Point of view

Euthanasia and the doctors – a rejection of the BMA's report

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Author's abstract

The working party on euthanasia set up by the British Medical Association produced its report in 1988 (1). The first of its terms of reference was 'to examine the ethical problems relating to euthanasia, terminal illness, and suicide' and as far as active voluntary euthanasia (AVE) is concerned it failed conspicuously to do its job. The purpose of this article is not to restate the case for AVE but to examine the reason for the failure. (Figures in square brackets refer to sections in the report.)

The report defines AVE as 'an active intervention by a doctor to end life' [2] though it sometimes refers to it as 'killing the patient', perhaps to add emotive appeal to its case. Passive euthanasia it defines as 'a decision not to prolong life' or a 'non-treatment decision' [3]. The working party is to be congratulated on its very thorough discussion of passive euthanasia. For the first time doctors in Britain have been given by their professional association clear guidelines on the withholding or withdrawal of treatment in a variety of circumstances: non-resuscitation after cardiac arrest [80], withdrawal of a respirator [81], abstaining from intrusive feeding regimes [84–90], and the administration of analgesics in doses needed to relieve pain even though this will hasten the death of the patient.

But the story of its treatment of AVE is very different. The report itself laments 'a striking lack of realistic education in ethics and the more humanly-demanding areas of medical care. Sometimes "hard science" replaces caring medicine in our undergraduate and graduate medical teaching' [179]. This lament suggests that the ethical problems in the area would go away if our doctors were trained to be more sensitive at the bedsides of their patients. But the problems are far too deep for such a remedy. What is lacking in medical education is training in how to think about the general principles of morality and their application in practice – in short – in moral philosophy.

Philosophy is, in part, the rational investigation of

controversial questions and its principles are just as sacred to the disciples of Socrates as those attributed to Hippocrates are to his. Moreover, they are more securely grounded. For we can ask why human life has any value at all even though the question seems 'academic' in the bad sense because we already know the answer. On the other hand, the question 'Why look at this problem rationally?' hardly makes any sense, since its very form expresses a commitment to rationality. Several of these principles are violated in the report.

First, it should go without saying that in a controversy such as that about AVE an opponent's position should be presented, with its supporting arguments, in the strongest possible form. For if this is not done the supporters of AVE who, as we shall see, constitute a majority of the general public and a substantial minority of general practitioners will not be convinced. Yet the case for AVE is not presented till half-way through the report, and long before then AVE has been tacitly assumed not to be a morally permissible option [48,75,92].

The working party tries at the start to excuse itself from any serious consideration of the possibility that AVE might sometimes be permissible by quoting (and misapplying) one of the most eminent of contemporary moral philosophers, R M Hare. 'Doctors would do well', he wrote, 'having adopted some fairly simple set of principles which copes adequately with the cases they are likely to meet, to dismiss from their minds (*at least when they are doctoring*) the possibility of there being further exceptions to their principles. For doctors, like all of us, are human, and if once they start thinking, *when engaged on a case*, that this case might be one of the limitless and indeterminate set of exceptions to their principles, they will find such exceptions everywhere' [12, emphasis added].

Wise words; but the members of the working party were not doctoring or engaged on a case. Their task was precisely to examine the moral foundations of their traditional practices, to think the unthinkable.

Secondly, inconsistency must be avoided. Blatant self-contradictions are not likely to be found in a report written by intelligent and educated men; but in an area in which the important concepts do not have sharply defined boundaries, it is easy to hold positions which,

Key words

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while not strictly inconsistent, make awkward bedfellows. For example, AVE, passive voluntary euthanasia (PVE), and assisting suicide are distinct concepts in the sense that it is easy to specify cases which fall unambiguously under one or other of them; but they come so close in some cases that it is difficult to claim, as the report does, that legalising AVE will lead to unacceptable consequences while at the same time allowing the various types of PVE which it recommends. (The reply that even in such cases AVE and PVE remain different in *intent* will be considered later.)

Thirdly, an opponent's case must not be seriously misrepresented. The most glaring example of misrepresentation occurs in passages in which the report deals with proposals to legalise AVE. 'We have stressed the choice of the patient but claimed that it stops short of the point where a doctor would be *required* to do something which goes against the basic ethical commitments of medicine' [74, emphasis added]. 'Autonomy does have its limits. In particular it cannot *compel* a doctor to end a patient's life' [139, emphasis added]. Any reader of the report who is not familiar with what supporters of AVE actually say is bound to get the impression that they want legislation which would require doctors, in certain circumstances, to kill patients at their request. But euthanasia on demand has never been on the agenda of any of the twenty-eight Right-to-Die societies in the World Federation. The submission made to the working party by the Voluntary Euthanasia Society in England made it very clear that the legislation it sought was permissive only. The situation it aimed to bring about is one in which neither a patient who asked for euthanasia nor a doctor who gave it would be guilty of an offence, and this situation, it believes, would be advantageous to both doctor and patient. To rub in the point the VES added that 'there is no question of anyone being required to act against their consciences'.

Finally, in any branch of practical ethics the claims and counter-claims of the two sides are bound to be heavily dependent on assertions of empirical fact. So it is incumbent on the disputants to ensure that their claims are adequately backed by evidence and that the evidence advanced by the other side is not misrepresented, distorted, or suppressed.

To take first the working party's presentation of its own case: it argues that AVE, even if morally permissible, is unnecessary. Both within and without the hospice movement the substitution of palliative for intensive care, a substitution it wholeheartedly commends, obviates the need for AVE. 'It is uncommon for patients in hospices to ask for euthanasia... The multidisciplinary hospice approach to such patients can prevent this sorry state from ever being reached. The necessary skills are now available and it is gratifying that they are being taught and practised in much wider contexts' [168]. But, aside from the fact that some people might prefer death to the best care in the world and the fact that the reason

why people in hospices do not ask for euthanasia may well be that they know that the request will not be granted, the claim that palliative care makes euthanasia unnecessary needs to be supported by evidence of the availability of such care to all who need it. It is demographically certain that the increased proportion of old people in the population will place heavy burdens on the health service. The report, for all its emphasis on proper care for the dying, produces no evidence that such care is likely to be available on the required scale.

Turning now to the duty of a disputant not to misrepresent or suppress evidence cited by the other side, the report devotes four sections [151–154] to results of opinion polls submitted to the working party by the VES as evidence of support for AVE amongst the general public and general practitioners. It is safe to say that no one reading these sections would have a clear and true idea of the evidence submitted. The report tells us neither what questions were asked in the poll of public opinion nor what the answers were, which is suppression on a grand scale. The poll of medical opinion is suppressed entirely, perhaps because its publication would cast serious doubt on the report's view that AVE is condemned by the medical profession as a body.

Suppression apart, there is much misrepresentation of the evidence submitted. At the outset we have an insinuation that the VES was incompetent, even dishonest. 'The Voluntary Euthanasia Society has attempted to strengthen the case for active termination of life by conducting public opinion polls which purport to show widespread agreement with the idea of voluntary active euthanasia' [151]. And at the end 'we do not accept that tailoring what is morally right to the opinion of a majority is necessarily correct' [154]. Quite so; but this is not an argument which it was open to the working party to use in view of its frequent use of the argument from majority medical opinion on the other side. And the argument, whether or not the working party had a right to use it, would only be effective if the VES had used opinion polls to support the moral case for AVE. But the argument from public opinion was a political, not a moral argument.

The VES is an organisation dedicated to changing the law, and in our political system public opinion and the opinion of relevant professional bodies on a moral issue is rightly used to influence legislators. So it was not irrelevant for the VES to show that AVE, in a narrow range of circumstances, is supported by nearly three-quarters of the general public; and since the BMA's *Handbook of Medical Ethics* had stated that 'the profession condemns legalised active euthanasia' (2) it was not irrelevant for the VES to submit evidence which casts doubt on that statement.

In Section 153 the report suggests that the favourable poll figures might be inflated owing to the phenomenon called the Acquiescent Response Set. It is well known that a question can, if posed in one form, elicit more favourable responses than it would have

done if it had been posed in a different form, and polls conducted by amateurs are often suspect for this reason. But in fact the polls were conducted not, as the report says, by the VES (another misrepresentation) but by NOP Market Research Ltd (3).

The working party did not give its readers a chance to see the text of the main question asked in the poll of public opinion. It ran as follows: 'Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided that they have previously requested such help in writing. Do you agree or disagree with this?' Couched as it is in purely neutral terms, this question gives no support to the insinuation that the 72 per cent favourable response (also omitted from the report) might have been seriously inflated by the Acquiescent Response Set, especially as it is strikingly similar to the results of similar polls in other countries very like our own such as France, Canada, and the United States (4).

The response from general practitioners was, as one would expect, much less favourable to AVE. Only 30 per cent 'strongly or mostly agreed with euthanasia as a concept' as against 59 per cent who strongly or mostly disagreed. The doctors were then asked the following question: 'At the moment euthanasia is illegal. Suppose the law was changed to permit voluntary euthanasia and there was a patient on your list, whose case you knew well, who suffered from an incurable physical illness that was intolerable to them. If that patient made a signed request that you end his/her life would you consider doing so or not?' Thirty-five per cent of the GPs polled said that they would definitely consider it and a further 10 per cent said that they might possibly do so. This is a substantial minority and it suggests that the report's view that AVE is condemned by the profession as a body is exaggerated. It also shows that for this substantial minority reluctance to administer AVE is not so much a moral commitment as an unwillingness to break the law.

Active and passive

If someone suffering from high spinal injuries asks for his respirator to be removed (a request for PVE) and the doctor agrees, death is certain and immediate. So, as the report says in Section 83, his request is effectively a request for AVE. In some of the examples of PVE recommended by the report death, though not instantaneous, will rapidly supervene. It is in these cases that the report fails to take sufficient care to ensure that the arguments it uses to rule out AVE as morally impermissible do not also rule out the types of PVE it recommends. It uses two specific and two more general arguments for its position in these cases.

The argument from irrevocability 'Action to terminate a person's life is irrevocable and allows no respite for re-evaluation, whereas a decision not to prolong life is often capable of reappraisal once the patient experiences the true implications of the step he has taken' [92.3]. Neither of these points is entirely

true. It is not true that a non-treatment decision is always revocable. If a doctor orders at the request of a patient that the patient should not be resuscitated in the event of a cardiac arrest, the patient can change his mind until the arrest occurs. After that, he cannot; nor can the doctor revoke his order without disastrous consequences to the patient. The same is true in the case of a doctor who administers an analgesic at a strength known to be lethal.

On the other side of the coin, it is true that once a doctor has not only agreed to a request for AVE but has carried it out, the patient cannot reconsider his request. But there is plenty of time for reconsideration between the original request and its implementation. In Holland, where the practice of AVE is open and not uncommon, the request is not granted without extensive discussions designed, in part, to satisfy the doctor that it is 'rational and durable'.

The argument from intent 'The law identifies the *intent* to kill another human being as most serious. Intent must be firmly established (rather than just the fact of death at the hands of another) when a crime is treated as murder. If the outcome or result was all that was important in medical decisions, as some moral philosophers have suggested this would change the moral foundation of the law' [94]. This point of law, however, is one that contrasts intentional with *unintentional* killing such as cases of accident or mistake. Though unintentional killing may be the subject of a lesser charge where negligence is present, the charge of murder can only be brought if the accused *intended* to kill or to do grievous bodily harm to his victim. So this legal point is irrelevant to a discussion of AVE, which is always intentional.

The working party seems to have confused this distinction between intentional and unintentional homicide with the quite different distinction between *intention* and *motivation*. This is the distinction that is relevant, and is in fact the topic of the following sections. It is true as a general rule that it is enough for conviction that the accused intended to break the law; at this stage of the trial his reason for doing what he did, his motive, is irrelevant. But even this is not true in all cases. As the report notes [114] intentional killing is not murder or, indeed, any crime at all if the act was necessary for the defence of innocent life. Moreover motivation is often an important element both in a decision as to whether a person is to be prosecuted and at the sentence stage of a trial if there is one. Cases of mercy killing are often not prosecuted and when they are they rarely receive more than a nominal sentence. So the legalisation of AVE could not be said to change the moral foundation of the law.

Turning now from the legal to the moral issue, the report distinguishes between 'acts performed to relieve suffering and acts performed to kill the patient' [144]. However close they may come in other ways PVE and AVE are acts which always differ in intention, and to make its case for disallowing AVE in situations in

which it recommends PVE the report relies on what is known as the Principle of Double Effect. Briefly stated, this is the principle that if an act is expected to have two effects, one good and one bad, it is permissible if the agent's intention was to produce the good effect (the bad effect being merely a foreseen but unintended consequence) but not if it was to produce the bad effect. Thus a doctor may not kill his patient to end his pain but may act to relieve the pain even though he knows that his action will kill the patient. This Principle of Double Effect is the official doctrine of the Roman Church; but it is questioned even within that Church, finds little favour among Protestants and is rejected by most secular moral philosophers because it is known to lead to some highly counter-intuitive results. In any case the principle is irrelevant to the dispute between supporters and opponents of AVE since it only comes into play if it is already agreed that the death of a patient to whom a doctor has administered AVE is a 'bad effect' and that is just the point at issue. Supporters of AVE hold that in some cases the death of a patient, so far from being a bad effect, is a consummation devoutly to be wished. Anyone who wants to use the Principle of Double Effect to show that it is wrong to kill a person who is suffering from an incurable and intolerable illness must also hold that the *death* of that person, however brought about, is in itself a bad event.

In addition to its two specific arguments the report relies on two more general ideas, of which the first is the idea that AVE runs counter to the traditions of medicine as a discipline and to the training and intuitions of doctors and paramedics. AVE 'also goes against the intuitions of those doctors who care for dying patients and indeed of most medical and nursing personnel' [61]. 'Requests for voluntary euthanasia are requests for doctors to act in ways that are at variance with all their training and inclinations' [71]. 'The medical profession has a right to limit patient autonomy where the patient demands some "treatment" that runs counter to settled and informed medical opinion' [72].

All this is undoubtedly true, and doctors and nurses will inevitably find it difficult to change policies and practices they have acquired in the course of their training. But the question is whether, in view of greatly changed circumstances, they should not make a serious attempt to modify their traditional stance. Historically, medical ethics rests, not on the one principle that a doctor must not take life, but also on the principle that a doctor must always act in the best interest of his patients. What is new in our situation today is that these two fundamental principles sometimes point in different directions. For it is sometimes in a patient's best interest to die as quickly and painlessly as possible.

Until very recently there has seldom been any conflict between the two principles because doctors were not commonly able to keep alive those in whose best interest it was to die. But medical technology has

changed all that. Patients can be, and sometimes are kept alive even against their will in circumstances in which there is no possibility of recovery. The question is whether they should be.

To the extent of advocating various forms of PVE the report recognises the new situation, but in refusing to take the next step it is once more in danger of inconsistency. 'Medicine is a discipline in which doctors act to preserve or restore life to whatever extent they can' [92.1]. But a doctor who orders that a patient be not resuscitated or one who administers an analgesic sufficient to control the patient's pain even though it will also shorten the patient's life is certainly not acting to preserve or restore life to whatever extent he can. Yet both these forms of PVE are recommended in the report.

We know that some doctors practise AVE today, though we do not know how many and the evidence is entirely anecdotal, doctors being naturally unwilling to admit in public to a practice the law calls murder. We also know that it is not practised as much as it was before World War II or even thirty years ago, and the change is due, in part, to a sociological revolution. Most people used to die in their own homes or the homes of relatives, and in the vast majority of cases a death certificate signed by a doctor who had in fact killed the patient would not be questioned. It is interesting that Lord Dawson of Penn who, as we now know, intentionally ended the life of George V in 1936, was opposed to the legalisation of AVE on the grounds that good doctors did it anyway in suitable cases and that it was better to keep the law out of the doctor-patient relation as far as possible (5).

But times have changed. Nowadays three-quarters of us die in an institution where AVE cannot be carried out by a single doctor without the knowledge of colleagues and paramedics. As we have seen, a substantial minority of doctors say that it is only fear of legal consequences that prevents their practising AVE, and though the lawyers tell them they have nothing to fear, they are not convinced. In these changed circumstances the relation between the two fundamental principles of medical ethics clearly needs to be thought through afresh.

The second general argument is drawn from the idea of the inestimable value of human life. 'We believe as a premise that human life is of great value and should be cherished' [11]. 'Nevertheless ... one pervasive feature of medical practice has remained unchanged - the conviction that human life is of inestimable value and ought to be protected and cherished' [72]. Here the working party has fallen into the very common trap of thinking that something can be valuable in the abstract without specifying to whom or in whose eyes it is valuable. The trap is disguised by the fact that the context of the discussion will almost always give us the answers so clearly that the questions need not be asked. When it is said in a theological context that every human life is of inestimable value, we know that what is meant is that every human life is of inestimable value

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to God and in God's eyes. But the report explicitly disclaims any reliance on theological premises [148] and without that support the questions must be faced, and they are not always easy to answer.

Most people cling to their own lives even when those lives seem to others, and even to themselves, starkly miserable. But some do not; there comes a time when they find life insupportable and they long for release. If the autonomy of the patient is to be paid more than lip-service we must allow people to answer questions about the value of their lives for themselves. Certainly there are cases in which a person's life is of value to others, for example if he is the sole breadwinner of a family which will be left destitute at his death. But this type of case must be very rare in the circumstances envisaged by the legislation proposed by the VES. Certainly too, survivors grieve when someone dies; but that grief is coming to them in any case, and the tragedy lies, not in the AVE but in the conditions that led to its request.

The report even goes so far as to suggest that life should be prolonged against a person's will because doctors themselves may get something out of it. That, at least, seems to be the meaning of the following sentence taken from Section 62 on the disabled who are

not terminally ill. 'It is a far more demanding and challenging task to attempt to discover value in the terrible situation that exists, but it is more in accord with the ethos of medicine to make that attempt than to kill the patient'. That the working party can refer to *voluntary* euthanasia as 'killing the patient' is a measure of the open-mindedness and sensitivity with which it approached its task.

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be (with correlative debate about what counts as a health-care need and what as a mere health-care *want*; and how can satisfaction of such needs best be *measured*); how much tax for health care can Government justifiably levy?; what are the proper principles whereby Government should undertake the macroallocation of the overall 'tax cake' between competing State objectives such as education and defence – and given some overall Government allocation to health care, how should it be distributed equitably in the face of competing health-care needs, if it is agreed that not all those needs can be met. In the face of the inexorable – and indeed often literally

wonder-ful – development of new and effective health-care techniques, such a debate and a proper mechanism for encouraging and sustaining it – becomes ever more necessary.

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News and notes

Ethical issues in *in vitro* fertilisation

A new 'scope note', Scope note 10, on Ethical issues in *in vitro* fertilisation, has been published by the Kennedy Institute in America. It lists important committee statements and offers an annotated bibliography on the legal, philosophical, public policy and religious aspects of the procedure.

Scope notes, the Kennedy Institute points out, are not designed to be comprehensive reviews, but to

bring together recent information related to specific topics in biomedical ethics.

Copies are available from: the National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057, USA. Cost is \$3.00 prepaid and \$5.00 outside the USA and Canada.