Assisted Suicide: Compassion and Choice or Callousness and Coercion?

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An American organisation, *Compassion and Choice*, formerly the Hemlock Society, has adopted an appealing and catchy slogan to promote their campaign for assisted suicide. The words 'compassion' and 'choice' resonate with modern society since their antonyms are cruelty and coercion. There is a danger that this language may help shut down the debate and generate a false impression that only religious people, driven by paternalism and imbued with the belief in a God of punishment, will have any objection to this practice. But there are powerful reasons why even atheists may balk at the normalisation of assisted suicide. As clinical psychiatrist and ethicist Dr. Mark Komrad points out, euthanasia is a violation of an ethical injunction that predates Christianity, with the Hippocratic Oath of ancient Greece prohibiting it. Referring to psychiatrists in particular, he said 'We prevent suicide, we do not provide suicide.'

The religious arguments against assisted suicide are well known to the readership of *Intercom*. The secular arguments are generally less well appreciated. It should not be forgotten that many powerful organisations, such as the American Psychiatric Association, the American Medical Association, the World Medical Association (WMA, formed in the wake of the Holocaust) and a raft of others, including the Israeli Medical Association, are opposed. However the British Medical Association is neutral, while the Canadian Medical Association favours assisted suicide and, along with the Royal Dutch Medical Association, has campaigned for the WMA to adopt a neutral position.

Turning to the secular arguments, one is that the human life is precious and should be valued. All humans deserve to be treated as such, irrespective of age, sex, race, religion, social status or their capacity for achievement. Those who are frail or elderly should not be treated in an inferior manner when it comes to respecting their right to lifelong care until nature takes it inevitable course. The proponents of assisted suicide may well counter this, arguing that giving an individual choice in how they die is actually showing them respect rather than the contrary. This omits the unintended consequence that subtle coercion may remove choice from the frail and elderly if they are groomed into perceiving themselves as a burden, especially if assisted suicide becomes socially normalised. Living in a continent which faces a huge ageing population, it is unarguable that such a solution would have some appeal to governments struggling to deal with the pension crisis and with health resource problems.

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This utilitarian approach is very much at variance with the dogma of respect. For example, the philosopher Immanuel Kent stated that human beings should be regarded as a value in themselves and not as a means to achieving another goal, such as reducing healthcare costs. Human beings should also value themselves in all their vulnerability and frailty, and shun the pressure of self-deprecation and defeatism.

An argument against the introduction of assisted suicide is the slippery slope hypothesis. This proposes that once the slope has commenced, it will only get steeper. This implies that once a behaviour is minimally tolerated it will open more doors and extend the criteria for general acceptance of that behaviour. There is some evidence of this in respect of assisted suicide, as its use has extended from those who were terminally ill and had unmanageable pain, through to conditions that were difficult for individuals to deal with emotionally, such as motor neurone disease, then further reaching others with conditions such as depression, and finally, perhaps most cruel of all, to children who may be autistic or suffering with depression. Canada is to the fore in trying to extend Medical Assistance in Dying (MAID) to children.

Another secular concern is that MAID cedes too much responsibility and power to doctors who may begin to assume godlike authority where life and death are concerned. Their narcissism might run riot, generating singular decisions that ending lives prematurely would be the best option for some, who know no better. The nebulous question of quality of life crops up here and it may spur power-seeking doctors to decide who has and has not a good quality of life. In other

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words, identifying those whose life is unworthy of life. How can the poor person living alone in a tower block, compromised by emphysema, have a fruitful, meaningful life when viewed from the perspective of a wealthy doctor living in a leafy suburb, unless one clings to the view that of itself every life is worthy of life? Deviation from that value would rapidly unleash eugenic euthanasia.

Consider how a patient would feel, knowing that their doctor supported and/or practised euthanasia. Could you trust that doctor to unquestioningly offer the best treatment possible, up to the natural end of life? Could you trust them to have your best interests at heart? And might the day come when, despite your protestations, you come under the doctor's needle, as happened recently in Holland?

The question of advance directives needs to be considered also. If an individual at a time of full or near full health makes a decision that at a certain point in the course of their illness their life should be ended, surely there can be no quibble about accepting that person's wishes? However, this argument neglects the reality of the medical evidence that as people progress through different stages of an illness, their level of psychological adaptation changes. Impairments that previously appeared impossible to live with, over time are accommodated and accepted. We know that human beings are resilient and that adhering rigidly to advance directives without making allowances for the ability to adapt to changed circumstances and to factor in the inner strength that people possess, is in itself disrespectful of the human condition.

Another of the emotive arguments is that unexpected suicide among cancer patients can be reduced when sufferers are aware that assistance with death in the face of intractable pain is available. This knowledge, according to the arguments, defers the rush to suicide and reduces the desperation that leads to suicide. Thus, the availability of assisted suicide actually reduced the actual suicide rates, even when those dying with assistance are excluded from the data. This can be tested by studying the suicide rates in states where it has been legalised and comparing rates of suicide before and after the legal changes.

Professor David Patton, from the Industrial Economics Department of Nottingham University, compared rates of non-assisted suicide in Washington and Oregon between 1990 and 2013. The study, published in 2015 in the Southern Medical Journal, found that there was a 6.3% increase in total suicides (assisted and non-assisted) and no decrease in non-assisted suicides, as claimed by proponents of the measure.

One of the arguments against physician-assisted suicide is that it would be hypocritical to, on the one hand, spend millions on suicide prevention initiatives while at the same time recommending suicide to others as a way out of their turmoil. What type of message is this, that is so empty of hope and marked by pessimism towards our patients? Does this give the wrong message to vulnerable people? Should not those who are requesting assistance be referred for psychiatric evaluation, given the data on the high prevalence of depression in this group? And of course the answer is yes. A further question is whether assisted suicide increases suicide contagion when it is presented as viable option in difficult situations. The Oregon Health Authority Data (2015) showed that as of 2012, the Oregon suicide rate was 42% higher than the national average, and this data did not include cases of assisted suicide. Further studies in other states on this question are continuing.

As the threat to the innate value of human life continues apace, it is crucial to be well informed, and one of the very helpful resources is the Charlotte Lozier Institute and the work of Richard Doerflinger.[1]

Note

[1] See www.lozierinstitute.org. For an interview with Richard Doerflinger on Physician-Assisted Suicide and Euthanasia, see https://lozierinstitute.org/qa-with-the-scholars-physician-assisted-suicide-and-euthanasia/. - Ed.

Patricia Casey is Consultant Psychiatrist, Mater Hospital Dublin and Professor Emeritus at UCD. She is a columnist with the Irish Independent