Physician-assisted Suicide: Some Reasons for Rejecting Lord Falconer's Bill

by Professor John Keown

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His work has been cited by the US Supreme Court, the Law Lords, the Court of Appeal, and the House of Lords Select Committee on Medical Ethics. He testified before the Australian Senate committee considering the Northern Territory euthanasia law, and testified as a witness for the Attorney-General of Canada in Carter v Canada (Attorney-General), a case concerning a challenge to Canada's law against voluntary euthanasia and physician-assisted suicide.

His latest paper is 'A Right to Voluntary Euthanasia? Confusion in Canada in Carter' (2014) 28(1) Notre Dame Journal of Law, Ethics and Public Policy 1-45.[1]

The Assisted Dying Bill [HL] 2014-15

Lord Falconer's Assisted Dying Bill would enable *'competent adults who are terminally ill to be provided at their request with specified assistance to end their own life'*. Its first reading took place on 5 June and its second reading, the general debate on the Bill, is scheduled for 18 July.

http://services.parliament.uk/bills/2014-15/assisteddying.html

1. The case for legalising voluntary, active euthanasia (VAE) and/or physician-assisted suicide (PAS) has been repeatedly and exhaustively considered, and overwhelmingly rejected, by legislatures, courts and expert committees worldwide, not least by the House of Lords.

2. The case has also long been rejected by the medical profession. The World Medical Association reaffirmed its opposition in 2013.[2] In 2006 a survey by the Royal College of Physicians of its members found that over 70% (and 95% of those in palliative medicine) agreed that:

   '[W]ith improvements in palliative care, good clinical care can be provided within existing legislation and...patients can die with dignity. A change in legislation is not needed.'[3]

3. A first major reason for maintaining the historic legal and medical prohibition on intentionally killing patients, and intentionally helping them to kill themselves, is the fundamental equality-in-dignity of all patients. As the House of Lords Select Committee on Medical Ethics put it in 1994:

   'That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.'[4]

4. VAE and PAS are, by contrast, grounded in the belief that some patients have lives which are no longer 'worth living' and that they would be 'better off dead'.

5. Once the law abandons its historic, bright-line prohibition on intentionally ending the lives of patients, or on intentionally helping them to end their own lives, it invites arbitrary and discriminatory judgments about which patients would be 'better off dead'.

6. Lord Falconer's euphemistically-named 'Assisted Dying' Bill is based on such judgments. It is also a 'foot in the door'.

7. The Bill would allow PAS for the 'terminally ill'.[5] But:

   (i) The two main arguments typically used to justify PAS equally justify VAE. The first is respect for patient autonomy. The second is that death would benefit the patient by ending suffering (though the Bill does not even require suffering, merely that the patient be 'terminally ill'.) If those arguments justify lethal *prescriptions*, they equally justify lethal *injections* (especially if the patient is physically unable to commit suicide).

   (ii) Those arguments equally justify ending the lives of those who are not 'terminally ill', and who face suffering for many years, not merely six months.[6]

8. The Dutch, the pioneers of VAE and PAS since 1984, agree with the leading academic advocates of so-called 'assisted dying' that such limitations are indefensible. Dutch law allows both VAE and PAS, and whether the patient is 'terminally ill' or not. Further, there is now much support in the Netherlands (including from the former Health Minister, an architect of their law[7]) for granting requests by the elderly who are 'tired of life'. And why not?

   The Falconer Bill is, clearly, a first step onto the same, precipitous slope.

9. Moreover, if relief of suffering justifies ending the lives of patients who request death, *why deny this benefit to suffering patients merely because they are incapable of requesting it?* Again, the Dutch, together with their leading academic defenders, recognise that compassion cannot logically be confined to the competent. This logical argument is unanswerable.

   In 1984 the Dutch courts declared VAE lawful because of the doctor's duty to relieve suffering. In 1996 they ruled that this duty equally justified lethal injections for disabled newborns.[8]

   The Falconer Bill would, again, be but a first step down the same path.

10. The case for VAE/PAS does not, then, rest mainly on 'respect for patient autonomy'. Under proposals like those in the Bill, the autonomous requests of only *some* patients would qualify. And they would qualify because of the judgment by *others* that they would indeed be 'better off dead'. Any such judgment is fundamentally arbitrary and threatens, in particular, the most vulnerable members of the community.

11. No wonder disability groups are at the forefront of opposition to legalisation. They see more clearly than many: first, that it would signal social acceptance of the notion that some people would be 'better off dead', and, second, that the disabled would be prime candidates for this discriminatory designation.

12. In any event, how autonomous would requests for PAS actually be? In 2006, 'deeply worried' by Lord Joffe's Bill to decriminalise PAS, the Royal College of Psychiatrists observed that studies of the terminally ill showed that depression is strongly associated with a desire for a hastened death and that, once depression is effectively treated, 98-99% change their mind about wanting to die.

    It also cautioned that many doctors do not recognise depression or know how to assess for its presence in the terminally ill and that, even when they do recognise it, often think that 'understandable depression' is not real depression or cannot be treated.[9]

13. The Falconer Bill would allow two registered medical practitioners to approve a request for PAS even if neither had any particular expertise in assessing capacity; in diagnosing or treating mental illness; in diagnosing 'terminal illness'; or in palliative medicine.[10] Neither need be the patient's regular doctor. There is nothing to prevent a patient (or the patient's relatives) 'shopping around' to find two compliant doctors.

    The two doctors would be required to examine the patient and his or her records, certify that the patient is 'terminally ill'; has the capacity to decide to commit suicide and has a 'clear and settled intention' to end his or her life, which has been formed 'voluntarily' and 'on an informed basis and without coercion or duress'.[11] A single examination by each doctor would presumably suffice. And how, for example, are the doctors to *know* whether the request is truly voluntary and is not the result of pressure from others, or of being made to feel a burden?

    The Bill places enormous reliance on certification by two doctors. Leaving aside the ethics of abortion, a similar scheme of regulation under the Abortion Act 1967 has proved obviously ineffectual.

14. All this brings us to a *second* major reason why proposals to relax the law have (with few exceptions) been globally rejected: concerns about effective enforcement and control, not least to ensure that the lives of those who do *not* want to die - particularly those who are vulnerable to pressure – or whose suffering could be alleviated by palliative care, are protected.

15. These concerns have been amplified by the experience in the Netherlands, where several comprehensive, government-sponsored, surveys since 1990 have disclosed widespread breach of the legal guidelines, and with virtual impunity.

    Those surveys have shown that, since legalisation in 1984, not only have doctors in thousands of cases breached the requirement to report, but they have also ended the lives of thousands of patients without the required request.[12]

Small wonder the Dutch euthanasia regime has now been criticised twice by the United Nations Human Rights Committee, in 2001 [13] and in 2009. [14]

The experience in Belgium, which adopted the Dutch model in 2002, exhibits these same two failures, with only around half of cases reported, [15] and a high incidence of euthanasia without request. [16]

And, even if *all* cases were reported, this would hardly demonstrate effective control. How many doctors are likely to report that they have breached the guidelines? Any scheme of regulating VAE/PAS which is reliant on self-reporting (like those in the Netherlands, Belgium and Oregon) is intrinsically ineffective.

16. Comprehensive surveys like those in the Netherlands have yet to be carried out in any of the handful of US states which have legalised PAS, most notably Oregon. But the monitoring procedures in Oregon are even laxer than the essentially 'rubber stamp' review procedure in the Netherlands and Belgium. As an analysis by Professor Alexander Capron, the leading US health lawyer, concluded, Oregon's safeguards are 'largely illusory'. [17]

    Further, the annual statistical reports of the Oregon Health Authority are far from reassuring: its report in 2014 discloses that, since the law came into effect in 1997, the two most common reasons for accessing PAS have been 'losing autonomy' and being 'less able to engage in activities making life enjoyable'; that for 40% a reason has been feeling a burden on others; and that only 6% of patients have been referred for psychiatric evaluation. [18]

17. A recent, thorough review of the data from the Netherlands, Belgium and Oregon by three judges of the Irish Divisional Court led them to agree with the Supreme Courts of Canada, the US, the Law Lords, and the European Court of Human Rights, [19] that a blanket ban on PAS is entirely justified.

    The Divisional Court noted that one study in Oregon showed that of eighteen patients who obtained PAS, three had been suffering from depression which had not been diagnosed or been the subject of independent psychiatric evaluation. [20]

    The Court also noted a high incidence of euthanasia without request in the Netherlands and Belgium. It observed that in 2005, '550 patients in the Netherlands (some 0.4% of *all* deaths)' were euthanised without an explicit request, [21] and that '1.9% of *all* deaths which took place in the entirety of Flanders between June and November 2007 were without explicit request'. [22] The Court concluded that the fact that such a 'strikingly high level of legally assisted deaths without explicit request' occurred in the Netherlands and Belgium 'without any obvious official or popular concern' spoke for itself as to the risks of legalisation. [23]

18. All this confirms the observation of the late Lord Bingham in the *Pretty* case:

    > If the criminal law sought to proscribe the conduct of those who assisted the suicide of the vulnerable, but exonerated those who assisted the suicide of the non-vulnerable, it could not be administered fairly and in a way which would command respect. [24]

19. Remarkably, the Falconer Bill kicks the key question of how it would secure effective control into the long grass, gesturing at a 'Code of Practice' which 'may' be issued by the Secretary of State, [25] and to unspecified 'monitoring' by the Chief Medical Officer. [26] This sketchy Bill invites Peers to buy a pig in a poke.

    Even if the Bill included a requirement such as prior approval by a judge or some other official (as did the Voluntary Euthanasia (Legalisation) Bill, rejected by the House of Lords in 1936), there could be no guarantee it would prove more than a formality, and a formality which many doctors would ignore. If many doctors in the Netherlands and Belgium ignore even the 'light touch' regulation there, what reason is there to suppose that doctors in England and Wales would comply with an even more bureaucratic procedure?

20. In sum, the Falconer Bill:

    (i) undermines a fundamental and historic legal and ethical principle: respect for the equal worth of all patients.

    (ii) is a 'foot in the door'. The main ethical arguments which will be used to support it, misguided understandings of 'autonomy' and 'beneficence', are equally arguments for euthanasia for the competent, and for the incompetent, and, in either case, whether 'terminally ill' or not.

    (iii) evades a vital question: 'Precisely how will it ensure what relaxed laws in other jurisdictions have conspicuously failed to ensure: effective control of PAS, not least to protect those who do not want to die and those for whom there are alternatives?'

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em paragens ignotas, não está directamente ligado a estas sucessivas mortes celulares, porque as pode proceder de algum tempo.

Uma síncope por fibrilação ventricular, a que uma terapêutica, como por exemplo uma injecção intra-cardíaca de adrenalina, não veiu dar a chicotada salvadora, vale espiritualmente tanto para o significado da morte, como o finar após uma moléstia, que tenha causado as maiores lesões corporais.

Mas para a medicina são coisas totalmente diversas, ainda que condizentes a um mesmo fim.

Sôbre vários aspectos, muito interssa aos médicos êste assunto.

Aliviar padecimentos, faz parte dos sens dons, e bastas vezes a sua intervenção é reclamada, para à maneira dos eutanasófilos, apreçar a *boa morte* de quem está penando.

Suponhamos, que, auxiliados por todos os recursos da arte, temos a certeza dum diagnóstico, que o mal pela sua natureza e grau de evolução, é considerado como absolutamente incurável pela experiência secular, que o doente, torturado por acerrimas dores, implora convictamente a morte, e a família compadecida reitera os seus pedidos.

É êste o problema, em toda a sua nudez de tragédia e magnitude de responsabilidade profissional, que se lhes apresenta tantas vezes.

O que deve pensar e o que deve fazer o médico?

Certeza do diagnóstico! vã gloría dos nossos conhecimentos; como se desmentem às vezes as afirmações mais fundamentadas! Num problema em que há quasi um infinito de variáveis, como é o do diagnóstico e seus afins, a-pesar-de todas as provas laboratoriais, pode haver enganos duma sciência, tão longe ainda da precisão da matemática.

Os maiores defensores da eutanásia teem escrupulos ao reconhecer esta verdade, e apenas Binding, contra os pontos de vista médico, jurídico e social, afirma que no caso de um êrro, seria apenas um homem a menos, de pouco valor, se tivesse sobrevivido à sua enfermidade.

Erros de diagnóstico, mas principalmente erros de prognóstico, a mais difícil das afirmações que temos de fazer aos doentes, o vaticínio do seu futuro mórbido.

Incurabllidade é um conceito relativo, que como já dizia Bacon, mais não é que a expressão da insuficiência actual dos nossos conhecimentos, palavra que talvez não exista nos recursos indefinidos da natureza.

E' certo, que em dada altura da sua evolução, certas doonças que são tambem graudes males sociais da humanidade, como o cancro e a tuberculose, se podem considerar absolutamente incuráveis.

Mas até a um condenado à morte é altamente imoral praticar a morte piedosa, suprimindo assim, não o espectaculo bárbaro da sua execução como exemplo às turbas, mas o tempo de burilar a sua alma na conversão, ou na aurora do arrependimento.

Se confessei sinceramente os erros de que a medicina é capaz, como coisa humana e sempre imperfeita que é, cabe-me agora o prazer de servir a minha dama, constatando, para minha argumentação os grandes progressos que a teem enriquecido.

Milhares de cultores da deusa Hígia trabalham hoje nas clínicas e laboratórios, e todos os dias brotam do seu labor profundo, novas descobertas e se rasgam novos horisontes.

Seria extemporâneo e desviar-me-ia do meu propósito o alongar-me na sua exemplificação.

Mas como nos atrevemos nós a cortar uma vida, se amanhã poderemos ter a sua salvação?

Ainda ha bem poucos anos, se iniciou o tratamento da paralisia geral, a malarioterápia, que dá grandes resultados nessa forma de loucura tão frequente e grave, um daqueles casos em que muito se assanhava a arte matadora dos eutasanófilos.

Aparecem muitas vezes notícias de descobertas sensacionais que se não confirmam. Esse simples facto seria origem de dramas morais, pelo desespero que deveria invadir os autores dum assassínio-pseudo-piedoso, ao reconhecer que a sua vítima poderia ter sido salva, angústia que aliás o tempo não justificaria, mas de tal sugestão, que o assunto já foi aproveitado para novelas de grande êxito.

A dôr exteriorisada pelo enfermo não é mais do que uma sensação subjectiva, de estados extremamente variáveis; a sua intensidade de modo algum pode ser um critério para avaliar o grau das lesões. Todos sabem mesmo que muitas afecções altamente dolorosas não são das mais graves, e quanto não varia não só a sua repercussão exterior, em relação com a força de vontade do doente, como os graus de sensações nos diferentes indivíduos, dependentes como são do seu estado de espírito. constituição e raça.

«Lamentai os homens à sua chegada, e não à sua partida dêste mundo», pois dum modo geral, a dor não está à cabeceira dum moribundo, correspondendo ela à capacidade de reacção, que então declina a passos largos. Alguns, que tendo estado agonisantes e conservado a consciência, depois melhoraram, contam que nada sofriam então. Não podem descrever as suas sensações: a modo que uma quietude divina, em que se desenham vagas reminescências dos momentos mais doces da sua vida.

São os sofrimentos invencíveis, cuja modelação pode ocultar exageros apaixonados ou caracteres histéricos, e não a fatalidade da doença, que induzem à prática da eutanásia terapêutica.

Teremos nova restrição, se nos lembrarmos da inconsciência pré-moral, que tantas vezes se observa, e em que, pela ausência de consentimento e de móbil piedoso, nem sequer há bases para nela se pensar.

A-pesar-do aperfeiçoamento da arte de matar, e da gravidade dos ferimentos, na grande guerra

não teve éco o punhal da misericórdia com que antigamente se acabavam de matar os feridos, e em casos em que a nossa sensibilidade hesitária ante tal descalabro dum corpo humano, nunca se implorou nem foi praticada a morte piedosa. O retemperamento varonil das energias, e as prosperidades da analgesia e terapêutica cirúrgicas, explicam essa vitória das consciências.

O último baluarte em que se apoia a eutanásia é pois, o desejo de morrer para fugir às dores, que nada teem que ver com o chamado instinto da morte, nem com a desejável calma e confianças espirituais antes daquilo, que Sócrates chama «o maior bem da vida».

Já provei a nulidade do valor jurídico dêste último argumento, resta apenas o seu valor como justificação moral.

Pode-se duvidar de que um doente em caquexia esteja no pleno uso das suas faculdades mentais, perguntando, se o que exprime é a verdadeira tradução do seu íntimo pensamento.

Pela certa no inconsciente vive ainda pujante o instinto da vida; o desejo que se lhe sobrepõe, pertubado pelas dores pode provir duma auto ou hétero-sugestão, e com a maior facilidade, ante a mentira dumas melhoras, variar para o arrependimento.

Mesmo no seu fecho, a vida não deixa de ser uma perene cobiça pelo que se não possui, e o que sofre suspira pela morte como por um tesoiro; mas, quando ela na verdade chegar, pedirá mais umas horas para continuar a trazer às costas o fardo das suas dores, como na fábula de La Fontaine: «a morte e o lenhador».

Outros não desesperam da cura, e só quem não viu morrer um tísico, é que ignora a euforia dos seus sentimentos e o colorido das suas esperanças.

Demais, aqêlele em que a vontade de morrer for verdadeira e intensa, ilude toda a vigilância e acaba por se suicidar; os verdadeiros vencidos extinguem-se por si próprios.