Assisted Suicide: Engaging with the Debate

The newspapers love stories about assisted suicide. Healthcare regulators are troubled by it. Legislators across the world are both bored by it and scared by it. Some academics have built their careers on it, and it is the whole life of many lobbyists. Almost everyone seems to have a view: agnosticism is unusual, and so is moderation. The subject polarises, and raises voices. Nuance tends to be drowned out in the hubbub. This article seeks to provide the information necessary for intelligent engagement in the debate.

Suicide: the historical perspective

What one thinks about assisted suicide will be affected by, although not necessarily determined by, what one thinks about suicide itself. It is common, and wrong, to think that opposition to suicide is always based on some form of religious faith, and that suicide's opponents are always encumbered by metaphysical baggage. There have been many views. Plato, broadly, frowned on suicide. Socrates, in the *Phaedo*, taught that, since the gods have placed us, for punishment, on duty inside the 'guard posts' that are our bodies, to wrench oneself out of one's body was to desert, and so incur divine wrath. In the *Laws,* Plato was even more forthright: suicide is a disgrace. If one cuts oneself off from one's body, one should be severed from the human community and interred in a nameless grave. There were, however, some exceptions. They included: (a) when one commits suicide out of shame at having done something monstrously unjust; and (b) where there is immense personal misfortune. Would Plato have extended (b) to cover great personal pain or a feeling of futility? It seems unlikely. He urged a stiff upper lip. For him it was cowardly not to meet smilingly whatever life threw.

Aristotle has little to say about suicide. He seems to regard it as an offence against the state.

The Stoics sound much more modern. For them, suicide did not necessarily connote moral flabbiness. Suicide might be justified if it was impossible to flourish as a human being. If physical illness robbed an individual of the capacity to flourish, suicide was a defensible option.

The tone of the Judaeo-Christian scriptures is generally, although not explicitly, opposed to suicide. Suicidal individuals (unless you see Jesus's march to Calvary as suicidal) tend not to be heroes: think of Saul and Judas. Paul, in some of his more fraught and poetical moments, said that he longed more to be with Christ than to continue in his earthly body, but that's against the grain of Christian thinking. In the early Church, although martyrs were revered, by and large they were not encouraged. Life was regarded as a gift from God, and since it was his, it was God and only God who should decide when it was taken away. Suicide, then, was a blasphemous usurping of the divine prerogative.

Augustine, influentially, saw it as breaking the commandment 'Do not kill'. The main reason given by the Bible for not killing a human is that each human is made in the image of God, and accordingly to kill a person is to efface that image. It's an act of cosmic vandalism. Aquinas

agreed, and argued further that suicide was an offence against natural law (since we have had the instinct to self-preservation embedded within us by benevolent providence), and an offence against the wider community (because, as John Donne was later to put it, no man is an island unto himself, and all are diminished by the death of one). For mediaeval Christians, steeped in these thoughts, suicide was a presumptuous abomination. Decent people should not share a graveyard with suicides.

These attitudes barely moderated as the Middle Ages wore on. The Reformers agreed with the Catholics that suicide was deplorable. Even Locke, in the 17th century, keen libertarian though he was, thought that suicide was beyond the pale.

The Enlightenment's rediscovery of Stoic ideas of human autonomy led to an often contemptuous revisiting of the traditional Christian views of suicide. David Hume's attack on those views was part of his more general attack on the notion of natural law, his insistence on individual responsibility and consequential rights, and his essential utilitarianism.

Kant, of course, was steadfastly against suicide. For him, freedom consisted in choosing to obey the 'Universal Law' – which was, more or less, co-extensive with Christian morality. Someone who chose to commit suicide could, by definition, not do so freely, and there was nothing offensive about prohibiting them from doing so, or stigmatising them for the choice. For him, being properly human was about rationally choosing to align oneself with the Universal Law: someone who chose 'wrongly' was in an important sense sub-human.

In modern philosophical (as well as popular and political) discourse about suicide, two principles tend to stand head to head: the notion of autonomy and (often rephrased in near-secular language, such as the 'sanctity of life'), the notion of the Imago Dei – the specialness of man.

Assisted suicide and euthanasia

Assisted suicide is what it says: it is assisting someone to commit suicide themselves. In the eyes of many, but not all, it is very different from euthanasia, which is the active killing of X by Y.

In terms of the physical actions involved, the distinction between the two may be slight. Suppose that X has motor neurone disease and has indicated a desire to die. Because of her MND, X cannot lift to her lips the fatal dose of barbiturates which has been prescribed. Y puts the pills on her tongue. Is this assisted suicide, or is it euthanasia (which is murder in most jurisdictions)? What if X is capable of lifting her hand to her mouth, but incapable of reaching out to the bedside table to pick up the pills? If Y puts the pills in her hand, is he guilty of murder?

Lawyers tend to shift uncomfortably from foot to foot when presented with such examples. There is no clear legal answer to the questions above. Is the morality of the two situations different? To explore that question we have to look at the distinction between acts and omissions.

Acts and Omissions

Consider four cases:

1. X has incurable cancer and is in terrible pain. All palliative options short of terminal sedation have failed. She repeatedly begs her doctor, Y, to put her out of her misery, saying: 'You would do this for your dog, wouldn't you? Am I worth less than your dog?' Y eventually agrees and injects X with a bolus of potassium chloride. X dies immediately.

2. Tony Bland was crushed at the terraces at Hillsborough. He went into a Permanent Vegetative State. He was self-ventilating but had to be given artificial nutrition and hydration (ANH) through a naso-gastric tube. His treating clinicians and his family agreed that continued ANH was futile: he was never going to recover consciousness. But his clinicians were worried about withdrawing the tube. They would be doing that with the intention of ending his life. Doing an act with the intention of killing is, where death results, the crime of murder. They went to court for guidance.

3. Miss B had a bleed into her cervical spinal cord. She was paralysed from the neck down and had to be maintained on a ventilator. She decided that her life was not worth living. She asked for her ventilation to be stopped. Her treating clinicians refused. She went to court for a declaration that her continued, unwanted treatment was unlawful – and indeed amounted to an assault. The only question for the court was whether she was competent to make the decision. It was decided that she was, and accordingly that the ventilation was unlawful. It was stopped, and she died: see *B v An NHS Trust* [2002] 2 All ER 449.

4. X has multiple sclerosis. She is wholly mentally capacitous. She wants to die but, without help, cannot. A relative puts a lethal dose of drugs on her tongue. X dies.

In Case 1 there is no defence to murder. But is it materially different from Case 2? The House of Lords, who considered Case 2 in *Airedale NHS Trust v Bland* [1993] AC 789 decided that it was. Case 2 was not murder because the withdrawal of the ANH was an omission and not an act. It was legally different from pressing the plunger of the syringe in Case 1. But is it ethically different, and if so why? Lord Browne-Wilkinson, in the House of Lords, was clear about the law, but not about the ethics. He said, at p. 885:

'How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law and nothing I have said casts doubt on the proposition that the doing of a positive act with the intention of ending life is and remains murder.'

Few think that, in Case 3, Miss B should have been compelled to stay alive against her will. This includes most people with an instinctive disapproval of suicide per se. Is flicking the switch to turn off the ventilator an act or an omission? Legally this distinction, on the facts of this case, probably doesn't matter, since what killed her was not, really, the flick of the switch but the bleed that paralysed her. One can see that this is different in some respects from Case 4, where the death is caused by the drugs rather than the multiple sclerosis. But are Cases 3 and 4 *morally* different? Can it not be said that Miss B is suicidally ideated, and that switching off her ventilator is, for all ethical intents and purposes, identical to the respect for a competently reached decision to commit suicide that we see in Case 4? It has been suggested that an unwanted, failing body is essentially a life-support device, and that one has a right to have one's body switched off just as one has a right to have an onerous ventilator switched off. (Shaw, 2007; cp McLachlan, 2010).

I do not seek to arbitrate, merely to highlight the issues.

Some have contended that, however much the boundary between acts and omissions can be blurred in thought experiments, the distinction is of real moral significance (Randall, 1997; Asscher 2008). They may say that, while one can dream up omissions that are plainly morally equivalent to actions, that sort of equivalence is unusual, and where it occurs, the law has sufficient flexibility to ensure that evil omitters are adequately punished. This appeal to legal practicability suggests to some of their opponents that the distinction is not a philosophically fundamental one. Those who assert that acts and omissions are importantly different may appeal to the 'yuck' factor: some may feel an inchoate distaste for an act that has a fatal consequence which they do not feel for an omission with the same consequence. Others insist that this sort of fastidiousness is just moral cowardice.

Assisted Suicide Legislation

Few countries now criminalise suicide itself. In the UK, which is typical, pressure for the decriminalizing of suicide came from the medical profession, which saw the existence on the statute book of an offence of attempting suicide as professionally embarrassing. Doctors would potentially have to pump out the stomach of a suicidal patient and then be the principal prosecution witness in the subsequent trial.

Assisting suicide is, however, an offence in many jurisdictions, including the UK, Canada, France, Germany and Australia. Some contend that the existence of this type of legislation is legally anomalous: there are few examples of other situations where it is lawful for A to do act X, but unlawful for B to help A to do X. Others argue that the law's prohibition of assisted suicide differs from the non-criminalisation of assisting other lawful acts. First, suicide was not made lawful: it was decriminalised. This meant that someone who unsuccessfully attempted suicide would not be prosecuted. And second: decriminalisation did not imply approval of suicide. Some of these issues are explored below.

Should assisted suicide be lawful? Jurisprudential Basics

The first thing to do is to distinguish between law and ethics. It may sometimes be appropriate:

(a) for the law to be silent about things that are morally culpable; and

(b) for the law to cause or tolerate injustice in an individual case because to do so is an inevitable consequence of creating a legal environment which, overall, does more good than harm.

I deliberately do not give examples of cases (other than assisted suicide) that might fall within (a) or (b) because the subsequent discussion may then become hijacked by comparisons between those examples and assisted suicide.

Law is not always, or not always directly, about the regulation of conduct. Philosophers talk about the 'expressivist' function of law – whereby the law enshrines the principles by which society wants to live. Those principles, and therefore the laws that embody them, may be aspirational rather than realistic, although wholly unrealistic laws are unlikely to be good laws. Laws that are routinely broken are unlikely to command respect, and if the laws aren't respected, the principles embedded in them are unlikely to be.

On that point, it needs to be understood that, in most jurisdictions, the mere fact that an offence appears to have been committed does not necessarily mean that there will a prosecution. Usually there is a two-stage test: (a) The evidential test: is there a reasonable chance of proving that the offence has been committed? And (b) The public interest test: is a prosecution in the public interest.

In the UK, in the aftermath of the Purdy case (*R (on the application of Purdy) v DPP* [2009] UKHL 45: see too *R (on the application of AM v DPP* [2012] EWHC 2381 (Admin)), the DPP published the criteria that he would use in deciding whether or not it was in the public interest to prosecute cases of alleged assisted suicide (Crown Prosecution Service, 2010). Prosecutors undertake a difficult audit of the competing legal, ethical, political, sociological and personal interests in play in any particular case.

Let us suppose that we agree that suicide itself should not be criminalised. What are the arguments for and against a law making it a criminal offence to assist someone to commit suicide? All the arguments have a huge literature lying behind them, which I can neither summarise nor reference adequately. Sometimes I point to some of the headline papers that support or contradict the various propositions. Some of the arguments overlap with those relating to euthanasia, but one must be very wary of confusing the two issues.

The arguments for and against the criminalisation of assisted suicide

Does a right to commit suicide entail a right to assisted suicide?

This is sometimes argued. Rachels (2006), for instance, contends that: 'If it is permissible (or if a person has a right) to do a certain action, or bring about a certain situation, then it is permissible for that person (or he or she has a right) to enlist the freely given aid of someone else in doing the act or bringing about the situation, provided that this does not violate the rights of third parties.'

Others say that this is too simple, saying (for instance), that there may be good utilitarian reasons for not allowing an agent to carry out the wishes of someone who wishes to die. Such reasons may include concerns about the damage that may occur to the role and standards of the medical profession (Kass, 1993), concerns that assisted suicide may decrease the resources given to life-saving treatment or palliative care (Wennberg, 1989), or concerns about vulnerable patients (discussed below). A variation on this argument is that these utilitarian contentions raise serious empirical questions which must be answered empirically, and that accordingly it is simply wrong to say that it follows logically that a right to suicide necessitates a right to assisted suicide (Gunderson, 1997) .

Protection of the vulnerable

Many people who want to commit suicide will (the argument goes) be vulnerable for some reason or other. Many or most will have a life-threatening illness. Depression is a common feature of such illnesses. Depression can truncate capacity. It is therefore very hard to ensure that a decision to commit suicide is truly free . Suicidal ideation may evaporate with proper psychiatric treatment. Even where there is no formal capacity-truncation, patients may feel pressurised by relatives or carers to commit suicide. This need not take the dramatic form of express suggestions or insinuations by those relatives or carers: a person may simply feel that they don't want to 'be a burden'. A law is needed to make would-be pressurisers think twice, and to make it illegitimate for someone to be helped to kill themselves simply because they feel themselves to be a 'burden'. An expressivist point: In any civilized society, 'burdens' like this are really privileges, which should be joyfully shouldered.

There are, of course, several important empirical questions at the heart of this debate. I cite, mostly without further comment, some of the references commonly used in the course of the debate: some are pro assisted suicide: some are against. First: are patients who request assistance with suicide in fact likely to be depressed? (Draper et al, 1998; vane Der Lee et al, 2005; Ganzini et al, 2008; Levene & Parker, 2011). A comment: Levene and Parker's systematic review concluded: 'It is clear that both undefined depressive symptoms and clinical depression are found at high levels in patients making requests for euthanasia/PAS, with most studies across the quality spectrum estimating that a quarter to a half of requests came from depressed patients.' The Royal College of Psychiatrists (2006) asserted that: 'Studies using systematic assessments in

terminally ill patients have clearly shown that depression is strongly associated with the desire for a hastened death, including the wish for [physician-assisted suicide] or euthanasia.' Second: if such patients are depressed, is that depression likely to be relevant to the wish to die? (Ganzini et al, 2000; Hamilton & Hamilton, 2005; Booshard et al, 2008; Stewart et al, 2011). Third: If it is relevant to that wish, is treatment likely to change the wish? (Ganzini et al, 1994; Hooper et al, 1997; Hawton & Fagg, 1998; Kugaya et al, 1999). And fourth: if vulnerable people are put at risk by assisted suicide per se, is that risk changed by legalisation of assisted suicide?

A good example of the tone of the debate about vulnerability is in a pair of competing papers comparing the experience of physician-assisted suicide in Oregon. Battin et al (2007) argued that there was generally 'no evidence of heightened risk' to vulnerable people from the legalisation of physician-assisted suicide or voluntary euthanasia. Finlay and George (2011), reviewing Battin et al's conclusions and some of the subsequent literature, disagreed, questioning the research methodology Battin et al had used.

It is not hard to think of cases of assisted suicide which, according to anyone, *should* be regarded as criminal. An example, based on a recent case: the defendant, over many months, systematically convinces his teenage girlfriend that she is worthless, demon-possessed, and should kill herself. He persuades her to drink a bottle of vodka, takes her to a nearby bridge, and urges her to jump off. She does. However liberal one is on the question of assisted suicide, he should be prosecuted.

Assisted suicide takes many forms. It is, say the supporters of legislation criminalizing assisted suicide, impossible to draft a law that catches all the truly culpable cases without potentially catching some less culpable ones, (Steinbock, 2005), and accordingly, since it is important to catch the culpable ones, and appropriate exercise of prosecutorial discretion will prevent less culpable parties from prosecution, the legislation should stay as it is. Their opponents always agree that protection of the vulnerable is important, but tend to contend that the criminal law is not the best way to achieve it. They often advocate assisted dying legislation that has built into it safeguards (such as psychiatric examinations, the involvement of lawyers or even formal tribunals, cooling off periods between a request for assisted dying and action on it, and so on).

As to the bridge-jumping type case, they tend to agree that this sort of conduct should be criminalised, but argue that it is absurd to legislate as if it is comparable to the much more usual assisted suicide case (say, where a patient with MS wants to die slightly earlier than her disease would have her die). They say that it is possible to draft legislation that distinguishes between these types of cases.

The defenders of legislation against assisted suicide respond that they have seen no convincing drafts of legislation with safeguards that would work in the emotionally, sociologically and medically messy real world - or of legislation that can catch the bad cases (such as the bridge-jumper), but not the others. Since the *Purdy* case and the subsequent prosecutors' guidelines,

some of the wind has been taken out of the abolitionists' sails. Those guidelines suggest that prosecutions will be decided upon using criteria that are likely to be acceptable to the abolitionists. Indeed the record in the UK of prosecutions for assisted suicide suggests that the law is likely to be deployed that way. There has been, for instance, no prosecution of anyone who has helped a terminally ill relative to go to the Dignitas facility in Switzerland. If the law produces in practice acceptable results, what remaining arguments can there be against the retention on the statute book of legislation criminalizing assisted suicide?

There are broadly two. It may be said that, regardless of how the law is in fact administered, the mere existence of a law may inhibit people from seeking assistance with suicide, and therefore it may condemn them to a prolonged, painful and distressing life that the state has a duty to help them avoid. And second, some would use expressivist language to say that there is an absolute right to end one's life at the time and in the way that one chooses, and that the value of autonomy which grounds that right should be enshrined and proclaimed in the nation's legislation.

The expressivist argument

We have touched on this already. Those in favour of the criminalization of assisted suicide say that anti-assisted-suicide legislation declares, as one of society's core values, that we should not involve ourselves in deliberately bringing about the deaths of others. Those opposed to such a law agree that expression of values is important, but that it is more important to express respect for autonomy. They tend to see the expressivist view as a creature of the notion of the sanctity of life. They might well add that the sanctity of life is an incurably religious doctrine (perhaps with its origins in the Imago Dei) and that to base one's law-making on it is to allow the dictatorship of an ancient creed, unshared by most modern people.

Slippery slopes

Some argue that legalising assisted suicide will inevitably lead to euthanasia.

If one thinks that euthanasia should be available, this will not be an argument against assisted suicide. The arguments for and against euthanasia are themselves complex and cannot be ventilated here.

This argument is often peppered by reference to other jurisdictions (notably The Netherlands and Belgium). The evidence from those jurisdictions is hard to interpret (a) because of queries over the methodology used to gather the data, and (b) because extrapolations between those jurisdictions and others are complex and difficult. The historical, sociological, historical and legal backgrounds may differ very significantly.

Two arguments, however, are not clouded by the difficulties of comparison. The first relates to the relevance of advance decisions ('living wills').

The UK Mental Capacity Act 2005 is fairly typical in giving to an advance decision which is 'valid' and 'applicable' the same status as a request by a capacitous patient - though it does not make valid a request for assisted suicide or euthanasia, both of which are unlawful.

What, though, if assisted suicide is a legal option? Does that change things? Some argue that it does. This rests on the belief that, since autonomy is the main issue at stake both in assisting the suicide of a capacitous person and in honouring an advance decision, there is no way to stop the creeping rule of autonomy, and hence an irresistible claim for the euthanasia of an incapacitous patient who has previously made an advance decision indicating that they would wish life-sustaining treatment to be withheld should they find themselves in circumstances that in fact pertain (for instance, a diagnosis of Alzheimer's dementia).

Whatever the rhetorical force of this argument for euthanasia, a legal revolution would have to occur for it to prevail. However difficult it may or may not be to defend it from philosophical first principles, the distinction between the withdrawal of life-sustaining treatment and active killing is easy enough to recognise legally and has a well-recognised emotional appeal.

The second and better argument goes:

(a) Assisted suicides are sometimes unsuccessful.

(b) Where this happens, the subject may be in distress or, if not in distress, plainly capable of living, perhaps in a coma, for a long time.

(c) In such circumstances there will be an irresistible temptation to complete the job by an act of euthanasia.

Groenewoud et al (2000) found that 'problems of any type were more frequent in cases of assisted suicide than in cases of euthanasia. Complications occurred in 7 percent of cases of assisted suicide, and problems with completion (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16 percent of the cases; complications and problems with completion occurred in 3 percent and 6 percent of cases of euthanasia, respectively. The physician decided to administer a lethal medication in 21 of the cases of assisted suicide (18 percent), which thus became cases of euthanasia. The reasons for this decision included problems with completion (in 12 cases) and the inability of the patient to take all the medications (in 5).' The assisted dying lobby would no doubt rely on such studies as indicating the need for euthanasia. That reliance, of course, presupposes acceptance of assisted suicide and assumes also that in euthanasia there is no more at stake, ethically, legally or societally, than there is in assisted suicide.

The role of the physician

One argument for (physician) assisted suicide is that the duty of physicians is to relieve suffering. If that means giving relief that proves lethal, so be it: that is just part of the job.

Another argument is that proper patient-centred care means respecting the autonomy of the patient. (Dworkin, 1997) If the patient insists on dying, it is paternalistic and unacceptable for the doctor to refuse to help.

Physicians' views

A majority of doctors across the world oppose the legalisation of assisted dying legislation (Lee & Price et al, 2009; Seale, 2009). Psychiatrists are amongst the concerned. In the UK, for instance, the Royal College of Psychiatrists (2006) said that it was 'deeply worried about the possible unintended effects of the Assisted Dying for the Terminally Ill Bill if it were to be enacted.'

Further, it has consistently been found that physicians who care for patients at the end of their lives are significantly more likely to oppose physician-assisted suicide than are physicians who do not treat such patients (Craig & Cronin et al, 2007; the findings are not restricted to physicians. Generally, the greater contact a person has with dying patients, the less likely they are to favour the legalisation of assisted suicide (Fekete & Osvath, 2002; Hanlon, Weiss & Rees, 2000)

Most of the studies, though, relate specifically to doctors' attitudes to physician-assisted suicide rather than to assisted suicide per se. The significance of this lacuna in the evidence is questionable. In practice, many assisted suicides (and particularly those types of assisted suicide advocated by the assisted dying lobby) will involve physicians.

The significance of the fact that (for instance) palliative care physicians are more likely to oppose assisted dying than doctors further away from the death bed is similarly debatable. It may be said that palliativists oppose assisted dying because they think (or know) that it is not necessary – that the pain and anxiety that trigger suicidal ideation can be palliated. Or simply, and more generally, that they are the people who really know the facts about dying, and accordingly should be listened to particularly carefully. Conversely, it may be said that their opposition presumes (as is not the case) that good palliative care is available to all; or that palliativists resist assisted dying out of professional pride – because it involves an acknowledgment that their specialty has failed the patient; or that palliativists' opposition is born from an intrinsic distaste about getting involved in assisted dying (which is more likely for them than it is for, say, a rheumatologist). If palliativists were really concerned about patient welfare, and sufficiently professionally detached, the argument continues, they would put their own distaste aside. This latter argument raises fundamental questions about the nature of medical professionalism and the right of conscientious objection.

Whatever the merits of these arguments, it is clear that the medical profession's opposition to assisted dying has been and remains a significant obstacle to legalisation (Warnock & Macdonald, 2008).

Public views

A 2005 UK Parliamentary report, reviewing the literature from across the world, noted that general populations broadly agree that there should be legalisation by some route of some form of assisted dying (Select Committee on the Assisted Dying for the Terminally Ill Bill: Report, 2005).

Asking for a show of hands, it may be said, is rarely a substitute for evaluating the arguments that one would hope (but perhaps not expect) had led to the raising of hands.

Conclusion

This commentary offers no conclusion. It has simply sought to outline some of the arguments that might help in reaching a defensible conclusion.

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Conflicts of interest

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