

## A Case Against Permitting Intentional Medical Killing

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*Insofar as the problem to be solved is unbearable physical suffering, there is no need to change the law and legalize intentional medical killing to find a solution. The law as it now stands does nothing to prevent the expansion of the availability of palliative expertise. And it already permits palliative sedation, if that is necessary, and even if it should help to cause death. The expansion of palliative expertise and palliative sedation are alternative solutions to the problem that the legalisation of medical killing would solve. What is more, they are preferable alternatives. They are preferable because they avoid the risk of incorporating into law the principle of 'arbitrary' autonomy. And it is desirable to avoid this, lest such 'arbitrary' autonomy undermine the formation of citizens who are capable of caring for, and respecting, one another. In a nutshell: the legalization of intentional medical killing threatens to give us a radically liberal society at the expense of a substantially humane one. We should avoid that if we can. And we can, because there is a more prudent alternative.*

The question before us is whether the law should permit doctors to help patients kill themselves, or kill them at their request—that is, the question of the legalisation of physician-assisted suicide (PAS) or voluntary euthanasia (VE). (Henceforth, when I refer to both of them, I will speak of 'intentional medical killing'.) In the UK, intentional medical killing is currently illegal—as is the case in most jurisdictions. But there are many people who think that the law should be changed, and attempts are frequently made to do so.

### **Two arguments in favour**

The case for the legalisation of intentional medical killing combines two main arguments. The first is practical, and narrowly focussed: there are some terminally ill patients who are suffering intolerably, and whose distress cannot be managed adequately by palliative medicine and care. In such cases, doctors should be permitted to relieve their patients in the only way possible, namely by helping them kill themselves or by killing them upon their request.

The second argument is one of principle, and ranges much more widely: namely that individuals should have control over the timing of their own deaths. Different people value life differently. A form of life that is bearable for one person may be insufferable for another. Only the individual is in a position to decide when her life has become intolerable; and she should be given the freedom in law to end it when she wants. She should be granted her right to 'autonomy'.

### **Against the argument from unbearable suffering**

Take the practical argument first. The problem is that some patients suffer intolerably. Why does this problem arise? Because of inadequate palliative medicine and care, usually the lack of available expertise. Insofar as that is the cause of the problem, the solution requires no change in the law but rather a change in healthcare policy: to increase the provision of palliative resources.

In rare cases, however, palliative medicine and care prove inadequate, not because of insufficient resources, but because a patient's pain and distress cannot be managed without palliative sedation—and because palliative specialists are unwilling to sedate their patients because of the risk that it might kill them. I hold that palliative specialists should be willing to use palliative sedation since

there is no moral objection—and there should be no legal one—to an act that causes, helps to cause or hastens death, *provided that* it aims to relieve a patient from pain, and that no other effective means were available.

Therefore, my incipient judgment on the first plank of the case for legalizing intentional medical killing is this: insofar as the problem is the relief of intolerable physical pain, there are alternative solutions: namely, the extension of the availability of palliative expertise; and in extreme cases, the use of palliative sedation. But my *incipient* judgment will be incomplete until I explain why these *alternative* solutions are *preferable* to the legalization of intentional medical killing. My answer is that legalization will jeopardize society's commitment to the high value of individual human lives, and its support for those lives when they are ailing. It will make society more liberal at the expense of making it less humane.

For if we breached the law's absolute prohibition of medical killing, we would be unable to agree on where to draw the line—on how to limit eligibility. Many might agree that patients who are terminally ill and in intolerable pain might as well be killed as sedated. But others will point to the chronically and severely debilitated and say that *they too* suffer intolerably. And what about those in severe mental or existential distress? Why should "unbearable suffering" be limited to *physical* illness? Once we permit the medical killing of patients to relieve unbearable suffering, there will be no compelling reason to draw the line in one place rather than another. And if we add to that logical difficulty the culturally popular appeal of an 'arbitrary' concept of autonomy, then we will tend towards medical killing on demand.

### **Against 'arbitrary' autonomy**

So we come to the second plank in the case: the principle of 'autonomy'. Now the law already grants limited autonomy. Patients may opt to refuse treatment, and health care staff are legally obliged to respect this. On this basis advocates of intentional medical killing argue that the law already permits patients to commit suicide passively. Why then should they not be allowed to commit suicide actively? I agree that there is no moral difference between intentional suicide that is carried out by passive means and that which is performed actively; but I disagree that the law's upholding of the right to refuse treatment amounts to the legal sanctioning of passive suicide. After all, the law continues to classify aiding and abetting suicide as a criminal act.

Rather, in recognising the right to refuse treatment the law may more reasonably be read as saying that (i) forcing patients to accept treatment is often futile—there are too many ways for a resistant patient to sabotage it and (ii) that the individual patient is best and perhaps uniquely placed to judge when a treatment is too burdensome. This is partly because pain-thresholds vary, and partly because physical pain is seldom merely physical, but also involves the patient's sense of the meaningfulness of his predicament and so his relationships. So when a patient refuses treatment, he need not be intending to commit suicide but rather be turning his finite energies from a futile attempt at prolonging his life to other tasks—such as settling his affairs or making peace with his children, maybe even with his God.

Now a patient refusing treatment might indeed be intending suicide; but in allowing him to proceed, the law is merely confessing its incompetence to distinguish suicidal intentions from other ones and is therefore ceding benefit of doubt. Thus the law need not, and should not, be read as affirming the right to suicide.

So the law does already recognise a limited autonomy. But the principle of 'arbitrary' autonomy that comprises the second plank in the case for legalizing intentional medical killing is significantly different. It is not limited to the terminal stage of a physical illness. It is not just the freedom to decide when the struggle to survive is no longer worthwhile, and to accept the inevitability of death. It is the individual's freedom to be *the sole arbiter* of when his life is no longer valuable, and when it should be terminated. This 'arbitrary' autonomy is not merely an extrapolation of the law but differs significantly from that which is already legally enshrined.

The fact of difference does not necessarily entail rejection of 'arbitrary' autonomy. However, I think that we should reject it because the logic of 'arbitrary' autonomy suffers no restriction. Any attempt to limit it is dubbed 'paternalist'. All have it equally, whether grief-stricken, lovelorn, young, elderly, philosophically pessimistic, morbidly masochistic, dying or in physical pain. It disqualifies others—society in general, parents or healthcare staff—from preferring their own judgments of a patient's worth and prospects to the patient's. It demands that the law abandon any substantive commitment concerning what makes a human life valuable and limit itself to protecting an individual's right to decide the timing and method of his own death and execute his decision. So if a physically

healthy young man decides to bring his life to a masochistic climax by allowing someone else to slaughter and consume him, then 'arbitrary' autonomy would require the law to be indifferent.

If this example seems too bizarre and alarmist to be taken seriously, then consider that it actually happened two years ago in Germany. Armin Meiwes advertised on the internet for a well built male prepared to be slaughtered and consumed. Out of over eight hundred respondents he eventually selected a 43 year-old, whom he took home, dismembered, killed, and ate, apparently with the victim's consent.

Now Meiwes was convicted of a crime only because German law had not accepted the principle of 'arbitrary' autonomy, that individuals are the sole arbiters of the worth of their own lives, and of how and when they should end. In German law, as in English and Scottish, someone may be guilty of treating their own lives too cheaply—however willingly they do so. Such law is in this respect 'paternalist' (I use the word ironically): it is committed to an objective view of the worth of human life by which the decisions of individuals can be judged—and contradicted.

I believe that English and Scottish law should not adopt the principle of 'arbitrary' autonomy and so permit medical killing on demand. If we did so and entered the interminable quarrel over how to define intolerable suffering, 'arbitrary' autonomy would present itself as an attractive escape route: let the individual decide for herself!

Am I being unduly pessimistic and alarmist? The example of the Netherlands suggests not. For more than two decades Dutch society has been engaged in a uniquely longstanding experiment in legalizing intentional medical killing. The main criterion is that the patient is subject to 'unbearable suffering', thereby precipitating sustained controversy over what kinds of suffering are eligible, and who gets to decide how unbearable they are. Some courts have recognized that 'unbearable suffering' need not be either terminal or physical.

In the *Chabot* case of 1994 the Dutch Supreme Court judged that a 50 year-old woman, who was physically healthy but in persistent grief over the death of her two sons, was subject to 'unbearable suffering' and legally eligible for PAS. Six years later in the *Sutorius case* a trial court in Haarlem judged it legal to give assistance in suicide to an elderly patient who felt his life to be "empty and pointless". An

Amsterdam appeal court did later overrule the trial court's judgment, arguing that doctors have no competence to judge such 'existential' suffering. And the Supreme Court did refuse to quash Dr Sutorius' subsequent conviction on appeal, holding that a patient must have 'a classifiable physical or mental condition' to be eligible for medical killing.

Nevertheless, in 2004 the KNMG (Royal Dutch Medical Association) published the 'Dijkhuis report', which argued that someone who is no longer able to bear living any longer and has a hopeless outlook on their future could be said to be 'suffering from life' and should therefore be eligible for PAS or VE. This view has not yet won the support of a majority of the KNMG's members, but it is being championed by the Dutch Right to Die Society (NVVE). If the NVVE should get what it wants, the Netherlands will be well on its way to enshrining in law the principle of 'arbitrary' autonomy. 'Suffering from life' is not a medical condition, and there are no medical grounds on which doctors would have the authority to contradict an individual's claim that he feels such suffering to be unbearable and hopeless.

#### **In a nutshell: the case**

We have been discussing 'arbitrary' autonomy in order to show why palliative solutions to unbearable physical suffering are *preferable* to the legalization of medical killing. They are preferable because the legalization of medical killing will tend toward killing on demand; because legal killing on demand will incorporate into law the principle of 'arbitrary' autonomy; and because 'arbitrary' autonomy will pose a grave threat to the humane character of society by undermining the formation of citizens who are capable of caring for and respecting one another. The law as it now stands does nothing to prevent the expansion of the availability of palliative expertise. And it already permits palliative sedation, if that is necessary, even if it should help to cause death. Thus expansion of palliative expertise and palliative sedation are alternative solutions to the problem that the legalisation of medical killing seeks to solve.

Succinctly put: the legalization of intentional medical killing threatens to give us a radically liberal society at the expense of a substantially humane one. We should avoid that if we can. And we can, because there is a more prudent alternative.

#### **Epilogue: what's Christian about it?**

My argument to this point has neither referred to Scripture nor mentioned God, Jesus, or the life to come. How, then, can it claim to be a *Christian* argument? My answer is that the argument is

sufficiently informed at all relevant points by at least three Christian beliefs.

First, God has given or created human worth *before human choosing*. It is given to us, not invented by us. That is why we should reject 'arbitrary' autonomy.

Second, God calls human individuals to live their temporal lives so as to become fit for eternal life. Christian ethics is accordingly concerned about how an act shapes the agent as well as how it shapes the world—that is, about the agent's intention, and not just the consequences of his act. It was no accident that the doctrine of double effect was originally formulated by Christian minds.

Finally, human beings and societies are susceptible of sinful corruption. Those who propose to legalise PAS or VE invariably and sunnily assume that the social environment in which the new law would operate is fundamentally, predominantly and securely humane. Christians, who are disposed by belief and liturgical practice—and by hope—to pay attention to the darker side of human life, are more realistic.

### **For further reading**

- Badham, Paul. *Is there a Christian Case for Assisted Dying? Voluntary Euthanasia Reassessed*, London: SPCK, 2009
- Biggar, Nigel. *Aiming to Kill: The Ethics of Suicide and Euthanasia*, London: Darton, Longman, and Todd, 2004
- Board for Social Responsibility of the Church of England. *On Dying Well*, London: Church House Publishing, 2000
- Finlay, Ilora. 'Ethical Decision-Making in Palliative Care'. In Paul Badham and Paul Ballard (eds). *Facing Death: An Interdisciplinary Approach*, Cardiff: University of Wales Press, 1996
- Gill, Robin (ed.). *Euthanasia and the Churches*, London: Cassell, 1998
- Keown, John. *Considering Physician-Assisted Suicide: An Evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill*, London: Care Not Killing Alliance, 2006

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