LIFE, DEATH AND AUTONOMY:
WHY EUTHANASIA SHOULD NOT BE CONTROLLED BY THE DOCTORS

FABIAN TASSANO

Christian ideology plays little role nowadays in the workings of social policy. The illegality of suicide was removed in England over thirty years ago.[1] Medical technology exists which makes possible the painless ending of life. One might therefore expect to be in a position where, if one thought it appropriate to end one's own life, one could do so in a relatively comfortable and trouble-free way. Nothing could be further from the truth, however.

The technology which would enable individuals to make decisions about the value of their own lives is monopolised by the medical profession. The drugs which would kill quickly and painlessly are not available to private individuals, forcing them to resort to highly unpleasant alternat-ives. In certain extreme circumstances, some doctors are apparently prepared to make the relevant drugs available to individual patients. However, the context of such cases makes it clear that it is very much the doctor, rather than the patient, who controls the technology and on whose ultimate approval its application depends. In any case, this practice of 'voluntary euthanasia' is currently illegal, even if this aspect of the law is not one which is very rigorously enforced.

This manifestation of the resistance of the community, and that of the medical profession in particular, to individual autonomy may be considered bad enough. Medical practice goes further than this, however, in overriding the wishes of its clients. Not only will doctors refuse to provide a service which is wanted (in this case, the chemicals required for a painless death), but they will give treatment *against the wishes of the patient* where this is considered to be in the patient's 'interests'.

The reluctance of medical practitioners to provide individuals with the means to their own death is often speciously justified by reference to the sanctity with which doctors are expected to regard all human life. The Hippocratic Oath is sometimes invoked: "I will give no deadly medicine to anyone if asked ..."; or the Declaration of Geneva: "I will maintain the utmost respect for human life." More pragmatically, it may be argued that doctors must work by a single, overriding principle — to improve health and prolong life — and that it would place them in difficult positions if they had to compromise this aim. This defence rings somewhat hollow, however, in the face of what actually happens in practice. For we find that doctors do make 'termination' decisions as a matter of course, and without the consent of their victims. We are not speaking here only of the killing of foetuses. Doctors apply non-voluntary euthanasia to the elderly, to comatose patients and to handicapped babies, among others. What sort of a profession is it which refuses to do what its clients want, and kills them without their consent?

THE WISHES OF THE INDIVIDUAL OR THE OPINIONS OF THE DOCTORS AND OF SOCIETY

As an illustration, consider two recent cases of doctors wishing to terminate the lives of their patients. The behaviour of Dr Nigel Cox, who administered a lethal injection to his terminally ill patient in response to her request that he do so — for which he was found guilty of attempted murder — was condemned by the British Medical Association on the grounds that "deliberately shortening a patient's life is not the purpose of a doctor".[2] By way of contrast, in the case of Tony Bland, a young man in a 'persistent vegetative state', the medical experts did not apparently perceive a difficulty, in spite of the fact that the patient's explicit consent to his proposed euthanasia was obviously unobtainable. Professor Bryan Jennett, an authority on Bland's condition, expressed surprise that the Home Office might consider ceasing to feed Bland as an act of murder. "Doctors take decisions like this all the time," he was quoted as saying. "We say we are not going to operate on this case, or that we are not going to take this chap to intensive care. It's no more than an extension of that."[3]

It appears that where medical opinion considers the life of an individual to be unequivocally valueless, the wishes of that individual may become irrelevant to the question of euthanasia. On the other hand, where a doctor provides death as a service which the patient specifically requests, but which contravenes the self-imposed rules of the medical profession, this is regarded as unethical. This suggests that what is crucial in determining whether doctors end the life of a given patient, and indeed whether treatment in general is

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25 Chapter Chambers, Esterbrooke Street, London SW1P 4NN
www.libertarian.co.uk email: admin@libertarian.co.uk

Fabian Tassano is a Chartered Accountant and a self-employed tax consultant. He took a First in Natural Sciences at Cambridge University, and is now doing an MPhil at Oxford University.

Director: Dr Chris R. Tame
Editorial Director: Brian Micklethwait Webmaster: Dr Sean Gabb

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given, is not the wishes of the patient but the opinions of the doctor and the views of society as a whole.

THE ALL-IMPORTANT DISTINCTION IS NOT SECURE

This state of affairs having developed as a result of the gradual collectivisation of medicine over the last hundred years or so, it is now being proposed that the medical industry be partially liberalised to permit patients suffering from terminal conditions to enlist the aid of doctors to end their lives. In other words, it is suggested that doctors should under certain circumstances be able to *kill* their patients with impunity. One of the conditions for this is ostensibly to be the consent of the patient.

Now many of the people who advocate this form of euthanasia are apparently agreed that the consent of the patient is crucial, and that *involuntary* euthanasia is ruled right out of court. Yet consider the proposed development in the light of the current situation. On the one hand, assisted suicide, where a person such as your relative helps you to die, is currently illegal, and there is no suggestion that it be made otherwise. On the other hand, *doctors* killing certain categories of patient without their consent, such as the senile or the comatose, by withholding treatment, is a regular occurrence. Is the legalisation of euthanasia more likely to be a development out of the former or the latter of these two policies?

Certain features of the history of the voluntary euthanasia movement must also give pause for thought. In 1950, for example, Lord Chorley had this to say to the House of Lords on the subject of the Voluntary Euthanasia Bill then being debated. One objection to the Bill, he said, is that it "does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so, but we must go step by step."[4] At the first annual meeting of the American Euthanasia Society in 1939, at which the Society's Treasurer Charles Nixdorff proposed specific euthanasia legislation, it was reported in the *New York Times* that

> Infant imbeciles, hopelessly insane persons ... and any person not requesting his own death would not come within the scope of the act. [Nixdorff] explained to some of the members who desired to broaden the scope of the proposed law, that it was limited purposely to voluntary euthanasia because public opinion is not ready to accept the broader principle. He said, however, that the society hoped eventually to legalize the putting to death of nonvolunteers beyond the help of medical science.[5]

In fact, the supposedly all-important distinction between voluntary and involuntary euthanasia, which it is often confidently assumed will be scrupulously respected, turns out on inspection to be a good deal less secure than is usually thought. We can already see some sign of this if we consider the way in which euthanasia is frequently described as 'mercy-killing', and compared with putting down an injured animal. There are reasons for killing people who are visibly suffering which have nothing to do with their own wishes, and there is evidence to suggest that it may be primarily these, rather than patients' desire to die, which drive the euthanasia programme. To justify euthanasia on *utilitarian* grounds, we do not merely invoke the suffering of the patient, but also the suffering of his relatives and the inconvenience caused to medical staff. There are grounds for suspecting that the consent requirement is not primary, but is rather thrown in as a sop because killing a person against his will, however much it is supposed to be in everyone's best interests, still offends certain old-fashioned moral prejudices. Consider, for example, the following defence of a utilitarian approach to euthanasia by the philosopher James Rachels, which elegantly evades the question of whether the arguments used may be thought to legitimise killing people against their will.[6]

> Suppose a person is leading a miserable life — full of more unhappiness than happiness — but does not want to die. This person thinks a miserable life is better than none at all. Now I assume we would all agree that this person should not be killed; that would be plain, unjustifiable murder. Yet it *would* decrease the amount of misery in the world if we killed him — and so it is hard to see, on strictly utilitarian grounds, it could be wrong. ... So, suppose we substitute a better conception of welfare: rather than speaking of maximising *happiness*, let us speak of maximising *interests* — let the principle of utility say that actions are right if they satisfy as many interests as possible. ... the new principle avoids the problems that plagued the old one: if it is in a person's best interests to have freedom of choice in religion, or in choosing to remain alive, then the principle will not countenance taking away that freedom or that life.

In other words, a person will be allowed to decide for himself whether to continue living provided we consider it to be generally in people's overall long-term interests to make such decisions for themselves. It is hard to see how this approach to utility is more sympathetic to autonomy than the maximisation of happiness. It does illustrate, however, how autonomy is seen as something to be *accommodated* rather than something to be given priority.

IT MUST BE THE PERSON HIMSELF WHO CHOOSES TO DIE

I do not intend here to discuss the question of whether, and in what circumstances, people should be given full access to the means of ending their lives. My own view is that it is unacceptable to restrict the supply of pharmaceuticals in any way, and that if people want to commit suicide, they should not be chronically prevented from doing so in the most painless and convenient way available. However, I realise that this goes against the grain of the prevailing attitude on suicide, which is to regard it as at best a temporary irrationality and at worst a sign of a deranged mind, except possibly in circumstances so extreme that the majority of people would agree that a person's life was unbearable.

Let us leave to one side, however, the question of whether a person should ever be prevented from committing suicide. Let us consider a situation in which suicide has been fully legalised for a finite set of circumstances. By 'fully legalised' I mean that not only is it not *punishable per se* to kill oneself, but also that the means to do it painlessly are readily available. What must be considered as being crucial in any such arrangement is that, whatever the conditions are which must be fulfilled to gain an exemption from the normal prohibition, it must be *the person himself* who chooses

if and when to die, and not someone else. Otherwise it would not be a partial legalisation of suicide but a partial legalisation of murder.

Now if one or more other persons are to be involved in the act of suicide as assistants, it is surely of paramount importance that those persons should be clearly under the control of the would-be suicide. This strikes me as a much more important condition than that they should not stand to benefit from the person's death. The possibility of a pecuniary motive in such cases is so obviously labelled that it is readily suspected by police and judges, and tends to be seized upon by juries. On the other hand, gratuitously destructive or ideological motives, which may well arise when the suicide assistant is not fully and genuinely answerable to the suicide, are not something which the law tends to recognise. Another point is that people who stand to gain financially from the suicide's death usually have at least a relationship of some kind with the person and therefore are likely to have a greater than average psychological resistance to killing them against their will. Strangers having no relation, neither emotional nor economic, with the person are on the other hand unlikely to have as much compunction about failing to respect that person's wishes.

Since doctors are to play the role of assistants under the currently favoured proposals for euthanasia, the crucial question therefore arises, *are doctors under the control of their patients*? I believe that the answer to this is unequivocally negative, and that doctors are therefore quite unsuitable as suicide assistants, and should certainly not be entrusted with the power to kill.

More seriously, it is proposed not only that doctors should add to their armoury of monopolies the power to end human lives, but also that they are to be the arbiters in deciding whether the conditions for permissible 'suicide' are met in any particular case. I would argue that the world view of the medical profession, both covert and explicit, and in particular the fact that the interests of *other people* (relatives, the community, society as a whole) are taken into account in making decisions about patients, makes this possibility an extremely dangerous one.

THE INHERENT PATERNALISM OF MEDICINE

Allowing people complete freedom to choose their own death, in the sense of removing *all* the legal obstructions, is a development to which we do not seem to be very near. There has always existed a certain horror about suicide. It is an act which some people regard as the supreme expression of a person's autonomy: an apparent rejection of all social conventions and responsibilities, and an assertion of the person's assessment of his or her own life as being of insufficient value compared with the effort required to continue it. Wittgenstein called suicide "the elementary sin", and warned that "if suicide is allowed then everything is allowed".[7]

As things stand, there appears to exist too much resistance to the idea that people should be allowed to terminate their lives on the basis of their own evaluation, for there to be a significant liberalisation of the pharmaceutical laws. The Church of England, for example, seems to be echoing public opinion rather than Christian doctrine when it argues that if a person

> ... has dependents who need him, or if he has a positive contribution of a recognisable kind which he could still make to the well-being of others, these could be sufficient grounds for denying him, in the general interest, the exercise of his right to die.[8]

If, however, people are to be deprived of the power to choose whether to live or die, we should at least be consistent and not give that legally sanctioned power to make those choices to others. If assisting a person to kill himself is to be treated as a crime, apparently because of the danger of abuse if it were not, it should be treated as an even more serious crime when the assistant is a doctor. Similarly, since murder is treated as the most serious crime of all, the intentional taking of life by a doctor without the patient's consent, however much it is supposed to be in the patient's best interest, should be treated as an at least equally serious crime.

Paternalism—putting patient's 'interests' above their wishes — is endemic at all levels of medicine. The tenet that 'doctor knows best' is applied not merely when it comes to determining whether a patient's life is so awful that it should be actively terminated. In every other area of medicine — deciding *whether* to treat, *how* to treat, whether to save or whether to let die — doctors apply considerations other than the wishes of the patient in deciding what is appropriate. Apart from the 'interests' of the patient, these considerations include the patient's ostensible quality of life, the costs and benefits to the community, the doctor's ethical preferences and the appropriate allocation of resources. "Should each doctor care for his own patients [or] should each behave as a member of a group whose aim is the good of all patients?" asks Professor Martin Hollis,[9] concluding that the doctor has responsibilities to the community which go well beyond those to any one of his individual clients.

Medical paternalism has expanded to the point where we should be extremely wary of augmenting the powers of the profession still further. Yet the very breadth of those powers has created a climate of passive acceptance in which their extension to new areas elicits relatively little protest.

"MERCY-KILLING"

We must recognise the root of the euthanasia issue, which is that individuals are denied access to chemicals which would provide a painless death. Because medical paternalism has progressed to a highly advanced stage, practically all pharmaceuticals are out of bounds to the layman. However, it is plausible to suppose that, even if drugs such as antibiotics or contraceptives were available over the counter, the supply of those drugs which lent themselves readily to suicide would nonetheless be controlled. Society is currently not prepared to countenance that people should be able to kill themselves painlessly simply by buying something from the chemist.

What then of the proposal that doctors should be permitted to kill a patient suffering from a suitably horrific illness, subject to the patient's consent? What those who advocate this are saying, in effect, is that, having denied the person the right to control his body, society will give it back to him under certain conditions. We should be very suspicious of such a conditional liberty. Whose interests does it serve if this apparent concession is made? Ostensibly the decision of death will become one of partnership between society, the patient and the medical professionals, in the sense that all three must give their consent for the act of killing to go ahead. Society will give its decision in the form of procedural rules; the doctors concerned by deciding whether the

patient's condition warrants euthanasia; and the patient himself by signing a form. However, it should be considered carefully whether the balance of power is evenly enough distributed to make each of those decisions equally meaningful.

It is also worth asking oneself why it is almost always mercy-killing, and only rarely assisted suicide, that is discussed. It is true that patients sometimes get into a condition where it would be impossible for them to ingest without aid a lethal drug placed in front of them. On the other hand, many seriously ill patients who would prefer to die are perfectly able to perform the necessary bodily actions which would make them alone responsible for ending their life. Indeed, one wonders how many of the former type of patient passed through a stage of being of the latter type, during which they would have ended their lives if they had been allowed access to the means. Why, then, is it almost invariably the image of the doctor administering a lethal injection that is invoked in discussions of euthanasia? This alone should make one wary of the assumption that it is the patient's autonomy which is primarily at stake in the euthanasia controversy, rather than the feelings of observers such as doctors, nurses and relatives. The latter possiblity would certainly make sense of the ominous argument sometimes produced that 'we do it for dogs; should we treat humans any less kindly?'. On the basis of the evidence provided by discussions of the subject, one would realistically have to conclude that the sort of euthanasia proposed was, at least potentially, 'killing with consent' rather than 'killing by request'.

AN OPTIMISTIC ASSUMPTION

Once we allow doctors to kill their patients with their patients' consent, as opposed to letting patients have access to the means of death, we are unquestionably closer to the possibility of involuntary euthanasia. Even if this step did not mean that we found it easier to contemplate killing conscious patients without their consent — an optimistic assumption which may be questioned — we will nevertheless have legitimised one of the factors required for involuntary euthanasia, namely homicide, and thereby eliminated one of the safeguards against it.

It is naive to assume that doctors are invariably benevolent and that they operate only on the basis of our best interests, notwithstanding the fact that the profession behaves as if this attitude of supplicatory veneration were *de rigueur*. The modern presumption in favour of doctor benevolence has meant that the powers of the medical profession have grown to intolerable levels. The response to the apparent dilemmas which this development has generated is to *reduce* these powers, not to consider ways of increasing them.

One way in which the aims of the euthanasia lobby could be partly advanced, without involving us in the dangers of expanding doctor power, is to strengthen the consent requirement for treatment. Although nominally a practitioner must obtain the consent of a competent patient before he can carry out medical intervention, in practice this requirement is only weakly observed. The requirement that a patient must agree to treatment should not be imagined to mean that doctors necessarily sit down with their patient and discuss carefully, and without putting any pressure on the patient, the options available, including non-intervention. What typically happens if, for example, a person is found to have a life-threatening tumour is that he is rushed off to hospital for an operation and is expected to sign a standard form when he gets there. Of course he is theoretically entitled to 'get off the bus' at any point, but how many of us have the mental strength to think things through, arrive at a decision, and then argue with the professionals, in a situation like this?[10] This is obviously not made any easier if a patient is not given all the information about his condition or the possible courses of action and associated risks and benefits.

THE STRONGEST POSSIBLE SAFEGUARDS

Before the euthanasia problem can be solved in a tolerable way, it is necessary for users of medical services to recognise that *they have no genuine control* over those services. Patients must ask themselves, what is it that gives doctors the right to have power over them? Is a situation in which the medical profession has gradually and tacitly appropriated the medical technology to itself, and assumed a position of power over a sick person's body, an acceptable one? If sufficient people find the answer to this to be negative, then the response must be to demand that medical technology, and in particular the pharmaceuticals which produce a painless death, should be freely available. If they were, euthanasia would cease to be an issue, since a doctor would generally have to comply with his patient's request for the means to his own suicide.

As long as the power of having access to pharmaceuticals remains monopolised by doctors, we need to have the strongest possible safeguards against the abuse of this power. Making it acceptable for doctors to *kill* their patients, under conditions determined partly by doctors, is a move which cannot possibly have sufficient safeguards to prevent it from being used as an instrument of control over others, and which undermines the existing protection which patients have in other areas against being exploited by doctors.

NOTES

1. The act of suicide—although not that of assisting suicide — was decriminalised by the Suicide Act 1961.
2. *The Sunday Times*, 20 September 1992.
3. *The Sunday Times*, 27 September 1992.
4. Quoted in Yale Kamisar, "Euthanasia legislation: some non-religious objections", in A. B. Downing and Barbara Smoker, *Voluntary Euthanasia*, Peter Owen, London, 1986, p. 131.
5. *Ibid*, p. 132.
6. James Rachels, *The End of Life*, Oxford University Press, 1986, pp. 155-156.
7. Ludwig Wittgenstein, *Notebooks 1914-1916*, Blackwell, Oxford, 1979, p. 91e. Of course, Wittgenstein's apparent abhorrence of suicide was not without personal significance, in view of his permanent state of pessimism verging on depression. Elsewhere he asks, "How can a man be happy at all, since he cannot ward off the misery of this world?", *ibid*, p. 81e. Three of Wittgenstein's brothers committed suicide.
8. Church of England General Synod, *On Dying Well*, Church Information Office, London, 1975, pp. 6-7.
9. Martin Hollis, "A death of one's own", in J. M. Bell and Susan Mendus, eds., *Philosophy and Medical Welfare*, Cambridge University Press, 1988, p. 8.
10. In David Hare's film *Strapless*, the heroine doctor reveals to one of her cancer patients who has been undergoing harrowing chemotherapy that he does not have to go on with the treatment if he does not want to. The sympathy of the audience is aroused; how kind of her to tell the unhappy young man that he may choose not to fight his cancer. On reflection, one wonders why he was not told this to begin with.