articles

Resolving the Conflicts over Assisted Death

Sir Patrick Bateson, FRS

In 1988, when he was still Provost of King's College, Cambridge, Pat Bateson chaired a Network May Dialogue between Richard Dawkins and Brian Goodwin. I had not seen him since and met him again last November when he was giving a lecture in Rome and we were both guests at Spineto Abbey. He said that he had written an essay on assisted death and I sent him Mary Midgley's article from last summer's Review, questioning the quest for physical immortality. Here he considers issues raised by assisted death.

My father had died at a relatively young age from a stroke. My mother married again. After several years, however, my step-father also had a massive stroke. As he lay unconscious in hospital with a very poor prognosis, he developed pneumonia. This disease is often described as the old man's friend because it allows the patient to slip away peacefully without any suffering. However, my step-father was not allowed that privilege. He was given an antibiotic and the pneumonia was cured. He recovered consciousness but he could neither speak nor walk. He languished for two more years but he was trapped in torment inside a useless body. He could just about signal with his eyes his recognition of our presence when we came to see him, but his condition was a source of great suffering to him. Before one visit by my mother and me, he had with super-human effort swept his lunch onto the floor in his anger and frustration. Why had he been allowed to suffer so? If he had been treated like a pet he would have been allowed to die two years earlier when he contracted pneumonia.

When I have discussed this and similar cases with medical doctors, they admit that if a patient is dying at home, they will sometimes quietly assist death by withholding treatment or actively administering a lethal dose of a drug. They insist that assisted death is not the same as euthanasia when the patient's views are unknown. In a hospital, doctors behave differently, even when their judgement is that the patient will never recover. Typically they operate in teams. If they took a unilateral decision, they may fear that their actions will be reported and that they will then risk prosecution. Moreover, it can always be argued by others that sometimes patients do recover, at least partially, after prolonged comas or severe strokes.

The Timing of Inevitable Death

Humans know that they must eventually die and many, at least, wish to put off the moment of death for as long as possible. In affluent countries, by far and away the most expense and medical care is spent in the last twelve months of most lives. The very rich may even ask that they be frozen immediately after death in the hope that at some future date, the technology might be available to resuscitate them.

Nevertheless, many people with progressive and incurable diseases want to die before they are totally incapable. Sir Terry Pratchett, a best selling novelist, has written eloquently about the problem. He has been diagnosed with early onset Alzheimer's disease. The disease is inexorable and he would like to be able to seek help in choosing the moment when he might end his own life. In most countries it is illegal to help people to die. You can go, as a member of the family or as a friend of the person who wishes to die, to the Dignitas clinic in Zurich where assisted death is legal. But the procedure is expensive and, disagreeably, the person who wishes to die has to self-administer the fatal cocktail. Moreover, if the friends or family members are from the UK, they risk prosecution when they return home.

In his BBC Dimbleby lecture Pratchett (2010) suggested that a tribunal could establish the facts of the case well before the assisted death might take place. The members of the tribunal would ensure the person wishing to die was of sound and informed mind, firm in their purpose, suffering from a life-threatening and incurable disease and not coerced by a third party. He suggested that the tribunal should include a lawyer with good listening skills and expertise in family affairs and a medical practitioner experienced in dealing with the complexities of serious long-term illnesses.

Pratchett stated that: "The tribunal would also have to be a check on those seeking death for reasons that reasonable people may consider trivial or transient distress. I dare say that quite a few people have contemplated death for reasons that much later seemed to them to be quite minor. If we are to live in a world where a socially acceptable "early death" can be allowed, it must be allowed as a result of careful consideration."

The tabloid press ridiculed his idea of what they called "Death Committees", but as Pratchett had already said: "It grieves me that those against assisted death seem to assume, as a matter of course, that those of us who support it have not thought long and hard about this very issue."

He concluded movingly:

"I would like to die peacefully ... and I hope that will not be for quite some time to come, because if I knew that I could die at any time I wanted, then suddenly every day would be as precious as a million pounds. If I knew that I could die, I would live. My life, my death, my choice."

Those critics of Pratchett who were more thoughtful than the tabloid journalists said that any legalization of assisted death could play into the hands of unscrupulous people who wished to get rid of an aged relative who caused them trouble and even might, when he or she died, leave them wealth and possessions. In a superb article by the former Editor-in-Chief of the New England Journal of Medicine, Marcia Angell, wrote about the effects of the Death with Dignity Act passed by the Oregon legislature in 1994. Angell (2012) pointed out that concerns about an ethical "slippery slope" have not been borne out. Good palliative care has increased. The law is not used

disproportionately by the poor or the uninsured. It is used by people like Pratchett who value independence and their ability to control what happens to them. Above all, no evidence exists of coercion by unscrupulous family members. Nevertheless, profound differences of opinion about assisted death still exist. An attempt to introduce a Death with Dignity Act in Massachusetts in 2012 was defeated by nearly 52% of those voting. The Catholic archbishop of Boston, Cardinal Seán O'Malley, described assisted dying not as compassionate, but as an act of "sheer brutality."

Resolving Conflicts

Resolutions of conflicts between seemingly irreconcilable interests or value systems are common enough. Consider for example the conflict between maintaining fish stocks and caring for the people in fishing villages; or the conflict between having pure air and providing sources of energy from fossil fuels; or the conflict between farming and the conservation of habitats. Sloganising intransigence can end up with outcomes that are regarded as undesirable by everybody: no fish and no fishing villages; dirty air and devastated sources of energy; dead waterways, unproductive land and massive reductions in biological diversity.

Turning now to the moral dilemmas faced by whether or not it should be acceptable to help someone to die, consider the conflict between the individual's wishes and those of the friends and family. If both are strongly in favour then no problem arises and conversely if both parties are against, the decision not to proceed is clear. How do we draw the line between what is acceptable and what is not? Those who favour assisted death suggest that pre-eminence should be given to the subject's own wishes. Many will argue, however, that the prevailing ethics of the society might be strongly opposed to assisted death. Some will state that it is God's choice when a human will die. In a secular society, on the other hand, others will argue that a God's wishes cannot be determined by rational inquiry. On this view harsh Christian theology, to take just one example, should not be given precedence over human compassion, one of Christianity's most endearing features. Plenty of examples exist where the scruples of a religious minority have been over-ridden by the wishes of the majority. Contraception, abortion and stem cell research are three cases in point. In the UK suicide was decriminalised in 1961. So a second set of oppositions must be considered, namely that between the views of the subject and those of society.

The three assessments are these; the wishes of the patient, the wishes of family and friends, and the prevailing consensus in society as a whole. The three dimensions can be brought together in a single decision cube. I have shown this in Figure 1. The decision space is not absolute, it depends on consensus and, in any particular case, the outcome is contingent on the assessments made along the different dimensions of the space. Some of the moral tensions are not easily resolved in the abstract since the position that a person adopts will be swayed by the choices they are offered. Social psychologists have often noticed the contextual effects that can arise when different forms of assessment are used. This tendency to base judgements on the last assessment that has been made can be met in part by ensuring that the different dimensions on which the final choice depends are made independently and only then are they brought together for the overall decision.

The decision cube is emphatically not a cost-benefit piece of accountancy since it does not depend on a common currency or on balancing incommensurable properties. It is a pragmatic approach that can be helpful, I believe, in determining whether or not a decision to assist the death of a person should be taken. It is similar to the weighing carried out by a judge faced with conflicts in a court of law. I did not imagine that the positions of the lines indicating whether or not to give assent to a assisted death would be forever frozen. The positions represent a political consensus acceptable to the majority of the public. Therefore they would require debate in the institutions set up in democracies in order to bring together a representative set of opinions

Some people will never agree with such an approach. Their views should be respected but not heeded if they belong to a marginalised minority. I fully accept that some doctors and nurses would be unwilling to take a person's life, no matter how compelling were the arguments for doing so. They should not be required to do something that conflicts with their moral convictions. They have the right to hold a conscientious objection. However, they do not have the right to prevent somebody else who, for compassionate reasons, believes that it is appropriate that a person should be helped to die. Nor do they have the right to withhold taxes when the expense of an assisted death is covered by the state. The more interesting case, discussed by Mark Wicclair (2011), is whether they have the right to withhold information that might be beneficial to the person seeking assistance in ending his or her life. However, this issue does not bear on how to resolve the conflicts that bear on whether assisted death should proceed. The decision cube, then, is my offering to a tribunal of the type recommended by Terry Pratchett, were such a tribunal to be established.

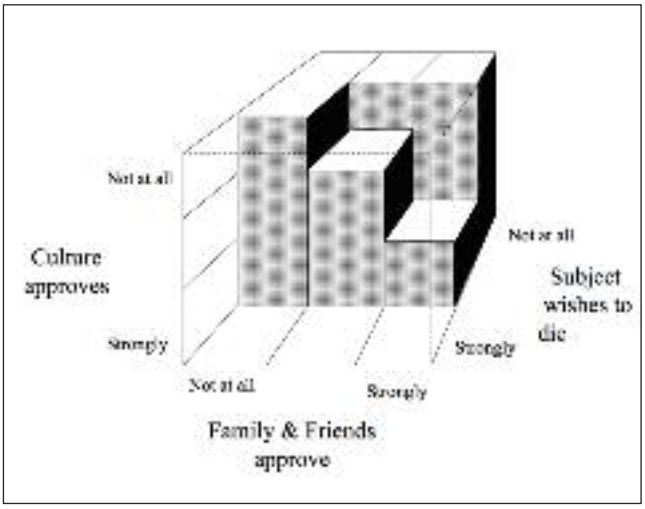

Figure 1. A decision cube for making a judgement about whether or not an assisted death should proceed. Three independent assessments are made. The first assessment is of the subject's own wishes, the second is of the wishes of the family and friends and the third is of the consensus view about assisted death in the subject's society. If the three assessments fall into the solid part of the cube, assisted death would be deemed unacceptable, otherwise it would be deemed acceptable.

Reference

Angell, M. (2012). May doctors help you to die? *New York Review of Books, October 11 2012*, 39-42.

Pratchett, T. (2010) Shaking hands with death. BBC Dimbleby lecture, 2 February 2010. http://www.humanistlife.org.uk/2010/02/shaking-hands-with-death-terry-pratchett-gives-the-dimbleby-lecture/Tversky, A. & Simonson, I. (1993) Context-dependent preferences. *Management Science*, 39, 1179-1189.

Mark Wicclair (2011) Conscientious Objection in Health Care: An Ethical Analysis. Cambridge: Cambridge University Press.

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