REVIEW ARTICLE

Euthanasia: protecting 'right to die' by denying 'right to live'

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SUMMARY

This essay primarily discusses voluntary active euthanasia (VAE); the administration of drugs with the explicit intention to end life at the explicit request of a patient[6] and physician assisted suicide (PAS); a variant of VAE where final act of administration of lethal drug is performed by patient and physician merely prescribes or supplies the lethal drug. Euthanasia is discussed with special reference to English Law.

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INTRODUCTION

Although in Netherland, under Common Law, active euthanasia was decriminalised in 1984, it took almost two decades before it was formally legalised following Euthanasia Act 2002. In the mean time, euthanasia in the form of medically assisted suicide became legal in Luxemburg, Belgium and Switzerland. However, despite extensive debate, changing public opinion and highly publicised legal cases, it remained illegal in many other developed and developing countries of the world. The very notion that 'we do not in any circumstances allow the deliberate taking of life' has survived a century of change[1] in philosophical and social attitude towards euthanasia.

In the UK, a recent denial of 'right to die' to Jack Nicholson has reignited the debate that whether or not, with relevant to euthanasia, the English law is 'morally obtuse.[2] Proponents advance two key legal arguments; (i) Law condones 'doctrine of double effect'; hastening death through palliation, on the premise that doctor did not intend, rather merely 'foresaw' death, but (ii) exonerates doctors from 'murder' despite their 'intention' to bring patient's death by withdrawing or withholding medical treatment; describing their conduct as an 'omission' rather than 'act'. Moreover, while appealing to moral arguments; autonomy and beneficence advocates frequently refer to euthanasia practices in Netherlands, often claiming that by legalising, and incorporating safeguards, euthanasia can be regulated effectively without abuse.[2]

In this article, I will first attempt to define and distinct key terms, used in euthanasia debate. This will be followed by critical evaluation of the criticism of English Law by the proponents of euthanasia and explaination as why such criticisms are morally unjustified. Secondly, I will closely examine the empirical evidence from Netherlands to gauge whether euthanasia could be regulated? Lastly, I will argue why 'active euthanasia', despite an attractive proposition in few individual cases, could not and should not be adopted as a public policy and that the current English Law is morally commendable.

KEY TERMS AND DISTINCTIONS

Death is an *event*, whereas dying is a *process*. In the past people used to die within few days following onset of illness, in the confines of their homes without much medical intervention, because then little could be done. However, advancement in medicine has made this process slower, prolonged and burdensome.

Killing and Letting Die: Beauchamp and Walters[3] described *killing* as 'family of ideas' involving 'direct causation of another's death', whereas *letting die* represents allowing natural death to follow an injury or disease, with no causal intervention. However, distinguishing killing and letting die in this way implies that killing (positive act) is morally *wrong* and letting

die (omission) is *not*, but Rachel[4] argues that if causing death is *intentional* than 'killing is not in itself any worse than letting die'. *Killing is wrong* is not a moral *absolute*; killing in self defence, killing (by police) of hostage-takers to save hostages etc, are *acts* that couldn't be prejudged as *wrong* merely because someone is *actively* killed.

Euthanasia and Physician Assisted Suicide (PAS): Etymologically it originates from Greek *eu* 'well' and *thanatos* 'death' meaning 'good death' or 'dying well'. further expanded as 'the act or practice of ending a person's life in order to release the person from an incurable disease, intolerable suffering or undignified death.[3] However, Keown[5] identifies euthanasia in three shades; 'active intentional termination of life', 'intentional termination of life by act or omission' and 'intentional or foreseen life-shortening', perhaps to accommodate English Law interpretations of *process* of dying in medical context. In fact *euthanasia* involves influencing the *process* of dying to bring death earlier than expected with a desire to alleviate unwanted, painful and burdensome experience of dying.

This essay, will primarily discuss voluntary active euthanasia (VAE); the administration of drugs with the explicit intention to end life at the explicit request of a patient[6] and physician assisted suicide (PAS); a variant of VAE where final act of administration of lethal drug is performed by patient and physician merely prescribes or supplies the lethal drug.[7]

Current English Law

Murder and Manslaughter: Intentional killing is unlawful and constitutes murder. Although there is no statutory definition but under Common Law a person would be guilty of murder if;

1. A causes the death of person B - *actus reus*
2. A intended to cause death or grievous bodily harm - *mens rea*
3. A could not provide defence of his conduct

Hence, under English law 'active' euthanasia *would* constitute murder. However, doctors are more likely to be prosecuted for manslaughter; causing death through gross negligence or serious breach of duty of care,[8] therefore, 'passive' euthanasia *could* constitute manslaughter.

Suicide and Assisted Suicide: Although Suicide Act 1961 decriminalised suicide; however aiding, abetting, counselling or procuring for suicide remained criminal offences. The Act was further clarified and endorsed by House of Lords and European Court of Human Rights.[9,10] Hence PAS constitutes a criminal offence under English law.

Refusal of Medical Treatment: The legal principle that doctors cannot treat patients without valid consent is deeply enshrined in English law; and patient's right to refuse medical treatment, even if that threatens their life, is legally protected.[11]

Palliative Care and Law: Under *doctrine of double effect,*[12] main versus side effect, principle, and doctors can lawfully administer pain relieving drugs to terminally ill with full knowledge and anticipation that such drugs could hasten death.

Withdrawal or Withholding of Life-sustaining Treatment: Lawfulness of *intentional* causing of death by discontinuing life-sustaining treatment was established in *Airedale v Bland,*[13] under premise that such *conduct* would not constitute 'act', rather an 'omission'.

Is English Law morally obtuse?

There are three main criticisms of English law; (i) Causing death is permissible with *pain killers* but not by *lethal injection*, (ii) *intentionally* causing death by an *act* is murder but not by *omission*, and (iii) There is a *right to die* by refusing medical treatment but not to *active assistance* in death.

Intention versus Foresight: Doctrine of Double Effect: Intention by definition; 'aiming to bring about a consequence' is different from foresight; merely 'awareness' that such a consequence might or would occur.[5] Otlowski criticises English law treatment of palliative care practices; administration of pain killers that eventually hasten death, and rejects 'doctrine of double effect'[14]; "if the first purpose of medicine – the restoration of health – could no longer be achieved, there was still much that the doctor could do and he was entitled to do all that was proper and necessary to relive pain and suffering, even if the measures he took might incidentally shorten life by hours or perhaps even longer" (Devlin J, *R v Adams*).[12]

Although, an absence of *mens rea,* might exonerate doctors from murder but they could still be convicted of manslaughter, if *causation* could be established that patient died consequent to unscrupulous administration of pain killers.[15] However, Otlowski argues that determining *causation* in the presence of terminal illness could be *very* difficult; therefore doctors are in fact off the hook.[14]

Moral distinction between 'intention' and 'foresight' is actively contested. Gillon[16] describes them as 'logically, experimentally, conceptually, legally and morally' different and Keown[5] draws clear distinction between the two, but his example that a 'tipsy guest' who drinks too much at wedding reception 'foresees the inevitable hangover but hardly intends it', is rejected

by Harris[17]that even if 'a person does not intend to have a hangover, they are responsible for it' and should be held accountable for missing from the work next morning. He explained that such distinction is based on *expression* of problem rather than *morality* of conduct. Commenting on group of trapped *potholers,* who can only escape by moving a boulder and thereby risking death of one of the member, Harris suggests two expressions; 'intending to make an escape route, foreseeing that this will kill someone' or 'intending to make an escape route by killing someone'. In my view, Harris himself is focussing on *expression* rather than *morality*. Here *moral* question is whether escaping by *risking* death would be moral or not? If entire group intends to escape then escaping is indented *result*, moving boulder is the *act*, saving life is *motivation* behind the act and risking fellow member's death is *unintended* or *foreseen* result. Evaluating the *conduct* under *motivation-intention-action-result* approach, a *moral* distinction could be made whether the group *intended* or had *foreseen* fellow member's death.

Consider example of doctor A and B, both oncologists. Dr A has patient X with terminal cancer, requiring very high doses of morphine for pain relief. Dr A despite being aware of 'hastening death' effect of morphine, feels obliged from duty of care, administers a high dose of morphine; patient expectantly dies few hours later. Dr B has patient Y, with characteristics similar to patient X, which he expected to have died the night before; thereby freeing bed for a new patient. He being aware of 'hastening death' effect, administers (same dose as X received) morphine to hasten death to free up the bed. There is clear *moral* distinction between conducts of two doctors. Doctor A intends pain relief and foresees death as consequence, whereas, Doctor B intends death to release bed. In my opinion, intention and foresight could be *morally* differentiated by using *motivation* which triggers the act, as litmus – '*motivation-intention-action-result doctrine*'.

Legal status of intention and foresight distinction became controversial when Lord Steyn in *R v Woollin*[18] declared that 'a result foreseen as virtually certain is an intended result'. McGee suggests that moral distinction between the two is only possible when foreseeing is 'probability'; palliative care and not 'certain'; withdrawing life-sustaining treatment.[19] So could *motivation-intention-action-result* doctrine be applied to morally distinct intention from foresight, when consequence is virtually *certain* rather than *probability*?

<u>*Withdrawal or Withholding Treatment:*</u> In *Bland v Airedale*[13], the House of Lords ruled that though withdrawing of life-sustaining treatment was motivated by an 'intention' to cause death of Bland, doctor couldn't be held criminally liable because consequent death couldn't be attributed to withdrawal rather to underlying condition. Ruling was underpinned by controversial *act/omission* doctrine; *omitting* treatment doesn't constitute *killing* rather *letting die*. Keown claims that 'intentional killing' by *act* or *omission* constitute *euthanasia* and their Lordships, by ruling that 'doctors couldn't intentionally end the life of a patient by an act but they could do so by withholding/ withdrawing artificial feeding', had compromised the *sanctity of life* principle.[20] He argues that when withdrawing/withholding treatment doctors, while foreseeing rather intending death, were intending to relieve Bland from burdensome, futile treatment, and on that account only it should be permissible in Law.

McGee[19]challenges Keown's intention/foresight distinction applied to *Bland*[13]. He claims that *artificial nutrition* couldn't be regarded as burdensome or futile treatment; it was keeping Bland alive, hence the *only* purpose to withdraw it is to cause death. He argues that doctor's duty of care doesn't extend to *active artificial prolonging of life at all cost*. He provides an alternative *moral* distinction between lawful withdrawals of life-sustaining treatment and euthanasia; "...*euthanasia interferes with nature's dominion*, whereas, withdrawal of treatment *restores* to nature her dominion after we had taken it away when *artificially* prolonging the patient's life" (McGee p.383).[19]

In my opinion, both Keown and McGee are right. Moral distinction could be made between *intentional* death by act or omission, and *foreseeing* death when withdrawing life-sustaining treatment. Consider Rachel's[4] classic example of Smith and Jones. Both stand to gain inheritance, if their respective cousin; six years old child, dies. Smith actively drowns the child while taking bath. Jones intends to do the same but before he could have acted, the child slips in bathtub, hits his head, becomes unconscious and drowns. Jones does nothing to save him. Both get their inheritance. Rachels[4] argues that there is no moral difference between two conducts; though Smith kills by *act* and Jones by *omission*, because both intended to cause death. Now let's modify the scenario. The child suffers from severe motor neuron disease, and requires assistance for bath taking. Smith (aware of inheritance gain) deliberately drowns the child, whereas, Jones (unaware of inheritance gain) finds the child thrashing in the bathtub but allows him to drown to release him from his suffering. Applying *motivation-intention-action-result* doctrine, a clear *moral* distinction could be identified between the two conducts; first is motivated by desire to gain inheritance second to alleviate

suffering.

Finally, even if the Law was morally 'misshapen',[13] it is morally re-shaped by Mentally Capacity Act 2005 that clearly states that when considering withdrawing life-sustaining treatment 'the best interests of the person concerned' should be determined and must not 'be motivated by a desire to bring about his death'. The Act in effect overrides the *Bland*[13]; withdrawal or withholding of treatment with *intention* to bring about death.

Refusal of Medical Treatment: Proponents advance two arguments; (i) the Suicide Act 1961 did not define suicide, therefore, would a refusal of medical treatment, with intention to die, constitute suicide? Would doctor's compliance with such refusal should constitute aiding or abetting suicide? Lord Goff[13] dismisses such argument; "....there is no question of the patient having committed suicide, not therefore of the doctor having aided or abetted him in so doing. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or could have the effect of prolonging his life, and the doctor has in accordance with his duty, complied with his patient's wishes" (*Airedale v Bland, p.11*).[13]

As Keown[5] noted that although, the Act decriminalised suicide but 'it did not create a right to suicide'. Herring[8] concurred; just because 'adultery is not a crime' hence there is a 'right to commit adultery'. Even proponents of euthanasia agree that the Act 'created no right to suicide'.[2]

(ii) Even though there is no 'right to suicide', but by upholding patient's 'absolute right' to refuse medical treatment, even if it trumps the privileged 'sanctity of life' principle and irrespective of 'whether the reasons for making that choice are rational or irrational, unknown or even nonexistent', did Lord Donaldson[12] implied that patient's 'right to die' existed?

Right to die: autonomy, beneficence and sanctity of life

Whether European Convention of Human Rights confers 'right to die' was extensively reviewed in *Pretty v DPP*[10] by House of Lords, which unanimously declared that *no 'right to die' with or without assistance exists* and European Court of Human Rights[11] upheld that judgement. Criticising the judgement, Freeman[2]noted; "In refusing Mrs. Pretty assistance with her suicide it seems that we treat the competent worse than we do those who lack competence (like Bland)..... Bland could not exercise any autonomy: Mrs Pretty was able to indicate what she wanted, but the law prevented her husband doing any thing about it" (Freeman p.254).[2]

Is Freeman suggesting that Law should treat autonomy; 'self determination' including, 'right to choose time and manner of death' as a moral *absolute*?[7-8] Gillon[21]argues that when balancing individual's autonomy against distributive justice; the *overall harm* to society versus *overall benefit* to individual(s), legal ban on buying of kidneys for transplant is justified; hence autonomy is not a moral *absolute*. Significant parallels could be drawn between 'right to buy' and 'right to die'; both are legally banned, individual autonomy is overridden for greater societal good, individual suffering (of buyers) is ignored to prevent exploitation of vulnerable (sellers).

Does 'Right to Die' Promote Autonomy? For Ford[22] the answer is no. At philosophical level, she argues that life has an *intrinsic* value that represents autonomy; consciousness, rationality, self awareness, valued by others, and *extrinsic* value; what is achieved by exercising that autonomy. For human flourishing both should be respected and nurtured. Just because illness has diminished *extrinsic* value; pain, unbearable suffering or loss of dignity etc, we still *ought* to preserve *intrinsic* value of life till it's lost too. At practical level, despite the fact that euthanasia for psychological problems is permissible under Dutch law, 10% of terminally ill patients with severe depression were granted, whereas 12–39% were denied VAE and PAS;[23] suggesting that legalising euthanasia does not necessarily promote autonomy; 'right to die'.

Could Death be Beneficial to Patients? For Harris[23] the answer is yes. He rejects Ford (2005) personhood paradox; autonomy flourishes only if *extrinsic* value of life is preserved, and identifies personhood as 'set of capacities that make it possible for a creature to value its own existence'.[23] According to him if someone does not *value* existence than 'they are not wronged by being deprived of it'.[23] Brock[7] concurs that when 'life is no longer considered a benefit by the patient' rather a 'burden' and 'is worse than no further life at all' then death 'may be the only release from their otherwise prolonged suffering and agony'.[7] If patients are best judge for their existence, pain and unbearable suffering, as Harris and Brock have claimed, then why 38-62% of GP and 24-88% of euthanasia review committee members are willing to disregard patients' own judgment of their suffering, when requesting euthanasia.[25] Again, patient's autonomy; judging owns suffering, is overridden.

It is evident that even where euthanasia is legal, patients don't have unconditional 'right to die' rather VAE and PAS are available to them merely as 'options', provided doctors concur with their request. But if euthanasia is simply another 'option'; alternative to palliation, available to mentally *competent*, than why wouldn't it get extended to mentally *incompetent*? Is this not what

Keown[5] describes as slippery slope argument; A should not be permissible, even if it is morally acceptable, because it would lead to B which is not acceptable.[8] Magnusson[26] argues that euthanasia, as *option* is already being practice *underground* and real question is not 'whether the law should regularise an unlawful practice' but 'how best to regulate *underground euthanasia'*. So when evaluating permissibility of euthanasia, the key argument is, whether the *overall harm* to society is significant enough to deny euthanasia, as an *option*, to individuals.

Public policy argument: Can we regulate euthanasia?

Responding to practice of *underground euthanasia*, Magnusson[26] proposed three solutions; (a) keeping euthanasia illegal and strengthening prosecution of offending doctors, (b) legalising euthanasia, (c) educating and influencing offending doctors. He dismisses option 'c' as burying head in sand approach and option 'a' as unworkable without intruding too much into legally protected privacy of the doctor-patient relationship. He advocates legalisation of euthanasia to prevent euthanasia abuses, ignoring the fact that doctors who are contravening current laws could disregard new rules too.[5] Freeman goes further and proposes a 'concise' guideline with sufficient safeguards to protect vulnerable, which he believes once incorporated into statute, 'would eliminate most abuses'.[2]

The Dutch Evidence: In Netherlands VAE and PAS is permissible only if patient's request is voluntary and well considered and his/her suffering is unbearable and hopeless. Moreover, all euthanasia cases *must* be reported to regional euthanasia review committees which should inform prosecutors about noncompliance with euthanasia guideline.[6] It is estimated that every year physician's actively terminate life of 550 patients without explicit request,[6] and more than twice that numbers are deeply sedated, to hasten their death, for non-alleviation of pain/suffering reasons.[27] Despite two decades of legalisation, still 20% of euthanasia and PAS cases are not reported because either physician don't regard them as euthanasia or to evade scrutiny for not following guidelines.[27] Review of reported cases revealed that only in 65% cases, requests were well considered, only 62% were considered to have unbearable suffering, whereas, in 35% cases reasonable alternative to euthanasia were available but not applied.[28] So what does evidence tell us? Even advocates of euthanasia admit that physicians follow guidelines in majority but not all cases and 'the transparency envisaged by the Act still does not extend to all cases.[6] Physicians frequently demonstrate non-compliance with guidelines.[28] Even staunch supporters of euthanasia; Magnusson[26] and Freeman[2] admit that no safeguards can eliminate all abuses; question is how much abuse should be considered acceptable to justify a 'right to die'?

'Miscarriage of euthanasia': The last argument

I agree with Magnusson[26] that no law would ever be 'perfectly safe' and I also agree with his 'harm minimisation' approach but what I don't agree is his direction of 'harm minimisation'; which inclines towards *protecting* autonomy of *many* competent while accepting *deprivation* of 'right to life' to *some* vulnerable, elderly and incompetent. My argument is; which is greater harm; 'denying death its dominion'[2] or depriving *life to its holder?* The main argument behind abolishment of death penalty in the UK was not to show compassion to convicted or because execution was considered immoral, rather because there is no *perfectly safe law* for murder, and even if conviction is *beyond reasonable doubt* there could still be *miscarriages of justice*, leading to loss of innocent life; as it happened in the case of Birmingham six.[29] It was considered more acceptable harm to spare lives of many *rightly* convicted murders than to execute *wrongly* convicted *few* innocents. In my opinion, same analogy applies to euthanasia; there would never be a 'perfectly safe law' that could prevent *miscarriage of euthanasia*, hence it's better to error on the side of preserving 'right to life' than protecting 'right to die', a position which is *ethically* more justifiable than the converse.[26]

CONCLUSION

Euthanasia inherently had and always will be controversial. Current English Law is not perfect and does raise moral questions; but it is still, in my view, *morally* well balanced and ethically justifiable; recognising the value of autonomy, beneficence, non-malfeasance, safeguarding right to life and balancing between individual rights against societal responsibilities. The state's first positive obligation is active protection of 'right to life' and if that necessitates denying some their right of self determination, so be it.

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