

Why active euthanasia and physician assisted suicide should be legalised

If death is in a patient's best interest then death constitutes a moral good

Last month Diane Pretty was refused the legal right to choose the circumstances of her own death.¹ She suffers from motor neurone disease and is experiencing the disintegration of her body. She faces a death that she believes will entail indignity and suffering and physically cannot kill herself. The court has denied her request that her husband be allowed to help her. This decision may be consistent with legal precedent but is morally wrong. That is why the law should be changed.

Suppose that Mrs Pretty became permanently and severely incompetent as a result of brain damage and that her life was being sustained by medical technology. If her doctors believed that medical treatment could provide no benefit because of her inability ever to engage in any self directed activity, then legally they could withdraw life sustaining treatments, including hydration and nutrition.² In such circumstances they would foresee that she would die as a result of their failure to perform what would ordinarily be their duty to protect life and health. In most other circumstances clinicians are not allowed this discretion to accelerate foreseeable deaths through inaction.

Against the background of the duty to care, the moral and legal status of not saving a life through failing to treat can be the same as actively taking that life.^{3 4} For example, a doctor who knowingly allows a patient who could be saved to bleed to death in emergency care might be accused of murder. What is deemed to be morally and legally important here is not the emotionally appealing distinction between omission and commission but the justifiability or otherwise of the clinical outcome. Indeed, the distinction between omission and commission may be of little value in some healthcare settings. When doctors turn off ventilators, foreseeing that death will result, it makes little sense to say that they do so passively.

So it is sometimes acceptable for doctors to stop life sustaining treatments when there are grounds for assuming that this is in the best interests of severely incompetent patients. Equally, action and inaction may be deemed morally and legally equivalent in the context of a deliberate failure to carry out the duty of care to save life when clinicians agree that it should be saved. Thus parliament and the courts should take the next step of recognising that this same equivalence should hold when there is clinical agreement that it is

in the best interests of some severely incompetent patients to end their life.⁵

The most articulate opponents of involuntary passive and active euthanasia accept that there is no moral difference between commission and omission in the medical withdrawal of life sustaining treatment. Nor do they reject the non-provision of life sustaining treatment in principle. However, they do argue that to be acceptable, such non-provision must fulfil two conditions that rule out involuntary euthanasia in practice.^{6 7}

Firstly, for severely incompetent patients the continuation of treatment must be deemed to be of no medical "benefit" or too "burdensome." However, for opponents of euthanasia such judgments of benefit and burden must not be linked to any claim that the patient's life is no longer worth living. Once it is accepted that doctors should be allowed to make clinical decisions to end life passively on the basis of such claims, active euthanasia in the best interests of such patients would be the next logical step. Secondly, opponents argue that withdrawing treatment for severely incompetent patients must never be done with the intent of causing death—even if death is a foreseeable consequence. It can only be done to relieve suffering. To do otherwise, they claim, would be tantamount to active euthanasia, and this they see as morally wrong. These arguments are unacceptable for two reasons.^{8 9}

On the one hand, we need to ask what makes life sustaining treatment of no benefit or too burdensome if it can achieve its designated aim of saving life. Severely incompetent patients can only be said to be unable to benefit from further life sustaining treatment or to find it too burdensome if—bottom line—they are judged incapable of benefiting from further life itself. Therefore, when the continuation of life sustaining treatment is described as being of no benefit or of too much burden, the clinician must already have decided that the life of the incompetent patient in question is not worth living and therefore not worth prolonging. This is why withdrawal of treatment is deemed to be in the best interest of the patient and consistent with the duty of care to protect this interest.

On the other hand, if death is in the best interests of some patients—if the withdrawal of life sustaining treatment can be said to be of benefit in this case—then death constitutes a moral good for these patients. And if this is so, why is it wrong to intend to bring about this moral good? For example, suppose a doctor refuses to

withdraw life support from an incompetent patient when the clinical team agrees it to be appropriate. He does so for no other reason than his realisation that part of his intention is that she dies a quick and painless death. Far from being morally commendable, his refusal should be viewed as incompatible with what is of real moral importance—the best interests of his patient.

Provided the circumstances are clinically warranted, doctors should be able to withdraw life sustaining treatment when they intend to accelerate death as well as to relieve suffering. Morally, the distinction is irrelevant in this particular context. If passively ending the life of severely incompetent patients is legally and professionally acceptable then involuntary active euthanasia should have the same status.

Returning to Mrs Pretty, why should we not also legalise voluntary active euthanasia in light of these arguments? Were she permanently and severely incompetent, we have seen the circumstances in which her doctors would be allowed to end her life passively and should be allowed to do so actively. Therefore, should she not be able to invite them actively to end her life and to advise them about how this should be done? No one has questioned her competence or courage. Yet her own perception of her best interests, and the perception of those who know and love her, have been judicially overruled.

This decision becomes all the more morally questionable when we realise that Mrs Pretty can refuse life sustaining treatment at any time, and her doctors are legally obliged to respect her choice.¹⁰ Some doctors would probably be only too glad to help Mrs Pretty to end her life. This support should be regarded as a moral good instigated in her interests and at her request. It should be legally condoned—either by the interpretation of existing law by a more courageous judiciary or by new legislation.

Finally, if it can be morally right to kill some competent patients at their request, then it must be

morally justified to give them the medical wherewithal to kill themselves. It is open to debate whether what Mrs Pretty requires can best be described as voluntary euthanasia or assisted suicide. To provide either of these to appropriate patients who make a competent request represents respect for their autonomy and their desire to die with what they perceive to be dignity.

Of course, any coherent advocate of active euthanasia and physician assisted suicide must take seriously the problem of slippery slopes—of deciding when a request for helping dying is appropriate. Though this may be difficult, it cannot be impossible. The most important question remains: in the face of so much moral right, where is the wrong?

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Reducing violence in severe mental illness

Community care does not do well

Two years ago, Munk-Jørgensen initiated a continuing debate about the development of psychiatric care for severely mentally ill people in a paper entitled "Has deinstitutionalization gone too far?"¹ He pointed out that the reduction in numbers of psychiatric hospital beds had been accompanied by a continuing increase in the number of forensic psychiatric patients as well as an increase in suicides and readmissions in Denmark. Similarly, Webster et al reported a doubling of the number of forensic patients within the past decade in Canada.² In the USA, meanwhile, a considerable proportion of severely mentally ill people do not live within the community but are imprisoned³ or homeless.⁴ The study by Walsh et al in this issue (p 1093) is the first randomised controlled study to examine whether an increased intensity of psychiatric community care can reduce violence among severely mentally ill patients managed in the community.⁵ Its results are disappointing.

A considerable proportion of patients in this study—more than one in five—carried out physical attacks both in the intensive intervention group and in the standard care group. The intensive care group had received over twice as many contacts (which included those related to medication and to the criminal justice system). Before we draw harsh conclusions about the ineffectiveness of outpatient psychiatric care, however, we should keep in mind one limitation of Walsh et al's study. They recorded whether patients ever committed physical attacks during the observation period, but frequency and severity of violence were not recorded. Thus, it is possible that the frequency and severity of the violence were reduced in the experimental group, even though the number of patients committing violent acts was not. Nevertheless, we are still confronted with the politically meaningful question of whether our present forms of outpatient care are adequate for certain groups of psychiatric patients.

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