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Euthanasia

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Abstract

What is euthanasia? Basically, killing someone for their own good. The aim here is first to clarify this and second to explore the relationship between this killing and that envisaged under the proposed assisted dying scheme. There are important differences. With euthanasia the focus is on the patient's best interests, doing what is good for her, while with assisted dying the emphasis is on autonomy, and doing what she wants. A suggestion is that the former concern is the one to prioritize.

What euthanasia is, and what 'euthanasia' means, is widely even if not always well understood. Stemming from the ancient Greek it refers, literally, to a good death, and so, with its prefix, is akin to a eulogy, euphoria, eugenics and e(utopia). But what, for openers, is good about it?

Typically the good death is most obviously a good dying – shifting from life to death with the minimum of pain, distress and fear as to what is to come. But at least as important is the idea that death, or being dead, in cases where euthanasia might be involved, is better than, preferable to, life, or being alive. Being dead, most of us think, isn't in itself a good state, doesn't feel good or have inbuilt good features. Rather it's neutral, effectively empty, devoid of feeling. But being in this endless neutral state, or no longer existing, though not good in itself, or intrinsically good, can still be relatively or extrinsically good, and so better than life when circumstances are such that life is and is seen to be bad. And, it should be added – an important point, and I come back to it – it is better for the one who dies. In the notorious philosopher's example, a fat man is thrown in front of a train as a way of saving the lives of others. It might be overall good that he dies, but it isn't good for him, and his death isn't going to count as euthanasia.

A further point to make about euthanasia is that, despite the etymology, it's better seen not only as a death but as a killing. Death is chosen, aimed at and, as will be hoped, is successfully achieved. It's not euthanasia if death occurs through accident or old age, or if you're killed by a robber or terrorist, even if by chance dying, or being killed, is good for you. But who is it that chooses death? It can, but needn't be the one who dies. I might decide it's best for me to die. You might decide that your cat, old and ill, is no longer living a good life, and it would be best for her, though upsetting for you, if the vet, as they say, puts her to sleep, and out of her misery. And it could be the same with people, when their pain is so intense and all-consuming that they can't decide, or when some brain disease prevents them from thinking, or thinking straight. Who then does the killing? It can, but needn't be, the one who is killed, the recipient of the good death. I choose to die

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and either I kill myself, or I get someone to kill me, or it's a kind of team work. And it can but needn't be someone who is personally involved. A friend or partner might kill me, or it might be a doctor or some other stranger, in it for the money.

Euthanasia, or talk about euthanasia, might have started with the ancient Greeks but of course it's still with us today. And the NHS gives a brisk but still useful definition:

> Euthanasia is the act of deliberately ending a person's life to relieve suffering.

Thin on detail, but what they give here is pretty much consistent with what I've said above.

What is the status of euthanasia in the UK? Ask around, and you'll find many people think it's illegal. And checking on the internet, it's clear that this is widely held. But it's wrong on two counts. First, euthanizing animals is of course permitted in law. And second, suicide is no longer a crime. Now I'm not suggesting that all suicides are cases of euthanasia, but some are. For certainly there are some, perhaps many, suicides where the person decides, after due reflection, to kill themselves just because they see no end to their present and intense suffering. And it's just not part of the meaning of euthanasia that the one who kills is distinct from the one who dies. So then euthanasia, in at least a couple of its forms, is a fairly common occurrence in the UK today. Moreover it's an accepted occurrence. There's no push to insist that animals die only of natural causes, and no drive to return to the days when suicide, in all its forms, was outlawed. Indeed, one form of euthanasia was until relatively recently often encountered, with it being well known, even if hush hush, that the family doctor would use his skills, and his drugs, to help ease the passage from life to death. And a couple of related examples. I might, when ill and in hospital, refuse further treatment, choosing

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to die sooner rather than, because of the discomfort and indignities involved, later. For similar reasons I might decline further food and drink, and so directly cause my earlier death. These too are forms of euthanasia, deliberately ending my life in order to relieve suffering. Moreover, doctors will get involved here, reducing the pain and discomfort, and so helping me to die.

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The Assisted Dying Bill, currently making its way through the UK parliament, is said by its opponents to represent a massive shift in society's attitude to life and death. Hence, in part because we can't predict how people will respond to such shifts, we should, at the least, proceed with extreme caution. But I hope to have done enough to suggest this is a massive exaggeration. Even though there've been both religious and legal constraints, many people have long wanted to find a way out of a bad life, and have often looked to the medical profession for assistance and guidance with this.

Should we think, then, that even if it's differently guised, this bill is in effect offering not something completely new, but just an extension of familiar and long-standing practices regarding euthanasia? There are some similarities, but there are, as well, important differences.

The bill could have been couched in terms of assisted suicide. The deaths to be considered here are only those both chosen by, and then executed by, the one who dies. And then the bill offers only to a few others – just some of those working within the medical profession – permission to help with this killing. It will still be illegal for friends and family to aid a suicide. And there are severe limits on just which suicides might be assisted. Only those suffering from a terminal illness, and with – as anticipated – a life expectancy of no more than six months are offered aid by this bill. There's a further condition – those wanting to die must be able to demonstrate they have competence – their desire is genuine, properly thought through, persistent, unadulterated by interference and pressure from others.

Some of these restrictions will appear irrational. Jess is able, in spite of her illness, to reach out, take and swallow pills unaided. Jo, because of her illness, is unable to do this. Steve's illness causes him much pain, and will continue to do so until, as anticipated, he fairly soon dies. Sue has to bear, on a day-by-day basis, similar pain. But in her case it's expected to be years before the end. Jess and Steve are offered medical assistance under this bill. Jo and Sue, both of them surely in a worse condition, get no help. The bill's opponents express concern that we're thus far considering only the thin end of a wedge, and, despite assurances to the contrary, we're on a slippery slope to an ever-widening provision of the death service. Supporters of the bill should, I think, in part accept this. But rather than fear we'll soon be stumbling, out of control, down into some morass, they should instead suggest that we may succeed in climbing even higher up the mountain. More prosaically, they should acknowledge that the bill as currently envisaged is a stopgap, a toe in the water model, and if all goes to plan then extensions are likely. The first car drivers had, not unreasonably, to follow a pedestrian carrying a red flag, and with a top speed of 4 mph. We travel much faster now.

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In certain respects, then, the Assisted Dying Bill is cautious and conservative, offering only a

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truncated version of a policy on euthanasia. But in a further, and important, respect it is unconscionably liberal, and arguably needs amending.

Euthanasia involves killing in order to relieve, or escape, suffering. Assisted Dying, as in the current Bill, licenses killing under certain conditions. One of these involves a very limited life expectancy. Now it might be assumed that if someone has, and knows they have, less than six months to live they will find this in some ways painful or distressing. Still, there's no explicit requirement for this, and what is assumed might not be the case. But why then would they want to die? Well, they may want to leave their assets as soon as possible to children or grandchildren, or to find a way around some dated covenant, or, with a taste for ceremony, to fine tune the manner and timing of their exit rather than leave it to chance. Nothing wrong with these as reasons, but they don't in any obvious manner license demands on the health service to assist. Suppose (as I suggested is likely) we do, in time, though still insisting that someone suffers from a terminal condition, drop the six-months requirement. It seems even less likely that all those wanting to die, and requesting assistance with this, will, in the familiar sense, be suffering, or having to bear discomfort and distress. So then it seems even less likely that they can make legitimate demands on the health service. It seems, to put it bluntly, that the Assisted Dying Bill has less of a connection with what is good, or better, for people than might have been expected.

I should, though, be less blunt, and say more. Key players in the debate here are notions of *autonomy* and *best interests.* Noticeable too are appeals to *rights*, with many of those supporting the bill insisting that there is a right to die, meaning not only that death should not, against our wishes, be delayed, but that it might, when we so wish it, be brought forward. But a right to suicide – I might kill myself – doesn't straightforwardly imply a right to assisted suicide – I might demand that others kill me. Still, such a demand can in certain circumstances legitimately be made. And the case for assisted suicide is at its strongest when autonomy and best interests are both present and in play; so then when someone, without confusion or coercion, freely chooses death and when their situation is such that it really would be better for them if they were to die.

It seems, however, that the Assisted Dying Bill, as presently construed, puts too much emphasis on what someone wants, and not enough on what is best. There could, further down the line, perhaps be a place for some commercial death business, but as presently construed the bill envisages an intimate link between killing and the state-managed health service – not at all an oxymoron when we understand, as we should, that this service is primarily concerned with health, well-being, doing what is good for patients, caring for them, and not with preserving and extending life whatever the circumstances. Given this link, the argument for assisting with death needs to appeal not only to what someone wants, or what interests them, but also to what they need, or what is most in their interests. So then a concern to relieve pain and suffering should get a foregrounding it presently lacks.

Euthanasia gets this right of course, but arguably goes wrong with the other key notion, neglecting to give autonomy the attention it deserves. For I can give you a good death, deliberately kill you to end your suffering, whether or not you want or agree to this. Vets do this with animals, and doctors might do it with people, were it to be permitted. Should it be permitted? We might make two distinctions.

First, there's the distinction between non-voluntary and involuntary euthanasia. In the least controversial cases death is good, or best, and the patient wants to die. But in some of the cases where death is for the best the patient has no desires either way, while in others she very much wants to live. She may be conscious and in spite of considerable suffering insisting on this right now, or she may have signalled her wishes in advance. Either way, an argument for involuntary euthanasia, overruling the patient's desires, is hard to make, and unlikely to get support. Non-voluntary euthanasia, in contrast, appears to many at least something to be considered.

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Yet second, and related, we should consider again the question of who benefits. Suppose the patient is in an irreversible coma and has given no indication of what they would want in such circumstances. Doctors and family are together thinking of terminating life support. This might, all things considered, be the right thing to do, but it’s perhaps too easy to assume that this is best for the patient, rather than, as might be the case, for the distressed family or the depleted hospital resources. For a non-voluntary killing to be properly classed as euthanasia, it has to be altogether clear that it’s the patient, the one killed, who will benefit.

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