflect a frustration that, on the one hand, doctors generally have neither the academic training in philosophy nor the analytic skills which would be required for them to understand and engage in argument with philosophers and bioethicists, and on the other, that philosophers and bioethicists without clinical experience do not understand the realities and complexities of medical practice. This seems to point at least to a real difficulty in communication between the two groups, if not a deeper problem in the relationship between medicine and bioethics. The possibility of such a deeper problem is recognized by Melbourne philosopher and physician, Paul Komesaroff, when he claims that “bioethics is deficient because it is unable to provide an adequate account of day-to-day decision making in medicine, as a result of which it cannot provide any substantial guidance for medical practice” (Komesaroff, 1995).
For one participant (Kerry) this frustration was expressed towards me, in the interview, when she seemed to interpret my attempts to clarify her reasoning as criticism, and she expressed the view that time and money would be better spent on patient care than arguing about semantics. However, this was the exception, with other interviews being characterized by participants’ openness and willingness to explore apparent inconsistencies in their arguments without feeling threatened. Nevertheless, I detected some uneasiness in some participants when they felt “pushed” by my questions which sought to uncover the basis for their reasoning, which they found difficult to explain. Some participants even interpreted my questioning as an attempt to persuade them that there was no meaningful conceptual or moral distinction between killing and “letting die”.

In addition to general comments about bioethics, two participants expressed particularly negative attitudes towards the utilitarian bioethics that they associated with Monash University. Although Peter Singer has not been at Monash for some time, he and fellow utilitarian Julian Savulescu (now based at both Oxford and Melbourne Universities) would probably be the philosophers/bioethicists best known to Melbourne doctors, being prominent contributors in both the mainstream media and medical journals. It is not surprising in the Melbourne context that some participants understand bioethics to be predominantly, if not exclusively, consequentialist. In view of the rejection of consequentialist reasoning by most of them, this may also contribute to their negative attitudes to bioethics and the perception of a lack of constructive interaction between it and the medical profession.

11.9 Conclusion
My findings suggest that, despite their commitment to relieving suffering, and their acceptance that there are situations when it is appropriate to let a patient die, the idea of themselves “taking control” of the timing of a patient’s death by AVE or PAS is very difficult for many doctors to accept as part of the medical role. Further, doctors are not willing to give up their own moral autonomy in making such decisions.

In relation to how those who make a conceptual distinction between killing and letting die do so, several features of doctors moral reasoning may be contrasted with the reasoning of some philosophers and bioethicists in a number of ways. In relation to why
they think AVE by doctors and PAS are wrong, while general arguments against killing are important, even more important in this group was the consideration of whether AVE and PAS are compatible with the medical role, and congruent with the goals and limits of medical practice.
Chapter Twelve  Conclusion

12.1 Summary of key findings
Of the thirty study participants, half of whom were atheist/agnostic, and half of whom professed religious belief (Christian or Jewish), seventy three percent believed AVE to be morally wrong, 10 percent believed it would be morally permissible under some circumstances, but did not support its legalization, and 17 percent both believed it to be morally permissible and supported its legalization. Participants agreed about the permissibility of “letting die” by treatment abatement under certain circumstances, the moral obligation doctors have to relieve suffering, the unwillingness felt by most doctors to kill a patient and the importance of doctors being able to exercise moral autonomy in deciding whether to perform AVE/PAS if these were legalised.

Doctors thought about the distinction between killing and “letting die” in terms of “taking control” (or not) of the timing of a patients death. Several features of doctors’ reasoning in relation to the distinction are identified: that it is from the perspective of the doctor as moral agent, the extensive use of concrete and particular clinical examples, and an inclusive understanding of “letting die”. All but one participant made a clear conceptual distinction between killing and “letting die”. Seven criteria were described, but two of these (that death occurs immediately, and that death is caused directly) were not used consistently. Thus, participants used a combination of up to five criteria (that it involves an act, not an omission, that it is artificial, not natural, that the doctor causes death, not the underlying disease, that death is certain to result, and that death is intended, not merely foreseen), each of which was necessary but not sufficient for a medical action to be called “killing”. Twenty two maintained the traditional version of the distinction, that while killing is always wrong (at least for doctors in their medical practice), “letting die” may be (but is not always) permissible. Five distinguished morally in some respects between killing and “letting die”, but did not think that medical killing (AVE or PAS) is necessarily wrong. Three did not attach any moral significance to the distinction, on the basis of consequentialist reasoning, which was rejected by most of the other participants.

The other theme identified has to do with why doctors attached moral significance to the distinction, and that is the place of killing in the role of a doctor. Twenty five participants thought that AVE/PAS were either not part of, or actually antithetical to the
medical role. However the medical goal of achieving a good death was used by two and that of relief of suffering by five participants, to justify these practices.

12.2 Original contribution of this research
The views and arguments of philosophers are well represented in the literature on killing and “letting die”, but those of ordinary clinicians untrained in either law or philosophy are not. There have been many quantitative studies, both in Australia and overseas, of medical attitudes to killing and “letting die” in the medical context, but none have specifically addressed the question of the nature of the difference between them. This study addresses the question of how doctors who work with dying patients understand the conceptual and moral distinction, if any, between killing and “letting die”, in the medical context. Using a qualitative methodology allows an exploration of their moral reasoning in relation to this question, and allows them to discuss it in their own terms.

The theoretical underpinning for believing that doctor’s understanding and moral reasoning in this area might make an important and distinctive contribution to the wider debate in bioethics, is found in the concept of an internal morality of clinical medicine. According to this concept, the moral norms of medicine are generated, at least in part, from the nature of medicine as a practice with its own particular and characteristic goals. MacIntyre claims that these goals “can only be identified and recognized by the experience of participating in the practice in question. Those who lack the relevant experience are incompetent thereby as judges of internal goods” (MacIntyre, 1984, pp.188-189). A more modest claim is that the judgments of those who are immersed in a particular situation should be given special weight (Gillett, 1994). Both claims imply that practicing clinicians, and especially those doctors who work with dying patients, may have particular insight about medical killing and “letting die” in relation to the internal morality in relation to the goals of medicine. Doctors in this study have been given the opportunity to express their views and moral reasoning, which, on the one hand, allows them to contribute to the debate about killing and “letting die”, and on the other, allows their views and reasoning to be exposed to scrutiny and critique.

12.3 Strengths and limitations of this study
The strengths of this study lie in the sample size, and in the representation of participants from a wide age range, both genders, three different disciplines, and with
extensive clinical experience, particularly experience with “letting die”. In addition, a
great deal of rich, personal, nuanced and frank material was elicited from participants,
perhaps related to confidence engendered by knowledge of the medical training of the
interviewer, who may have been perceived more as a colleague than as a critic.

One of the limitations of this study might be that, as it turned out, three of the four
hospitals at which recruitment took place were affiliated with Catholic health care
providers. There was also a higher proportion of Catholic doctors than in previous
studies of Australian doctors (but also a higher proportion of atheist/agnostics), a very
high proportion of “white Anglo-Saxon” participants, and a lower level of approval of
AVE/PAS than in previous Australian studies. In addition, most participants were in
hospital based practice. However, the purpose of the study was not to establish the level
of support for AVE/PAS, or the proportion of doctors in general, or even the proportion
of palliative care physicians, oncologists and intensivists) who distinguish morally
and/or conceptually between killing and “letting die”. It is well established that the level
of support for AVE/PAS is lower among doctors than among the general population,
and that many doctors distinguish morally between killing and “letting die”. The
purpose of the study was to find out, if they made this distinction, how and why they did
so.

12.4 New directions for research
Several potential avenues for future qualitative research arise from consideration of this
project. The first would be a similar study, involving doctors practicing in other medical
disciplines, who also deal with dying patients, but in different contexts. This could
include geriatricians, neonatal paediatricians and neurologists, especially those who
work with patients with motor neurone disease and other chronic disabling neurological
disorders. The second would be a similar study, but with doctors recruited through
professional associations or specialist colleges rather than through hospitals. In this
way, general practitioners could be included, and the possibility of less restrictive
conditions being placed on the research might lead to participation by doctors who were
willing to discuss their experience of practicing AVE/PAS. It would also be very
interesting to explore the attitudes to killing and “letting die” of doctors from non
“white Anglo-Saxon” backgrounds, and with religious beliefs other than Jewish or
Christian, and in countries where AVE and/or PAS has been legalised.
Finally, it is recognized that this project has examined the distinction between killing and “letting die” from one perspective only, the medical perspective. The perspectives of others involved in such decisions could also be explored: patients (prospectively), family members, nurses and other health professionals.

12.5 Implications of this study

There is long standing disagreement amongst philosophers about the nature of a distinction between killing and “letting die” and whether it has any moral significance. The issue has particular relevance in medical practice, in relation to the debate over the moral permissibility of active voluntary euthanasia and physician-assisted suicide.

There are three ways in which it may be argued that doctors ought to abandon the distinction, long held in medicine. The first is that certain currently accepted medical practices, such as the withdrawal of artificial ventilation or of artificial nutrition and hydration, and the administration of analgesia and/or sedation in the terminally ill, commonly called “letting die”, are in fact killing because they cause death. Therefore, it is argued, it is illogical for doctors to refuse to consider causing death by other means, such as a lethal injection. This study suggests that this argument finds little support among doctors, even among those who do not think that AVE/PAS is necessarily always wrong. Participants used a combination of up to five criteria (act/omission, artificial/natural, causation, certainty/uncertainty and intention) to make a generally clear and consistent conceptual distinction between medical killing and “letting die”.

The second argument is that, while killing and “letting die” may be distinguished conceptually, there is no necessary moral difference between them because some cases of “letting die” are clearly as bad as killing. Again, this study suggests that such an argument is unlikely to be persuasive to doctors, since those who maintained it did not claim that while killing is generally wrong, “letting die” is always permissible, but rather that, while killing an innocent person is generally wrong, some cases of “letting die” are also morally wrong, but some are not.

The third argument is that is that, while killing and “letting die” may be distinguished conceptually, there is no necessary moral difference between them, because killing is
not necessarily wrong in itself. This argument arises from the basic disagreement in moral philosophy between traditional, non-consequentialist morality and ethical theories and modern consequentialist morality and ethical theories. The findings of this study suggest that doctors have some implicit acceptance of the idea (consistent with traditional, non-consequentialist morality) that there is a morality internal to clinical medicine which excludes killing but does not require doctors always to strive to prevent their patients from dying. They suggest that consequentialist reasoning in relation to medical killing and “letting die” is unpersuasive to many doctors, even some of those who do not think that AVE/PAS is always wrong.

The philosophical debate about the moral significance of the distinction between killing and “letting die” and the closely related question of the moral permissibility of AVE/PAS for doctors, seems to have reached an impasse. Further, if the reasoning of philosophers and bioethicists is largely opaque to intelligent and reflective medical practitioners, it has little opportunity of influencing medical moral reasoning or practice. The findings of this study suggest that genuine and constructive dialogue between bioethicists and doctors about the morality of killing and “letting die” would more likely result from an approach based on the goals of medicine and its internal norms, than on approaches based on a continuation of the theoretical debates about the coherence of the conceptual distinction between them, or about the general wrongness of killing.
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Appendix A

LETTER TO DOCTORS (Participant Information Form)

Version 6 Dated March 18 2005
Full Project Title: The doctor as moral agent, with reference to the distinction between killing and “letting die”
Name of Investigator: Denise Cooper MB.BS. B.Th. MBHL
Co-Investigator: (senior clinician at Hospital 1)

Dear Dr.

I am writing to invite you to take part in a qualitative research project which will explore the attitudes, reasoning and understanding of experienced medical clinicians in relation to the moral distinction, if any, between “killing and “letting die”.

Participants are senior clinicians from the specialties of palliative care, intensive care, and oncology, at four Melbourne hospitals. In addition, doctors who have publicly stated that they have “helped patients to die” will be invited to participate.

Purpose and Background

I am hoping that between 30 and 40 clinicians will participate in this project.

Previous studies have shown that doctors have a variety of views on the permissibility of active euthanasia, and other end of life decisions. Official Statements from Medical Associations worldwide distinguish morally between active euthanasia and appropriate withholding or withdrawal of treatment, even when this results in death. This position is strongly criticised by some bioethicists. There has been no previous qualitative study of how clinicians understand and explain this difference, and whether they think it is morally significant.

You are invited to participate in this research project because it is expected that the experience and opinions of medical practitioners who work with the severely and/or terminally ill will provide particular insight into these issues.

I am undertaking this research project for a Ph D. at the University of Melbourne. My supervisors are Prof. Michael Ashby (Palliative care), Dr. Bernadette Tobin and Dr Gordon Preece (moral philosophers), and Dr. Fiona Mc Dermott (Social work). Participation in this project will involve

- A single semistructured audiotaped interview with the student researcher, of up to one hour’s duration.
- Participants will be invited to discuss a recent difficult end-of-life decision.
- Examples of other questions which may be used include:

  “Some people put a lot of emphasis on the difference between killing and “letting die”. What do you understand by these terms?”

  “Do you think there is a difference between killing and “letting die” in the medical context and if so, how would you explain it?”
“Do you think there is a moral, or any other kind of difference between giving a patient a lethal injection and giving them a lethal prescription to enable them to commit suicide?”

“Do you think voluntary active euthanasia or physician assisted suicide can be part of the role of a doctor?”

“How do your views about religion or spirituality influence your thinking in this area?”

- Checking the completed transcript for accuracy (via email, or post if you prefer).

Possible Benefits

You will have the opportunity to contribute to the bioethics debate in this area, where clinicians’ understandings and opinions are not often canvassed in depth. A copy of the summary of the research findings, discussion and conclusions will be sent to you on request.

Possible Risks

In Australia, no individual charges have ever been brought against a doctor or other health professional who has admitted in the research context to “helping a patient to die”. Nevertheless, there is a very slight risk that disclosure of actions in relation to the death of a patient might lead to charges being laid against you when the research is published. Your anonymity and confidentiality will be protected as far as possible (see below), but it would be wise not to reveal identifying information about patients or yourself that could incriminate you.

The audiotape of the interview will be destroyed once a transcript has been made and you have checked it and are satisfied that it is accurate. The transcript itself is required to be kept for seven years and would therefore be available if required by the police or the courts. There is also the (probably very slight) possibility of the student researcher being required by the court to give evidence. During or after the interview, you may ask for sections of it to be deleted from the tape and/or the transcript. If you reveal any information which could incriminate you, that portion of the tape will be wiped (and therefore not transcribed).

You are encouraged to contact Dr. Jack Warhaft, Director of the Victorian Doctors’ Health program (9495 6011), or your Medical Defence Association, if any questions or concerns arise as a result of the interview.

Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. Results will be published in a deidentified form in a Ph. D thesis, and in peer-reviewed journal articles and conference presentations.

Audiotapes and transcripts of the interviews will be stored in locked filing cabinets to which only the student researcher, Denise Cooper, has access. Transcripts will also be stored on a password protected computer. All records will be labelled only with pseudonyms and the date of the interview. Records will be kept for seven years and then destroyed.

There will be no written record of the names of participants, and no master list linking names with pseudonyms or codes. There will be no written consent form. Emails to and from you containing transcripts will be deleted. In any publication, information will be provided in such a way that you cannot be identified.
Further Information or Any Problems
If you require further information or if you have any problems concerning this project, you can contact the principal researcher, Dr Denise Cooper yyyy yyyy and 0438 595527 (AH)

If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Once you understand what the project is about and if you agree to take part in it, you will be asked to give verbal consent, by which you indicate that you understand the information and that you give your consent to participate in the research project.

Complaints and Research Participant Rights
If you have any complaints about any aspect of the study or the way in which it is being conducted or any questions about your rights as a research participant, then you may contact the Administrative Officer, Human Research Ethics Committee at your hospital on Telephone: xxxx xxxxx.

You will need to tell the Administrative officer the name of the principal researcher, Denise Cooper.

Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Ethics Committee of your institution.

Thank you for considering being involved in this research. If you have any questions or wish to discuss the project or make a time for the interview, please contact me by phone, or by email d.cooper@pgrad.unimelb.edu.au.

I will contact you by telephone in 7 days to ask if you would be willing to be involved in this project, and if so, to make a time for the interview.

Yours sincerely,

Denise Cooper
Appendix B

Participant Information and Consent Form
Version 9 Dated March 18 2005
Site: Hospital 2

Full Project Title: The doctor as moral agent, with reference to the distinction between killing and “letting die”
Principal Researcher: (Senior clinician at hospital 2)
Student Researcher:    Dr. Denise Cooper

Dear Dr.

I am writing to invite you to take part in a qualitative (phenomenological) research project.

The aims of the study are:

- To explore the experience of clinicians who work with the severely and /or terminally ill, and the way this relates to their understanding of “killing” and “letting die”

- To explore clinicians’ modes of conceptualising and moral reasoning in relation to whether they perceive a moral distinction between “killing” and “letting die” or not, and

- To explore how their attitudes and reasoning are related to their understanding of medical practice.

Participants will be senior clinicians from the specialties of palliative care, intensive care, and oncology, at four Melbourne hospitals. In addition, doctors who have publicly stated that they have “helped patients to die” will be invited to participate.

Purpose and Background
I am hoping that between 30 and 40 clinicians will participate in this project.

Previous studies have shown that doctors have a variety of views on the permissibility of active euthanasia, and other end of life decisions. Official Statements from Medical Associations worldwide distinguish morally between active euthanasia and appropriate withholding or withdrawal of treatment, even when this results in death. This position (which is also the personal view of the student researcher) is strongly criticised by some bioethicists. There has been no previous qualitative study of how clinicians understand and explain this difference, and whether they think it is morally significant.

You are invited to participate in this research project because it is expected that the experience and opinions of medical practitioners who work with the severely and/or terminally ill will provide particular insight into these issues.

I am undertaking this research project for a Ph D. at the University of Melbourne. My supervisors are Prof. Michael Ashby (Palliative care), Dr. Bernadette Tobin and Dr Gordon Preece (moral philosophers) and Dr. Fiona Mc Dermott (Social Work).

Procedures
Participation in this project will involve
• A single semistructured audiotaped interview with the student researcher, of up to one hour’s duration.

• Participants will be invited to discuss a recent end-of-life decision that raised the question of the difference, if any, between “killing” and “letting die”.

• Examples of other questions which may be used include:

  “Some people put a lot of emphasis on the difference between killing and “letting die”. What do you understand by these terms?”

  “Do you think there is a difference between killing and “letting die” in the medical context and if so, how would you explain it?”

  “Do you think there is a moral, or any other kind of difference between giving a patient a lethal injection and giving them a lethal prescription to enable them to commit suicide?”

  “Do you think voluntary active euthanasia or physician assisted suicide can be part of the role of a doctor?”

  “How do your views about religion or spirituality influence your thinking in this area?”

• Checking the completed transcript for accuracy (via email or post if you prefer).

Possible Benefits

You will have the opportunity to contribute to the bioethics debate in this area, where clinicians’ understandings and opinions are not often canvassed in depth. A copy of the summary of the research findings, discussion and conclusions will be sent to you on request.

Possible Risks

In Australia, no individual charges have ever been brought against a doctor or other health professional who has admitted in the research context to “helping a patient to die”. Nevertheless, there is a very slight risk that disclosure of actions in relation to the death of a patient might lead to charges being laid against you when the research is published. Your anonymity and confidentiality will be protected as far as possible (see below), but it would be wise not to reveal identifying information about patients or yourself that could incriminate you in criminal activity. If you have any questions or concerns of a legal nature, you would be advised to contact your Medical Defence Association.

The audiotape of the interview will be destroyed once a transcript has been made and you have checked it and are satisfied that it is accurate. The transcript itself is required to be kept for seven years and would therefore be available if required by the police or the courts. There is also the (probably very slight) possibility of the student researcher being required by the court to give evidence. During or after the interview, you may ask for sections of it to be deleted from the tape and/or the transcript. The interview will be stopped and the audiotape wiped if details of an event are revealed that would incriminate a participant in a criminal act.

You are encouraged to contact Dr. Jack Warhaft, Director of the Victorian Doctors’ Health Program (9495 6011), if you wish to discuss any issues further after the interview.
Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. Results will be published in a deidentified form in a Ph.D. thesis, and in peer-reviewed journal articles and conference presentations.

Audiotapes and transcripts of the interviews will be stored in locked filing cabinets to which only the student researcher, Denise Cooper, has access. Transcripts will also be stored on a password protected computer. All records will be labelled only with pseudonyms and the date of the interview. Records will be kept for seven years and then destroyed.

There will be no written record of the names of participants, and no master list linking names with pseudonyms or codes. There will be no written consent form. Emails to and from you containing transcripts will be deleted. In any publication, information will be provided in such a way that you cannot be identified.

Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the student researcher Denise Cooper on yyyy yyyy and 0438 595527 (AH)

Other Issues

If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Once you understand what the project is about and if you agree to take part in it, you will be asked to give verbal consent, by which you indicate that you understand the information and that you give your consent to participate in the research project.

If you have any complaints about any aspect of the project, or any questions about your rights as a research participant, then you may contact (the Ethics Coordinator, Human Research, telephone xxx xxxxx. If you have any complaints about the way the research is being conducted, you should contact the student supervisor, (senior clinician), telephone xxx xxxx. You will need to tell them the name of the student researcher, Denise Cooper.

Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee at this hospital.

Thank you for considering being involved in this research. If you have any questions or wish to discuss the project or make a time for the interview, please contact me by phone or by email d.cooper@pgrad.unimelb.edu.au.

I will contact you by telephone in 7 days to ask if you would be willing to be involved in this project, and if so, to make a time for the interview.

Yours sincerely,

Denise Cooper
Appendix C

Participant Information and Consent Form
Version 3 Dated April 22 2005
Site: Hospital 3

Full Project Title: The doctor as moral agent, with reference to the distinction between killing and “letting die”
Principal Researcher: Denise Cooper MB.BS. B.Th. M.B.H.L.

Dear Dr.

I am writing to invite you to take part in a qualitative research project which will explore the attitudes, reasoning and understanding of experienced medical clinicians in relation to the moral distinction, if any, between “killing” and “letting die”.

Participants are senior clinicians from the specialties of palliative care, intensive care, and oncology.

Purpose and Background
I am hoping that between 30 and 40 clinicians will participate in this project.

Previous studies have shown that doctors have a variety of views on the permissibility of active euthanasia, and other end of life decisions. Official Statements from Medical Associations worldwide distinguish morally between active euthanasia and appropriate withholding or withdrawal of treatment, even when this results in death. This position is strongly criticised by some bioethicists. There has been no previous qualitative study of how clinicians understand and explain this difference, and whether they think it is morally significant.

You are invited to participate in this research project because it is expected that the experience and opinions of medical practitioners who work with the severely and/or terminally ill will provide particular insight into these issues.

I am undertaking this research project for a Ph D at the University of Melbourne. My supervisors are Prof. Michael Ashby (Palliative care), Dr. Bernadette Tobin and Dr Gordon Preece (moral philosophers), and Dr. Fiona McDermott (Social Work) and Prof John Zalcberg (medical oncologist).

Procedures
Participation in this project will involve

- A single semistructured audiotaped interview with the student researcher, of up to one hour’s duration.

- Participants will be invited to discuss a recent end-of-life decision that raised the question of the distinction, if any, between “killing” and “letting die”.

- Examples of other questions which may be used include:

  “Some people put a lot of emphasis on the difference between killing and “letting die”. What do you understand by these terms?”
“Do you think there is a difference between killing and “letting die” in the medical context and if so, how would you explain it?”

“Do you think there is a moral, or any other kind of difference between giving a patient a lethal injection and giving them a lethal prescription to enable them to commit suicide?”

“Do you think voluntary active euthanasia or physician assisted suicide can be part of the role of a doctor?”

“How do your views about religion or spirituality influence your thinking in this area?”

- A brief follow up telephone call within 24 hours of the interview.

Possible Benefits

You will have the opportunity to contribute to the bioethics debate in this area, where clinicians’ understandings and opinions are not often canvassed in depth. A copy of the summary of the research findings, discussion and conclusions will be sent to you on request.

Possible Risks

In Australia, no individual charges have ever been brought against a doctor or other health professional who has admitted in the research context to “helping a patient to die”. Nevertheless, there is a very slight risk that disclosure of actions in relation to the death of a patient might lead to charges being laid against you when the research is published. Your anonymity and confidentiality will be protected as far as possible (see below), but it would be wise not to reveal identifying information about patients or yourself.

The audiotaped interviews and transcripts are required to be kept for seven years and would therefore be available if required by the police or the courts. There is also the (probably very slight) possibility of the student researcher being required by the court to give evidence. During or after the interview, you may ask for sections of it to be deleted from the tape and/or the transcript.

You are encouraged to contact Dr. Jack Warhaft, Director of the Victorian Doctors’ Health Program (9495 6011), if you have any issues or concerns you wish to follow up further after the interview. If you have questions or concerns of a legal nature, you would be advised to contact your Medical Defence Association.

Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. Results will be published in a deidentified form in a Ph. D thesis, and in peer-reviewed journal articles and conference presentations.

Audiotapes and transcripts of the interviews will be stored in locked filing cabinets to which only the student researcher, Denise Cooper, has access. Transcripts will also be stored on a password protected computer. All records will be labelled only with pseudonyms and the date of the interview. Records will be kept for seven years and then destroyed.

There will be no written record of the names of participants, and no master list linking names with pseudonyms or codes. There will be no written consent form.
In any publication, information will be provided in such a way that you cannot be identified.

**Further Information or Any Problems**

If you require further information or if you have any problems concerning this project, you can contact the principal researcher Denise Cooper yyyy yyyy or 0438 595527 (AH).

**Other Issues**

If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Once you understand what the project is about and if you agree to take part in it, you will be asked to give verbal consent, by which you indicate that you understand the information and that you give your consent to participate in the research project.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact (the HREC representative) on telephone number xxx xxxx.

You will need to give the name of the researcher, Denise Cooper.

**Ethical Guidelines**

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the (Hospital 3) Human Research Ethics Committee.

Thank you for considering being involved in this research. If you have any questions or wish to discuss the project or make a time for the interview, please contact me by phone, or by email d.cooper@pgrad.unimelb.edu.au.

I will contact you by telephone in 7 days to ask if you would be willing to be involved in this project, and if so, to make a time for the interview.

Yours sincerely,

Denise Cooper
Dear Dr. [Name],

I am writing to invite you to take part in a qualitative research project which will explore the attitudes, reasoning and understanding of experienced medical clinicians in relation to the moral distinction, if any, between “killing” and “letting die”.

Participants are senior clinicians from the specialties of palliative care, intensive care, and oncology. In addition, doctors who have publicly stated that they have “helped patients to die” will be invited to participate.

**Purpose and Background**

I am hoping that between 30 and 40 clinicians will participate in this project.

Previous studies have shown that doctors have a variety of views on the permissibility of active euthanasia, and other end of life decisions. Official Statements from Medical Associations worldwide distinguish morally between active euthanasia and appropriate withholding or withdrawal of treatment, even when this results in death. This position is strongly criticised by some bioethicists. There has been no previous qualitative study of how clinicians understand and explain this difference, and whether they think it is morally significant.

You are invited to participate in this research project because it is expected that the experience and opinions of medical practitioners who work with the severely and/or terminally ill will provide particular insight into these issues.

I am undertaking this research project for a Ph D at the University of Melbourne. My supervisors are Prof. Michael Ashby (Palliative care), Dr. Bernadette Tobin and Dr Gordon Preece (moral philosophers), and Dr. Fiona McDermott (Social work).

**Procedures**

Participation in this project will involve

- **A single semistructured audiotaped interview with the student researcher, of up to one hour’s duration.**

- Participants will be invited to discuss a recent end-of-life decision which raised the issue of the distinction between “killing” and “letting die”.

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**Appendix D**

**Participant Information and Consent Form**

**Version 4 Dated March 18 2005**

**Site: Melbourne University**

**Full Project Title: The doctor as moral agent, with reference to the distinction between killing and “letting die”**

**Principal Researcher:** Dr. Denise Cooper

**Associate Researcher(s):** Prof. Michael Ashby

Dr. Fiona Mc Dermott

Dr. Gordon Preece
Examples of other questions which may be used include:

“Some people put a lot of emphasis on the difference between killing and “letting die”. What do you understand by these terms?”

“Do you think there is a difference between killing and “letting die” in the medical context and if so, how would you explain it?”

“Do you think there is a moral, or any other kind of difference between giving a patient a lethal injection and giving them a lethal prescription to enable them to commit suicide?”

“Do you think voluntary active euthanasia or physician assisted suicide can be part of the role of a doctor?”

“How do your views about religion or spirituality influence your thinking in this area?”

A brief follow up telephone call within 24 hours of the interview.

Possible Benefits

You will have the opportunity to contribute to the bioethics debate in this area, where clinicians’ understandings and opinions are not often canvassed in depth. A copy of the summary of the research findings, discussion and conclusions will be sent to you on request.

Possible Risks

In Australia, no individual charges have ever been brought against a doctor or other health professional who has admitted in the research context to “helping a patient to die”. Nevertheless, there is a very slight risk that disclosure of actions in relation to the death of a patient might lead to charges being laid against you when the research is published. Your anonymity and confidentiality will be protected as far as possible (see below), but it would be wise not to reveal identifying information about patients or yourself.

The audiotaped interviews and transcripts are required to be kept for seven years and would therefore be available if required by the police or the courts. There is also the (probably very slight) possibility of the student researcher being required by the court to give evidence. During or after the interview, you may ask for sections of it to be deleted from the tape and/or the transcript.

You are encouraged to contact Dr. Jack Warhaft, Director of the Victorian Doctors’ Health program (9495 6011) if you wish to discuss any issues further after the interview. If you have any questions or concerns of a legal nature, you would be advised to contact your Medical Defence Association.

Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. Results will be published in a deidentified form in a Ph. D thesis, and in peer-reviewed journal articles and conference presentations.
Audiotapes and transcripts of the interviews will be stored in locked filing cabinets to which only the student researcher, Denise Cooper, has access. Transcripts will also be stored on a password protected computer. All records will be labelled only with pseudonyms and the date of the interview. Records will be kept for seven years and then destroyed.

There will be no written record of the names of participants, and no master list linking names with pseudonyms or codes. There will be no written consent form.

In any publication, information will be provided in such a way that you cannot be identified.

**Further Information or Any Problems**

If you require further information or if you have any problems concerning this project, you can contact the principal researcher Dr Denise Cooper yyyy yyyy or 0438 595527 (AH)

**Other Issues**

If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Once you understand what the project is about and if you agree to take part in it, you will be asked to give verbal consent, by which you indicate that you understand the information and that you give your consent to participate in the research project.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact the Executive Officer, Human Research Ethics, Melbourne Research and Innovation office, University of Melbourne, on 8344 2073

You will need to tell her the name of the principal researcher, Denise Cooper.

**Ethical Guidelines**

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the University of Melbourne.

Thank you for considering being involved in this research. If you are interested in being involved, have any questions or wish to discuss the project further, please contact me by phone, or by email d.cooper@pgrad.unimelb.edu.au.

I will send a reminder note about the project if I have not heard from you in the next three weeks.

Yours sincerely,

Denise Cooper