

## Euthanasia: above ground, below ground

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The key to the euthanasia debate lies in how best to regulate what doctors do. Opponents of euthanasia frequently warn of the possible negative consequences of legalising physician assisted suicide and active euthanasia (PAS/AE) while ignoring the covert practice of PAS/AE by doctors and other health professionals. Against the background of survey studies suggesting that anything from 4% to 10% of doctors have intentionally assisted a patient to die, and interview evidence of the unregulated, idiosyncratic nature of underground PAS/AE, this paper assesses three alternatives to the current policy of prohibition. It argues that although legalisation may never succeed in making euthanasia perfectly safe, legalising PAS/AE may nevertheless be safer, and therefore a preferable policy alternative, to prohibition. At a minimum, debate about harm minimisation and the regulation of euthanasia needs to take account of PAS/AE wherever it is practised, both above and below ground.

tragedies and suicides that seem to fuel public debate about euthanasia in the pages of newspapers and even academic journals? Significantly, each new case is seen as a defining moment in the debate: the case that could tip the balance in favour of legalisation. The usual participants weigh in to do battle over the same old questions, but nothing ever seems to change.

If the euthanasia debate has reached something of a stalemate, these questions may be part of the problem. We have assumed for too long that it is Nancy Crick, or Dianne Pretty, celebrity dissidents like Jack Kevorkian and Philip Nitschke, or prosecuted doctors like Nigel Cox and Timothy Quill who illustrate what is at stake in the euthanasia debate. We need a change of focus. For every death, and every dissident doctor who makes it into the media's spotlight, there are thousands who do not. Intentionally assisting a patient to die, whether by physician assisted suicide (PAS) or active euthanasia (AE) carries enormous risks, both for patients and society generally. If we are concerned about the risks of euthanasia, the issue we should be confronting is how best to regulate *underground euthanasia*, rather than whether the law should regularise an unlawful practice that happens anyway.

Concepts of public health, patient safety, and harm reduction are evident in the euthanasia debate, but they feature overwhelmingly in the context of arguments opposing the legalisation of euthanasia. Commentators speculate about the impact that a legal right to die would have upon the physician–patient relationship,<sup>10</sup> or upon the broader, moral fabric of society,<sup>11</sup> and warn about the risks of a slippery slope. “[O]nce we agree to the principle of doctors performing voluntary euthanasia by what effort of societal will, on what rock of ethical principle, can we resist its extension to ever new categories of sufferers?” asks Robert Manne.<sup>12</sup> “There is no such will: no such fixed and reliable principle”, he argues. To legalise euthanasia is to set in motion a “subtle transformation of ethical sensibility. Over time we become blind to how we once thought”.<sup>12</sup> In Manne's view, the criminal law functions as a kind of “moral dyke”: to breach that dyke, even for the sake of competent, suffering patients is ultimately to put other vulnerable classes of patient at risk.

The assumption that the risks all lie with legalisation is rarely contested. In this paper, I will not argue that legalisation could ever be perfectly safe, but rather that the debate about harm minimisation is more difficult than opponents of euthanasia admit, mostly because they are silent about the risks posed by underground PAS/AE. I will begin by drawing on my own

On 22 May 2002, Nancy Crick, a 69 year old grandmother living on Australia's Gold Coast committed suicide by drinking a lethal cocktail of barbiturates.<sup>1</sup> For months previously, Nancy had advertised her intention to do so on her website, <nancycrick.com>. With 21 family members and friends present to witness the death, Crick's suicide all but guaranteed the police investigation that followed. According to her doctor, Philip Nitschke, the manner of Crick's dying was evidence of a new radicalism within the voluntary euthanasia movement, and was intended to force a precedent for the right not to die alone.<sup>2–3</sup> Putting the short, sharp media feast to one side, however, Crick's death appears to have achieved little in political terms. Queensland Premier Peter Beattie immediately ruled out legal change,<sup>4</sup> while days later, the Australian Medical Association voted 79 to 34 against a motion to move towards a neutral position on voluntary euthanasia.<sup>5</sup> In retrospect, Crick's death was seen as a public relations disaster when a postmortem revealed that Crick had an inoperable twisted bowel, rather than bowel cancer, when she died.<sup>6–7</sup> On 6 August 2002, detectives swooped on Nitschke's home outside Darwin, confiscating computers, files, and disks.<sup>8</sup> Recently, the investigations concluded, with no changes laid.<sup>9</sup>

Two years on, who remembers Nancy Crick? And in another year from now, what will mark her death out from the slow parade of personal

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interview based research into covert assisted death to illustrate what underground euthanasia is really like, before suggesting how covert euthanasia invites a reassessment of euthanasia policy.

### UNDERGROUND EUTHANASIA—SURVEY EVIDENCE

At the empirical level, the existence of a euthanasia underground is difficult to deny. Surveys consistently demonstrate that a significant percentage of doctors comply with patients' requests to take active steps to hasten death: up to 12.3%, for example, in Baume and O'Malley's survey of 1268 doctors in New South Wales and the Australian Capital Territory.<sup>13</sup> In a more recent survey of Australian general surgeons, 5.3% reported administering a bolus lethal injection, while 36.2% reported giving an overdose of drugs with the intention of hastening death (more than half, or 20.4% of respondents, did so without a clear request by the patient).<sup>14</sup> In a 1994 study of 312 British doctors, Ward and Tate reported that 124 of 273 doctors answering the relevant question (45%) had been requested by a patient to hasten death; 12% of these respondents complied.<sup>15</sup> A survey of 1000 Scottish healthcare workers found that 4% had assisted suicide either by providing drugs or advice.<sup>16</sup>

A similar picture emerges from the USA. A national survey of 1902 American physicians found that 3.3% had written at least one lethal prescription, while 4.7% had provided at least one lethal injection.<sup>17</sup> A survey of American oncologists found that 3.7% had performed euthanasia, while 10.8% had assisted suicide.<sup>18</sup> American surveys, like those elsewhere, show that medical opinion is fragmented over the question of assisted death. In a random sample of American physicians, 44.5% favoured the legalisation of PAS (33.9% were opposed).<sup>19</sup>

These and dozens of similar studies suggest that we have passed the point where it is reasonable to deny evidence of underground PAS/AE by asserting that the wrong questions were asked, or that doctors failed to distinguish between actions taken with the intention of hastening the patient's death, and pain relief involving the lawful administration of analgesics. No-one suggests that the majority of doctors have participated in assisted death; many doctors, of course, come nowhere near death in their daily practice. But the weight of survey evidence demands a response: wherever you turn, somewhere between 4% and 10+% of doctors have illegally assisted a patient to die. Perhaps doctors themselves feel quite comfortable with this, but should we? Where is the outcry from euthanasia opponents if each of these deaths is best understood as murder by the physician?

Two recent, thought provoking books illustrate this point. John Keown's *Euthanasia, Ethics and Public Policy*, published in 2002, runs to 291 pages and contains a five chapter critique of Dutch euthanasia practice, but just four paragraphs on the implications of surveys into the illicit practice of PAS/AE.<sup>16</sup> Margaret Somerville's *Death Talk* contains 348 pages of text, but (on my reckoning) just four pages on the illicit practice of euthanasia.<sup>20</sup> It is time opponents of legalisation balanced their concerns about what *might happen* if euthanasia is legalised with the reality of what doctors already do.

### WHAT IS UNDERGROUND EUTHANASIA REALLY LIKE?

Despite the growing body of statistical evidence, remarkably little is known about the circumstances in which doctors provide covert assistance to die, whether these attempts result in what was perceived to be a good death for the patient, and the long term impact of involvement on health carers themselves. In *Angels of Death: Exploring the Euthanasia Underground*,<sup>21</sup> I reported on 49 detailed, yet pseudonymous interviews with doctors, nurses, and therapists working in

HIV/AIDS health care, principally in Sydney, Melbourne, and San Francisco. Half of the interviewees volunteered to be interviewed by identifying themselves to me following seminars I gave to doctor groups, while the other half were referred by interviewees, and other contacts. Certain interviewees played a pivotal role in referring me to key players within the informal "euthanasia networks" which—I discovered—had grown up around involvement in HIV medicine and in the gay community, particularly up until the mid-1990s when protease inhibitors became available and dramatically slowed the number of AIDS deaths.

Despite their mostly good intentions, interviewees painted a troubling picture of covert PAS/AE. It is true that many deaths were peaceful and were reported as being positive occasions for all concerned. For example, an eminent physician, Joseph, was asked by his hairdresser to prescribe a lethal dosage of drugs to assist the death of the hairdresser's lover, who was dying from AIDS. Joseph had heard about the man's deterioration *second-hand*, during haircuts, but Joseph had never met him. He admits that "there was no assessment involved whatsoever". Joseph recalls:

I wrote a prescription to a patient who I had never seen and I sent it to him in the mail. I heard that next time I went in to get my hair cut that it was the most beautiful experience that my stylist had ever had. It was [St] Valentine's Day and they had a lovely meal with champagne ... and they held each other and then his partner took his pills and was released.

Not all deaths end as sweetly as this. Take Stanley, a therapist and former priest, who presided over the death of a patient who swallowed 15 Seconal tablets (a barbiturate), but who failed to take an antiemetic. It was only after the patient had swallowed his own vomit that the drug took effect. In many cases doctors and nurses miscalculated the dosages required to achieve death and resorted in panic to suffocation, strangulation, and injections of air. Of the 88 detailed narratives that interviewees gave to illustrate their euthanasia credentials, nearly 20% involved "botched attempts". Suffocations were referred to euphemistically as "pillow jobs" by several interviewees:

"It was horrible", said one doctor (now head of a large community organisation). "It took four or five hours. It was like Rasputin, we just couldn't finish him off." "I tried insulin, I tried just about everything else that I [had] around and it just took forever ... [It was] very hard for his lover. So I um sort of shooed the lover out of the room at one stage and put a pillow over his head, that seemed to work in the end [laughs, nervously] ... That was one of the worst [clearing throat] one of the most horrible things I've ever done."

Another doctor, Tony, reflected:

I think the ultimate obscenity ... was one of my patients ... who helped a friend of his to die at home by helping him take a large quantity of sleeping pills and then holding a garbage bag over his head until he died, and I think that is absolutely ... appalling and barbaric, and primitive.

It was incidents like this that cemented Tony's decision to assess patients who requested PAS/AE with the help of a trusted psychiatrist. In his case, assistance to die took the form of building up his patient's dependence upon cortisone, and then suddenly withdrawing it while administering

morphine, or simply administering massive doses of liquid morphine and Largactil (chlorpromazine): “you can just keep on pumping it into the stomach until they die”.

For me, the most striking feature of these accounts was the way they betrayed the absence of norms or principles for deciding when it was appropriate to proceed. One doctor injected a young man on the first occasion they met, despite concerns from close friends that the patient was depressed. The doctor had a chat with a hospital physician who had been involved in the patient’s care who “seemed to think that death would be a nice thing”. It later emerged from a community nurse I interviewed, who was involved in the same incident, that the patient had only told his parents the week before that he was HIV positive. Even those closest to the patient were concerned about depression.

In another case, a patient brought his death forward by a week so as not to interfere with the doctor’s holiday plans. The doctor supplied a palatable mixture of barbiturates ground up by a pharmacist, but absented herself during the death itself. Absent doctors were a feature of several accounts, attending briefly to inject the patient, before fleeing the scene for personal and legal reasons. Annoyed at having to fit in a home visit a few hours before her scheduled flight, the doctor was also irritated to find that the patient’s friends had failed to lay him out straight before rigor mortis set in. The grieving friends also left the organisation of the funeral to her (she narrowly avoided paying for it herself).

On another occasion, a doctor injected the entire contents of his doctor’s bag into a comatose patient after a failed overdose, reflecting that “I realised he [was] not going to survive this ... I might as well speed it along. I think also because it was four o’clock in the morning, I had a cold and I felt dreadful and I just wanted to get out of there”.

Underground euthanasia has spawned a culture of deception. Deceit is all-pervasive. It encompasses the methods used to procure euthanasia drugs, the planning of the death itself, and the disposal of the body and associated paperwork. Prior to death, doctors admitted to fabricating symptoms to create a plausible clinical basis for the prescription or administration of escalating dosages of drugs. The following example is drawn from the interview with Merrill, a devout Christian who acknowledged the tension between his faith and participation in euthanasia:

*Interviewer:* [But] what if, for example, the patient isn’t in chronic pain and so Demoral [a barbiturate] is not really medically indicated?

*Merril:* ... probably in that instance I would develop some chronic pain [very quiet]

*Interviewer:* ...[so] you’re hoping to fudge the system to some extent?

*Merril:* To protect me and the patients.

Other interviewees depended less on creating a plausible scenario for administering very high dosages of drugs, and more on the trust of the patient’s family and loved ones. Josh, for example, had used a veterinary drug called Lethabarb (pentobarbitone), sourced from a friendly vet, in two successful episodes. Josh felt that Lethabarb was “incredibly humane” because “you don’t have the agonal respirations ... all that awful stuff”. Several interviewees admitted to the outright theft of drugs. Others—particularly in hospital—hoarded the excess morphine left in the vials after the charted dose had been given.

While euthanasia is easier to carry out in community settings, there were examples of hospital and hospice euthanasia. A variety of social processes made hospital

euthanasia possible. These ranged from cooperative overdosing carried out by one or two functionaries acting at considerable personal risk, to whole hospital units staffed by people of like mind that fostered, to a greater or lesser degree, a culture of euthanasia.

One nurse interviewee, Liz, saw herself as the odd person out in a hospital unit that apparently used to “book in” patients to receive a lethal infusion of drugs. Although Liz had participated in *voluntary* euthanasia on previous occasions, she drew the line when the unit physician instructed her to send the mother of a dementing patient home to get a shower, and to administer a fatal infusion to the patient in her absence. The physician’s words to her were: “Get it up and get him [the patient] out of here by sundown.” What came across most strongly in the interview was Liz’s sense of isolation and bewilderment: “it was like I was the only person there [who] could see clearly what was happening”, she said. “It was murder. The doctor played God, he thought he was God ... he’d decided this was the time for this patient.”

In *Angels of Death*, I argue that these actions add up to more than the random misdeeds of doctors and nurses acting in isolation. Collaborative euthanasia takes many forms: referring a patient to an activist doctor for “assessment”, writing a “lethal prescription”, charting a lethal infusion, accessing the patient’s vein, administering a lethal injection or infusion, directing the procedure in a non-specific capacity, as well as being on call should anything go wrong, signing the death certificate, and countersigning cremation forms. Lying on death certificates was universal. Cremation is usually favoured over burial. “You sit in sweat waiting for cremation to occur”, said Peter, a community nurse. “All the people you speak to, if they’re being honest, will say the same thing: *we’re all waiting for the smoke to go up in the crematorium.*”

In summing up the overall impression gained from the interviews, it is difficult to disagree with Edmund Pellegrino—a long-standing opponent of euthanasia—who points to the risks of doctors acting outside of the established professional framework. “To exalt compassion over traditional professional obligations ... is seductive but dangerous. Danger lurks behind the benign face of compassion so flexibly interpreted.”<sup>22</sup>

## RESPONDING TO UNDERGROUND EUTHANASIA

How, then, should we respond to the absence of professionalism that characterises illicit, covert PAS/AE? How can we best minimise the risks for patients? In terms of policy choices, there would appear to be three major alternatives to the status quo:

- Protect patients by keeping euthanasia illegal, while actively investigating breaches and enforcing the law rigorously.
- Legalise, in order to “re-regulate” the practice of PAS/AE. Clearly, this option covers a range of more specific options.
- Educate and influence those who will nevertheless continue to participate in illicit euthanasia.

### Option 1: keep euthanasia illegal and try to prosecute the offenders

The first option—attractive to moral conservatives—is to “prosecute the offenders” in the hopes of wiping out underground practices. In practical terms, however, any such policy is bound to fail. Callahan and White argue that ensuring full compliance with the criteria forming part of any statutory regime that permitted euthanasia is impossible, since it would require an intrusion into the legally protected privacy of the doctor–patient relationship.<sup>23</sup> As a factual claim, this may or may not be true, although legally it is not a

satisfying objection, since medical confidentiality is not absolute and can not be used to cloak blatant criminality. What the privacy of the clinical relationship does do, however, is camouflage illicit PAS/AE. The interviewees I spoke to were generally concerned about exposure and careful with whom they shared details of their involvement. To all outward appearances they were trustworthy, law abiding professionals. Aside from the occasional show trial, or Kevoorkian-style admission, there is no realistic chance of purging the health professions of those who participate in assisted death.

Any attempt to suppress the covert practice of euthanasia by actively investigating suspicions and prosecuting offenders would also require a massive commitment to policing clinical functions. The most common euthanasia recipes consist of overdoses of relatively accessible, therapeutic drugs.<sup>24</sup> A more aggressive policing of analgesics, sedatives, and antidepressants would have a disastrous impact on pain relief and symptom management. The resulting climate of “defensive medicine” would seriously undermine palliative care. Doctors would fear giving adequate levels of pain relief, and chronically ill and dying patients would suffer because of it. It seems plausible to argue that a policy of aggressive policing would not only fail, but because of its effect on patients, could also lead to renewed calls for PAS/AE to be legalised.

### Option 2: legalise, in an effort to “re-regulate” euthanasia

A second response to the illicit practice of PAS/AE—attractive to libertarians—is to legalise euthanasia. The argument is that a statutory regime creates space for law to re-regulate euthanasia and to protect vulnerable patients by including safeguards in the statutory protocol that doctors would be obliged to follow when providing lawful assistance. Opponents of euthanasia typically respond by questioning the overall efficacy of a statutory regime and by shooting holes in the safeguards it would contain. Opponents claim that legalisation will fail to reduce underground euthanasia, that legalisation will fail to ensure that “above ground” assessments are safe, and that legalisation will result in more unsafe killing, both above and below ground.

These arguments deserve careful scrutiny. However, if we are to talk sensibly about legalisation as a harm minimisation strategy, we need to be clear on what the criteria for success of any statutory regime would be. If a statutory procedure worked effectively, according to the safeguards embodied within it, people would use it and they would die. It is difficult to guess how “popular” a PAS/AE statute might be. If the Oregon experience is any guide, surprisingly few might die this way (91 people died with assistance under Oregon’s PAS statute between 1998 and 2001).<sup>25</sup> <sup>26</sup> On the one hand, any sudden rise in lawful euthanasia deaths, both initially and over time, might be seen as evidence that covert practices were being “re-regulated” and driven above ground (policy success). Advocates would argue that the policy was working and that those who died, died better deaths.

On the other hand, for those who see euthanasia as inherently wrong, regardless of the circumstances, any lawful killing would be grounds for concern, and for suspicion about the failure of safeguards (policy failure). For these opponents, the only safe euthanasia law is one whose safeguards are so complex and bureaucratic that no patient could ever qualify for assistance. (Oddly, no similar plea is made for safeguards when a patient is choosing to forego life preserving medical treatment, despite the fact that death will result and despite evidence that the major determinants of decisions to withdraw care are highly idiosyncratic to the healthcare worker concerned.)<sup>27</sup> When PAS/AE becomes visible, however, the temptation for moral conservatives is

to interpret anything other than minimal use of euthanasia statutes as evidence of a dangerous slide down a slippery slope. Prohibiting all PAS/AE may or may not be the safest policy, but moral opposition ought not to cloud our assessment of empirical questions including whether legalisation prompts health professionals to redirect their assistance within lawful boundaries, and whether health professionals comply with specific safeguards. However, such empirical evidence carries little weight for those who regard a PAS/AE statute, whatever its safeguards, as the moral equivalent of “guidelines about how to carry out the procedures at death camps”.<sup>28</sup>

What, then, about the frequent claim that the safeguards inserted into any PAS/AE statute would be manipulated according to the values of the doctor concerned, or simply ignored?<sup>29–31</sup> This is an empirical question that deserves research. Several cautionary points, however, should be made. First, the “safer” the safeguards inserted into any statute (to protect the vulnerable or to minimise the number killed), the harder it will be for a patient to access assistance under the statute, regardless of their circumstances. A PAS/AE statute that is “too safe”, however, may fail in its aim of re-regulating illicit practices. Since prohibition has failed to prevent covert euthanasia, any statutory regime must—if it is to do any better—attract some measure of support and voluntary compliance from doctors. If the law is too bureaucratic, too intrusive, or gives insufficient legal shelter to doctors acting in good faith, it will be ignored in practice and will fail in its objective of re-regulating PAS/AE. The challenge for those interested in minimising harm is to design a regime that is robust, but which is also more attractive than the stresses and risks of illicit action. Locating this middle ground is all the more controversial because of the feared consequences of “unsafe” law.

Secondly, legislators are unlikely ever to come up with a *perfectly safe* law. Euthanasia opponents sometimes try to goad advocates of legalisation to put forward a “safe” proposal, which can then be gleefully shot down.<sup>31</sup> The underlying problem is that the process of assessing patients, and interpreting safeguards, calls for *judgements*, and judgements can be value-laden, difficult, and uncertain. This is true elsewhere in medicine, and undoubtedly so in end-of-life decision making. The fact that concepts like “unbearable suffering”, “terminal illness”, depression and competency have fuzzy edges does not mean that they provide no constraints at all.<sup>32</sup> Ultimately, however, the safety of a statutory regime rests on a moral commitment from doctors themselves. A PAS/AE statute will be safest when doctors treat statutory safeguards not as technical requirements or a “tick sheet” to be filled in, but as an invitation to engage deeply with their patients’ experiences and values, appreciating the complex nature of suicide talk and the mis-expression of pain and distress in terms of suicide.<sup>33–36</sup> The function of safeguards is to give moral pause: to take suffering seriously but also to signal the value of the patient’s life, the interests of loved ones and society generally, within a framework that empowers the doctor to act in the small number of cases that are most difficult.

But why should doctors be thrown into the role of killers? Opponents of euthanasia frequently argue that advocates of legalisation seem intent on dragging medicine into what is really a debate about suicide, to the detriment of patients, and the integrity of the profession.<sup>37</sup> This is misconceived. Euthanasia is not just a stimulating topic for the ethics stream of a medical conference in the Bahamas. It is fundamentally a regulatory challenge that revolves around what doctors do. Any attempt to regulate PAS/AE cannot but focus on doctors because *it is doctors who are doing the killing*. Regardless of whether PAS/AE remains lawful or

unlawful, medicine (and nursing) have a central role in the debate.

On the whole, despite their assumption that the laws that prohibit PAS/AE work in practice, opponents of euthanasia tend to be law sceptics. They point to non-compliance with the criteria required to make out the defence of “necessity” following PAS/AE under Dutch criminal law as a basis for the broader claim that if euthanasia were legalised, doctors would ignore the statutory safeguards and patients would be no better off.<sup>15 38 39</sup> van der Wal and colleagues report that between 1990 and 1995, the reporting of PAS/AE rose from 18% to 41% of cases. In 1995, formal consultation with a colleague occurred in 94% of reported cases, but in only 11% of unreported ones.<sup>40</sup> In 12% of cases where consultation did take place, however, the consultant never saw the patient.<sup>41</sup> Hendin, among others, has argued that Dutch consultants “seemed to be facilitators of the process rather than independent evaluators of the patient’s situation ...”.<sup>42</sup>

It is important to remember that our ability to castigate the Dutch about their rates of non-compliance comes courtesy of the relative transparency created by the Dutch policy of legalisation. If we wish to make ambit claims about slippery slopes, it is only fair to point out that the reporting rate for Britain, Australia, and most other countries, is zero.<sup>43</sup> Nevertheless, even partial compliance with statutory safeguards may represent an improvement on the kinds of clinical decisions that currently occur in secret. As one interviewee said, if euthanasia is to be practised, “it needs as much recognition as a tonsillectomy; if you’re going to medicalise it and give doctors all this power, then it needs to be subject to scrutiny, like a surgical audit”, in order to protect patients from mentally disturbed, impaired, or alcoholic doctors. Whatever the shortcomings of Dutch policy, it is likely to be very difficult to institutionalise mechanisms that will protect patients so long as PAS/AE remains illegal.

### Option 3: educate and influence the lawbreakers

For the foreseeable future, PAS/AE is likely to remain illegal in many countries. Nevertheless, this need not rule out strategies to guide, influence, and educate those who will continue to ignore the criminal law’s prohibition on physician assisted suicide and euthanasia. These doctors would surely do *less harm* if they had the opportunity to calibrate their actions against some sort of benchmark, some minimum set of criteria that would flag the issues, risks and pitfalls that are present when health professionals do provide assistance.

The challenge of influencing covert practices is most acute for professional medical organisations, who are in the best position to access their membership with information, decision making pathways, guidelines, and other resources. Perhaps because their memberships are so divided about the issue, professional medical bodies have little incentive to provide leadership in this area. Unfortunately, this results in rash and ill-considered practices both by patients and health professionals. In my study, some interviewees felt compelled to assist their patients because they felt that this was better than the brutality of amateur suicide. Examples included horrific injuries caused by patients jumping from bridges, jumping from windows, and in one example, crashing through hospital windows and severing the jugular vein.<sup>44</sup> Doctors participating in PAS/AE also complained constantly about the way in which the criminal law inhibits frank discussion of “hard cases”, nurtures ignorance, leads to desperation, “botched attempts”, ambiguous “double-speak”, deceit and deception, and high levels of distress and burnout.<sup>45</sup>

The argument that the illicit practice of PAS/AE should be rewarded with “professional guidelines” may anger some

opponents. These critics may need to separate their private views about the moral wrongness of euthanasia, from the policy question of how to minimise harm and to better protect patients’ interests. Euthanasia policy shares a tension between moralistic and consequentialist approaches also seen in the context of drugs policy, and—at least in Australia—in the debate about clean needle distribution programmes.

### CONCLUSION

The euthanasia debate is not about Nancy Crick or Dianne Pretty, as troubling as their cases were. It is about how best to regulate what doctors have always done, and what they will probably always do. The choice is not between having euthanasia, and not having it, but letting it stay underground, and trying to make it visible.

For those who see the world in black and white, and struggle to understand why others see it as shades of grey, legalising euthanasia because there is an “underground” is about as morally compelling as legalising paedophilia (“with safeguards”) simply because paedophilia also occurs “underground”. Adopting a harm minimisation approach does not mean, however, that we cannot distinguish between degrees of harm. Nor does it mean that, if something is illegal, we must mindlessly legalise it in order to regulate it. In the case of paedophilia, there is a high degree of social consensus that paedophilia is not only immoral, but that it causes serious harm to children. Creating a class of child prostitutes would certainly, in my view, be wrong, even if it could be shown that, on average, fewer children would be predated upon if paedophilia were “regulated”.

In the case of euthanasia, however, there is genuine disagreement about whether or not voluntary euthanasia to relieve terminal suffering, is morally wrong. This disagreement itself ought to challenge our assumptions about absolutist prohibitions: there is a distinction, too frequently forgotten in debate about medical ethics, between the private morality according to which we might choose to live our own lives, and the public morality of law and public policy. Even assuming that euthanasia is morally wrong, disagreement persists over the consequences of legalisation; in particular, whether legalising PAS/AE would cause less harm overall, than prohibition. A similar argument might be made about the “heroin underground”. I might strongly disapprove of non-medical heroin use, but nevertheless believe that it is wiser for society to operate safe injecting rooms to minimise the risks of overdose and transmission of HIV/hepatitis C through dirty needles. I would also go further and give serious attention to programmes supplying free heroin to registered addicts so as to simultaneously reduce the crime arising from the fact that criminals control supply, while ensuring that addicts can access the counselling and medical assistance that give them the best chance of beating their addiction. But the fact that I might take this view on heroin does not commit me to the view that it is right to legalise all “undergrounds”, just because they exist.

The debate about the legalisation of euthanasia needs to take account of euthanasia whenever it is practised, both above and below ground. I do not discount the possibility that in the end, moral conservatives *may be right*. Nevertheless, this is a case that opponents need to make in the light of an honest appreciation of what doctors do, and the risks and harms of euthanasia when it is practised in secret.

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