In Praise of Fudge: Euthanasia

Christopher Cowley

The debate surrounding voluntary euthanasia (physician-assisted suicide) is usually couched in very personal terms: what are the individual's rights? How can we best respect his autonomy? Is he rationally competent to decide such a serious matter? Non-voluntary euthanasia (of, say, a comatose patient) is equally focused on the individual, using the language of 'best interests'. The thought is that if we can work out what we *owe* the individual, then everything else ought to follow; above all, the law can be modified to protect or enforce that obligation to the individual. After all, it is widely accepted that the law's function is purely to mediate and regulate relations between individuals.

I want to suggest that this is a simplistic understanding of the law's function, at least in the euthanasia debate. The law also has an important *symbolic* function, namely to express a society's deepest-held values, in this case the absolute sanctity of human life. Such a categorical symbol, however, is compatible with a certain inconsistency and non-transparency in the application of the law: in short, a deliberate fudge. The result is that euthanasia is officially condemned but, in limited cases, privately tolerated. I will be defending this arrangement.[1]

The Euthanasia Debate

I will assume that the main points on either side of the debate are well known by now, and I will only recapitulate them briefly.[2] On the one hand are the stock of arguments that flow essentially from John Stuart Mill's Harm Principle, the basis for so much of liberal thought. Everybody can do exactly what they like, so long as they do not *harm* anybody else in the process: only then can the state justifiably intervene. Famously, this allows an individual to harm himself. This is not the end of the matter, of course, for 'harm' is sometimes difficult to define.

This basic liberal right has given rise to other individual rights, which were famously cited by Diane Pretty in her request for assistance in suicide. Pretty was suffering from a slow degenerative disease, and reached a stage where she was physically incapable of killing herself except by the prolonged and painful process of starving herself to death. She therefore asked that her husband Brian be granted immunity from prosecution if he helped her commit suicide. According to the Suicide Act 1961, committing suicide is not a crime in England, but assisting someone else's suicide is. Pretty argued that, according to the European Convention of Human Rights (now enforceable against public authorities in the United Kingdom[3]), she had three rights that were presently denied to her by the Suicide Act: (i) the ‘right to life’ entailed a right to die at a time and in a manner of her own choosing; (ii) the right to be free from ‘degrading treatment’ entailed a right to rid herself from the disease that was causing such treatment; (iii) the right to ‘respect for private and family life’ suggested that Pretty's decision to commit suicide was a private one. Pretty appealed the judgement several times, and was ultimately rejected by the European Court of Human Rights in Strasbourg.[4]

On the other side of the debate are two principal arguments, the first individual-focused. Any acceptance by the state of a conscious individual's decision must be based on that individual's competence. That means that the individual must be able to understand the situation he is in, understand the options available to him, and be sufficiently able to weigh the options and make a decision between them, without undue coercion or enticement by third parties. This principle grounds the doctrine of informed consent in all legal transactions, from buying a pair of socks to accepting or refusing any kind of medical treatment.

As such, a competent patient can refuse all medical treatment, knowing that he will die as a result. This is perfectly legal and, in the strict legal sense, is not euthanasia.[5] What is prohibited by law is sometimes called 'active' euthanasia, where a drug is administered in order to shorten life. But even if treatment-refusal is legal, doubts can be raised about whether *anyone* can be competent enough to truly understand what it means to die: the sheer irreversibility of it, the bleak fact of being denied any further choices beyond this one. In addition, any competent decision has to be free of 'undue coercion or enticement'. The worry is that if the law explicitly permitted euthanasia in carefully-defined cases, this would increase the risk of family members – especially those standing to inherit – 'leaning' on the patient and thereby influencing his decision, at the very least inducing a guilt that he is a 'burden'. This is already possible under the present system, but would be made worse if the law were liberalised further. While not a conclusive argument against euthanasia, it does at least suggest that *extensive* discussion with the patient will be required to ascertain their wishes.

With regard to clearly incompetent patients, especially those in a coma, or permanent vegetative state (PVS), the landmark legal case in England was that of Tony Bland in 1993.[6] Bland had been in a coma for four years, and there was no grounds for hoping in a recovery. The case was important in three respects. (i) It was agreed that it was not in a PVS patient's best interests to continue life in this state. (ii) Bland was breathing normally, and so no ventilator could be switched off. However, he obviously required food and water to be administered artificially. These were now to be designated 'medical treatment', and therefore could be withdrawn on the grounds of medical futility. The controversial result was that Bland was effectively starved to death.[7] (iii) This judgement explicitly declared that this act was not to be considered one of 'euthanasia'.

The more familiar argument against euthanasia is the so-called 'slippery slope'. Instead of an individual-focused argument, this one is society-focused. Under the present system, killing another human being is very serious, and this is reflected in the severe punishment for murder and manslaughter. Legally permitting certain types of physician-assisted suicide would gradually come to undermine the widespread social reluctance to kill, thus leading to further relaxation of the law in future. Such future relaxations would have unpredictable consequences, but the slippery slope proponents worry that they could result in eventually permitting acts which we would not even consider now, e.g. killing people with slight mental or physical disabilities. One only has to look at attitudes to abortion since the Abortion Act in 1967 to see how societal attitudes there have changed, and many people feel great unease about the present policy of abortion 'on demand'.[8]

Finally, the slippery slope will also undermine two other important elements in medicine: it will corrupt doctors themselves, and it will corrupt society's *view* of doctors. After all, doctors are meant to be – and are meant to be seen to be – in the business of curing and healing with all the skill, tools and knowledge at their disposal. At the very least they can slow the progress of inevitable disease. The slippery slope argument warns against a future where doctors would come to consider – and again, would come to be seen to consider – killing as a viable option a little too soon.

The Nature of the Fudge

I do not want to develop or defend any of the above arguments for or against euthanasia. But what I say will be related to the societal attitudes which the slippery slope was meant to endanger.

As I said, active euthanasia is illegal; on the other hand withholding treatment, even when this is certain to result in the patient's death, will be legal when the patient competently requests it, and may be legal when the patient is incompetent. But the situation surrounding the word 'active' is not so clear. If I inject a patient with potassium chloride, this has no known therapeutic benefit and my intention can only be one of deliberately causing death.[9] However, many analgesics, while relieving pain, also have the well-known side-effect of injuring an already fragile body and thus hastening death. When treating a terminally ill patient in great pain with diamorphine, am I *primarily* relieving the pain, or am I accelerating death? This is called the 'double effect' – two effects are known to result from a single procedure, but only one of them is directly intended. If I administer the diamorphine, knowing that death will be accelerated, the principle of double effect says that I can defend myself against the accusation of murder or manslaughter by describing my principal intention as being that of relieving pain – if I could have achieved pain-relief without death, I would 'of course' have chosen it.

There are some obvious problems with the principle. First of all, it requires some sort of clear understanding of the *severity* of the pain, such that nothing else can be used except a drug with such lethal side-effects. Second, it is open to obvious misuse: I can eliminate a business rival by pushing him under a passing lorry, and then claim that my (quite innocent, your lordship!) intention was merely to remove him from the market. Third, if both effects of an action are *known*, then there is a real sense in which I can be said to have *intended* both effects: they were a package deal, it was both or nothing, and I knowingly chose both. So the principle of double effect is hardly a very robust defence against a full-blown accusation of manslaughter. Nevertheless, it is enough for the legal fudge to work.

The fudge I'm talking about is the known gap between theory and practice. Officially euthanasia is prohibited, and this prohibition would also override any attempted defence on the grounds of double effect. In practice, however, the law regularly turns a blind eye to the occasional dose (or slightly higher than usual dose) of analgesic.

We need to understand the difference between a fudge and discretion. Discretion is where the law *cannot* by nature be any more precise. A policeman on the beat is given certain powers, e.g. to stop and search, and in his training he will receive *general* guidance on the sort of circumstances that would legally justify a stop and search. But

it is impossible to specify every possible circumstance, to specify one set of circumstances down to the tiniest detail, and to expect the policeman to compare the situation before him to that in the rulebook so precisely. So the policeman has to use his discretion, sometimes called his judgement. The quality of his judgement will also depend on the judgement he is forced to exercise in ordinary non-professional situations, but above all he will be helped by the quantity of experience on the job, and by observing experienced colleagues 'get it right' even when they lack sufficient evidence (the sort of thing presented in court) or explicit guidelines.

Back to the fudge surrounding euthanasia. The reason this is not a question of judgement or discretion is that the law *could* be made much more precise, and *could* be enforced much more effectively. But the thought behind the fudge is that it is somehow better if it remains vague and general. Interestingly, the current fudge can be criticised by both opponents and proponents of euthanasia: opponents claim that a vague law allows too much euthanasia, proponents that it does not allow enough of the right kind. Surely *any* law, both sides argue, if there is to be any point to it, has to be made as precise as possible and enforced as much as possible, otherwise it would just be a bit of paper.

In addition, the spectre of Harold Shipman now haunts the euthanasia debate. For wasn't he able to get away with the two hundred or so murders precisely because of an irresponsible lack of supervision within the medical profession and the law? Opponents of euthanasia will call for much tighter and more explicit legislation to prevent future Shipmans. For the perverse possibility exists that Shipman might even have thought that he was acting in his victims' best interests. Indeed, he might even have believed that he had obtained their explicit consent to that end. The answer, conclude the opponents, is more precise guidelines, tighter supervision, accountability and record-keeping.

Proponents of euthanasia, such as the Voluntary Euthanasia Society, will agree to tightening up the net to prevent future Shipmans, but will argue for explicit criteria that patients would have to meet in order to be granted their wish to die. In other words, euthanasia should be bound by the principles of the ideal contract: each side is free and informed about the present situation, about the available options and their consequences, and no undue enticement or coercion is involved. The purpose of the law is to regulate the contractual intercourse, enforce it if necessary, and prevent the violation of its terms, and all of this should be open and explicit.

In Defence of Fudge

The problem with this criticism is that the law is often *more* than an instrument for regulation and enforcement; it is also a powerful symbol of the most important values in a society. Think about the intricacies surrounding immigration and citizenship law, for example. And so it is the case with euthanasia.

On the one hand, the present law expresses an unequivocal message about the value of life – of *any* human life, even the most handicapped or the most comatose – and about the seriousness of harming or taking it. Normally, the only plausible defence for killing another is in self-defence, or in deferred self-defence as part of a defending army. And even though some see a tenuous link between abortion and self-defence

(the mother defending herself from the 'parasite' foetus), this is not plausible at all in the case of euthanasia.

On the other hand, the law *implicitly* acknowledges that some situations can truly be so awful for a patient that it does make sense to say that they would be 'better off dead.' Cases of great suffering during a terminal illness, reinforced by direct entreaties by the patient, would seem the most likely case. But this acknowledgement has to be implicit, because the whole point of the principle of sanctity of life would be lost if it were thought of as subject to explicit qualification in this way.

However, this fudge goes against the dominant tradition of moral philosophy in the modern West, a tradition that is often called 'realist' – in the sense that there is a real truth of the matter of what ought to be done in this situation, and we (doctor, patient, legislator) just have to discover that truth and act accordingly. Praise and blame then follow for performing or neglecting the morally correct action. There are two implications of this moral realism. (i) The truth is in principle universally *transparent*: we can *all* search for it and discuss it – and are accountable to it – without regard for our respective positions in society. (ii) The law, beyond its role of regulating society in arbitrary ways (e.g. driving on the left), is also designed to reflect mainstream moral norms and provide an instrument for enforcing compliance.

Moral realism is certainly plausible as a framework for understanding most of the moral business of society. But it contains a certain oversimplification of the modalities of prohibition, permission and obligation that can become problematic. It is possible and very familiar, for example, to be obliged and yet not obliged to do an unpleasant family duty. The practice of gift-giving and forgiveness is not entirely subject to precisely codifiable rules of obligation, nor is it always clear what praise or blame is appropriate. The normally laudable demand for consistency and transparency can be out of place in the clutter and confusion of human affairs. This is not because the clutter and confusion *prevents* the achievement of the transparency ideal in the same way that, say, human selfishness might prevent the creation of the socialist utopia, for it can still make sense to strive for a utopia. Instead, I am suggesting that some aspects of human affairs are *essentially* resistant to the transparency ideal. As soon as one lays down rules for gift-giving (as one does with children, for example), then what is being given is no longer a gift in the full sense of the term.

And so it is that the law can declare euthanasia to be an unequivocal wrong, and yet implicitly acknowledge that it is sometimes for the best. Such matters on the fringes of life are essentially opaque. One way to see this intuitively would be to consider the responses of praise and blame. According to the realist model, praise and blame is logically connected unproblematically to the performance or neglect of the morally correct action, a crude sort of reflex-reaction, if you will. However, even if it were best that this patient should die, it would surely be perverse to *praise* the doctor for carrying it out. The act of euthanasia is a loss for everyone involved, an occasion for sadness even if not always for grief, a time to curse the gods for their inscrutable cruelty. Such desolation is not alleviated by talk of patients' rights or by smug back-patting.

The Intimacy of the Final Hours

What the present system does mean is that we have to trust doctors. Trust is a tricky notion. At the core it means going beyond the available evidence and giving the other the benefit of the doubt. But there is a distinction between reasonable and unreasonable trust; I trust my doctor to diagnose my kidney infection because I lack the relevant expertise by which to formulate a specific and serious doubt. As long as I believe that he has been properly trained and accredited, then I take the pills he prescribes me.

It is very easy to point at Shipman and say the we need more institutional safeguards, but this will then force us to trust the safeguards and those who designed them. At some point there has to be trust, or else no institution would work at all, and I would never get out of my bed in the morning out of sheer paranoia.

There is more to trust than this, however. I trust my GP to prescribe me the right pill, but in so doing I am trusting, as it were, the profession rather than Dr. Jones. As traditionally conceived, however, the GP gets to *know* his patients over the longer term. This knowledge is more than expert knowledge of the human body and its mechanical defects; it is also a knowledge about life, about people, and especially about *this* person, his patient. There is a lot the GP will come to know about the patient which he can't even articulate beyond saying 'that's not what Mrs. Smith would want.' Those demanding greater transparency and consistency, more detailed medical notes and clear application of rules will be disappointed by this process, and will be afraid of its potential for abuse. But I think it's safe to say this arrangement is not being abused. Those individuals who choose to become GPs have to already have an interest in and concern for ordinary people, otherwise they would not be attracted to the job or endure it.

What I am building up to is the scenario where a GP is alone with a terminally ill patient. There is no more that medical technology can do except ease the pain. These moments are extremely intimate precisely because of the proximity of death; there is no reason for the patient to hide anything. And it is this intimacy, this utter privacy, that grounds the trust and the knowledge required for the GP to make a decision about euthanasia, far removed from the glare of the parliamentary legislative committee. It is not an accident that many GPs say they feel 'privileged' to have shared such final hours with their patients.

Christopher Cowley
University of East Anglia

[1] Alexander McCall Smith also supports the current fudge, although for slightly different reasons. See his 'Euthanasia: the strengths of the middle ground' in: *Medical Law Review*, vol. 7, Summer 1999. A much more extensive defence of the status quo, including a comparison with the experience in the Netherlands and Australia, is provided by John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation*, CUP 2002.

[2] The literature on euthanasia is vast. For a concise, straightforward and balanced account of these points, see Stoffell B. 'Voluntary euthanasia, suicide and physician-assisted suicide' in: Kuhse H. and SingerP., *A Companion to Bioethics*, Blackwell 1998. The British Medical Association's view is available from: http:// www.bma.org.uk/ap.nsf/Content/ Physician+assisted+suicide:+The+ law

[3] According to the Human Rights Act (HRA) 1998. It should be noted that the UK was always a party to the European Convention. What the HRA changes is the local enforceability.
[4] A good discussion of the Pretty case is available in Brazier M., *Medicine, Patients and the Law*, 3rd ed. Penguin 2003, p. 445-447. The ruling is available on-line at: http://www.echr.coe.int/Eng/Press/ 2002/apr/Prettyjudepress.htm
[5] At the same time as the Pretty case, there was a woman named Ms B., who was being kept alive on a ventilator. She asked for the ventilator to be switched off, knowing full well that she would die as a result, and was judged to be competent in her request. Peter Singer famous argued that there is no ethically relevant distinction between competently refusing life-saving treatment and competently demanding a lethal injection. See his 'Ms B and Diane Pretty: a commentary,' *The Journal of Medical Ethics*, 28 (2002)
[6] See Brazier, *op. cit*. p. 449-453
[7] This ruling is now being challenged by Lesley Burke. Burke is suffering from a degenerative brain condition which will eventually put him into a PVS. He wishes not to be starved to death once in the PVS. See the following BBC news item: http://news.bbc.co.uk/1/hi/ health/4544799.stm
[8] Strictly speaking, the 1967 Abortion Act states that any abortion prior to 24 weeks' gestation requires the consent of two practising doctors. In practice, however, it is easy to find two doctors to consent without asking many questions. This is another example of a fudge in the law, but one that needs correcting, I would argue.
[9] I am referring to the case of Nigel Cox, who in 1992 administered a lethal dose of potassium chloride to a dying patient, for which he was convicted. For further details, see Keown, *op. cit*. p. 11 *ff*.