Death and dying are not comfortable topics for discussion. They raise uneasy questions and anxieties, reminders of our own frailty and vulnerability, and fears about the impending loss of loved-ones. But I am absolutely convinced that these are vital topics that we cannot avoid and must face head-on.

Just as we can’t escape being confronted with death and dying in our personal lives, so also these topics have taken on strategic importance in the public arena. Scarcely a week goes by without another high profile media story highlighting the inadequacies of end of life care in our health services, or the tragic story of an individual who committed suicide to escape the suffering and indignity of a terminal illness.

Sophisticated campaigning organisations across the world are using these personal tragedies as the driving force to change the law to allow various forms of medical killing. Their efforts seem to have been highly effective in influencing public opinion in favour of legislation for medically assisted suicide or ‘assisted dying’ as it is increasingly (but misleadingly) called.

Of course these are much more than philosophical, political or legal issues. We must never forget the personal tragedies and fears that lie behind the public debates. Our first responsibility is to empathise, to try to comprehend and enter into, the human suffering, fear and desperation which many people face at the end of life. If we wish to follow the example of Christ we should talk about these issues not with condemnation, judgement and rhetoric in our voices but with tears in our eyes.
The history of euthanasia in the UK

“If you don’t know where you are going, it’s sometimes helpful to know where you have been...”  (William Temple).

There is a strong tendency in current debates about medical killing to ignore the historical perspective. The implication is that this is a new problem which requires new solutions. Yet the reality is that euthanasia has been actively discussed in the UK for almost 150 years, whilst the morality of suicide and mercy killing has been a matter of debate for more than 2000 years, starting in the pre-Christian era. This article provides a brief review of the history of euthanasia both in the UK and internationally. The content is inevitably somewhat academic and also disturbing. For those who wish to fast-forward to the present, please see the companion article Euthanasia in the modern world on the website johnwyatt.com.

In 1870 an English schoolteacher named Samuel Williams published an essay entitled “Euthanasia”. He proposed that “in all cases of hopeless and painful illness, it should be the recognised duty of the medical attendant, whenever so desired by the patient, to administer chloroform, or such other anaesthetic as may by and by supersede chloroform, so as to destroy consciousness at once, and put the sufferer to a quick and painless death; all needful precautions being adopted to prevent any possible abuse of such duty, and means taking to establish, beyond the possibility of doubt or question, that the remedy was applied at the express wish of the patient.” His essay was reprinted several times and contributed to a vigorous debate on the topic.

It is striking that right from the beginning mercy killing carried out by a doctor was christened with a euphemistic title, for euthanasia means simply “good death”: eu-thanatos. As we will see the use of ambiguous and misleading terminology by campaigners has been a feature of the debate right up to the current time.

There seems little doubt that the remarkable advances in medical anaesthesia in the 19th century had stimulated Williams’ essay. Chloroform was a new, powerful (and potentially lethal) addition to medical practice and was being increasingly used to abolish pain during childbirth and in surgical operations. Why should it not be used, under strict guidelines, to induce a painless death in cases of hopeless and painful illness? An editorial in The Spectator conceded that Williams’ argument was persuasive but rejected it on practical and religious grounds. “Euthanasia would place an intolerable responsibility upon the patient, his physician and friends.”
Williams’ essay was also clearly influenced by recent evolutionary thought, encapsulated in the publication of Charles Darwin’s *Origin of Species* eleven years earlier in 1859. Williams wrote “A universal struggle for mastery and the universal preying on the weak by the strong is incessant; where conflict, cruelties, suffering and death are in full activity at every moment in every place... And the only factor in all this scene of carnage that can be pointed to as significant of beneficent design, is the continuous victory of the strong, the continuous crushing out of the weak, and the consequent maintenance of what is called “the vigour of the race”, the preservation of the hardiest races and of the hardiest individuals.” Williams argued that humans already behaved in counter-evolutionary ways. Modern medicine, although commendable, effectively sponsored the survival of the “unfit”. If this was ethically justifiable, then man was similarly justified in preventing the suffering at the end of the life which nature saw fit to impose.

Five years later the prominent birth control campaigner and socialist Annie Besant promoted the concept of “rational suicide”. “....when we have given all we can, when strength is sinking, and life is failing, when pain wracks our bodies, and the worst agony of seeing our dear ones suffer in our anguish tortures our enfeebled minds, when the only service we can render man is to relieve him of a useless and injurious burden, .... we ask that we may be permitted to die voluntarily and painlessly, and so to crown a noble life with the laurel wreath of a self-sacrificing death.”

Radical new ideas deriving from the Enlightenment were common amongst elite educated thinkers in Victorian England. There was the potent dream of building a better future for humanity based not on religious dogma but on science and rationality alone. At the same time the new rational philosophy of utilitarianism highlighted the moral imperative of minimising painful and negative experiences for humans and animals alike.

Several historians have pointed to the connection between the rise of interest in euthanasia and the development of eugenics in Victorian England. The new “scientific” eugenics sought to prevent racial degeneration by restricting the reproduction of those who were called the “unfit”, those with identifiable hereditary abnormalities who “cluster to the extreme left of the distribution curve, and whose powers of reason and memory were even below those of dogs and other intelligent animals”.

In 1901 Dr Charles Goddard, a prominent supporter of both eugenics and voluntary euthanasia, and Medical Officer of Health in London, delivered a medical paper entitled “Suggestions in favour of terminating absolutely hopeless cases of injury or disease”. In it he proposed offering euthanasia both to “those poor creatures with inaccessible and therefore inoperable malignancy” but also to mental defectives, referring to the large number of cognitively impaired individuals resident in the asylums “for example idiots, beings having only semblance to human form, incapable of improvement in education, and able to feed
themselves, or perceiving when the natural functions are performed, unable to enjoy life or of serving any useful purpose in nature”.

Dr Goddard’s views were extreme and were not supported by many in the overwhelmingly conservative medical profession. However proposals for “eugenic euthanasia” continued to be raised from time to time. Even George Bernard Shaw, in a speech to the eugenics Education Society in 1910, was reported to have supported “the lethal chamber” for those who wasted other people’s time because they needed looking after.

The eminent neurologist Dr Tredgold was a leading authority on mental deficiency. In his textbook of 1922 he discussed the idea of a lethal chamber for those with severe mental defect. He suggested that society would “not necessarily be unjustified” in adopting mercy-killing as “a self-defence mechanism for ridding itself of its antisocial constituents”, but public opinion was such that this proposal could not be contemplated at the present juncture. Prof Richard Berry was another eminent expert in the field of mental deficiency. In 1930 he proposed a “lethal chamber, under state control” designed for the “painless extermination” of low grade defectives. His views were opposed by many in the official eugenics movement although it was noted in an official review that his proposals had “provoked a rather surprising amount of support”.

Euthanasia in Nazi Germany

(This section contains distressing details about the reality of euthanasia in Nazi Germany and you may wish to fast-forward to the next section. However I believe that we cannot merely shut our eyes to the realities of what has happened in Europe in living memory. This is especially important for medics and health professionals)

Professor Berry’s proposals were similar to those put forward in Germany by Karl Binding, a professor of law, and Alfred Hoche, a professor of medicine. Their book “Permission for the destruction of worthless life, its extent and form” identified three categories of individual in whom euthanasia or “allowable killing” would be justified. The first category consisted of patients who were terminally ill. The second category included those patients who had lost consciousness and consequently were unable to make their own decision about life or death. In such cases it was proposed to have a neutral adjudicator who could anticipate their wishes for them. The third category were those described as “incurable idiots”, individuals who did not have the “slightest use” to society and provided an enormous burden, absorbing resources which might be employed more usefully in the task of national regeneration.

The right to live, the professors asserted, must be earned and justified, not dogmatically assumed. Those who are not capable of human feelings - those 'ballast lives' and 'empty
human husks' that fill our psychiatric institutions - can have no sense of the value of life. Theirs was not a life worthy of life, and hence their destruction was not only tolerable but downright humane. The arguments in favour of mercy killing were based not only on compassion towards those who were suffering from a life not worth living. It was also the huge financial cost to society which these lives represented. By 1935, popular medical and racial hygiene journals carried charts depicting the costs of maintaining the sick at the expense of the healthy.

At the same time as euthanasia was being promoted in Germany, forced sterilisation of the genetically unfit was being carried under the 1933 Law for the Prevention of Hereditary Diseased Offspring. All doctors in Germany were required to report patients of theirs who were mentally retarded, psychiatrically unwell, epileptic, blind, deaf, or physically deformed. By the end of World War II, it is estimated that over 400,000 individuals had been sterilised for eugenic reasons.

It's important to recognise that the discussion about eugenics and euthanasia for severely impaired individuals was not restricted to Germany alone. These issues were a matter of debate in many western countries including the United Kingdom, the United States and Scandinavia. However of the three categories proposed by Binding and Hoche - the terminally ill, the unconscious and the permanently disabled - it was the first category, the terminally ill who wished to be put out of their misery, that became the focus of euthanasia debate in the West. Eugenic sterilisation rather than euthanasia seemed a better alternative to the problem of “racial degeneration.”

In 1936 the Voluntary Euthanasia Society was founded in England. A Bill was submitted to Parliament but it was defeated in the House of Lords. In opinion polls, over 60% of the public supported the legalisation of euthanasia. In 1937, a questionnaire amongst American physicians found that 53% supported euthanasia. Approximately 2000 physicians and more than 50 religious ministers were among the members of the American Euthanasia Society in the pre-war period.

In October 1939, shortly after the outbreak of war, Hitler signed a "euthanasia decree" authorising specific physicians to undertake euthanasia “so that patients who, according to human judgment, are considered incurable, can, upon a most careful diagnosis of their condition, be accorded a mercy death.” Aktion T4 was the name of the official Nazi euthanasia programme. The name T4 was derived from the address of a Berlin villa which was the headquarters of the programme, officially entitled Charitable Foundation for Curative and Institutional Care. This body operated under the direction of Dr Karl Brandt, Hitler's personal physician.
A chilling film *Ich Klage an* (I accuse) was commissioned by Goebbels at the suggestion of Karl Brandt to make the public more supportive of the Reich’s T4 euthanasia programme. A woman suffering from multiple sclerosis pleads with doctors to kill her. Her husband gives her a fatal overdose, and is put on trial. He argues that prolonging life is sometimes contrary to nature, and that death is a right as well as a duty. The film culminates with the husband’s accusation of society’s cruelty for trying to prevent such deaths. This sentimental and misleading portrait of euthanasia was of course far from the terrible realities of the T4 programme.

The official T4 statistics recorded that 70,273 people were killed, but in 1946 the Nuremberg Trials found evidence that in reality about 275,000 people were killed under T4. The programme included newborns and very young children. Midwives and doctors were required to report to T4 officials children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms.

In 1949 an American psychiatrist Leo Alexander, who had attended the Nuremberg War Trials, wrote an influential paper entitled ‘Medical Science under Dictatorship’, published in the New England Journal of Medicine. In it he traced the historical roots of the Nazi euthanasia movement. How was it that respected doctors could have participated in such horrendous acts? Alexander concluded that, “It started with the acceptance by doctors of the idea, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in the beginning referred to the severely and chronically sick. Gradually the sphere of those to be included was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted… But it is important to realise that the infinitely small lever from which this entire trend of mind received its impetus was the attitude towards the incurably sick.”

“The life not worthy to be lived”. This idea was the “infinitely small lever” that led inexorably to the catastrophic consequences of the T4 euthanasia programme Leo Alexander’s conclusion seems remarkably prescient. As we will see, this idea is still around and it is central to the current push for euthanasia and assisted suicide. When under the proposed legislation I agree to assist your suicide, I am in effect agreeing with you that your life is not worth living. What will be the long term consequences in our society of this “infinitely small lever”?

As the unspeakable horrors of the Nazi euthanasia programme emerged into public view after the end of the Second World War, it is not surprising that the demand for the legalisation of euthanasia in the rest of Europe subsided for a period.

*The history of euthanasia in the Netherlands*
We will examine the development and current practice of euthanasia in the Netherlands in some detail, because it provides an instructive example of how various forms of mercy killing have become increasingly acceptable, within a modern European context over a 40 year period, together with the challenges this has posed for doctors.

Attitudes towards euthanasia and the process of dying started changing in the Netherlands in the 1970s. Commentators have suggested that this reflected both changes in cultural attitudes and changes in medical technology. On the cultural front there was increasing individualism, secularism and a desire for democratic discussion and debate about death and dying. At the same time there was a new awareness of the impact of new medical technology, increasing the doctor’s ability to postpone death.

Questions about the prolongation and the termination of life became the subject of public debate. TV shows and radio programmes investigated the process of dying and the importance of being told the truth at one's deathbed. Symposia were organized, and “support in the dying process” became a familiar concept. Opinion polls showed that a growing proportion of the population thought that life could sometimes be actively terminated and that ‘euthanasia’ should be made legal.

To begin with, the word ‘euthanasia’ was used with a range of meanings but a process of conceptual clarification gradually took place. Euthanasia came to refer exclusively to the active termination of life, usually by a doctor administering a lethal injection. This was distinguished from the withdrawal of life supporting treatment and the use of pain-controlling medication at the end of life, which came to be regarded as ‘normal medical practice’. ‘Euthanasia’ in the Netherlands is almost universally defined as the situation in which a doctor kills a person who is suffering ‘unbearably’ and ‘hopelessly’ at the latter's explicit request.

In 1973 the Dutch Association for Voluntary Euthanasia (NVVE) was formed. It remains active and influential to the present day. The Association's stated goal was to work toward the social acceptance and the legalisation of voluntary euthanasia. To distinguish its aims from the horrors of the Nazi euthanasia programme, the NVVE has always emphasized that euthanasia should be entirely voluntary in nature. One of its most important roles had been the formulation and distribution of ‘euthanasia statements’ or advance directives, in which a person declares that, should an illness or accident “cause such physical or mental damage that recuperation to a reasonable and dignified standard of life becomes impossible”, he or she refuses all curative treatment and wishes to have euthanasia performed.

Until 2002 euthanasia was explicitly prohibited by the Dutch Criminal Code. But from the 1980s, the Dutch courts have held that a defence of “necessity” was available to a doctor charged of intentional homicide or assisted suicide. The first acquittal of a doctor accused
of mercy killing took place in 1983 and this was upheld by the Dutch Supreme Court. The essence of the legal defence was that the doctor was confronted by an irreconcilable conflict. On the one hand there was an absolute medical duty to prevent suffering which was “unbearable and hopeless”. On the other hand there was a medical duty to protect and preserve life. Faced with this intractable conflict of duties the doctor could claim that he or she had no choice but to terminate the patient’s life as the only means to bring an end to the suffering.

Over the 1980s a series of test cases developed the procedures by which a doctor who had terminated the life of their patient could claim immunity from prosecution. The doctor had to demonstrate that he or she had acted “with due care”. Over time this was specified as:

1. The request for euthanasia must be voluntary and un-coerced
2. The request must be “well-considered”, (in other words rationally defensible)
3. The patient's desire to die must be a lasting one;
4. The patient must experience their suffering as unacceptable or “unbearable”. It was the doctor's task to investigate whether there were medical or social interventions which might make the patient's suffering bearable.
5. The doctor concerned must consult an experienced colleague.

It is important to note, first, the emphasis on “unbearable and hopeless suffering”. In order for euthanasia to be legally justified in Holland there has to be suffering which is both “unbearable”, that is experienced by the patient as totally unacceptable and intolerable, and “hopeless”, that is there is no possibility of amelioration through medical treatment or social intervention. Clearly suffering is a subjective experience which only the patient can describe, but it is the clinical responsibility of the doctor to determine whether the patient’s suffering reaches the level of being both “unbearable” and “hopeless”. There have been many cases in the Netherlands where the patient’s request for euthanasia has been turned down by their doctor, because the degree of suffering was regarded as insufficient.

Second, euthanasia can only be legally performed by a physician, and within the context of an established doctor-patient relationship. Only a physician can experience an irreconcilable conflict between the medical duties to relieve suffering and to protect life.

Third, there is no requirement in Dutch law and practice for the patient to have a terminal illness, or to have a purely physical source of suffering. Provided that the threshold of “unbearable and hopeless suffering” is reached, any patient is capable of requesting euthanasia and their doctor can claim the protection of legal necessity.

Fourth, although in the Netherlands the term “euthanasia” is only applied to the voluntary request of a legally competent patient (one who is in full possession of rational faculties), it
is clear that the legal defence of necessity could in principle apply to any patient who was suffering unbearably and hopelessly. Whether the patient was competent or not and whether they were requesting euthanasia or not, the physician would still be placed in an irreconcilable conflict of duties. If a physician had a duty to end the unbearable suffering of a legally competent adult, why was there no duty to end the life of a suffering baby, a patient in a permanent coma or with advanced dementia?

In 1991 the results of the Remmelink Commission, an official investigation into the extent of euthanasia in the Netherlands, were published. About 1.7% of all deaths (2300) per year were due to euthanasia and 0.2% (400 deaths) to assisted suicide. The research also revealed, controversially, that in about 0.8% (1000 deaths) the life of a patient was ended without there being an explicit request.

This article is adapted from material in *Right to die? Euthanasia, assisted suicide and end of life care*, by John Wyatt, published by IVP.

For current euthanasia and assisted suicide practices in a range of countries please see the article:

**Euthanasia and assisted suicide – current realities**

For Christian and practical medical responses to the issues of euthanasia and assisted suicide please see the articles

Euthanasia and assisted suicide - Christian responses and perspectives

Euthanasia and assisted suicide - medical issues in the care of the dying person

Euthanasia and assisted suicide – palliative care and legal aspects