

## The Case Against Assisted Dying

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Do we value the lives of all our patients – even those we think (perhaps rightly) do not currently value their own lives? *Should* we value not only the patient's health – in the limited sense of 'quality of life' - but his or her presence in the world? This is the central question in discussing euthanasia: the deliberate ending, by act or omission, of a life seen, by the doctor and/or by the patient, as lacking in value.

### **Worthless lives?**

Often presented as an issue of autonomy, euthanasia – even voluntary euthanasia – tends to involve an endorsement by the doctor of the view that someone's life is not worth living. Conditions are normally proposed for euthanasia: it is not normally thought to be sufficient that the patient want to die. After all, would a doctor perform euthanasia on a patient whom the doctor thought was merely temporarily depressed? Surely not - any more than he or she would amputate a limb, simply because the patient for some reason thought the limb should be removed.

All suicidal people want to die: if we give euthanasia to some, but not to others, are we not endorsing the view that some people are (in the words of the disability activist Alison Davis) 'right to want to die'?<sup>i</sup> If physically well suicidal people are supported in living, not 'assisted in dying', why not provide such support also to disabled or terminally ill suicidal people? Conversely, if we really believe death is a benefit to anyone with certain disabilities, why not provide this 'benefit' also to those who are unable to request it?

### **Non-voluntary euthanasia**

Non-voluntary euthanasia is, in fact, a natural sequel to voluntary euthanasia: if death is seen as a benefit urgently needed by some, this benefit is likely to be extended to a wider pool of patients. In the Netherlands, euthanasia has been legally available for decades, and a series of government-ordered surveys have been carried out to track the results. These results are very much more alarming than the optimistic gloss they receive from the survey authors and the Dutch Government might suggest.<sup>ii</sup> In particular, figures for active non-voluntary life-termination are sometimes as high as 1,000 a year – and this does not include those killed by 'terminal sedation' or palliative drugs given with the explicit purpose of ending life.<sup>iii</sup> By no means all of those killed without request are non-competent at the time. The survey authors candidly acknowledge that non-voluntary life-termination seems rather difficult to prevent; they suggest that if patients want to live, they should say so clearly, orally and in writing, well in advance.<sup>iv</sup>

It is, of course, true that some killing by doctors goes on in countries where this is illegal. However, covert voluntary euthanasia is no more a reason to make this practice legal than covert non-voluntary euthanasia is a reason to legalise non-voluntary killing. In fact, the legalisation of voluntary killing is likely to cause other forms of killing by doctors to be taken less seriously. In the Netherlands, very few doctors have been prosecuted for breaking the law on euthanasia and assisted suicide, and those few convicted have been treated with remarkable leniency.

## **Oregon**

Oregon, whose law permitting assisted suicide (though not euthanasia) came into force in 1997 is often presented as a model for other legislatures to follow. In fact, Oregon polices assisted suicide even less than does the Netherlands: self-reporting by doctors is followed by no investigation, but merely a passive reporting by the relevant authority.<sup>v</sup> And although nothing like the official Dutch surveys has been carried out in Oregon, there is anecdotal evidence of patients being pressured to die or undertreated on the grounds that they have a suicide prescription and need nothing more.<sup>vi</sup> It is worth pointing out that reported pain in Oregon has worsened since assisted suicide was legalized,<sup>vii</sup> and that the State, which funds assisted suicide, is less ready to fund essential medical services for those who want and need them.

## **Complicity in suicide**

But do not patients, or some patients, have rights of autonomy which need to be respected? Yes, they do – but not to the point of involving doctors in complicity in suicide, thus harming not only the patient, but wider society, which receives the message that some people's lives are, quite literally, not worth living. In this context, it is worth remembering that euthanasia and suicide can be carried out by omission – providing, of course, that the aim in stopping or refusing treatment is to hasten death, not simply to avoid what is seen as a burdensome procedure.<sup>viii</sup> In particular, advance directives will sometimes, though not always, have a suicidal motive,<sup>ix</sup> and should be scrutinized for signs of this, as well as for any sign the patient lacked sufficient information on the treatment/care refused. The Mental Capacity Act, which has been rightly criticized, nonetheless commendably prohibits those assessing a patient's best interests from being motivated by a desire to hasten death.<sup>x</sup> Such a motive is sadly not unknown among health professionals, perhaps especially those who find their own mortality and fragility psychologically troubling.

## **Conclusion**

Elderly people are already disadvantaged in terminal care, and will suffer further if euthanasia is seen as a 'quick fix' for their needs. There is ample evidence from the Netherlands that where euthanasia is legalized, patients are killed without request, even if this remains illegal. Euthanasia and assisted suicide confirm the suicidal in their low estimate of their lives' value, while the non-suicidal are, at least, disheartened by the public view of lives such as theirs. No doctor should agree with a

suicidal patient that his or her life has no value. Those working in geriatric medicine should lead the way in valuing the lives of all their patients, including those who, in pain or distress, do not see their own lives as worthwhile.

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<sup>i</sup> Davis A. Patients need medical help to live with dignity until they die naturally. *BMJ* 2002; 324: 846.

<sup>ii</sup> Keown J. *Euthanasia, Ethics and Public Policy*. 2002; Cambridge University Press, Cambridge.

<sup>iii</sup> Keown J. *Considering Physician-Assisted Suicide: An evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill*. 2006; Care Not Killing Alliance, London: 10.

<sup>iv</sup> Van der Wal G, van der Heide A *et al.* *Medische Besluitvorming aan het einde van het leven: De praktijk en de toetsing procedure [Medical Decisionmaking at the End of Life: The Practice and the Review and Verification Procedure]*. 2003; De Tijdstroom, Utrecht: 201.

<sup>v</sup> Keown J. *Considering Physician-Assisted Suicide: An evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill*. 2006; Care Not Killing Alliance, London: 11.

<sup>vi</sup> Keown J. *Considering Physician-Assisted Suicide: An evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill*. 2006; Care Not Killing Alliance, London: 13-14.

<sup>vii</sup> Fromme EK, Tilden VP, Drach LL, Tolle SW. Increased Family Reports of Pain or Distress in Dying Oregonians. *J of Palliative Med* 2004;7:431-442.

<sup>viii</sup> Gormally L, ed. *Euthanasia, Clinical Practice and the Law*. 1994; The Linacre Centre, London.

<sup>ix</sup> Watt H. Cooperation problems in care of suicidal patients. In: Watt H, ed. *Cooperation, Complicity and Conscience: Problems in Healthcare, Science, Law and Public Policy*. 2005; The Linacre Centre, London: 139-147.

<sup>x</sup> Mental Capacity Act. <http://www.legislation.gov.uk/acts/acts2005/50009--b.htm>.