Assisted Dying? An Ethical Exploration of some Concerns around Legalisation

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From its Greek origins euthanasia, a 'good death' has come to have a multitude of meanings in a modern context such as a merciful death, the 'ending of suffering', 'palliation' or even 'assisted-suicide'. The issue of euthanasia, is by no means simple, and there is often a propensity to focus on the historical and philosophical. The modern worldwide flourish of scientific research has, thus far, failed to find answers to much of the unknowns surrounding death and dying. Even the precise physiology, underpinning the decline of the autonomic system, remains elusive and contentious.

While traditionally most, if not all, forms of euthanasia were considered 'immoral', much of the contemporary assisted-dying discussion revolves around a more modern interpretation of euthanasia, where due consideration is given to the voluntary or involuntary nature of assisted-dying, and the intention of the active or passive action. The types of assisted-suicide will be discussed, followed by some of the ethical concerns surrounding practical and legislative implementation of euthanasia.

Voluntary active assisted-dying (VAAD) is the active assisting of a patient to take their life, on the basis of a request to do so. Passive voluntary assisted-dying (PVAD) is the more passive provision of tools, such as writing a prescription, providing medication, that a patient can use themselves to take their own life, on the basis of a request from the patient.

It is worth acknowledging that both of these, VAAD/PVAD, rely on the patient having an understanding of the process to make it voluntary. Involuntary assisted dying also exists, both actively (where a physician might administer drugs resulting in the patient's death, with or without 'double effect', Double effect is a principle that says it is permissable to act in a way that may have both good and bad consequences, as long as the bad effect is not intended) and inactively, where a physician prescribes medicines that can result in death, but does not inform the patient of this eventuality. It is these latter two scenarios of involuntary assisted dying that troubles many when faced with the possibility of legislating for euthanasia in any form (Bishop, 2006b). This worry stems from the potential to abuse a system where VAAD and PVAD may be legislated for, but be exercised on those who have not voluntarily requested it.

Beyond the obvious ethical questions of autonomy, non-maleficence, beneficence, mercy and utility, which Hume, Rawls and many others discuss, there are distinct ethical issues that arise when it comes to legislating and implementing a formal procedure for assisted-dying. In Europe: Belgium, Luxembourg and the Netherlands all have legalized certain forms of euthanasia, and most work within the constraints of a medical model. These medical models often relate to patients who have capacity, who are terminally ill and who have requested assisted-dying (Hurst & Mauron, 2003).

A framework exists of ethical decision-making that identifies four topics for consideration in medical models. Similar systems, or variants of this model, are used in the European states that facilitate medically-modelled euthanasia. The four domains are: the medical indication, the quality of life, the patient's personal preference or previously expressed preference, and contextual considerations (Jonsen, Siegler, & Winslade, 2010). The model accounts for the principles of beneficence, non-maleficence, autonomy and the principles of justice.

Models provide structure and the necessary framework to make as many of the difficult decisions as objective as possible. There is always a risk here that physicians, in spite of the more objective scales, grades and formulaic tools of a framework, could run into trouble have difficulty with subjective judgements, making decisions based on futility, or in more sinister contexts skewing discussions and pressurising patients and families into making 'involuntary' decisions. It would be hard to refute the genuine risk that legislating for VAAD/PVAD might come with increased frequency of involuntary VAAD/PVAD, though the absence of them poses a continued failure to provide justice and fairness, and fails to acknowledge harms within the status quo.

It would also be naïve to suggest that VAAD and PVAD do not occur outside of a legal framework, including in Ireland, in both voluntarily and involuntary contexts. Martha Minow, Professor of Law in Harvard asks, which 'lie' is more beneficial: the lie that VAAD/PVAD does not occur at all, or the lie that 'institutional powers' would be able to prevent all vulnerable from ever succumbing to involuntary VAAD/PVAD (Bishop, 2006a)?

The fallacy that VAAD and PVAD do not occur is what allows society, the judiciary and healthcare professionals to turn a blind eye, or sympathetic glances, to cases where we might judge the situation to be understandable or warranted. The recent Irish case of Bernadette Scully, a GP that was accused of over-sedating her daughter who had microcephaly and severe epilepsy, is an example of appropriate prosecution (Cullen, 2016). However, the media and much of society rationalized the circumstances, intentions, purpose and the means that justified the actions in this scenario. The lack of legislation here results in politicians, prosecutors, the judiciary, medical professionals and the public to ignore cases of involuntary VAAD/PVAD, and avoid putting in place processes that might protect patients, physicians and the most vulnerable in society.

Would the provision of VAAD/PVAD legislation for those voluntarily seeking it, outweigh the inevitable risk and potential for those vulnerable among us to have VAAD/PVAD occur involuntarily, and illegally? In the absence of legislation, the greatest fault is the injustice and lack of fair and objective treatment of those at risk of involuntary VAAD/PVAD occurring and human subjectivity deciding who and when is prosecuted, sentenced, judged and/or held accountable. The risk that solitary human decisions; a doctor in a room, a judge on a bench, a Garda choosing to report a crime or not, might be the difference between prosecution or ignorance is not morally defendable. Due consideration to the ethics of accepting the status quo must also be deliberated.

Is there a role for a prescriptive legislation for VAAD and PVAD, or is there an alternative? Switzerland is of interest in this discussion. Swiss law classifies euthanasia as 'murder upon request by the victim', and thus finds euthanasia to be a type of murder, and consequently illegal. However, an exception clause legislates and condones assisted-suicide if motivated by altruistic intent. The Swiss model differs to the other European states, as well, in that it does not fall under the 'physician's role' or a medical model of ethical decision-making (Hurst & Mauron,

2003).

In light of this, one might wonder where the benefits and risks lie on the subject of legislating for assisted-dying? Should legislation be directly legalising of VAAD/PVAD, or should it be like a Swiss model with a 'Save and Except' clause. And while the government, medical authorities and other institutional powers can never really ensure there is no risk, Huxtable argues that there is a need to end "uncertainty, obfuscation and injustice". He believes this is to be through legislation, although he remains open to the shape that legislation should come in (Huxtable, 2004).

To digress, is there instead an alternative to euthanasia, and is there an ethical obligation to pursue alternatives? One might wonder if what we need most is a modern ars moriendi, a guide to the art of dying. Sean O'Mahony argues that the Irish ritual itself of dying is uniquely important and should continue to carry significance (O'Mahony, 2016), while Caitlin Doughty argues that the Irish, Muslim and Jewish approaches to death are healthy and human, and should be conserved, rather than be hidden from (Doughty, 2015).

The process of dying itself is at the heart of the euthanasia argument and our deep-rooted fear of pain and suffering. Some argue that legislating for euthanasia would morally desensitise death (Hurst & Mauron, 2003), while others believe that the transcendent meaning of humanity, independent of religion, is lost if leaving this world becomes mechanistic and perfunctory (Bishop, 2006b). "[Life isn't] about avoiding suffering" said Paul Kalinathi in his posthumously-published reflection When Breath Becomes Air (Kalinathi, 2016).

However, irrespective of these musings, in an Ireland where several high-profile cases have escaped prosecution - or as with Dr. Scully avoided sentencing. It is clear that the absence of legislation allows a blind eye to be turned on an important issue. for the turning of a blind eye to the issue. This reality could be an even greater immorality to those vulnerable that are not currently protected by the institutional powers, that might have some power to prevent involuntary VAAD/PVAD if it were to be legislated for.

To conclude, in progressing forward we might consider that legislating for assisted-dying might be a more egalitarian option, that treats all citizens equally, judges them as objectively as our institutions can ensure, and does so in an attempt to avoid negating the rights of those most vulnerable in society. We must consider the ethics of the act of VAAD/PVAD itself, but also consider the ethical implications for the implementation of assisted-dying legislation. Indeed, there is an obligation to consider ethics grounded in the reality and context in which the intended action is expected to operate within.

"It is not because things are difficult that we do not dare, it is because we do not dare that they are difficult." ~Lucius Annaeus Seneca

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