Euthanasia and the law

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This paper examines why the law concerns itself with euthanasia. The nature of the right to life and its protection in law is explored. Such a right demands legal intervention to prohibit, or at least control, involuntary and non-voluntary euthanasia. Voluntary euthanasia is not a violation of the individual's right to life as such, so on what grounds can law limit autonomy by prohibiting such conduct? It is suggested that, while concepts of sanctity of life still play a part in the legal debate, fears of abuse in any scheme for voluntary euthanasia largely explain the reluctance of many jurisdictions to follow the example of The Netherlands. Finally, the paper asks whether reform and regulation of voluntary euthanasia are as attractive options as they are sometimes portrayed.

Euthanasia in its original, literal meaning, a gentle and easy death, is what we all hope or pray for. The law plays no role in euthanasia if good fortune or good medicine allows such a death. Today, however, euthanasia all too often attracts a second meaning, an act or omission designed to hasten death and thus relieve the suffering of a dying or incurably sick patient. The law immediately rears its ugly head in its most awful guise. Has the perpetrator of such an act or omission committed the crime of murder? Other chapters of this issue explore the substantive laws of the UK, The Netherlands, Canada and the USA. Cartwright analyses the validity of any distinction made between killing and letting die. Ann Somerville examines the response to the euthanasia debate of organisations such as the British Medical Association. This chapter seeks only to investigate why law should concern itself with euthanasia. Dying is our inevitable fate. Family, friends and health professionals may be expected to help us meet that fate. Who wants a lawyer at the death bed?

A right to life

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"Everyone's right to life shall be protected by the law."2 The right to life is the fundamental human right. Absent that right, all other rights to liberty, privacy, family life and so on are meaningless. No qualification attaches to that right. Society may not demand that a human being achieve a set level of intellect or ability to assert that right to life. The
multiply disabled individual unable to care for herself in any sense, the
terminally ill centenarian are as much entitled to that right as the healthy
and distinguished editors of this Bulletin. The law’s legitimate interests in
protecting that right thus justifies legal intervention to prohibit (or at
least control) involuntary and non-voluntary euthanasia.

Involuntary euthanasia, in the sense of conduct designed to end the life
of someone who desires to go on living, is hardly worthy of debate. A
lethal injection to kill a tetraplegic perceived as a burden to her relatives
and the health care service is morally indistinguishable from common
murder. It matters not whether the homicidal act is carried out by spouse
or doctor. Yet are the barriers against involuntary euthanasia as
watertight as appears to be the case at first sight?

In most jurisdictions today, the unborn human entity can be killed. The
handicapped foetus in England may be destroyed at any time up to live
birth\(^3\). The right to life only crystallises at birth. The Downs syndrome
infant who survives the perils of her mother’s womb cannot be actively
destroyed any more than can her tetraplegic aunt.

Assume for the moment though, an ability on the part of both to
express a wish to live. May they be let die against their will? Certainly
withholding most routine treatments would contravene the law as much
as would active killing of the patient. But what of expensive, complex
therapies? Recently, in England, the father of a young girl suffering from
leukaemia was refused further treatment for her by the local health
authority. He believed cost to be a factor in refusing treatment to his
child, that her right to life was just too expensive to protect. The Court of
Appeal declined to intervene\(^4\).

Non-voluntary euthanasia, defined as conduct designed to end the life of
someone who has never expressed any wish either to die or survive, and
who cannot currently communicate any desires of his own, is equally a
legitimate concern of the law. Neither extreme youth nor age, disease nor
profound disability qualify the right to life, yet nor do they qualify the
right to compassion. The patient’s condition may be such that prolonging
life simply extends suffering. There are nearly always some means
available to extend life, to prolong the process of dying. The law is unlikely
to, and would be wrong to, demand that all available means be employed
to do so. When an infant, known only as C, was born with an
exceptionally severe degree of hydrocephalus, was blind and deaf and
became unable to feed naturally, the English Court of Appeal held there
was no mandatory obligation to resort to nasogastric or intravenous
feeding\(^5\). The medical evidence was that the child would not survive more
than a few more weeks whatever was done for her. The professionals’ duty
was to alleviate her suffering by all means short of actively ending her life.

More difficult than C’s case is the scenario where a patient is not
imminently dying but is irreversibly afflicted by a condition from which
he cannot recover. J was another infant born profoundly handicapped. He suffered acute brain damage at birth. He was likely to develop paralysis, blindness and deafness. His condition caused episodes of cyanosis and collapse. The baby was successfully resuscitated on at least two occasions. Given intensive care and treatment he could live into his teens. The Court of Appeal was asked if J suffered a further collapse, must he be resuscitated? The court said no. The best interests of the child must be evaluated. The court must attempt to assess the ‘assumed’ view of J and take full account of the instinct to survive. There would nonetheless be cases, and J’s was such a case, where ‘it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no commensurate benefit’.

The tragedy of Tony Bland is well-known. Crush injuries at the Hillsborough football stadium left the youth in a persistent vegetative state. He could breathe independently but all his other bodily functions and needs had to be met artificially. He received food and water via a nasogastric tube. Ultimately the English courts were asked whether it would be lawful to cease feeding the young man. For so long as artificial means maintained the necessary nutrition and hydration he would go on ‘living’ perhaps for several more years. The House of Lords found that it would be lawful to cease feeding Tony Bland and ‘allow him to die’. Once again the court maintained an absolute prohibition on involving any ‘external agency of death’.

The rights and wrongs of the judgments in Bland will be debated later by McCall Smith. Two points need to be made here about Bland and all other instances of non-voluntary euthanasia.

1. Clearly the law rightly concerns itself in such cases. The individual cannot assert or protect his own right to life, cannot balance the benefits of existence against non-existence for himself. The law plays a proper role in protecting him. How far formal external mechanisms to fulfil that role are needed may be disputed. The law must calculate how far society may reasonably entrust the protection of the patient to his family or his doctors.

2. The fundamental question posed by the operation of the law in such cases, however, is why maintain a prohibition on active killing. Once it is conceded a patient no longer benefits from life, why not end that life swiftly and mercifully?

A right to die?

Did Tony Bland, and the infants C and J have a right to die? No such right is articulated in the US Constitution, or the United Nations
Declaration on Human Rights, or the European Convention on Human Rights. Before returning to such cases of non-voluntary euthanasia, the so-called ‘easy’ case of voluntary euthanasia should be explored. If the willing patient may not be killed at his express request, clearly no other category of patient can be said to have a right to be killed. But, if a competent patient freely and fully understanding the consequences of her choice wishes her life to end, what business is it of the law’s to interfere with her autonomous choice?

As later chapters will illustrate, in practical terms a right to die may well depend on the accident of exactly what kind of condition precipitates a patient’s wish to die. A competent patient generally enjoys an absolute right to refuse further treatment. A person with terminal cancer can decide when enough is enough and prohibit further surgery or chemotherapy. Any imposition of unwanted treatment will constitute assault, however genuinely his doctors believe that the patient might benefit from continuing treatment. In England at least, no patient has to justify rejecting even life-saving treatment. ‘It matters not whether the reasons for refusal were rational, or irrational, unknown or even non-existent.’ Moreover patients can ensure that they control the stage at which treatment should cease even when that point arrives at a time when they are no longer able to communicate their wishes. Advance directives already have legal force in common law jurisdictions, even where no specific legislation yet exists. Providing there is unequivocal evidence that a certain mode of treatment was prohibited by the patient, it is as much assault to impose that treatment on the now unconscious or incompetent patient as to force similar treatment on an actively protesting individual.

In circumstances where refusing further treatment effects a person’s wish to die, he enjoys a right to die. However injury or disease may result in disability or suffering the patient finds intolerable, yet life looks set to continue. The terminally ill patient may regard the likely ‘natural’ termination of her life as too long delayed. Her desire to die encompasses a wish for immediate death, a demand to be killed. If a competent patient freely seeks to exercise such a choice that cannot be violation of his right to life? And what of other fundamental human rights?

The European Convention, albeit it nowhere touches on a right to die, establishes other rights pertinent to the patient who desires to die. No-one may be subjected to torture or to inhuman or degrading treatment or punishment. Does there come a point when continued existence equates to degrading treatment? Is ‘life’ sustained via tubes feeding you and tubes evacuating bowels and bladder equivalent to torture when imposed on an unwilling patient? Such may well be the case, but the right not to be subjected to degrading treatment does no more than reinforce the right to refuse further or continuing treatment. What of the right to privacy?
Might it be contended that so long as a competent patient who freely makes a choice to die can find a willing accomplice to effect an act that were he capable of carrying out himself would not be criminal, it is an invasion of privacy to interfere with that choice. If suicide is permitted society has accepted the individual’s right to choose to end her life. It may seem unjust to deny that right to those so ill or disabled as to be incapable of doing so independently.

In those jurisdictions who as yet refuse to lift the prohibition on active killing, the justification for the consequent denial of choice to the patient is often thought to rest on what has been judicially described as ‘society’s interest... in upholding the concept that all human life is sacred’\(^{13}\). Does a doctrine of sanctity of life still command support today? And are there perhaps other, more pragmatic, grounds for the law’s unease about active euthanasia?

Sanctity of life or legal pragmatism?

Traditional Judaeo-Christian belief in human life as a gift from a divine creator and thus literally sacred probably no longer commands majority support in the UK at least. Religious practice is a minority pursuit in England. In the absence of an active and universal faith in a divinity does the concept of sanctity of life cease to have any place in the law? If I profess to believe that life is sacred and ends at God’s command not mine, that belief mandates I may neither seek my own death nor hasten another’s. That faith, it might be argued, no more entitles me to enforce that belief on others than it would justify me in compelling non-believing neighbours to attend Holy Communion to ‘save their souls’.

There can be little doubt that Judaeo-Christian concepts of sanctity of life historically played their part in the law’s condemnation of active euthanasia and suicide. However, they were far from the sole factor influencing the development of laws on homicide. Preservation of public order and engendering safeguards against the fallibility, and outright evil, inherent in mankind, played their own role. Nor is adherence to sanctity of life an exclusively religious phenomenon. Seamless respect for human life in all its infinite variety is a value espoused by many atheists and agnostics. ‘Belief in the special worth of human life is at the heart of all civilised societies\(^{14}\).’ There would be few who would dissent from such a notion. Working out what such fine words mean is quite another matter. The House of Lords Select Committee on Medical Ethics concluded that they outlawed any reform of the law designed to ‘weaken society’s prohibition of intentional killing\(^{15}\).’ Yet their Lordships did not endorse (or at least not expressly) any concept that God prohibited such a course.
of action. They offered pragmatic, not theological or philosophical, grounds for maintaining such a ban.

'We do not think it is possible to set secure limits on voluntary euthanasia.' 'We are also concerned that vulnerable people...would feel pressure to seek early death.' Respect for human life, the right to life, even if it allows for the individual to choose to end that life, still demands that the law ensures no third party usurps the individual's choice. In principle, a right to seek assistance in dying might command recognition in a secular society. In practice, how can abuse by others of such a right be prevented? Choice requires options from which to choose. If hospice care is not available to all terminally ill patients, if standards of palliative care vary, are the necessary options available? Fear of covert compulsion clouds the debate on voluntary euthanasia. In The Netherlands, where the 'great experiment' on euthanasia is now in train, commentators suggest a significant number of patients have their life ended without their express consent. Others express the desire to die but do so out of fear of burdening their families. Hovering in the background too, beyond the boundaries of The Netherlands, is the issue of the cost of health care. If painless death is an option to the terminally or incurably ill, will publicly funded health authorities purchase expensive palliative care for their patients? Will private insurance cover the cost of dying slowly for increasing numbers of sick, very elderly patients?

However, the arguments just advanced are themselves pretty fallible. If it is right in principle to acknowledge a right to choose to be killed, the lawyers must struggle to find appropriate means of enforcing that right. Why should the suffering patient pay the cost of the law's inadequacy? The failure for the most part to confront reform of laws relating to active euthanasia suggests that some lingering notion of a more general doctrine of sanctity of life endures.

De-medicalising euthanasia

The logic of acknowledging a right to an autonomous choice to be killed is this. Legislation need do no more than ensure a means of obtaining unequivocal evidence of the individual's free and informed choice and that appropriate, humane mechanisms exist to effect that choice. A statute could provide as follows. An adult of sound mind should be entitled to request to be killed. That request should be made in front of two witnesses who attest that the request is made voluntarily and on the basis of informed choice. The request must be repeated after a waiting period of 7 days. That period could exceptionally be reduced by leave of the court. A licensed thanatologist (death-bringer) could then lawfully
end the person’s life in an approved manner. Regulations made under the statute would prescribe \textit{(inter alia)} what information must be made available to the person making the request, what training thanatologists should receive, and what qualifications witnesses must meet. Doctors and nurses would not figure in the picture at all. One of the anxieties expressed about active euthanasia, the ‘brutalisation’ of caring professionals, is countered. Alex Capron need no longer fear that he will never know whether his doctor approaches his bed wearing the white coat of the healer or the black hood of the executioner\textsuperscript{19}. The licensed thanatologist will wear a simple and distinctive uniform!

No voluntary euthanasia proposal I have seen, endorses such a simple scheme. All follow the lead of The Netherlands and medicalise ending life. A doctor must determine that the patient’s suffering is intolerable, that he is terminally ill, that other means of alleviating suffering are no longer feasible. A second independent doctor must confirm her colleague’s conclusion. Then and only then, doctors may end life. Euthanasia is a medical act performed when doctors judge that a patient’s quality of life is none or minimal. The exact pattern may vary but virtually all proponents of voluntary euthanasia, and any proposal for non-voluntary euthanasia, medicalise the process. There is a certain irony in this state of affairs. In a society which contains many members who do not believe in God, a society which vehemently objects to doctors ‘playing God’, whenever an attempt is made to re-write the script on euthanasia, doctors get cast as God. Perhaps unease at permitting active killing even by purportedly free choice runs deeper than we think.

\textbf{Covert euthanasia}

Critics of the House of Lords Select Committee’s inability to endorse active euthanasia because secure limits cannot be set on the practice have one especially powerful weapon at their disposal. It is almost universally conceded that doctors and nurses do occasionally, usually in the privacy of a patient’s home, end life. Pain relieving drugs are administered in dosages that will be more than likely to hasten death. The doctrine of ‘double effect’ endorsed in \textit{R vs Adams}\textsuperscript{10} can only tenuously be advanced to justify what is done as designed to relieve suffering and only incidentally hastening death. Covert euthanasia happens. It is carried out without any provisos for explicit request on the part of the patient. It is unregulated and so susceptible to all the potential abuses which are supposed to rule out regulated euthanasia. The law must be an ass to condone what it cannot bring itself to permit?
Euthanasia

The question which must be asked by doctors before they gleefully agree with that proposition is simple, if brutal. If a particular society cannot achieve consensus on the nature of human life, if a society concurs that even if it might accept voluntary euthanasia, strict safeguards must reinforce respect for human life, by what means can the law most effectively provide such safeguards? Can the boundary between an act of humanely ending suffering and an act manifesting disregard for the value of life be better policed than by the knowledge that crossing the boundary attracts a conviction for homicide? Could any other sanction better signal the responsibility the law attaches to 'playing God'? 'Unfair to doctors' would be a predictable response. Why should a professional act at peril of her liberty or risk depriving her patient of an ultimate manifestation of professional care? Maybe one rejoinder might be that unsatisfactory, even irrational, though the current law may seem, at least it usually keeps lawyers away from the death bed. Regulating, formalising, active euthanasia when a significant number of professionals and laypersons deplore such a move will have one certain result. The law will interfere more not less in the final stages of the professional's relationship with his patient.

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References

2 Article 2(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms
4 R vs Cambridge Health Authority ex p B. All Engl Rep & D 1995; 2: 129
5 Re C (a minor) (wardship: medical treatment). All Engl Rep 1989; 2: 82
7 At p 938 per Lord Donaldson MR
8 Airedale NHS Trust vs Bland. All Engl Rep 1993; 1: 821
10 Re T (above); Re C (refusal of medical treatment) All Engl Rep 1994; 1 819; Malette vs Shulman. Dominion Law Rep (4th) 1990; 67 321. See also Law Commission Report No. 231
Mental incapacity. London: HMSO 1995, recommending granting statutory force to advance directives

11 Article 3

12 Article 8. A number of judgments expressly seek to balance respect for the right to life with a right to 'human dignity'; see Airedale NHS Trust vs Bland. *All Engl Rep* 1993; 1: 821 at p. 855 per Hoffmann L.J. in the English Court of Appeal; Rodriguez vs A-G of British Columbia. *WWR* 1993; 3: 553, per Cory J in the Canadian Supreme Court


15 &lop cit&D: see para 237

16 &lop cit&D: at para 238

17 &lop cit&D: at para 239


20 *Criminal Law Rev* 1957; 365; see generally Brazier M. op. cit. at pp 446–7.