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Premises and evidence in the rhetoric of assisted suicide and euthanasia

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ABSTRACT

In debates about euthanasia and assisted suicide, it is rare to find an article that begins with an expression of neutral interest and then proceeds to examine the various arguments and data before drawing conclusions based upon the results of a scholarly investigation. Although authors frequently give the impression of being impartial in their introduction, they invariably reach their prior conclusions. Positions tend to be clearly dichotomized: either one believes that the practice of euthanasia or assisted suicide is totally acceptable or completely unacceptable in a just and moral society. Where there is some admission of a gray zone of incertitude, authors attempt to persuade us that their beliefs (preferences) are the only sensible way to resolve outstanding dilemmas. The practice of vehemently promoting a "pro" or "con" position may be useful when societies must decide to either legalize certain practices or not. Although only a handful of countries have thus far accepted the legal practice of euthanasia or assisted suicide (Belgium, Luxembourg, The Netherlands, the U.S. states of Montana, Oregon, Vermont and Washington, and Switzerland), scholarly articles in recent trends mainly promote legalization, to the point of recommending expansion of the current practices. Is this a case of the philosophers being ahead of their time in promoting and rationalizing the wave of the future? Alternatively, does the small number of countries that have legalized these practices indicate a substantial gap between the beliefs and desires of common citizens and the universe of the 'abstracted realm'? For the time being, what we do know is that more countries and states are debating legalization of euthanasia or assisted suicide, the nature of laws and legal practices vary greatly and both ethical and empirical assessments of current practices are the subject of much controversy. This article presents an examination of the premises and evidence in the rhetoric of assisted suicide and euthanasia. Inasmuch as any analysis cannot be totally impartial, we do not contend that our analysis is without influence from our experiences and philosophical affinities. Notwithstanding this caveat, we venture to propose that our scrutiny of the arguments and empirical data may offer some guidance to individuals who are attempting to reach practical conclusions based upon the available evidence, whether empirical or rationalized.

1. Introduction

1.1. Threshold vocabularies in debates about ending life

The practices of euthanasia and assisted suicide are frequently confused with refusing treatment, withdrawing treatment and the "double effect." Euthanasia involves an intentional act by a person (usually a physician) to end a person's life for compassionate reasons. The Canadian Senate Special Committee on Euthanasia and Assisted Suicide defined euthanasia as "the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve the person's suffering where the act is the cause of death" (Senate of Canada, 1995, p.8). In countries where euthanasia is not legal, ending a person's life for whatever reasons is considered a homicide, although punishments vary depending upon the circumstances of the killing. Assisted suicide is a specific type of suicide, that is, killing oneself intentionally. Adding the word "assisted" to describe the suicide implies that another person provided assistance, by providing the means, by providing information about how to commit suicide, or both (Mishara, 2002). In practice, assisted suicide generally involves providing lethal substances that one ingests in order to die. These practices differ from refusing treatment and withdrawing life sustaining treatment, where a "natural" death occurs without life being maintained by "artificial" means.

The 'double effect' in regard to end of life practices is when a physician provides only sufficient medication to completely arrest the pain and suffering, but that the effect of taking that medication in a sufficient amount to stop suffering has the side effect of accelerating death. Double effect reasoning follows from a long tradition that originated in the work of Saint Thomas Aquinas in the 13th century (Cavanaugh, 2006). Double effect reasoning is when the intended outcome is good (and thus morally justifiable), but one cannot realize the good outcome without also causing a foreseen, but not intended, bad effect. In double effect reasoning it is the morally justifiable intent and the accomplishment of the good outcome that counts. The secondary unintended harmful

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outcome is considered acceptable to attain the morally justified good result. In the case of a terminally ill person experiencing pain, control of pain and suffering is considered primordial, and controlling pain is justifiable even if life expectancy is compromised by the treatment, as long as the main intention of controlling pain is respected and no more medication is used than is required to attain an acceptable reduction in suffering. This approach indicates that in practice, only enough medication to control the pain and suffering can be provided so that life may be maintained as long as possible.

Despite generally accepted definitions of the different end of life practices, confusion remains in both scholarly writings and within the general public. Marcoux, Mishara, and Durand (2007) found that in Quebec, 70% of the population favors legalization of euthanasia according to their public opinion poll. However, in delving into the matter further, over two-thirds were unable to identify if vignettes depicted end of life practices correctly, often thinking that legalizing euthanasia means legalizing other practices, such as refusing or stopping treatment, which are already legal in Quebec. The more people were confused about the nature of euthanasia and other end of life practices, the greater the likelihood they would be in favor of legalization.

2. The constitutional sword: a double-edged conundrum

It is curious that theological arguments are rarely in the forefront of debates on euthanasia and assisted suicide. Constitutional guarantees are generally invoked as both the justification for legalizing euthanasia and assisted suicide and the justification for forbidding these practices. The Constitutional guarantees of freedom and non-discrimination are often cited as reasons for legalization. Choosing the manner, time and place of one's death has been described as a simple exercise of individual freedom of choice. However, legalization goes beyond simply allowing people to choose. In most countries there are no laws forbidding suicide, although the majority of countries have laws outlawing aiding and abetting in a suicide. Over and above accepting that people may choose to die, legalization involves either providing the means to kill oneself (as is the case in assisted suicide), or actually having a third party intervene to end a person's life (as in the case of euthanasia).

There are multiple justifications used to insist that the means and actions to end life be provided. To begin with, one can contend that without proper medical help, persons may botch their suicide attempt, the consequences leading to either suffering a horrific death or not dying, with the accompanying risk of becoming permanently handicapped.

Constitutional arguments are made that there is an inherent inequity in the case of the severely handicapped, for example, in reference to paralysis that occurs in advanced stages of certain degenerative diseases. Such persons are viewed as being unable to exercise the "right" to commit suicide because of their illness, thereby implicitly obligating the state to provide a means of ending their life by euthanasia, in order to effectively implement a 'choice to die.' The obvious counter-argument is that being free to act does not additionally confer an obligation for a just government to provide means for everyone to realize their desired actions, particularly the act of committing suicide. In countries where euthanasia is practiced, almost all those who die in this manner are fully capable of committing suicide. It is a rare exception that people requesting euthanasia are truly incapable of executing the act. Dramatic exceptional cases of advanced paralysis do not depict the actual norm. In The Netherlands most cases of euthanasia involve people suffering from cancer (76%) and less than 6% have a neurological disorder that may result in loss of motor control, with euthanasia administered while the patient is still capable of assisted suicide (Regional Euthanasia Review Committees, 2011). In Belgium, 75% of persons who died by euthanasia suffered from cancer and 7% had degenerative neurological disorders (Commission fédérale de contrôle et d'évaluation de l'euthanasie, 2012). In addition, research on the relationship between "the desire to die"' and "physical handicaps" exposes that, contrary to popular beliefs, people with disabilities are *less* likely to want to die by suicide or euthanasia than people without physical handicaps (Mishara, 1999).

Constitutional guarantees of freedom are also evoked as an argument against legalizing euthanasia and assisted suicide. It can be argued that the state has an obligation to protect its citizens, particularly the most vulnerable, to enable life (Finlay & George, 2011). Governments often intervene to protect citizens from self harm, requiring them to wear seatbelts and motorcycle helmets and in disallowing the purchase of harmful drugs. In both euthanasia and assisted suicide this protection can be fulfilled through prioritizing palliative care and psycho-social interventions before euthanasia is deemed a contemplatable option. The familiar counter-argument is that the societal obligation to enhance and preserve life is trumped by unavoidable physical or psychological suffering. Some secular constitutionalists contend that one must make a valiant effort at palliative care in all circumstances and that this is generally sufficient to significantly reduce pain and suffering.

Within all of the common law jurisdictions, the distinction is borne in mind that the mechanisms used by caring physicians who withdraw life support are not to be conflated with a proactive intervention. This cautionary approach is not without merit.

The remaining soul wrenching issue is whether we should show our support for the right to life in the face of possible transgressions by maintaining legal sanctions against all acts of euthanasia and assisted suicide. A middle ground position is that there should be carefully construed permission where individuals in circumstances of dire suffering have evidenced independence and voluntariness. As is the case in The Netherlands, they should have been personally appraised by at least two warranted professionals. Where there has been very carefully monitored surveillance, we should ensure that professionals will not be subject to civil or criminal liability.

Needless to say, the subject is emotionally charged. The American way of coping with the problem is instructive because, in one form or another, the pressures on both sides of the argument persist in other jurisdictions. Prohibitions against assisted suicide are seen to be protected by the American Constitution, but the practice of assisted suicide has been relegated and indeed decentralized in effect to the individual states. This 'cake and have it too' approach is likely to be sustained. In post World War II societies, judges as responsible decision-makers are fearful to let go of their guardianship role to be the paramount protectors of the right to life (Stark, 2002). However, in the face of overwhelming instances of human suffering and equipped with the modern emblems of 'autonomy' and 'self determination,' judges and legislative authorities will look for avenues to show a human face to competent citizens whose suffering has become unbearable (Allen, 2009). Once we have made an exception for such cases, the necessity of surveillance becomes the real question at hand. Based on evidence which can now be gleaned from jurisdictions which have allowed acts of assisted suicide, we should be all the more sensitive that the surveillance process brings with it a serious burden of guaranteeing that transgressions and misuse of professional discretion be avoided.

Judge-made decisions have enshrined the age-old commitment in Western legal systems (both civil and common law) of the right to life. There have been clearly defined exceptions based on defenses of bodily integrity, war conditions, or punishments for heinous crimes against humanity. Judges have had to deal with requests from individuals and lobbying forces and have had to essentially balance the weight of historical commitments with constitutional intrusions into the common law. Nevertheless, the preponderance has been for judges, for example in the common law jurisdictions, to be very wary of accommodating to requests based on personal autonomy.

It is noteworthy to reference the celebrated case of the Supreme Court of Canada Rodriguez v British Columbia (Attorney General) (1993), where the Court emphasized that although it was a compelling request, in fact the Canadian Charter of Rights and Freedoms trumped assisted suicide. The Court decided in favor of a total prohibition of