PHYSICIAN-ASSISTED SUICIDE? WHY NOT

By John Keown,* MA, DPhil, PhD, DCL

Introduction

The campaign to legalize physician-assisted suicide (PAS) and voluntary active euthanasia (VAE) is one of the greatest threats to human life in developed countries.[1]

In the US, PAS is now legal in six states (Oregon, Washington, Vermont, California, Colorado, Montana) and the District of Columbia. In 2015 the Supreme Court of Canada upheld a right to PAS and to VAE, and in 2016 the Canadian Parliament enacted legislation to accommodate that ruling. In November 2017 the State of Victoria, Australia, enacted legislation permitting both. The Netherlands has permitted both since 1984, Belgium since 2002, and Luxembourg since 2009.[2]

The campaign is particularly strong in the US. Bills to permit PAS are repeatedly introduced in state legislatures. Attempts have also been made to persuade state supreme courts that state statutes or constitutions permit PAS. It is only a matter of time until another attempt is launched in the federal courts to establish a right to PAS under the US Constitution; previous attempts were rejected by the US Supreme Court in 1997.[3]

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* Rose Kennedy Professor at the Kennedy Institute of Ethics, Georgetown University

[1] PAS involves a physician intentionally assisting a patient's suicide, as by providing the patient with a prescription for lethal drugs. VAE involves a physician intentionally acting to end a patient's life, as by injecting the patient with a lethal drug. They are the subject of this briefing because they are the focus of the current political debate. It should not be overlooked that important legal and ethical issues are also raised by withholding or withdrawing life-prolonging treatment, especially if the physician's intention is to shorten the life of the patient, as well as by respecting a suicidal refusal of such treatment, especially if the physician's intention is to assist the patient's suicide. See generally, John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2002); and John Keown, *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford University Press, 2012).

[2] For a critical analysis of such laws see John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2nd ed., 2018).

[3] *Washington v. Glucksberg*, 521 U.S. 702 (1997) and *Vacco v. Quill*, 521 U.S. 793 (1997).

The need to resist this campaign could hardly be more important or urgent. This short briefing sketches two powerful arguments that can be deployed against the case for legalization when lobbying legislators,[4] submitting briefs to courts, or engaging with the media.

Two Key Arguments against Legalizing PAS and VAE

1. We are all equal in dignity; no one has a life that is "not worth living."

First, the historic bright-line prohibition in the criminal law and in professional medical ethics on the intentional killing of patients and on intentionally assisting patients to commit suicide reflects a foundational ethical and legal principle: the inviolability of human life.

That principle is grounded in a recognition that everyone, regardless of illness, life-expectancy, age, disability, gender, race, religion or sexual orientation shares an intrinsic and ineliminable dignity and equality which makes it wrong for any physician intentionally to kill any patient or to help any patient kill themselves. (This does not mean our lives must be preserved at all costs; it is perfectly proper for physicians to withhold or withdraw treatments that are futile or too burdensome, even if they foresee—but do not intend—that death will be hastened.)

One of the many expert committees which have exhaustively considered the question of legalization and which have concluded that the prohibition on PAS and VAE should be upheld was the UK House of Lords Select Committee on Medical Ethics. It observed:

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[4] Whether those promoting legalization or those opposed to legalization (such as members of Congress seeking to overturn the DC law permitting PAS http://reut.rs/2ABd4CW or passing resolutions against PAS http://bit.ly/2BgNIf3).

> 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.[5]

Laws permitting PAS or VAE are, by contrast, grounded in the notion that there are two categories of patient: those with lives "worth living" and those who would be "better off dead." Such laws invite fundamentally discriminatory judgments about the worth of patients' lives. The superficially attractive argument that PAS or VAE is required out of respect for patient "choice" is specious. Laws and proposed laws for PAS and/or VAE do not allow them for *any* patient who autonomously wants them. They allow them only for *some* patients who want them such as the "terminally ill" or those "suffering unbearably." So, PAS or VAE are not fundamentally about choice at all but about the judgment that the requests of some patients should be granted because it is thought by others that they would be "better off dead." No wonder that disability groups are at the forefront of opposition to PAS and VAE. They see more clearly than many that any such judgment is fundamentally discriminatory. Those with disabilities are not the only ones who would likely find themselves being judged to have lives less "worth living" than others, or not "worth living" at all. The elderly, the poor, and people of color would also be at heightened risk.

The judgments that would be permitted by proposals to legalize PAS in the US, proposals which (like DC's recent law) are modeled on Oregon's law, are not only discriminatory, they are arbitrary. Their arbitrariness is exposed by the following questions:

- Why PAS only for those who are "terminally ill"? Why not for those with MS or severe arthritis, especially when the terminally ill may not be suffering at all whereas those with non-terminal conditions may face many years of grave suffering? Note also that typical proposals for PAS laws require merely that the patient have a "terminal" disease, not that the patient be suffering. Indeed, the two most common reasons for accessing PAS in Oregon have been "losing

[5] "Report of the Select Committee on Medical Ethics" (House of Lords, Paper 21-I of 1993-4) para 237.

autonomy" and being "less able to engage in activities making life enjoyable,"[6] not pain and suffering.

- Why lethal prescriptions but not lethal injections, especially if the patient is unable to self-administer the poison?
- Why a hastened death only for those who request it? Why not for those who may be suffering but who are (like babies or those with dementia or severe learning disabilities) unable to make a request? If death can benefit a patient in particular circumstances who is competent and who requests it, why not a patient in the same circumstances who cannot request it? Why discriminate against the latter patient because of their mental incompetence?

Supporters of proposals to legalize PAS have yet to produce cogent answers to these questions.

Such proposals would, then, be merely a foot in the door. As Booth Gardner, former governor of Washington and prominent supporter of its PAS law explained, it was but a first step. If he could persuade Washington to enact it other states would follow and gradually "the nation's resistance will subside, the culture will shift and laws with more latitude will be passed…."[7] He was right. Sooner or later, whether as a result of a legislative or a judicial action recognizing that the limitations are "discriminatory" restrictions on the newly-established "right to die," laws allowing PAS will be extended to allow euthanasia for those who request it and then for those who cannot. The Dutch and the Belgians realized years ago when they relaxed their laws that it made no sense to permit PAS but not VAE or to limit them to the terminally ill. And since then the Dutch have, logically, extended their law to permit euthanasia without request, in the case of disabled infants.

2. Legalization propels society down a slippery slope, for both practical and logical reasons.

Even if PAS or VAE were defensible in principle, effective legal control would prove impossible. First, it is practically impossible to define the requisite conditions with

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[6] Oregon Health Authority, "Death with Dignity Act: 2016 Data Summary", Table 1. http://bit.ly/2nyHELJ

[7] Daniel Bergner, "Death in the Family" *The New York Times Magazine*, December 2, 2007

sufficient precision or to enforce them in practice. Second, the ethical case for PAS for the terminally ill, which rests on the principle of respect for autonomy and the principle of beneficence, is also logically a case for PAS for the non-terminally ill, and for euthanasia both with and without request.

A clear majority of expert committees that have considered the case for legalization, like the House of Lords Select Committee and the New York State Task Force on Life and the Law[8] (whose report is the finest yet published), have rejected PAS and VAE because of the risks of abuse, especially to vulnerable groups. How, for example, are doctors to know that a person is competent and that their request is truly voluntary and not the result of clinical depression, or family pressure, or the fear of being a burden, or the misguided fear of dying in pain? This is especially problematic when (as under Oregon-type proposals) patients can access a hastened death without being examined by physicians with any expertise in either psychiatry or in palliative treatment.

Moreover, the evidence from those few jurisdictions that allow PAS or VAE reinforces concerns about effective control. The Netherlands legalized both more than thirty years ago. Its law permits physicians to end life only at the request of the patient and requires physicians to report all cases for review. However, six official, national Dutch surveys have disclosed that physicians have, with impunity, failed to report thousands of cases and that they have given lethal injections to thousands of patients without request. Dutch law allows even purely mental suffering as grounds for PAS and VAE, and there is now widespread support to extend the law to encompass elderly people who are simply "tired of life." In 2016 the Dutch government announced plans to permit assisted suicide for the elderly who have a "completed life."[9]

The evidence from Belgium, which followed the Netherlands in 2002, is no less disturbing: only 50 percent of cases have been reported to the review commission,[10] and the extension of the guidelines or "bracket creep" has been even swifter. *Allow Me*

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[8] New York State Task Force on Life and the Law, "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context" (New York, NYSTF: 1994)

[9] Government of the Netherlands, "Scope for assisted suicide for people who regard their life as completed" October 12, 2016. http://bit.ly/2jZI7lS

[10] K. Chambaere et al, "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium" (2015) 372(12) *New England Journal of Medicine* 1179.

to Die, a disturbing documentary broadcast in 2015 by the Australian channel SBS[11] about a mother being assisted in suicide by her physician because of her grief at the death of her daughter, graphically shows where any legalization logically leads.

The evidence from Oregon, where no comprehensive surveys like those in the Netherlands have been carried out, is far more limited and is certainly insufficient to substantiate claims that its Death with Dignity Act has prevented abuse. We simply do not know how many physicians have practiced PAS outside the law or how reliable the reports filed by physicians with the Oregon Health Authority have been. As the analysis of the Death with Dignity Act by Professor Alexander Capron of the Gould School of Law at the University of Southern California concluded, its safeguards are "largely illusory."[12]

Moreover, the minimal "review" procedure in Oregon is weaker even than that in the Netherlands and Belgium, and all three jurisdictions rely on self-reporting by physicians. Which physician is going to report that he or she has broken the law? And one Oregon study, which found that some patients accessed lethal drugs under the law even though they were depressed, concluded that "the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug."[13] This is hardly surprising, given that ordinary physicians lack expertise in diagnosing and treating depression. Finally, a bill has been introduced in Oregon to permit lethal injections.

Conclusions

In conclusion, there are two powerful arguments against legalizing PAS, neither of which, as their endorsement by expert committees illustrates, depends on theological premises or religious belief.

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[11] http://bit.ly/2jY1Gen. See also Charles Lane, "Europe's sinister expansion of euthanasia" *Washington Post* August 19, 2015; "Where the prescription for autism can be death" *Washington Post* February 24, 2016.

[12] Alexander M Capron, "Legalizing Physician-Aided Death" (1996) 5 (1) *Cambridge Quarterly of Health Care Ethics* 10.

[13] Linda Ganzini et al, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross-sectional survey" (2008) 337 *British Medical Journal* a1682.

(i) All of us share an equality in dignity. Laws that permit PAS or VAE are grounded in the notion that there are two classes of patients: those with lives "worth living" and those who would be "better off dead." Such laws are fundamentally discriminatory and arbitrary.

(ii) As the experience of those few jurisdictions permitting PAS or VAE illustrates, such laws cannot ensure effective control, for reasons both practical and logical. Practically, it is virtually impossible to define or enforce the stipulated criteria. Logically, the ethical case for PAS is equally a case for euthanasia both with and without consent.

These two objections explain why many more proposals to legalize PAS or VAE have been rejected than have been enacted.

The real challenge, from which legalizing PAS and VAE is a dangerous distraction, is to provide high-quality end-of-life care and social support to all, especially the poor, the disabled, and the disadvantaged.

Some suggested reading:

Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, 2006)

Emily Jackson and John Keown, *Debating Euthanasia* (Hart Publishing, 2012)

John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2nd ed., 2018)