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THE RIGHT TO DIE

by

Patrick Nowell-Smith
Professor Emeritus
York University
Ontario, CANADA

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Do we have a right to die at a time and in a manner of our own choosing? That this question is being more and more urgently asked is due to two changes, technological and social, that have occurred in our life-time. Modern medical technology has virtually eliminated the main killer diseases of the past; most importantly, the introduction of antibiotics has made possible the prevention and cure of pneumonia, a disease that used to be called "the dying man's friend". Human beings can be kept biologically alive, though unconscious, almost indefinitely.

As for the social change, before the first world war there could hardly have been an adult who had never watched over a parent, baby, child, neighbour, or friend and seen them die. In short death was familiar. And accepted. Sad, to be sure; often very sad indeed, but nonetheless accepted as part of the natural order of things, talked about openly, and frequently treated in literature. All that has changed. Apart from those professionally concerned few of us have seen a corpse unless it was laid out for viewing. Most of us will die in an institution. Death has replaced sex as the unmentionable topic.

Euthanasia is commonly divided into "active" (killing) and "passive" (letting die), a distinction to be challenged later. It is also divided into "voluntary", i.e. at the request or with the consent of the person and "involuntary", without such consent. The legal position in the United

Kingdom is simple. Until 1961 suicide had always been a Common Law crime and aiding suicide was therefore automatically a crime as well. The successful suicide could not, of course, be prosecuted, but he suffered certain disabilities such as forfeiture of goods; and an unsuccessful suicide could be prosecuted. By 1961 these practices had fallen into disuse, and when the crime of suicide was formally abolished, a new statutory offence of aiding suicide was introduced (except in Scotland) carrying a maximum penalty of fourteen years. Active euthanasia was always murder and still is. So much for the law on paper, which is pretty much the same in all Common Law jurisdictions.

However, this severity towards mercy killing and aiding suicide is in practice greatly mitigated by the wide powers of sentencing which our legal system accords to judges. If a doctor allows a grossly deformed baby to die, he will be discharged if he can show that his decision not to treat the baby was standard medical practice, and there must be many cases which are not even prosecuted. Also, where the motivation is clearly compassionate, judges usually impose a very light sentence or none at all.

Since the methods most of us would choose to commit suicide require the co-operation of others and that co-operation is illegal, it is clear that we have, at best, a very restricted <u>legal</u> right to die at a time and manner of our own choosing. Whether or not we have a <u>moral</u> right which ought to be acknowledged by the law will depend on the type of moral theory we take as a starting point. On a theory which starts with the concept of individual rights we have a right to do anything we like provided there are

no good reasons for prohibiting what we want to do, for example that it infringes the equal right of another. The countervailing reasons can be divided into the religious, the moral and the practical.

Of the religious reasons little need be said. It is argued that we are not absolute owners of our lives, but hold them in trust from a God who gave them to us, so that the times of our dying should be chosen, not by us, but by God. But whatever the theoretical merits of this argument, religious freedom is so deeply embedded in our society that it would be wrong to base any prohibition solely on the grounds that others have a religious objection to what we propose to do.

For a rights theorist, the negative right to life, the right not to be killed, is the most fundamental of all rights. When rights are listed it always comes first, for the very good reason that to deprive someone of life is to deprive him at one blow of all his rights, of all possibilities of earthly enjoyment. But if we grant, as no doubt we all do, that everyone has this negative right to life, it follows at once that we have a right to choose to die. For it is a feature of all rights that they can be invoked or not <u>at the option of the right-holder</u>. If you owe me ten dollars, I have a right to demand and get ten dollars from you. But I have no <u>duty</u> to require repayment; I am at liberty, if I so choose, to waive my right, in this example to forgive the debt. Similarly, the correlative of my right to life is the duty that falls on you not to kill me; but I can release you from this duty by requesting you to kill me or giving my consent. To deny this is to confuse the right to life with a duty, if there is one, to go on

living.

And in special circumstances there may be such a duty. For example if a person is the sole bread-winner of a family and has no life insurance it may well be his or her duty to struggle on against the desire to die. For some few of us, perhaps, some larger loyalty, even the national interest might require us to forego our right to die; but such considerations are rare and not likely to figure in the type of case that leads people to call for changes in the law on euthanasia and aiding suicide, that of people who either from incurable disease or from senility are unlikely to contribute substantially to the good of others.

A large majority of the people who join voluntary euthanasia societies are people in their sixties and seventies who are still enjoying life but do not like what they see in front of them in a society in which more than three quarters of us will die in institutions. They do not ask for the various guides to self-deliverance issued by some of these societies because they want to use the information now, but because they want the security of knowing that, in the words of John Donne, the keys of their prison house are in their own hands. The following letter sent to the Canadian society Dying with Dignity is typical.

> "I am seventy-nine years of age, in relatively vigorous health and constantly amused with life while it lasts. But I saw my mother and my father, years apart, in the same chronic care hospital suffering helplessly for months when they might have been quietly released; and this makes me dread a similar fate unless the law is changed so that

one can choose, if still able, to slip away in dignity from the inhumane methods many hospitals employ today to keep one from dying a natural death".

Inevitably some people will be sad when a person dies; but that sadness is coming to them anyway, and should be diminished rather than increased by the thought that the person they loved died as he or she wished to die.

But what if there is no one willing to kill me or to help me to die? What then happens to my right to choose death? This objection can be met by pointing out that the right to life and its corollary, the right to die, are only negative rights. My right to life imposes on you a duty not to kill me without my consent, but it imposes no duty on you to keep me alive, though you may for other reasons have such a duty. The same is true of the right to die. Supporters of voluntary euthanasia are not asking for Death on Demand. They are not asking that anyone be saddled with a duty to kill someone who asks for death. They assert only that neither a person who asks for help in dying nor a person, if there is one, who is willing to give such help is committing a moral wrong; and they claim that this moral position should be reflected in our criminal law.

Rights-based theories are not the only moral theories. If we look at the question from the point of view of the main rival theory, Utilitarianism, we get the same result. The Utilitarian judges the morality of an action by assessing the good and evil consequences, for the agent and

all others concerned, of either doing the action or not doing it. Obviously such calculations are not easy; but they are not always impossible. Ex hypothesi the person whose life or death is at issue has, when he asks for death, come to the conclusion that, for himself, dying is better than staying alive. He may be mistaken; but in many cases this is most unlikely, and in any case he is the best judge of his own interests. As for the interests of others, his choosing to die will be morally right so long as the benefit his remaining alive would confer on them is less than the burden it would place on them and on himself.

What, now, of the practical arguments: arguments to the effect that even if the moral admissibility of voluntary euthanasia were conceded, proposals to change the law would run into insuperable difficulties? First, no proposal to change the law has any chance of success unless it has the support of the medical profession which, it is said, it will never have. "Doctors vary in their approach to passive euthanasia but the profession condemns legalised active voluntary euthanasia (1). Nevertheless, there are physicians who practice it, though it is impossible to find out how many do so since they will not admit doing so in public. In the present state of British law such an admission would be a confession of murder.

Voluntary active euthanasia is practiced openly in Holland where there are between five and six thousand cases a year (2). The procedure starts with an application by the patient. A team is then formed consisting always of a doctor and a nurse, a pastor if the patient asks for one, and others as appropriate (3). The team discusses the application with the

patient and either grants or refuses it. Dr. Peter Admiraal, a leading proponent of the practice, was convicted some years ago of aiding suicide but was discharged on the grounds that his actions were medically necessary. "What made Dr. Admiraal's actions acceptable were (1) the patient's voluntary and spontaneous requests, (2) the rational and 'durable' nature of the requests, (3) the presence of unacceptable and 'endless' suffering and (4) Dr. Admiraal's consultation with his colleagues" (4). If the consensus of medical opinion can change in Holland, it could change in other countries too.

The second type of practical objection comes from the lawyers since the legal profession, like the medical, is on the whole opposed to active euthanasia and aiding suicide. Two years ago the Law Reform Commission of Canada produced a report on Euthanasia, Suicide, and Cessation of Treatment which recommended no change in the law other than a clarification of the patient's right to refuse treatment. One of the Commission's arguments for this conservative stance was to the effect that the law in action is much less harsh than the law on paper:

> "Our legal system has internal mechanisms which offset the apparent harshness of the law. It is possible that in some circumstances the accused would be allowed to plead guilty to a lesser charge...Finally in truly exceptional circumstances, the authorities already have it within their discretion to decide not to prosecute" (5).

But this is cold comfort indeed, since the circumstances in which euthanasia or help in committing suicide would be appropriate are, even now, not "truly

exceptional"; and as the population ages and the power of medical technology to keep people "alive" increases they are likely to become even more common.

Many doctors and para-medics are humane; they would like to put an end to suffering they know to be hopeless. They are also, on the whole, law-abiding people, and they have a special need to be careful of their reputations. That they are less inclined than they used to be to follow their humane inclinations is due to fear of possible prosecution and, especially in the United States, of malpractice suits if they do not pull out all the stops to keep a patient alive. It is less than fair to say to them, as the Commission in effect does, "what you are doing is against the law, but we may turn a blind eye".

The Commission's second line of argument was that any relaxation of the law could lead to mistakes and to serious abuses. This is a serious argument and will be examined later, but it is surprising that the Commisssion did not consider the possibility of building into a more liberal law safeguards against abuse. Perhaps the reason for this omission was that it relied most heavily on its third line of argument, that relaxation of the law would be "morally unacceptable to the majority of the Canadian people" (6). But is it? This is not a moral question, but a question of empirical fact, and the Commission should surely have produced some evidence for their opinion. It not only cited no evidence; it ignored such evidence as there is. In 1968 the Canadian Institute for Public Opinion (Gallup Poll) asked

the following narrowly worded question:

> "When a person has an incurable disease that causes great suffering, do you or do you not think that competent doctors should be allowed by law to end the patient's life through mercy-killing, if the patient has made a formal request in writing".

In 1968 45% of the firm answers were "Yes", 43% were "No". In 1974 the proportions were 55% to 35%. By 1978 the Yeses outnumbered the Noes by more than two to one, and this figure was confirmed in 1984. In Britain, a similarly worded poll in 1969 showed 51% of the population in favour of active voluntary euthanasia. By 1976 the proportion had increased to 69%; in 1985 it was 72%. In the United States the trend is similar, though the proportion of favourable replies is lower. In 1973 the Harris Poll showed only 37% in favour; by January 1985 it had reached 61% (7).

The disparity between legal and public thinking can also be illustrated by many cases in which a decision of a court has been criticized in editorials even of newspapers of a generally conservative complexion. One example must suffice. In December 1984 an eighty-four year old lady who had many reasons for ending her life tried to commit suicide by taking a lethal drug. She had a legal right to do so, but fearful that the attempt might not be successful, she asked a friend, Mrs. Charlotte Hough, to sit with her and to place a plastic bag over her head after she had lost consciousness. Mrs. Hough did what she was asked and reported her action to the police. She was initially charged with murder, but because of the uncertainty as to whether the old lady's death was due to the drugs or to

the plastic bag, she was charged with attempted murder. She pleaded guilty and was sentenced to nine months imprisonment, a sentence upheld on appeal (8). The judge said that although he had the greatest sympathy for Mrs. Hough, a prison sentence was necessary to uphold the law. On this The Sunday Times commented:

> "What is often morally right in this sensitive area remains legally incorrect because, as a nation, we tend to sweep discussion of death under the carpet. In 1976 Baroness Wootton introduced a bill into the House of Lords which would have brought a modicum of good sense and regulation to the subject of euthanasia. But it was not supported. As a result, uncounted numbers of people kept alive by medical science, often die without dignity...Mrs. Hough's crime was compassion and it served to underline once more the need for better legislation governing voluntary euthanasia and the dangers of being without it. People should be allowed to die on their own terms and, as Barbara Wootton once wrote, "not those of nature's cruelty or doctors' ingenuity" " (9).

The third type of practical objection arises from the possibility that mistakes will be made and abuses will occur. It would be a pity if someone were to choose death when a cure for his condition was just around the corner. As it stands, this objection is based on a misunderstanding of the nature of biomedical research. The time that elapses between someone's thinking of a new drug or a new application of a known drug and its actual availability is to be measured, not in weeks or months, but in years. So,

if there is really a new treatment likely to be available soon, that fact will be known, and the patient should be told what medical treatment can do for him now or in the near future and left to make a choice as to whether or not to hang on and hope for the best. New cures apart, there have certainly been cases of most remarkable and unexpected recovery; so it may well be true that some people who choose death would have recovered to lead meaningful lives. But such cases must, if we can have any faith in medical science, be very rare indeed and, from the very nature of choice, we can never know if one has occurred. So again the choice should be left to the patient.

The possibility that a more liberal law might be abused is a much more serious objection. How can we be sure that when a patient chooses death the choice is fully voluntary? Obviously this opens one of the most notorious cans of worms in the history of philosophy. Aristotle defined a voluntary action as one not done under compulsion or due to certain types of ignorance (10), and no one has been able to improve significantly on that definition. The immediate problem is what counts as compulsion. Subtle pressures that would not amount to coercion in law might be put on old people to sign their own death warrants, for example by greedy heirs who want to inherit, family members might want to get the old person off their backs. Senility, even without the aid of high technology, can last quite a time and people who need constant care can be a great nuisance. In such a situation it is possible to insinuate that the old person really has a duty to get out of the way, though it should be noted in passing that in the

majority of cases the pressure is the other way.

A more liberal law to mitigate the uncertainties and inhumanity of our current laws is urgently needed, but the problem of building into such a law adequate safeguards against abuse is one, not for philosophers, but for lawyers. For the law has great experience of dealing with problems of coercion and consent in other areas. For example, the validity of a contract may depend on whether the parties freely consented to its terms and in many crimes the guilt of the accused depends on whether or not he intended of his own free will to do the forbidden act. So we might, for example, insist that possible sources of coercion be fully investigated, that the would-be suicide has been fully informed of the options, and that his will has been expressed several times over a stipulated period. In the Dutch system the most serious abuses, coercion and fraud, are virtually eliminated since active voluntary euthanasia is practiced openly, only in hospital, and after consultations so wide that there can be no reasonable doubt that the patient's request is uncoerced, reasonable, and durable.

Passive euthanasia (letting die), whether voluntary or not, seems now to be generally accepted except, perhaps, in the United States where it is still condemned by Right to Life groups. But, while most religious leaders, doctors, and lawyers allow it to be morally permissible, they still regard active euthanasia as morally wrong. Their standard morality can be summed up in Clough's often quoted words "Thou shalt not kill, but needst not strive Officiously to keep alive". But what if any, is the difference?

There is certainly a <u>conceptual</u> difference between killing and

letting die. A lifeguard who holds a child's head under water till he drowns certainly kills the child; a lifeguard who sits on the bank watching the child drown as certainly does not. He lets the child die. But is there any morally relevant difference between these two cases? Is not the lifeguard in the second case just as culpable, just as responsible for the death of the child as the lifeguard in the first? The law has long accepted the principle that acts of omission can be just as criminal as acts of commission and popular morality accepts that they can be just as reprehensible.

So causing death is still causing death, whether the act is one of killing or merely of letting die when one could intervene to save life. If a baby is born with Tey-Sachs disease or anencephalic, it is routine practice to prescribe "nursing care only"; specifically, antibiotics are not given, and if the baby dies this is thought of as a merciful dispensation of providence. But in this sort of case the physician does not stand powerlessly by; he has the ability and the opportunity to prevent the death and is fully aware of the fact that, if he intervened, the baby would live, even if only for a little while. In such a case the physician, by refraining from intervention, intentionally and deliberately causes the baby's death, and there is no moral difference in favour of causing death by deliberate non-intervention over causing death by a positive act. If the former is morally permissible, as it is agreed to be, so too is the latter; on this point the standard morality is confused. However if pain is taken into account, a moral difference can be seen in favour of killing the baby.

For assuming it to be conscious at all, its suffering is less.

In spite of this, the medical profession is extremely reluctant to accept the morality of active euthanasia, and this is understandable since physicians are by training dedicated to the preservation of life. But the fundamental principle of medical ethics has always been that a physician should act in the best interest of his patient, and it is not always in the best interest of a patient to stay alive. That this is so has recently been recognized by two eminent bodies, the World Medical Assembly (11) and the United States President's Commission for the study of Ethical Problems in Medicine and Biomedical and Behavioral Research (12). Both these bodies advocate passive euthanasia in some cases as preferable to the use of "extraordinary" measures to keep a person alive. What neither of them asks, however, is whether letting a person die, even with the best possible care, really is in his or her best interest.

The question of what is in a person's best interest is not an easy one to answer and the World Medical Assembly did not attempt to answer it; but the President's Commission did.

> "In its report 'Deciding to Forego Life Sustaining', the Commission says that all patients have an interest in well-being and that, in addition to this, normal adult or competent patients also have an interest in self-determination...In other words, seriously disabled infants should, according to the Commission, not have their lives sustained if their lives are likely to contain more suffering and frustrated desires than happiness and satisfactions" (13).

In line with the Commission's thinking the United States Surgeon General recommended that an infant who cannot be nourished orally "should not be put on hyperalimentation for a year and a half....but should be provided with a bed and food by mouth knowing that it was not going to be nutritious" and thus allowed to die (14). But once it has been decided that it is better for the baby to die than to be kept alive by "extraordinary" means, would it not be in his best interest to die quickly and painlessly rather than slowly and perhaps painfully?

> "In one recently publicized case, and 85-year-old patient starved himself to death over a 47-day period. But who would seriously want to suggest that it is in the patient's best interests to be dehydrated and starved to death? It appears that the World Medical Assembly and the American President's Commission would" (15).

If there is no moral difference in favour of passive euthanasia (causing death by non-intervention) over active euthanasia (causing death by intervention) it is illogical to accept the former and reject the latter; and if there is, as has been suggested, a moral difference in favour of active euthanasia the consensus of medical opinion is immoral as well.

In the case of the competent patient who, in addition to an interest in general well-being, also has an interest in self-determination the inconsistency of the Commission's position is even more glaringly obvious, since it treats a competent person's interest in, and right to self-determination as paramount. Competent patients should be allowed to die, it says, when from their point of view, life in a distressing or

seriously debilitating condition is no longer worth while. Different people will decide differently when this point has been reached. Since normal adult persons have an overriding interest in the exercise of their "capacity to form, revise and pursue his or her own plans for life", "no uniform, objective determination can be adequate - whether defined by society or by health care professionals" (16). But there is no suggestion that the competent person whose right to self-determination is paramount is to be allowed to die at a time and in a manner of his or her own choosing if this requires, as it often does, the co-operation of others.

Postscript

I have been arguing that changes in the law of Common Law jurisdictions are urgent and that such changes are unlikely to be brought about unless they have the support of the medical profession, the majority of which holds to an illogical acceptance of passive, and rejection of active euthanasia. To judge from opinion polls, public opinion is very much more liberal on these issues; but opinion polls are notoriously unreliable since the respondents are often unaware of the complexities of the issues underlying the questions put. Other evidence suggests that the general public is, on the whole, indifferent. For example, the membership of the twenty-seven "Right to Die" societies that exist in seventeen countries remains very small, though it is growing fast.

What we need to bring about is a change in our whole society's attitude towards death and dying. Instead of sweeping it under the carpet

(many North Americans who are in other respects not mealy-mouthed use euphemisms for "death") we must re-learn to accept death, as our forefathers did, as not only the inevitable, but the natural end to earthly life. My ideal death is that of Socrates who took poison and died discussing the immortality of the soul with his friends. To be sure, his reason for choosing to die was that he had been condemned to death by the laws of his country which he felt bound to obey. But change that story a little. Socrates is growing old; he can no longer handle this stone-mason's tools with the old skill; worse still, he can no longer match his friends in philosophic discussion. Life has no more that he values to offer him; so he accepts death, not knowing what is to come, having enjoyed life to the end.

Patrick Nowell-Smith,
Professor Emeritus,
York University,
Toronto, Canada

END NOTES

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4. Dawson, op. cit. 23.
5. Law Reform Commission of Canada, Euthanasia, Suicide and Cessation Treatment (Ottawa 1984) (Emphasis added)
6. ibid.
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8. ibid. No. 23, 1-2.
9. The Sunday Times (London, 16 December, 1984).
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14. Quoted by Peter Singer and Helga Kuhse, "The future of Baby Doe", New York Review of Books, 1984, 31, 17-22.

15. Kuhse, op.cit. 611.

16. ibid. 612.