Against Volun

John Keown

I Introduction

Should the law allow doctors intentionally to kill their patients? When euphemisms like 'assisted dying' are stripped away, this is the stark question at the heart of the debate about the decriminalisation of voluntary euthanasia (VE).

Some people who support VE do so because they have seen loved ones die in distress, or because of their own fears about dying in distress. This is entirely understandable. There are urgent, grave questions about the limited availability of quality end-of-life care, even in developed countries like the UK and the US. We must, however, be careful before jumping to the conclusion that killing is the answer to deficiencies in caring. Whether the law should permit VE is a question which calls for careful reflection, not misguided emotion, simplistic slogans or media sound-bites. We are debating changing the law for the whole of society, not just the ethics of individual cases. Very hard cases can indeed make very bad law.

Whether the law should permit VE is a question which calls for careful reflection, not misguided emotion, simplistic slogans or media sound-bites.

Very hard cases can indeed make very bad law.

We are fortunate that few issues have been the subject of more comprehensive and informed expert debate. The case for decriminalising VE has, with few exceptions, been repeatedly rejected by legislatures and expert bodies worldwide, not least by the House of Lords, which has debated the matter across three quarters of a century. Why?

There are three key arguments against decriminalisation (none of which is religious):

1 It would be wrong in principle. It would breach a basic human right: the 'right to life', the right not to be intentionally killed.

2 The ethical case for VE is also, logically, a case for euthanasia without request ('non-voluntary' euthanasia or NVE).

3 Even if VE were not wrong in principle in certain 'hard cases' (as when requested by a competent, suffering, terminally-ill patient) decriminalisation would pose grave risks to the vulnerable, not least the dying, the disabled, the disadvantaged and the demented. In particular, it would expose the competent but vulnerable to pressure to request an earlier death and the incompetent to death without request.

What of the arguments for decriminalisation? In *Debating Euthanasia* (Hart, 2012) I consider ten, and conclude that none is persuasive. For reasons of space, I will here reply to one of the main arguments typically advanced: respect for autonomy.

II Respect for Autonomy

Isn't VE justified by respect for individual autonomy? Don't patients have a right to make their own decisions about the time and manner of their death? Campaigners for VE often ask: 'Whose life is it anyway?'

There are, however, several counter-arguments.

1 The Inviolability of Life

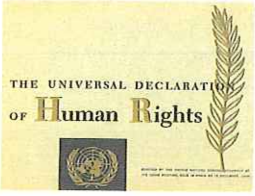
Our capacity to choose is undoubtedly important, for it is through our choices that we shape our lives and influence the lives of those around us, for good or for ill. But we should exercise that capacity responsibly by choosing for good, not ill. The advice 'Be careful what you wish for because you might get it' is

ary Euthanasia

prudent: consider King Midas. Neither the law nor professional medical ethics have ever held that the mere fact *that* I have chosen justifies *what* I have chosen. English law refuses to respect various choices, however autonomous. It disallows choices to be owned, eaten or executed, to buy illicit drugs or to drive while not wearing a seatbelt. In the medical context patients have no right to demand whatever treatments or drugs they may want. None of these autonomous choices need involve a risk of harm to anyone except the person making them but they are nevertheless disallowed by the law. Simply to claim, therefore, that patients have a 'right to choose' euthanasia because it is 'their life' begs the moral question.

The focus of our moral enquiry should not be some question-begging 'right to choose' but on what it is *right* to choose, on which choices merit, or do not merit, respect. Choices which undermine human flourishing, such as choices to kill or mutilate (whether oneself or another) simply lack moral justification. Further, given that our capacity for autonomy *is* so valuable, how can it be right deliberately to extinguish it by deliberately extinguishing its bearer? Must liberty not sometimes be limited in order to be possessed?

One important limit is the key ethical principle of the inviolability of life. (It is often referred to as the 'sanctity' of life but 'sanctity' has distracting religious overtones: as we shall see the principle can stand on solely philosophical grounds.) This historic principle, foundational to Western criminal law and professional medical ethics, holds that it is wrong intentionally to kill other people (at least if they are, like patients, not involved in unjust aggression). The principle is grounded in the recognition of the inherent dignity of each human being. The Preamble to the Universal Declaration of Human Rights (1948) proclaims that 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'. The Preamble has it right. Each of us shares an 'inherent dignity' and enjoys 'equal and inalienable rights' in virtue of our common membership of the human family. Human life is, like friendship and knowledge, a self-evident good and is, like them, a basic rather than an instrumental good. It is a basic element of human well-being, not merely a vehicle for a life of sufficient 'quality' or 'worth'. We *all* share a fundamental equality-in-dignity, regardless of our abilities or disabilities. There is no-one whose life is 'not worth living', no-one who would be 'better off dead', there are no 'second class' patients. The lives of *all* patients are worthwhile, even if some patients lose sight of their worth.


THE UNIVERSAL DECLARATI
OF Human Rights

To say that human life is a basic good is *not*, however, to say that it is the highest good and should be preserved at all costs. That would be 'vitalism' and morally indefensible. We all enjoy a 'right to life' but that is primarily *a right not to be intentionally killed.* It can, therefore, be perfectly proper for a doctor to administer palliative drugs to ease the pain of the dying even if the doctor foresees that the drugs will as a side-effect shorten life (though, properly administered, palliative drugs do not in fact shorten life.) It is also ethical to withhold or withdraw treatments which are 'futile' (that is, offer no reasonable hope of therapeutic benefit) or which are too burdensome to the patient, even if the doctor foresees that without them the patient will die sooner. There is nothing wrong with merely foreseeing the shortening of life, and even with welcoming the natural end to suffering which death may bring.

The principle of the inviolability of life has long been at the core of English law. Accordingly, the law does not require doctors to do everything possible to extend patients' lives. It recognises that patients have the right to refuse treatments which offer no reasonable hope of benefit or which they would find

Neither the law nor professional medical ethics have ever held that the mere fact *that* I have chosen justifies *what* I have chosen.

We *all* share a fundamental equality-in-dignity, regardless of our abilities or disabilities.

The principle of the inviolability of life has long been at the core of English law.

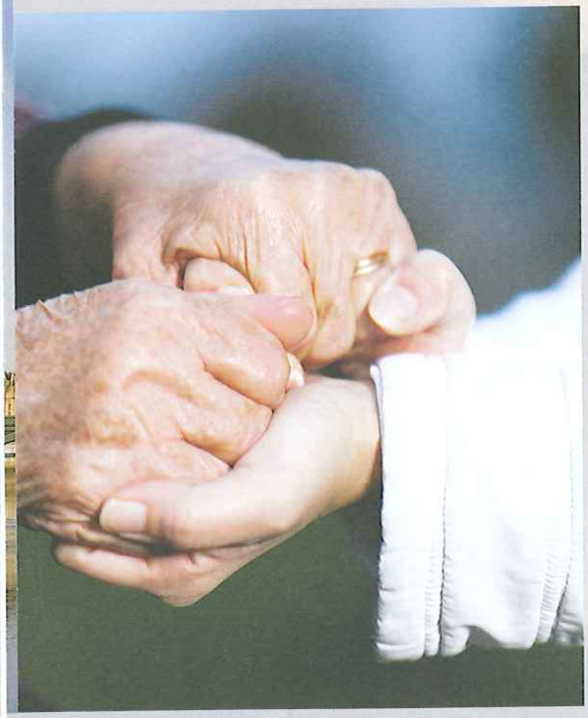
too burdensome, and that doctors may administer palliative drugs even in the unlikely event that they shorten life as an unintended side-effect. But while patient autonomy gives us a right to refuse procedures it does not give us a right to demand them: it is a shield not a sword. In particular, the law rightly holds that we have no right to be killed, or to be helped to kill ourselves, even if we are dying, and even if we want to die sooner. Patient autonomy yields to the inviolability of life.

The inviolability of life has also informed instruments on human rights. Article 2(1) of the European Convention on Human Rights (1950) provides: 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally…'. In 1999 the Parliamentary Assembly of the Council of Europe passed Recommendation 1418 on the 'Protection of the human rights and dignity of the terminally ill and the dying' which called on the Council of Europe to respect and protect the dignity of the terminally ill by upholding the prohibition on intentionally taking their lives, even on request.[1] The inviolability principle was relied upon by the important House of Lords Select Committee on Medical Ethics, chaired by Lord Walton, as a major reason for its rejection of euthanasia in 1994. Having listened carefully to the arguments for decriminalisation, the Committee concluded:

> We do not believe that these arguments are sufficient reason to weaken society's prohibition on intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.[2]

Some vulnerable patients, such as the frail elderly, might well be pressured into requesting euthanasia. Or they might simply be made to feel a burden by their relatives and by society.

2. The Autonomous Few v The Vulnerable Many



A second counter-argument is that decriminalisation would prejudice the vulnerable, both those who are autonomous and those who are not. Some vulnerable patients, such as the frail elderly, might well be pressured into requesting euthanasia. Or they might simply be made to feel a burden by their relatives and by society. How we feel about ourselves can, of course, be hugely influenced by how others feel toward us. And the dying, the disabled and the disadvantaged are hardly cherished by modern society.

Concerns about the vulnerable have figured prominently among expert bodies which have considered the case for decriminalisation. The Walton Committee concluded:

> We do not think it possible to set secure limits on voluntary euthanasia….It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused….These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.[3]

It continued:

> We are also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death….The message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.[4]

A contemporaneous and no less important report was produced by the New York State Task Force on Life and the Law. Some of the Task Force's members supported voluntary euthanasia in principle but even they joined the committee's unanimous conclusion that decriminalisation would be 'unwise and dangerous public policy'. Its report declared:

> After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.[5]

The Task Force's concerns have been echoed by the philosopher Onora O'Neill. As Baroness O'Neill she was a prominent opponent in the House of Lords of Lord Joffe's *Assisted Dying for the Terminally Ill Bill*, which sought to decriminalise PAS in 2006. She observed:

> Legalising 'assisted dying' amounts to adopting a principle of indifference towards a special and acute form of vulnerability: in order to allow a few independent folk to get others to kill them on demand, we are to be indifferent to the fact that many less independent people would come under pressure to request the same. Indifference to others may appeal to those with an exalted view of their own

> independence, but it is not a principle for those who are vulnerable and need others' help.[6]

These concerns should not be lightly dismissed, particularly as discrimination against the elderly and disabled, even in wealthy nations such as the UK and US, is a harsh reality. The scandal at the Mid-Staffordshire Hospital has exposed shocking abuse and neglect, even in the NHS.

The disabled are also victims of discrimination. Baroness Jane Campbell wrote that if Lord Joffe's Bill were enacted 'None of us will be safe'.[7] She pointed out that not a single disability rights organisation supported the Bill. Opposing an attempt to relax the law by Lord Falconer in 2009, she was the lead signatory of a letter from a battery of disability rights groups, from both the UK and the US, opposing his proposal. The letter read:

> A law decriminalizing assisted suicide would undoubtedly place disabled people under pressure to end their lives early to relieve the burden on relatives, carers or the state.

It continued:

> The concerns are not side issues that only affect disabled people. We are like society's 'canaries in the coalmine' who can often see the dangers of potentially discriminatory legislation before others, as it impacts on us even before the deed is done. We are scared now; we will be terrified if assisted suicide becomes state-sanctioned.[8]

Their concerns are unlikely to be assuaged by comments from some leading 'right to die' advocates. Baroness Mary Warnock, perhaps the most influential ethicist in British government circles, has claimed: 'If you're demented, you're wasting people's lives - your family's lives - and you're wasting the resources of the National Health Service'. She added: 'I think that's the way the future will go, putting it rather brutally, you'd be licensing people to put others down.'[9] Her prediction would likely prove all too accurate should we relax the law. The 'right to die' would surely in time become a 'duty to die', not least given the burgeoning costs of caring for a growing elderly and demented population. It is often said that the true test of a society is how well it treats its most vulnerable members. The very fact of decriminalisation could easily by itself signal to vulnerable groups, directly or indirectly, not only that they *may* seek an earlier death but that they *should*.

Would it be right to jeopardise the many vulnerable members of our society, whose numbers are set to grow as our population inexorably ages, to accommodate the desire of a small minority to control the timing of their death? Why do the wishes of a few to control the time of their death trump the interests of the many in not being killed, particularly by malice or mistake?

3. *How* Autonomous?

How autonomous would requests for euthanasia be? Even requests which were not compromised by pressure from grasping or uncaring or exhausted relatives might not be truly autonomous: there is an established link between requests for hastened death and clinical depression. In a key statement against the Joffe Bill the Royal College of Psychiatrists observed that studies of the terminally ill had clearly shown that depression is strongly associated with the desire for a hastened death, including euthanasia and physician-assisted suicide, and that once a patient's depression is effectively treated, 98-99% change their mind about wanting die. It also cautioned

> Many doctors do not recognise depression or know how to assess for its presence in terminally ill patients....Even when recognised, doctors often take the view that 'understandable depression' cannot be treated, does not count or is in some way not real depression.[10]

The Royal College was 'deeply worried' by the Bill.

4. Some Patients 'Better Off Dead'?

Decriminalising VE would not only allow doctors to act on requests which were *in practice* compromised by pressure or depression. It would also lead *in logic* to the decriminalisation of *non*-voluntary euthanasia (NVE). This is because, despite the emphasis campaigners place on autonomy, the case for voluntary euthanasia rests at least as much on the belief that some patients are (because of terminal illness, suffering or whatever) 'better off dead'. Campaigners are not proposing that euthanasia should be available simply because the patient has made an autonomous request. According to their own standard proposals *doctors* would have to decide whether the patient's request should be granted. And how would the doctor decide *other than on the basis of a belief that death would benefit the patient?* In the Netherlands, which has permitted VE for over a quarter of a century, doctors refuse many euthanasia requests. This illustrates the decisive role played by the *doctor*'s judgment that death would, or would not, benefit the patient. But a doctor who is prepared to make such a judgment forfeits any principled objection to NVE. *For: if death would benefit the patient, why deprive the patient of that benefit merely because the patient cannot request it?* Is a doctor not duty-bound to benefit his or her patient, competent or incompetent?

John Keown holds the Rose F. Kennedy Chair of Christian Ethics. With a degree in law from the University of Cambridge, he received his doctorate from the University of Oxford. His research has been cited widely, in particular by the U.S. Supreme Court (in its decision on physician-assisted suicide), by the English Court of Appeal (in the conjoined twins case, 2000); and by the House of Lords Select Committee on Medical Ethics. His publications include *Euthanasia Examined* (CUP, 1995), *Euthanasia, Ethics and Public Policy* (CUP, 2002), *The Law and Ethics of Medicine* (OUP, 2012) and *Debating Euthanasia* (Hart, 2012).

It is often said that the true test of a society is how well it treats its most vulnerable members.

Some have argued that euthanasia is only justified when there is both a request and suffering. But *why* are both necessary? Even if autonomy is thought to be a reason *for* VE, its absence is not a reason *against* NVE.

The inexorable slide down this 'logical slippery slope' has been illustrated by the experience in the Netherlands. The Dutch courts declared in 1984 that VE could be justified because of the doctor's duty to alleviate suffering. In 1996 they held that the very same duty could justify NVE, when they endorsed the administration of lethal injections to disabled babies.

As the 'logical slope' argument shows, permitting VE is no 'private' matter concerning only a few highly autonomous patients. It clearly has profound ramifications for the well-being of *all* patients who might be judged 'better off dead', not least those who are unable to refuse it.

5. Autonomy's 'Slippery Slope'

The previous counter-argument is often resisted by campaigners for VE on the ground that it is not the *doctor* who decides whether the patient's life is no longer worth living but the *patient*. As we have just seen, however, this retort fails. Under the proposals they themselves put forward the patient's autonomous request is by itself insufficient. But even if the retort were sound it would lead to another, no less precipitous, slope. *For: if the patient's own assessment were decisive, why would it not justify euthanasia for anyone who believed that they would be better off dead, whether terminally ill or not and whether suffering unbearably or not?*

Conclusion

As the above counter-arguments to one of the main arguments advanced for VE indicate, the case for decriminalising VE is much weaker than campaigners, and their many friends in the mass media, would have us believe.

In England in 2006 over 70% of members of the Royal College of Physicians (and 95% of those in the specialty of palliative medicine) agreed with the following statement:

> *With improvements in palliative care, good clinical care can be provided within existing legislation and ...patients can die with dignity. A change in legislation is not needed.*[11]

The euthanasia debate is in fact a tiresome distraction from providing what the vast majority of people want, and the vast majority of doctors want to be able to provide: better end-of-life care.

Notes

[1] http://assembly.coe.int/main.asp?link=/Documents/AdoptedText/ta99/EREC1418.htm

[2] Report of the House of Lords Select Committee on Medical Ethics (Paper 21-I of 1993-94) ('Walton') para 237.

[3] ibid para 238.

[4] ibid para 239.

[5] New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York: NYSTF, 1994) ix.

[6] Baroness O'Neill of Bengarve, 'A Note on Autonomy and Assisted Dying' (memorandum circulated to members of the House of Lords during their consideration of the Joffe Bill).

[7] J Campbell, 'Stop trying to kill us off' *The Guardian* (9 May 2006).

[8] Baroness Campbell et al, 'Open Letter from Leaders of Disabled People's Movement in UK and USA'. http://www.carenotkilling.org.uk/?show=775 .

[9] M Beckford, 'Baroness Warnock: Dementia sufferers may have a "duty to die"' *The Daily Telegraph* (18 September 2008).

[10] Statement from the Royal College of Psychiatrists on Physician-Assisted Suicide (2006).http://www.rcpsych.ac.uk/pressparliament/collegeresponses/physicianassistedsuicide. aspx. The guidance is currently under review.

[11] 'RCP cannot support legal change on assisted dying - survey results' http://www.rcplondon.ac.uk/news/news.asp?PR_id=310. Original italics.