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Abstract

In this paper I argue that no state should legalise euthanasia, either voluntary or non-voluntary. I begin by outlining three political arguments against such legalisation, by Russell Hittinger, Elizabeth Anscombe and David Novak. Each concludes, on different grounds, that legalised euthanasia fatally erodes the role and authority of the state. Although correct in their conclusion, the arguments they provide are deficient. To fill this gap, I elaborate what I call a 'fourfold dialectic' between autonomy and compassion, the two central motivations for legalising euthanasia. I show that these motivations systematically and progressively undermine each other, yielding a situation where individual autonomy and doctors' duty of care are effectively eviscerated. It follows that state authority, which depends on upholding both of these, is itself eviscerated. In this way, the conclusion of the political arguments above finally finds demonstrative support.

The Future in Our Hands? A Dialectical Argument against Legalising Euthanasia

Tom P. S. Angier

Introduction

At the heart of the debate on the legalisation of assisted suicide and euthanasia there lies a deep disagreement about the significance of a moral philosophical principle: namely, the principle of double effect.¹ The latter holds, in brief, that for any action, certain of its effects will be intended, and certain of them merely foreseen. An action is permissible, at least *pro tanto*, when none of its bad or evil effects is intended, either as ends or means, i.e. each is merely foreseen. In addition, there must be proportionately grave reason for permitting such bad or evil effects.² Traditionally, this principle has been taken to permit the withdrawal of futile, unduly burdensome or disproportionate medical treatment – as well as the giving of painkillers – even where a foreseen (yet non-intended) side-effect of these actions is the patient's likely death. Equally traditionally, the principle of double effect has been taken to prohibit assisted suicide and euthanasia, since both involve the intention to kill (with the doctor either assisting the patient to realise this intention, or directly achieving it him- or herself). Granted, such intentional killing may be done for a good end, e.g. to relieve what is judged unbearable and irremediable suffering – but that does not detract from the inherent, or all-things-considered badness of the killing itself. On the traditional view, to afford medical professionals even the limited power to kill is replete with dangers, and must be absolutely prohibited; only the non-intentional bringing about of death is permissible, and must, moreover, be strictly regulated.

The traditional view, which takes the distinction between intention and foresight with the utmost seriousness, inscribing it in legislation, is clearly at work in two judgements from Britain's House of Lords. As the *Report of the House of Lords Select Committee on Medical Ethics* puts matters, 'society's prohibition of intentional killing ... is the cornerstone of law and social relationships. It protects each one of us impartially, embodying the belief that all are equal'.³ And as Lord Goff of Chieveley writes, there is a 'Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia – actively causing his death to avoid or end his suffering'.⁴ That there exists such a 'Rubicon' has, however, increasingly been questioned, especially by consequentialist philosophers and their followers. For the consequence of (e.g.) withdrawing life-sustaining treatment, and of deliberately administering a lethal dosage, is, as they point out, the same: the patient dies. And if the patient's suffering is truly unbearable and irremediable, why not bring it to an end directly

¹ The principle is named after Thomas Aquinas' formulation of it, which involves the term 'duplex effectus'. See his discussion of killing in self-defence: Thomas Aquinas, *Summa Theologiae* (Cambridge: Cambridge University Press, 2006), IIa IIae Q. 64 art. 7.

² For an excellent summary of the principle, see David Oderberg, *Applied Ethics: A Non-Consequentialist Approach* (Oxford: Blackwell Publishing, 2000), 76-7. For more detail, see David Oderberg, *Moral Theory: A Non-Consequentialist Approach* (Oxford: Blackwell Publishing, 2000), ch. 3.

³ *Report of the House of Lords Select Committee on Medical Ethics* (Chairman: Lord Walton), 31st January 1994, para. 237. Quoted in John Finnis, 'Discourse, Truth, and Friendship', in *Reason in Action – Collected Essays: Volume I* (Oxford: Oxford University Press, 2011), ch. 2, 57.

⁴ *Airedale NHS Trust v. Bland*, 4th February 1993, AC 789. Quoted in John Finnis, 'Intentionally Killing the "Permanently Unconscious"', in *Intention and Identity – Collected Essays: Volume II* (Oxford: Oxford University Press, 2011), ch. 19, 313.

and assuredly? Is this not more compassionate than the alternatives? Besides, there are grounds, it is argued, for questioning the very distinction between intention and foresight. How are we to verify whether a death was intended or merely foreseen? As sponsors of the distinction acknowledge, even withdrawal of treatment can, in *certain* circumstances, amount to intentional killing.⁵ And in terms of philosophical psychology, is there any robust line to be drawn between intending and foreseeing? Surely, the sceptics maintain, intention reduces to how one directs one's mental attention; and if so, it is relatively easy to avoid the charge of intending to kill.

These and other criticisms have been levelled, relentlessly, at the principle of double effect.⁶ Philosophers such as David Oderberg have, arguably, provided it with equally robust defences (see note 2), but it remains the case that legally, at least, the principle has been put on the back foot. To take an example from American jurisprudence, Judge Reinhardt, in *Compassion in Dying v. Washington*, has emphasised 'the similarity between what doctors are now permitted to do' – viz. give painkillers with the intent to suppress pain – 'and what the plaintiffs assert they should be permitted to do' – viz. give painkillers with the intent to kill.⁷ In the Netherlands, Harry Kuitert did much to erase the distinction between 'active euthanasia' and (so-called) 'passive euthanasia', thereby paving the way for the legalisation of voluntary, active euthanasia in 2002.⁸ Indeed, many scholars of jurisprudence are now loath to place any weight on the distinction between intended and merely foreseen death. According to Nicholas Bamforth and David Richards, for example, to do so is to affirm a form of legal 'fundamentalism'.⁹ Judge Reinhardt, for his part, declares that laws prohibiting assisted suicide do 'injury' to some citizens solely 'to satisfy the moral or religious precepts of a portion of the population'.¹⁰ And the *Royal Dutch Medical Association*, or KNMG, is of the view that an outright ban on intentional killing is 'an extreme and rigid position'¹¹ – a view that directly influenced the Dutch Supreme Court.

Notwithstanding this shift in legal opinion, I shall argue that the traditional view is the right one. Not only is there clear evidence that jurisdictions which have crossed the moral Rubicon, and made intentional killing part of medicine, now face manifold and increasing evils. It was also inevitable that those evils awaited them in the first place. For despite ubiquitous appeals to autonomy and compassion – appeals which have some *prima facie*

⁵ See, for example, Oderberg, *Applied Ethics*, 74; John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge: Cambridge University Press, 2002), 42; John Keown, 'A New Father for the Law and Ethics of Medicine', in *Reason, Morality, and Law: The Philosophy of John Finnis*, ed. John Keown and Robert P. George (Oxford: Oxford University Press, 2013), ch. 18, 296-9.

⁶ See, for example, James Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986), 92-6; Peter Singer, *Practical Ethics* (3rd edition) (Cambridge: Cambridge University Press, 2011), ch. 7. Finnis diagnoses these criticisms as a hallmark of secular liberalism. See his 'Secularism and "The Culture of Death"', in *Religion and Public Reasons – Collected Essays: Volume V* (Oxford: Oxford University Press, 2011), ch. 22, esp. 340-41.

⁷ Quoted in Russell Hittinger, 'Private Uses of Lethal Force: The Case of Assisted Suicide', in *The First Grace: Rediscovering the Natural Law in a Post-Christian World* (Wilmington, Delaware: ISI Books, 2003), ch. 6, 149. Cf. Finnis, 'Euthanasia and the Law', in *Human Rights and Common Good - Collected Essays: Volume III* (Oxford: Oxford University Press, 2011), ch. 16, 256.

⁸ See Harry Kuitert, *Een Gewenste Dood: Euthanasie en Zelfbeschikking als Moreel en Godsdienstig Probleem* (Baarn: Ten Have, 1981), 29. I say 'so-called' because 'passive euthanasia' suggests that withdrawing treatment is necessarily a species of killing, a claim repudiated by those who uphold the traditional view.

⁹ See Nicholas C. Bamforth and David A. J. Richards, *Patriarchal Religion, Sexuality, and Gender: A Critique of New Natural Law* (Cambridge: Cambridge University Press, 2008), ch. 8.

¹⁰ See Hittinger, *The First Grace*, 143.

¹¹ Quoted in Gerbert van Loenen, *Do You Call This A Life? Blurred Boundaries in the Netherlands' Right-to-Die Laws* (London, Ontario: Ross Lattner, 2015), 115.

plausibility – it is precisely these notions that, when properly understood, generate the deep iniquities which assisted suicide- and euthanasia-practising regimes effectively embody. In order to show this, I shall begin by exploring three species of what I shall call the ‘political argument’ against euthanasia.¹² While this argument, as elaborated by Russell Hittinger, Elizabeth Anscombe and David Novak, is fundamentally on the right track, I will argue that – in its extant forms – it is incomplete, and misleadingly formulated. I will then move on to elaborate what I will call the ‘fourfold dialectic’ between individual autonomy and compassion for suffering. These two values constitute the central motivations behind the legalisation of euthanasia. Once they are unpacked, however, and the dialectical relations between them clarified, we will see that they inevitably and repeatedly undermine each other, generating a form of delusive practice. With this dialectical framework in place, we will finally be in a position to grasp the essential justice of the political argument. It is to the latter, then, that I now turn.

I. The Political Argument

Russell Hittinger develops the political argument against euthanasia in the context of American jurisprudence, but this context is inessential and I shall abstract from it in what follows. Hittinger begins with the observation that since (what he calls) ‘postmodern states’ are ‘[u]nsure of the scope of their own sovereignty, [they] are prepared to relocate sovereignty in the individual; in other words, postmodern states are prepared to be the guarantor of the rights of individual autonomy’.¹³ Such rights are relatively benign when they are balanced against considerations of the common good. But because such states increasingly absolutise individual autonomy – in the American case, invoking a strong right to privacy, or (alternatively) a strong ‘liberty interest’ – we see the advent of (purported) rights that threaten the common good. The limiting and most dangerous case of this, Hittinger maintains, is the right of citizens to request euthanasia, and the right of doctors, after due consideration, to facilitate their request. For, as he summarises things, ‘Men and women ... cannot exercise a private franchise to use lethal force and still enjoy political order’.¹⁴ On what grounds does he make this claim? According to Hittinger, ‘political order’ depends, *inter alia*, on the state’s ‘preserving its monopoly over lethal force’,¹⁵ for only the state properly has the *authority* to deploy such force. True, health-care professionals are often ‘impartial’ third parties, but they are not ‘official legislators, judges, or executives’, viz. the only personnel who, after due legal process, are empowered ‘to take away life, liberty, or property’.¹⁶ To delegate to doctors the state’s right to use lethal force is hence ‘asserting that the right be exercised without the ordinary constraints that the state must observe’¹⁷ – and this is destructive of political order.

Hittinger fills out his argument by citing Locke. In the *Second Treatise of Government*, §87, Locke holds that ‘Those who ... have a common established Law and Judicature to appeal to, with Authority to decide Controversies ... are in Civil Society ... ; but those who have no such common Appeal ... are still in the state of Nature, each being ... Judge for

¹² From now on, I shall use ‘euthanasia’ disjunctively, to cover either (doctor-)assisted suicide or euthanasia proper. For although these raise somewhat different moral issues (e.g. of guilt), the legal issues they raise are substantially similar, at least when euthanasia is voluntary, i.e. consented to. Of course, euthanasia can also be non-voluntary, i.e. performed where consent is impossible. When I discuss euthanasia of this sort, I shall make it clear.

¹³ Hittinger, *The First Grace*, 137.

¹⁴ Hittinger, *The First Grace*, 137.

¹⁵ Hittinger, *The First Grace*, 154.

¹⁶ Hittinger, *The First Grace*, 154.

¹⁷ Hittinger, *The First Grace*, 154.

himself and Executioner'.¹⁸ It follows, Hitinger adjures, that if the state transfers the power to use lethal force from one or more duly constituted public authorities 'back to individuals', this is 'tantamount to dissolving civil society'.¹⁹ Hitinger grants that, unlike in Locke's State of Nature, those requesting euthanasia have given their consent to the use of lethal force, and are therefore not strictly its victims. But this is not sufficient, he insists, 'for determining who has authority, under the social contract, to use lethal force'.²⁰ For the state's monopoly on such force, together with the legal constraints which govern its use, is a common good. It cannot be construed, therefore, 'on the model of commutative justice at private law where the consent of parties to a contract is a principal fact considered by the law'.²¹ To do so confuses legal with commutative justice, and this, Hitinger contends, is both inadmissible and highly injurious.²² For in effect it erases the distinction between public and private law, with the upshot that 'no one could know with any assurance where crime begins or ends'.²³ For this reason, he concludes, 'private franchises to use lethal force are repugnant to government as such'.²⁴

The overall argument is clear, but not cogent as it stands. For a start, Hitinger's continual reference to 'lethal force' is tendentious, since it suggests that doctors are coercing their patients, which *ex hypothesi* they are not. But there are more serious problems with the argument. On the one hand, it leaves a wide loophole for euthanasia advocates to exploit, since nowhere does Hitinger show it would be *impossible* to make euthanasia a matter of due public process. Perhaps there are significant practical problems to be overcome in this respect, and these may be sufficient to stymie a judicially-administered euthanasia regime. But this is not yet to show that such a regime is impossible in principle. On the other hand, it is doubtful whether Hitinger has secured his basic claim that medical oversight of euthanasia is insufficiently public, and thus necessarily beyond the purview of criminal justice. At least in some countries, doctors are functionaries of the state, and certainly in the Netherlands and Belgium, state bodies claim to monitor the provision of euthanasia in their respective jurisdictions. Even in the United States, as Hitinger admits, 'in the case of physicians, these are no ordinary private parties, but rather are private agents whose professional competence is licensed by the state'.²⁵ So it is not obvious, as yet, that euthanasia is so far below the radar of public scrutiny that its practitioners threaten the very existence of sound and effective government.²⁶ The suspicion remains that Hitinger is trading on Locke's vision of a descent into the State of Nature, where each person is 'Judge for himself and Executioner' – though in the case of euthanasia, no such descent has been established.

Elizabeth Anscombe agrees with Hitinger, insofar as she, too, takes the legalisation of euthanasia to be destructive of state authority.²⁷ But her grounds are significantly different. Perhaps because she is writing in 1980s Britain, where health care is provided largely by the state, she treats euthanasia *ab initio* as having to be supervised and implemented by state

¹⁸ Quoted in Hitinger, *The First Grace*, 157.

¹⁹ Hitinger, *The First Grace*, 157.

²⁰ Hitinger, *The First Grace*, 158.

²¹ Hitinger, *The First Grace*, 158.

²² David Novak also argues that legalising euthanasia confuses issues of the common good with those proper to private contract. See David Novak, *The Sanctity of Human Life* (Georgetown: Georgetown University Press, 2007), 145, 147.

²³ Hitinger, *The First Grace*, 158-9.

²⁴ Hitinger, *The First Grace*, 159.

²⁵ Hitinger, *The First Grace*, 154.

²⁶ Indeed, given that direct legal oversight of euthanasia would entail a massively 'statist' conception of its provision, perhaps it is preferable that the authority to carry it out is delegated to doctors.

²⁷ See Elizabeth Anscombe, 'Murder and the Morality of Euthanasia', in *Human Life, Action and Ethics: Essays* by G. E. M. Anscombe (Exeter: Imprint Academic, 2005), ch. 21.

authority. Now for Hittinger, this would open the door to the justification of euthanasia, since he believes it is first and foremost lack of state involvement which renders euthanasia impermissible. Not so Anscombe. As she argues, ‘Some think it would be within the competence of the State to authorise such killing as seems necessary for the common good. But’, she continues, ‘the right of the State to use violence has such a foundation as to put that idea right out of court’.²⁸ Why so? Because, according to Anscombe, that foundation is ‘the human need of protection against unjust attack’.²⁹ But in a euthanasia-practising regime, the state not only permits the killing of innocent people, it actually carries it out. It follows that it has undermined (a key aspect of) its own foundation, namely to protect citizens against injustice; indeed, it has denatured itself further, by becoming the agent of injustice. As Anscombe sums up her argument, ‘if the civil authority itself attacks innocent people, it nullifies the basis on which its use of violence is different from that of a gangster band. This remains true even if it pleads the common good as an excuse ... Civil authority cannot make it policy to decide on or license the killing of innocent people without losing the character of civil authority’.³⁰

The argument is ambitious, since like Hittinger’s, it claims to show that euthanasia eviscerates state authority. And it manages to close Hittinger’s loophole, since it envisions euthanasia as a form of state, not private action. But is it persuasive? The weakness of Anscombe’s argument lies in her conception of injustice. She holds, plausibly, that ‘someone who is murdered suffers a great wrong’,³¹ but her definition of murder is tendentious – viz. as necessarily involving ‘*the intentional killing of the innocent*’.³² This entails that any state that legalises and implements euthanasia is, in effect, a murderous regime, and hence is doing those who request and undergo it a ‘great wrong’. But this is too quick. For as Anscombe allows, there is at least one class of persons which can rightfully be put to death by the state – namely, those judged guilty of heinous crime. And if so, the question arises of why another exception to the category of ‘state murder’ could not be made, viz. those requesting and being judged fit to receive euthanasia. As David Benatar argues, philosophers like Anscombe extend ‘the inviolability principle only to innocent humans, and seem[...] to allow for the capital punishment of those convicted of a sufficiently serious crime ... [but if so,] why may we not make a similar exception for those who are suffering unbearably? While the latter, unlike the former, may be ‘innocent’, the relevance of this is merely stipulated by opponents of euthanasia’.³³

At this juncture, Anscombe appears to shift her ground, emphasising not so much the attack on human *innocence* as a condition of injustice, as the attack on *human* innocence. Being a human person imports ‘a tremendous dignity’, she declares, and in virtue of this, we cannot treat humans as we treat other animals. True, we can euthanise a dog, say, thereby ‘putting it out of its misery’: ‘sympathy makes it feel indecent to put up with its gross suffering, and may even incline one to terminate a reduced and pathetic existence’.³⁴ But human animals are different: we are ‘spirit as well as flesh’,³⁵ rational as well as instinctual,

²⁸ Anscombe, ‘Murder ...’, 265.

²⁹ Anscombe, ‘Murder ...’, 265.

³⁰ Anscombe, ‘Murder ...’, 265-6.

³¹ Anscombe, ‘Murder ...’, 266.

³² Anscombe, ‘Murder ...’, 262.

³³ David Benatar, ‘Assisted Suicide, Voluntary Euthanasia, and the Right to Life’, in *The Right to Life and the Value of Life*, ed. J. Yorke (Aldershot: Ashgate Publishing, 2010), 297. Another ‘opponent of euthanasia’ who makes this stipulation is John Keown. See, e.g., Keown, *Euthanasia, Ethics and Public Policy*, 41 n. 3.

³⁴ Anscombe, ‘Murder ...’, 269.

³⁵ Anscombe, ‘Murder ...’, 269.

and this should elicit a reverence and respect which is different in kind from that elicited by the life of a dog. To think otherwise, Anscombe asserts, is to treat human life as a mere ‘amenity’,³⁶ i.e. something to be discarded when it has become incommensurable. Much could be said here, but I think two points are worth bringing out. First, more needs to be said to show that humans’ possession of a rational ‘spirit’ provides strong grounds, in and of itself, to outlaw euthanasia. It could be objected that it is precisely such rationality that warrants the state’s serious consideration of requests for euthanasia in the first place. Secondly, and crucially, in shifting her ground Anscombe has effectively embarked upon a foundational moral argument, thereby abandoning her attempt to provide a purely political argument against legalising euthanasia. While that moral project is valuable *per se*, and one richly reflected elsewhere,³⁷ it is far too complex to be unpacked and assessed here.

David Novak’s political argument against legalising euthanasia is, in a sense, the least ambitious of the three surveyed here. This is because he neither claims that legalisation destroys state authority, nor embarks on a foundational moral argument. Rather, he focuses on how euthanasia purportedly undermines ‘the prime *raison d’être* of a society’,³⁸ a *raison d’être* the state should reflect and support. Novak prepares the ground by arguing that modern, liberal conceptions of autonomy have become ‘radically individualistic’, rendering individuals’ involvement with the state highly instrumental, and little more than a ‘necessary evil’.³⁹ The limiting case of this is state-provided euthanasia, since here individual citizens expect the state to provide a personal death-service – despite its severely detrimental effects on the common good. Novak argues for the latter on the grounds that euthanasia-provision directly contradicts ‘the prime *raison d’être* of a society’, which is ‘to care for all of its members in ways they are not able to care for themselves by themselves...’⁴⁰ Part of this care, he maintains, ‘should be the concern for self-destructive, suicidal persons ... even if that harm [viz. suicide] is self-chosen behaviour’.⁴¹ Such care reflects what Novak calls ‘primary human sociality, [the] primary need for others to need me and want me to abide in the world with them’.⁴² Without such care – from the family, first, but also from the state – society sends a message to those tempted by euthanasia of ‘ultimate abandonment’.⁴³

This argument has emotive appeal, but also papers over key difficulties. We can agree that ‘the prime *raison d’être* of a society is to care for all of its members in ways they are not able to care for themselves by themselves...’⁴⁴ But it does not follow from this that euthanasia should be outlawed. For despite Novak’s tendentious reference to lethal ‘violence’⁴⁵ – echoing here both Hittinger and Anscombe – he has not yet shown that killing cannot be a form of care. Granted, and as Anscombe points out, ‘you cannot take care of something by

³⁶ Anscombe, ‘Murder ...’, 270.

³⁷ See, e.g., Robert Spaemann’s reflections on the incomparable value of human beings, and the ‘ontological dimension’ of their dignity: Robert Spaemann, *Essays in Anthropology: Variations on a Theme*, trans. Guido de Graaff & James Mumford (Eugene, Oregon: Cascade Books, 2010), ch. 3; Robert Spaemann, ‘Human Dignity and Human Nature’, in *Love and the Dignity of Human Life: On Nature and Natural Law*, trans. David L. Schindler (Grand Rapids, Michigan: William B. Eerdmans Publishing Co., 2012). See also Oderberg, *Applied Ethics*, 59, 67, on the intrinsic value of human life, and human life as a ‘basic good’.

³⁸ Novak, *Sanctity*, 153.

³⁹ Novak, *Sanctity*, 145.

⁴⁰ Novak, *Sanctity*, 153.

⁴¹ Novak, *Sanctity*, 153.

⁴² Novak, *Sanctity*, 155.

⁴³ Novak, *Sanctity*, 157.

⁴⁴ Novak, *Sanctity*, 153.

⁴⁵ Novak, *Sanctity*, 154.

destroying it'.⁴⁶ But if one understands 'care' more expansively, as including (e.g.) much-needed relief from pain, then it is not obvious that euthanasia cannot count as a species of care. At the very least, it does not count obviously as a species of harm. Given this, it is telling that Novak's central example of societal care is the Hutterite practice of rallying around those with bipolar or manic-depressive disorder.⁴⁷ As Novak comments, this form of care ensures the Hutterites have a very low suicide rate. But it is consistent with this to hold that, even with the best psychological care in the world, there may be (especially physical) conditions which cannot be relieved short of death.

II. The Fourfold Dialectic between Autonomy and Compassion

I have argued, then, that the political arguments I have outlined against legalising euthanasia are deficient as they stand. Hittinger's argument for a collapse of state authority 'from below', Anscombe's argument for such a collapse 'from above', and Novak's argument from 'the prime *raison d'être*' of society all fail to establish their conclusion. Nonetheless, I think they are all arguing in the right direction: any state which legalises euthanasia is embarking on a socially disastrous journey, which will critically damage its authority. In order to see this, however, we need to delve deeper into the reasons given for such legalisation, and their profound inadequacy. Only against this background will the full force of the above arguments become clear.

The reasons for legalising euthanasia centre on two key values: individual autonomy and compassion for suffering. Although, as I shall argue, autonomy in this context is a delusive value, it is certainly at the forefront of the euthanasia debate – *qua* individual 'self-determination'. This is evident particularly in the jurisprudential debate, and nowhere more so than in America. In *Compassion in Dying v. Washington*, for instance, Chief Judge Barbara Rothstein writes that 'Like the abortion decision, the decision of a terminally ill person to end his or her life "involv[es] ... [a] choic[e] central to personal dignity and autonomy"'.⁴⁸ This judgement is heavily reliant on *Planned Parenthood v. Casey*, which defines individual liberty as 'the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State'.⁴⁹ One need not go this far, however, or wax so magniloquent, to see the main point: autonomy is being construed in such a way as to confer a strong, even overriding liberty-right⁵⁰ on the individual, granting him or her what Novak calls strong 'self-ownership'.⁵¹ And this construal is borne out clearly in the work of Ronald Dworkin, work that has had a marked influence on the jurisprudential debate, particularly in the United States. For Dworkin, 'Making someone die in a way that others

⁴⁶ Anscombe, 'Murder ...', 269.

⁴⁷ Novak, *Sanctity*, 157.

⁴⁸ Quoted in Hittinger, *The First Grace*, 139.

⁴⁹ Quoted in Hittinger, *The First Grace*, 139.

⁵⁰ It is worth noting that earlier American jurisprudence tended to dwell not on liberty-rights, but rather on privacy-rights, following Judge Brandeis' dictum that the 'right to be left alone' is 'the most comprehensive of rights and the right most valued by civilised men' (quoted in Hittinger, *The First Grace*, 135). But plainly neither abortion nor euthanasia is a private procedure, since they require significant public intervention. Hence the shift to liberty-rights. For more on this, see Hittinger, *The First Grace*, 148, 153; Novak, *Sanctity*, 144; Keown, 'A New Father ...', 303.

⁵¹ Novak, *Sanctity*, 152.

approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny'.⁵²

The trouble with Dworkin's assertion lies in its second clause, viz. 'he believes a horrifying contradiction of his life'. What this shows is that autonomous decisions have *grounds*, i.e. those who make them must provide reasons for what they decide. And it does not take much thought to see that not all reasons are on a par. For what if someone believed that dying supported by pillows was 'a horrifying contradiction of his life'? He or she would not be taken seriously, let alone judged the victim of 'a devastating, odious form of tyranny'. This points to the fact that reasons for decision are subject to rational scrutiny, and that self-determined decision is thus not sufficient *eo ipso* to command rational compliance. As Brenda Almond observes, while it may be true that 'The moral principle cited by those who favour voluntary euthanasia is autonomy' – at least typically, and in liberal societies – this amounts only to 'the right of people who are ill to make *informed* decisions concerning their own care or treatment'.⁵³ It follows that, notwithstanding the emphasis on self-determination and individual liberty in the public euthanasia debate, what legislation actually requires is careful sifting of what constitutes an informed decision to seek death. And as Oderberg remarks, this renders autonomy an 'ethical "red herring": 'If the request is genuine, that is, a sincere attempt at alienating the right to life, why *shouldn't* the doctor accede to the request? Why does an evaluation of the patient's reasons *matter*? The fact that the reasons *do* matter itself indicates that it is not the voluntariness component that is morally relevant, but the reason for the infringement'.⁵⁴

Two corollaries of this are worth highlighting. First, in practice, individual autonomy is not only sidelined by euthanasia regimes, it is effectively eviscerated. For as Finnis maintains, 'your right to autonomy does not give you the right to be assisted in suicide [or to be euthanised] unless you are ill *enough* or suffering *enough*, or depressed severely and incurably *enough* – in each case "enough" in the view of somebody else, *other people*'.⁵⁵ As Kevin Yuill puts matters, the bureaucratic apparatus and manifold interventions required by legalising euthanasia make individual autonomy merely notional; indeed, if doctors refuse to provide euthanasia, on what they take to be sufficient grounds, there arises the phenomenon of shaming 'unapproved suicides'.⁵⁶ And this serves only to underline the delusion of autonomy still further. Secondly, the demise of autonomy as a rationale for euthanasia ushers in what I shall call the 'second stage' of the dialectic between autonomy and compassion. Here the state must attempt to formulate a set of determinate conditions for applying euthanasia justly. And as Finnis suggests, this almost inevitably involves a recourse to various categories of 'suffering'. Indeed, this was the case from very early on in the Dutch journey to legalising euthanasia. As Gerbert van Loenen relates, 'What the public failed to notice was that in 1984 the [Dutch] High Court explicitly rejected self-determination as grounds for accepting euthanasia. The central issue for the highest court was the patient's suffering'.⁵⁷ Even in 1969, J. H. van den Berg, the godfather of the Dutch euthanasia movement, was of

⁵² Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (London: Harper Collins Publishers, 1993), 217.

⁵³ Brenda Almond, *Exploring Ethics: A Traveller's Tale* (Oxford: Blackwell Publishers Ltd, 1998), 159; my emphasis.

⁵⁴ Oderberg, *Applied Ethics*, 60.

⁵⁵ Finnis, 'Euthanasia and the Law', 258.

⁵⁶ See Kevin Yuill, *Assisted Suicide: The Liberal, Humanist Case against Legalization* (Basingstoke: Palgrave Macmillan, 2013), 152.

⁵⁷ Van Loenen, *Do You Call This A Life?*, 5.

the opinion that ‘Euthanasia’s appeal was not based on voluntariness ... or on self-determination, but rather on mercy (or compassion)’.⁵⁸

With this second stage of the dialectic, the full implications of legalising euthanasia begin to unfold. First, since the true rationale for euthanasia is compassion, not autonomy, the question arises of why an autonomous decision is even necessary for it to be authorised. As Finnis comments, if supposedly objective ‘judgements about ... a person’s life are decisive, why not also when the judgement about insufficient or negative quality of life is the same but the request for help to terminate life cannot be made? Or has not been made?’⁵⁹ And such in fact has been the direction of argument and practice. In the Netherlands, for instance, the 2005 *Groningen Protocol* opened the door to killing disabled infants. This has resulted in a significant number of deaths, especially of children with spina bifida.⁶⁰ And van Loenen details more widely the willingness of Dutch medical practitioners to implement non-voluntary euthanasia.⁶¹ Hence autonomous decision turns out to be not only insufficient for euthanasia, but also unnecessary. Secondly, and crucially, the task of arriving at a determinate and practicable construal of ‘unbearable and irremediable suffering’ proves impossible. For if euthanasia is restricted to those with terminal illnesses, the question arises of what ‘terminal’ means, and why those with other forms of illness are allowed to suffer. But if illness in general is admitted, why not mental illness as well as physical illness? For surely mental illness can also be a cause of severe suffering. But if mental illness is admitted, why not other claims to unbearable and irremediable psychological suffering, since it seems arbitrary and callous to restrict euthanasia ‘treatment’ to those with designated mental disorders. In this way, what looked like a viable and legislatable category unravels, revealing it as no more substantial than ‘autonomy’ before it.⁶²

Lest this be thought merely a logical claim – though it is also that – the empirical evidence demonstrates how compassion for suffering has licensed an almost infinite expansion of grounds for euthanasia. Belgium arguably bears most dramatic witness to this. In 2015, the daughter of Simona De Moor died during an operation aged 58; her mother, aged 85 and experiencing ‘unbearable grief’, decided soon after to request euthanasia. In perfect physical health, she was legally euthanised that June.⁶³ Godelieva De Troyer, from Hasselt,

⁵⁸ Van Loenen, *Do You Call This A Life?*, 100.

⁵⁹ Finnis, ‘Euthanasia and the Law’, 259. Cf. Anscombe: ‘most propaganda for euthanasia assumes it should be voluntary ... [but] this is only a way-station ... The drive is in the direction of killing people when their lives are judged useless or burdensome to themselves or the world’ (Anscombe, ‘Murder ...’, 268-9). Cf. also Keown, *Euthanasia, Ethics and Public Policy*, 44; Keown, ‘A New Father ...’, 300.

⁶⁰ See (e.g.) James Wilkinson, ‘Position Paper on the Groningen Protocol: Disability Stereotypes, International Human Rights, and Infanticide’ (Brussels: International Federation for Spina Bifida and Hydrocephalus, 2009), <http://www.ifglobal.org/images/stories/groningen-d.pdf>; Bruno Debois and Jacques Zeegers, ‘Euthanasia of Newborns and the Groningen Protocol’ (Brussels: European Institute of Bioethics, 2014), <http://www.ieb-eib.org/en/pdf/20150204-groningen-eng.pdf>.

⁶¹ See van Loenen, *Do You Call This A Life?*, 10-15, 71-7.

⁶² Cf. ‘the categories [of suffering] have a tendency to expand’ (Yuill, *Assisted Suicide*, 151); ‘after the [Dutch] Supreme Court accepted euthanasia in these classic cases [of “terrible physical pain, often as a result of cancer”], the court subsequently categorized “mental suffering” as suffering that could be avoided by terminating life ... in 2011, the debate focused mainly on the question whether the elderly person who is not ill but is tired of life has the right to request assistance to end his life ... the boundaries have been continually pushed back ... The discussion about one category of people for whom termination of life is accepted draws attention to an adjacent category ... to whom the same arguments ... can be applied. And so the position of the Netherlands is constantly shifting’ (van Loenen, *Do You Call This A Life?*, 72-3). Cf. also Finnis, ‘Euthanasia and the Law’, 263-4 n. 50, 268.

⁶³ See <http://www.dailymail.co.uk/news/article-3234917/Elderly-woman-85-reveals-decided-euthanasia-five-minutes-daughter-died-documentary-follows-journey-death.html>.

Flanders, had a traumatic childhood and a difficult marriage (her husband committed suicide). Feeling estranged from her children, and experiencing renewed depression, she requested euthanasia. She was legally euthanised on 19th April 2012; her family found out the next day.⁶⁴ In late 2009, another Belgian, Tine Nys, split up from her boyfriend. With a history of feeling unwanted and unloved, she requested euthanasia, and was legally euthanised in April 2010 at the age of 38.⁶⁵ Although Belgium has an official body that claims to monitor the implementation of euthanasia, no doctors to date have been accused of malpractice and prosecuted. And this state of affairs is approximated also elsewhere. A 75 year-old British ex-geriatric nurse, Gill Pharaoh, travelled to Switzerland in 2015 for assisted suicide. Despite being in perfect health and surrounded by family, she maintained she could not bear the prospect of old age and its burdens.⁶⁶ And more recently, a 70 year-old Greek man, Vassilis Dalianos, has requested euthanasia on grounds of crippling debt. He has appealed to the European Court of Human Rights, because Greece as yet does not permit euthanasia.⁶⁷

What these and similar cases point to is that the notion of ‘unbearable and irremediable suffering’ provides and can provide no genuine constraints upon action. As van Loenen documents, the Netherlands has seen a situation in which only terminal patients in excruciating pain were considered for euthanasia evolve into one where even natural death can be pre-empted as too ‘gruesome’,⁶⁸ and Dutch Ministers of Public Health advocate ‘legalizing assisted suicide for people who are tired of life’.⁶⁹ This heralds the third stage of the dialectic between autonomy and compassion, namely a reversion to autonomy – but this time in a purer, quasi-absolute form. For after confronting an increasing paucity of grounds for euthanasia, the conclusion is drawn that only the sufferer him- or herself properly knows when euthanasia is justified. Hence we have the advent of groups like the Dutch *Uit Vrije Wil* (‘By Choice’), which is lobbying for a suicide pill to be freely available to all Dutch citizens over 70.⁷⁰ And we see the tabling of a ‘death on demand’ law in the Belgian Parliament, which would mean doctors’ having to approve requests for euthanasia within a week, or to pass them on to doctors willing to give approval.⁷¹ This absolutisation of autonomy is anticipated by Novak, who predicts doctors’ being punished if they fail to comply with euthanasia requests.⁷² And it is elaborated by Robert Spaemann, who argues that ‘If it is allowed at all to kill someone at his request, and if the dignity of man consists only in his

⁶⁴ See <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment>.

⁶⁵ See <https://www.lifesitenews.com/news/belgians-speak-out-our-sister-shopped-for-a-doctor-to-label-her-autistic-so>.

⁶⁶ ‘I have gone just over the hill now’, Pharaoh claimed, ‘[and it] is not going to start getting better ... I have looked after people who are old, on and off, all my life. I have always said, “I am not getting old. I do not think old age is fun”’. See <http://www.dailymail.co.uk/news/article-3182813/Healthy-former-nurse-75-died-Swiss-suicide-clinic-deciding-didn-t-want-risk-burden-family-NHS.html>.

⁶⁷ See <https://www.lifesitenews.com/news/greek-farmer-requests-euthanasia-citing-debts>.

⁶⁸ Van Loenen, *Do You Call This A Life?*, 67.

⁶⁹ See van Loenen, *Do You Call This A Life?*, 74. After guiding the Euthanasia Act through Parliament in 2001, the Dutch Minister of Public Health, Els Borst, commented: ‘I have seen a person in this situation up close and later I talked to another. Both were 95 years old and both were simply fed up. They were bored out of their minds and unfortunately they were not bored to death’ (van Loenen, *Do You Call This A Life?*, 74). Cf. Wim Distelmans, who chairs the Belgian *Federal Control and Evaluation Commission* for euthanasia: ‘We at the commission’, he told the *New Yorker*’s Rachel Aviv, ‘are confronted more and more with patients who are tired of dealing with a sum of small ailments – they are what we call “tired of life”’. According to Aviv, Distelmans – who has himself euthanised over a hundred people – considers such ‘pain’ nonetheless to be ‘incurable’. See <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment>.

⁷⁰ See <http://www.uitvrijewel.nu>.

⁷¹ See <http://www.dailymail.co.uk/news/article-3491951/Belgian-lawmakers-vote-world-s-death-demand-law-mean-no-doctor-stop-patient-wants-die.html>.

⁷² See Novak, *Sanctity*, 121.

freedom ... then it is an impermissible paternalism to evaluate suicidal wishes of this kind at all'.⁷³

An impermissible paternalism, indeed – as Rachel Aviv puts it, there is increasing ‘disdain for doctors who assume that they know what their patients need’.⁷⁴ But of course it remains the case that doctors are the ones who administer euthanasia. So the fourth and final stage in the dialectic between autonomy and compassion is a recursion to the doctors’ perspective. This time, however, given the hollowing out of the actual grounds for euthanasia, and the *de facto* control of medics, what ‘compassion’ really amounts to will be systematically occluded. Doctors will be forced, in many cases, to invent grounds for euthanasia, both in face of the objective lack of them, and in order to maintain the appearance of rational accountability.⁷⁵ And other, more insidious pressures will inevitably be brought to bear – the most salient of these being moral and economic. As Finnis outlines the former: ‘what conceivable legislative pronouncements, ... physician reporting, official reporting, [etc.] ... could remove or even appreciably diminish the patient’s subjection to the pressure of the thought that my being killed is what my relatives expect of me and is in any case the decent thing to do ...?’⁷⁶ And as Novak outlines the latter: ‘[health providers] would save huge amounts of money if the average lifespan of their clients were shorter’.⁷⁷ Taken together, these insidious – but real – pressures corrode the last semblance of autonomy which the state affords its citizens. As Spaemann eloquently summarises matters: ‘Making suicide a right has grievous consequences, for then the bearer of this right is responsible for all the consequences, all the personal and financial burdens, which arise from the fact that he does not make use of this right. From this derives with logical necessity an illegitimate pressure on those who are old or sick’.⁷⁸

Conclusion

⁷³ Spaemann, ‘Human Dignity and Human Nature’, 34. Van Loenen notes that many, if not most Dutch citizens *already* believe they are entitled to euthanasia (see van Loenen, *Do You Call This A Life?*, 52, 57, 80, 105-106, 111). This suggests they believe euthanasia is a ‘choice-right’, rather than one grounded in objective interests. Benatar remarks that the ‘choice’ theory of rights makes the argument for euthanasia much easier, and that he ‘happen[s] to think that the Interest theory is preferable’ (see Benatar, ‘Assisted Suicide ...’, 299). But despite Benatar’s preference here, according to the dialectic I have outlined, it will not – and moreover cannot – be honoured under a euthanasia regime.

⁷⁴ See <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment>.

⁷⁵ NB the case of Tine Nys above, where the doctor in question seems to have invented a ‘diagnosis’ of autism (presuming this would justify euthanasia). See <https://www.lifesitenews.com/news/belgians-speak-out-our-sister-shopped-for-a-doctor-to-label-her-autistic-so>.

⁷⁶ Finnis, ‘Euthanasia and the Law’, 262. Cf. Keown, *Euthanasia, Ethics and Public Policy*, 56.

⁷⁷ Novak, *Sanctity*, 159. The chances of such economic motivations remaining taboo have lessened, because high-profile figures have not only recognised them, but also given them their endorsement. See, for example, Baroness Mary Warnock on dementia sufferers’ ‘duty to die’ (viz. duty to be killed): ‘A Duty to Die?’, *OMSORG* 4/2008, 3-5, <https://fagbokforlaget.no/filarkiv/Mary%20Warnock.pdf>. For a real world example of pressure to reduce ‘end-of-life’ costs (from the British NHS), see <http://www.dailymail.co.uk/news/article-2468112/Revealed-How-GPs-paid-50-bonus-elderly-death-lists.html>.

⁷⁸ Spaemann, ‘Human Dignity and Human Nature’, 40. In Finnis’ dramatic but rigorous formulation, in a euthanasia regime ‘Killing with intent becomes a routine management option. Oh yes, there are restrictions, guidelines, paperwork. Well meant. Not utterly irrelevant. But as nothing compared with our doctors’ change in heart, professional formation, and conscience’ (Finnis, ‘Euthanasia and the Law’, 260). This ultimate dependence on doctors is brought out well by van Loenen, who shows how the chances of being euthanised as a disabled infant vary strongly according to which Dutch hospital he or she is placed in (see van Loenen, *Do You Call This A Life?*, 180, 192).

In sum, I have argued that what begins as a call to defend the autonomy of citizens, and to show compassion to them in their suffering, devolves into a legal, moral and cultural tissue of contradictions and incoherent hopes. And this is borne out not only philosophically, but also by mounting empirical evidence. At the first stage of the euthanasia dialectic, there are heroic invocations of the individual right to self-determination, but these are quickly shown to disintegrate in face of individuals' subordination to various bureaucratic structures, and the actual priority of suffering. At the second stage, 'unbearable and irremediable suffering' itself turns out to be a highly unstable and unwieldy notion, which fails to place any real or determinate limits on the grounds for euthanasia.⁷⁹ This ushers in stage three, where it becomes apparent that compassion for suffering has opened the door to a form of pure autonomism: those requesting euthanasia now feel, and *are* increasingly entitled to it, however exiguous their grounds. Fourthly and lastly, this regime of *de jure* entitlement confronts the *de facto* control of the medical profession, which increasingly becomes the site of unaccountable decision-making, and pressures that further impugn the autonomy of citizens. All of which bears out the wisdom of the threefold political argument I detailed above. For what appeared there an over-stipulative and incomplete case – reliant on premises about the state monopoly on lethal 'force', guilt as a necessary condition of such force, and 'care' as excluding killing – has now been shown to be fundamentally well-founded. For a state that legalises euthanasia steadily erodes both individual autonomy over life, and doctors' accountability for life – and thereby, ultimately, its own authority, which rests on upholding both.

Those who argue for legalising euthanasia are sometimes alert to these forms of erosion (though they never consider the evidence for them in detail). They respond characteristically, however, by calling simply and solely for legal 'safeguards'. As Benatar writes, for example, we need 'to build robust safeguards into the legislation that legalizes [assisted suicide and voluntary euthanasia]'.⁸⁰ And Warnock holds that 'It should not be impossible to draft a [euthanasia] Bill with safeguards and penalties attached to prevent its scope being widened'.⁸¹ But this kind of response is profoundly misguided, and moreover shows a startling lack of realism. For it appeals as a bulwark against the erosion of patient autonomy and medical integrity to precisely the primary cause of their erosion: namely, the law. In the Netherlands and Belgium especially – the two jurisdictions where euthanasia has been legal the longest – the law has been gradually liberalised through a series of acts and amendments. I mentioned the 2005 *Groningen Protocol*, which extended euthanasia to non-voluntary cases involving disabled infants. But there are several other extensions I could have mentioned, of which the 2014 Belgian extension to 'terminally' ill children, with no age limit imposed, is only one.⁸² And now we see the tabling of a Belgian bill which proposes what appears a form of pure autonomism: viz. an absolute right to euthanasia (see note 71). So it is naïve and irresponsible to cast the law as a redoubt against change. No law, so far as I am aware, guarantees its own fixity or irrevocability (even at the constitutional level).

Even if this is conceded, however, and the journey of the Benelux countries lamented, there is likely to be a residual and highly indignant *cri de coeur*: 'Maybe you have shown that autonomy and compassion are inadequate bases on which to legislate, and maybe they do lead

⁷⁹ Here I would refer the reader to note 69 in particular, where Distelmans, the Chair of the Belgian euthanasia Commission – and himself a leading euthanasia advocate – declares that feeling 'tired of life' can amount to a form of 'pain' that is 'incurable'.

⁸⁰ Benatar, 'Assisted Suicide ...', 308.

⁸¹ Warnock, 'A Duty to Die?', 4.

⁸² See, e.g., <http://www.bbc.com/news/world-europe-26181615>.

to the incoherences you outline. But these are as nothing compared to the cases of genuinely unbearable and irremediable suffering that undeniably exist. Are you willing to see these continue, merely in order to save an abstract principle like that of double effect? This would be unconscionable. So whatever the problems entailed by legalising euthanasia, they are worth dealing with, given the great costs of doing nothing'. There are several flaws in this line of reasoning, but I will highlight only the most salient one, viz. the suggestion that there are only two alternatives: either legalise euthanasia, or callously let severe pain continue. This presupposes a false dichotomy. Denying the right to euthanise does not entail that citizens have 'a (negative) *duty* to live',⁸³ and hence a duty to endure all manner of pain. No one committed to banning euthanasia is committed to (say) the indefinite continuance of the pains of late-stage cancer. For there are already highly sophisticated drug treatments that can efficiently palliate such pain.⁸⁴ And furthermore, at any stage, patients can already refuse treatment designed to save life⁸⁵ – despite certain scare stories retailed by the media, which suggest that hospitals are bent on preserving life at all costs.

At this final juncture, there may still be an objection: 'Granted', the objector might say, 'in most cases pain can be palliated, and yes, patients are not under a blanket obligation to accept life-saving treatment. But there will always be a small number of cases where severe pain cannot be avoided, and for those cases, euthanasia is warranted. By insisting on a complete ban, you are condoning the existence of such cases, and that, again, is unconscionable'. But here I would say two things. First, the claim that 'there will always be a small number of cases where severe pain cannot be avoided' is highly disputable. The expert palliative care literature I cited in note 84 denies it, and anyway, there is clear evidence that physical pain is trumped as a motivation for euthanasia by fears of loss of autonomy and of becoming a 'burden'.⁸⁶ (This is something usually papered over by euthanasia advocates.) Secondly, *even if it were true* that some cases of severe pain inevitably slip through the net, this would by no means justify the overhauling of a state's legal and criminal justice system, and the subsequent (and likely irrevocable) damage done to its moral culture which I have outlined. We have seen that such damage is already being done in cultures at the heart of Europe; people of conscience have a responsibility to resist its spreading further.

⁸³ Benatar, 'Assisted Suicide ...', 300.

⁸⁴ For a book-length treatment, see Roger Woodruff, *Palliative Medicine: Evidence-Based Symptomatic and Supportive Care for Patients with Advanced Cancer* (4th edition) (Oxford: Oxford University Press, 2004). For public internet sources, see, e.g., Ilora Finlay, 'Improving Access to Palliative Care for Everyone', <http://www.ehospice.com/uk/ArticleView/tabid/10697/ArticleId/16594/language/en-GB/View.aspx>; Richard Doerflinger and Carlos Gomez, 'Killing the Pain Not the Patient: Palliative Care vs Assisted Suicide', <http://www.usccb.org/about/pro-life-activities/respect-life-program/killing-the-pain.cfm>; Roger Woodruff, 'Euthanasia and Physician-Assisted Suicide: Are They Clinically Necessary?', <http://hospicecare.com/resources/ethical-issues/essays-and-articles-on-ethics-in-palliative-care/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary>.

⁸⁵ See, e.g., Liz Gwyther, 'Withholding and withdrawing treatment: practical applications of ethical principles in end-of-life care', *South African Journal of Bioethics and Law*, 1 (1) (June 2008): 24-6. Several philosophers argue that excessive extension of life is just as unwarranted as its premature curtailment. See, e.g., Keown, *Euthanasia, Ethics and Public Policy*, 39, 43; Spaemann, *Essays in Anthropology*, 68; Spaemann, 'Human Dignity and Human Nature', 39, 42.

⁸⁶ See, e.g., Wesley Smith, *Culture of Death: The Assault on Medical Ethics in America* (San Francisco, California: Encounter Books, 2000), 115.