Dignity in dying should include the legalization of non-voluntary euthanasia

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Recent debates about the legalization of euthanasia have been focused on the right of competent adults to an assisted, quick and painless death when they believe that life is intolerable because of irreversible terminal illness with a short life expectancy.[1] This is hardly surprising, given the degree to which respect for autonomy has become the dominant legal and professional moral principle governing the conduct of related good clinical practice. After all, the argument goes, individuals already have the right to refuse life-sustaining treatment knowing that this will lead to their death. Clinicians have the same foresight when they remove feeding tubes or disconnect ventilators in these cases. Therefore, it seems mere sophistry to claim that there is some fundamental moral difference between this sort of clinical assistance and responding to a request for positive treatment guaranteed to provide an immediate death devoid of suffering. Public opinion already favours the legalization of voluntary active euthanasia (VAE) of this kind and professional medical opinion is catching up.[2]

These developments are to be welcomed. What could be more distressing than the spectre of patients with an irreversible terminal illness and a short life expectancy who believe that their life has become intolerable being refused control over when and how they die? Yet there is an even worse scenario: those patients who are experiencing such physical and emotional suffering but who are too incompetent to be able to conceptualize such a choice, much less demand it. Such patients may still have some fragmented understanding of, and control over, parts of their lives. This can create bewilderment and distress in the face of active treatment or decisions to withdraw such treatment with the slow death that may follow. This will often be exacerbated by the absence of any means of communicating their confusion and despair to those responsible for their care.

The fact that the best interest of these patients has figured so little in debates about euthanasia is understandable. Many reflective practitioners who support the legalization of VAE have reservations about taking the lives of those who have not executed relevant advance directives and who are defenceless to protect themselves through the exercise of their autonomy. Equally, the Nazi murder of incompetent children and adults continues to cast a dark shadow over the legitimacy of non-voluntary active euthanasia (NVAE). In my view, however, this emphasis on autonomy should be reconsidered in debates about euthanasia. The interests and needs of severely incompetent humans who may also be in the grip of intolerable suffering are just as important as those patients who are competent to control the circumstances of their death and wish to do so. Therefore, I believe that NVAE should also be legalized. I have four reasons for this belief.[3]

Best interests

Decisions to withdraw life-sustaining treatment from severely incompetent patients who have irreversible terminal illness with a short life expectancy must be justifiable in their best interests. Another way of putting this is that despite the potential of further treatment to keep such patients alive, its cessation must be judged to be beneficial. Different types of clinical scenarios are called upon to professionally and legally justify withdrawing life-sustaining treatment from such incompetent patients. For example, patients must be suffering from such severe brain damage that they will never be able to engage in self-directed activity or social interaction. Note that we are referring to the withdrawal of treatments that otherwise *will* potentially sustain life – for example, feeding tubes, ventilators and antibiotics. Yet how can treatments like these be said to be of no benefit if they do have the potential for continued life support?

Opponents of euthanasia do not like to confront the answer to this question,[4] which is that the lives of such patients are themselves of no further benefit to them due to the severity of their incompetence, the irreversible nature of their illness, the shortness of their life expectancy and the degree of their associated distress and suffering. If the judgement that continued life is of no benefit is implicit in any decision to withdraw life-sustaining

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treatment from incompetent patients, why make patients endure needless actual or potential suffering through waiting for disease to kill them after treatment has been withdrawn? If competent patients who are terminally ill should be legally able to choose assisted death because they believe that their lives are no longer worth living then should it not be possible for clinicians in partnership with families to make similar decisions on behalf of those who cannot competently choose for themselves? Because patients in a permanent vegetative state lack the capacity to experience anything, the same question can be asked about them. Life can provide them with no benefit and can thus be said to have no value.

The moral difference – action and inaction

One counter argument used to justify a slow rather than a quick death following treatment withdrawal focuses on a presumed moral difference between action and inaction. Withdrawing life-sustaining treatment from severely incompetent patients, as opposed to active killing, is believed to be morally appropriate because it constitutes doing nothing. It is disease that does the dirty work, not the clinician. Yet this argument cannot wash away the foreseeable suffering of severely incompetent patients sometimes forced to die avoidably slow and distressing deaths. There is no convincing moral difference between action and inaction where there is a clear duty of care to act. For example, if a father sees a baby drowning in the bath and fails to save it, his inaction is morally equivalent to drowning the baby. He foresaw with certainty the lethal consequence of his inaction and failed to discharge his paternal duty. Similarly, if a doctor in A&E does nothing to prevent her patient from bleeding to death, she will be in breach of her duty of care to save life and could be charged with murder. Again, her inaction is deemed to be morally equivalent to active killing.[5]

It is true that in appropriate circumstances, clinicians who starve severely incompetent patients to death are not deemed by law to have killed them actively, even if they begin the process by the removal of feeding tubes. The legal fiction that such starvation is not active killing is no more than clumsy judicial camouflage of the euthanasia that is actually occurring.[6] Clinicians should be encouraged to recognize the moral reality behind withdrawing life-sustaining treatment from severely incompetent patients: they are already killing their patients, whatever they may feel to the contrary. The law and professional guidance should be changed to enable them to do so more quickly, more humanely and without guilt.

The moral difference – 'natural' versus 'assisted' death

There is another even more widely accepted argument that the slow and distressing death potentially associated with withdrawing life-sustaining treatment from severely incompetent patients is inevitable in the practice of good medicine. Waiting for the patient to die from 'natural' causes after treatment has been withdrawn is mandated because there is something more morally important than the unsatisfactory experience of death among a few individuals: the moral virtue of the clinician responsible for care. For a clinician to intend the death of any patient is always morally wrong. This means that while it is acceptable to engage in clinical practices that will with certain foresight lead to the death of incompetent patients, this can only be done with the goal of relieving suffering, rather than death itself.

The fact that this 'double-effect' argument remains popular among many clinicians does little to support its moral coherence. On the one hand, we saw in the first argument that withdrawing life-sustaining treatment from severely incompetent patients is only morally justifiable if a judgement has already been made on acceptable clinical grounds that life itself is no longer of benefit to the patient. It follows that such withdrawals are predicated on the judgement that death is a *moral good* for such patients. Since this is so, there can be nothing morally wrong, and there should be nothing legally wrong, with intending actions or inactions which bring about this moral good, including NVAE.[7] Such acts will ensure a quick death with no distress. Equally, because patients in a permanent vegetative state lack the capacity for distress or anything else, their quick and intentional death may also be judged to be a moral good – life cannot be of any benefit to them whatever.

A moral decline in medicine

Many reflective practitioners would now accept the preceding arguments, while still not embracing the legalization of NVAE. Their argument – the only secular one left with any degree of coherence – is that this form of euthanasia may be morally justifiable in principle but that this fact should still not lead to changes of existing professional or legal practice. To do otherwise will lead to moral decline in medicine: a cheapening of life that will make both its practice and experience worse for everyone, even though it may indeed be true that some incompetent patients might benefit. Different slippery slopes are envisaged: for example, a decrease in the moral and professional fibre of clinicians, an increase in the probability of inappropriate killing (perhaps to save NHS money) or a decrease in patients' trust through fear of unwanted killing. There is no space here for detailed analysis of such anxieties – suffice it to say, there is no convincing empirical evidence to support them. Evidence from countries where voluntary euthanasia and physician-assisted suicide have been legalized suggests that clinical standards have not generally dropped, that there has been no substantial increase in inappropriate killing and that fear of medical murder is not widespread.[8]

Furthermore, we can make no comparisons between such countries and the standard of clinical care in the UK. As a result of the illegality of VAE and NVAE, along with the consequent lack of any legal mandate to collect the relevant information, too little is known here about end-of-life-decision making in clinical practice. Of course, there have been mistakes in the implementation of policy in countries where VAE is legal. However, the same can be said for health care policy in the land of Harold Shipman, Bristol and Alder Hey! What is clear is that appropriate incompetent candidates for withdrawal of life-sustaining treatment

should not be forced to die slow and distressing deaths because of the potential distress that the legalization of both VAE and NVAE might have on patients or doctors in the future. In no other area of public life is such blatant inequality is embraced: where the *actual* suffering of some is so readily believed to be morally trumped by what amounts to no more than speculation about the *possible* suffering of others. Slippery slopes can run in opposite directions! Of course, it might be argued that through adequate palliative care, severely incompetent candidates for withdrawal of life-sustaining treatment need not suffer in the ways here envisaged. However, in the context of the national shortage of expert palliative care for *competent* patients who may or may not wish active euthanasia, what would be the moral point in expending such valuable resources on severely incompetent patients whose best interests will be served by a quick and painless death?[9]

Despite their weaknesses, slippery slope arguments remain popular among opponents of the legalization of euthanasia. But are such arguments really behind their opposition? There is an easy test. Ostensibly, it is maintained that current approaches to euthanasia do not work because events of certain kinds have occurred in the countries involved (e.g. VAE in Holland for someone suffering from chronic and extreme depression). Yet it does not follow from such arguments that successful regulation is practically impossible, only perhaps that it should be more rigorous than it now is. However, in my own public debates over the years with opponents of euthanasia, it is clear that many are unwilling to accept the potential success of any form of regulation. If so, what is really being argued is that euthanasia is just *wrong*, irrespective of the problems of regulation or of any suffering that non-legalization may entail. Religious belief often fuels such dogma, although not always. What can also be at work is a deeply felt unwillingness to accept that regulated, intentional active killing can have a proper place in good medical practice or to accept the degree to which this already occurs in the withdrawal of life-sustaining treatment from severely incompetent patients. In any case, the fact remains that it is the beliefs of a minority of the population that prevent the majority from having access to the good death that VAE and NVAE provide, access which it is clear from opinion polls that they want and to which they should be entitled on the grounds of respect and compassion.

To conclude, I have argued that both VAE and NVAE should be legalized and rigorously and appropriately regulated. However, I have also maintained that attempts to change the law should not be restricted to VAE. To the degree that severely incompetent patients continue to suffer through being deprived of a quick and painless death, this suffering can be just as great or greater than that of competent patients with similar terminal illnesses. For this reason, it is morally wrong to remain silent about the needs and interests of such a vulnerable group for reasons of political expedience – for example, because it is believed that only VAE has a real chance at present of legalization.[10] To the degree that this silence is accepted by some supporters of VAE, they deprive themselves of one of the strongest arguments in its favour. Once it is recognized that withdrawal of life-sustaining treatment from severely incompetent patients is a form of killing that is morally equivalent to active killing (i.e. that passive euthanasia is morally the same as active euthanasia), it will be apparent that clinicians are already taking the lives of such patients through the consequences of decisions that they make about whether or not patients will benefit from further life.[6] All the more reason, therefore, for competent patients to exercise similar control over the evaluation of the value of their own lives and the circumstances of their own deaths.

Acknowledgements

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References

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