

HUMAN RIGHTS AND EUTHANASIA

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The concept of human rights, derived from considerations of the nature of mankind, originated within a political context. Called natural rights, they developed as a proclamation of liberty, to be used to guarantee freedom from attacks on one's life, dignity or property. They were considered to apply equally to each individual, or to equivalent groups, they were unconditional and they imposed on others a duty to respect them. Originally conceived as freedoms 'from' oppression and other injustices, they evolved to include, and largely become, freedoms 'to' have or do what may be wanted. More recently, to natural rights have been added welfare rights, claimed as entitlements to opportunity or goods, to be provided or respected by others.

Unlike the original concept, grounded in nature and reason, claimed welfare rights are grounded in the self-creating will, are of variable force and are frequently contentious. They are not universally applicable and many would be thought absurd and/or unattainable in many cultures.

Natural rights did not come into existence only when or because they were articulated. If a natural right is genuine, it always existed, even before it had been discerned. Genuine rights cannot be created just by claiming them, unless it can be agreed they have always existed, in nascent form.

In societies where moral absolutes are now less often acknowledged, the growth of moral relativism and pluralism has meant the attenuation or loss of former ways of determining the morality of human actions.

This creates new difficulties in evaluating many of to-day's complex issues, including some of those related to advances in medical treatment. Debate about their morality is impoverished in the following ways, by an eagerness to transform questions of right and wrong into questions of individual rights.

First, the subject matter being examined is changed when 'What is right?', where the focus is on the acts of the community of individuals, is replaced by 'What are the rights?', where the focus is on the acts of individuals in the community. Second, discussion of rights is subject to selective, and therefore distorted, consideration when only those rights are admitted into the debate which might help gain a desired outcome. Third, resort to claims of rights is not always, or even often, the best way to achieve a consensus, protective of the rights of everyone, not just of certain individuals or groups. These notions will be further discussed later.

After the end of the Second World War, when it had become apparent how extensively human rights had been lately so abused, the United Nations defined and proclaimed human rights, in the hope that they would thereby be better understood

and secured. Accordingly, in 1948, the Universal Declaration of Human Rights declared that 'the foundation of freedom, justice and peace in the world' is the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family'. Further, 'everyone has the right to life' and 'all are equal before the law and are entitled without any discrimination to equal protection of the law'.

This Declaration was supplemented by more specific proclamations, including the 1966 International Covenant on Civil and Political Rights, Article 6 of which states: 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'.

Words such as 'equal', 'inherent', 'inalienable', 'without discrimination' and 'arbitrary' were meant to define the essence of natural rights, particularly that they do not depend on circumstance or personal preference. Natural rights are not to be taken away and, just as importantly, are not to be given away. The right to life is to be protected by law, invariably and equally, and life is not to be taken for reasons based on opinion.

The right to one's life is declared to be the fundamental natural right, on which every other right depends for its existence and its validity.

When an attempt is made to justify euthanasia by using claims about human rights, it will be seen how problematical these claims become when they focus only on a single right, and when that one is of doubtful validity. Wide disparity between doubtful and genuine rights is not, however, commonly taken to be the prompt for some necessary exploration of the gap; rather the gap is simply ignored. Paradoxically, assertions of dubious rights generally go unchallenged, while insistence on respect for genuine rights may be labelled as evidence of religious or emotional bias.

The common reasons to want legalised euthanasia can be categorised as: seeking the compassionate relief of pain and suffering, providing protection for doctors who behave compassionately, showing respect for human rights and assisting in the containment of health costs.

There is a common presumption that there is a 'right to die', in the sense of an autonomous right to choose the time and manner of one's death, and that an appeal to this right will be sufficient ground for legalising euthanasia. There is an ethical right to die, in the sense of a right to be allowed to die, when one is dying and it is in one's interest to die, by discontinuing or not commencing unwanted, burdensome and/or futile medical treatment, and by providing all necessary comfort. But this is not what is meant in the context of euthanasia.

What is now implied are claims to new and different grounds, going beyond the wishes of an individual. They include claims to rights to request another to take one's life, to respond to that request by intentionally taking that life, and to justify such killing simply because it was requested. This is a vastly different position from what is generally understood by personal autonomy, though this extension is rarely made explicit.

A right to have one's life taken on request has never been recognised in codes of ethics or the law of any country. Its assumption conflicts directly with the genuine right to one's life, acknowledged and protectively enunciated in the Universal Declaration, to which most countries, including Australia, are signatories.

To those who question the application of international declarations of human rights to Australian conditions, Mr Justice Michael Kirby*, now a Judge of the High Court and a leading human rights campaigner, said: 'We in Australia, who enjoy so many blessings of nature, history, law and democratic institutions cannot be entirely cut off from international moves for the protection of universal human rights. The thought that we can pull up the drawbridge and shut out the influence of this global development . . . is as unrealistic as it is unworthy'.

A right to have one's life taken on request would conflict with, and overturn, the principle of the criminal law in this as in every nation that human life that presents no threat to another is inviolable, and that protection for all innocent life against predation is necessary. A minimal requirement before removing that protection, therefore, should be a full discussion of all the consequences of any proposed change.

Could this novel, claimed right to die be justified, even occasionally, by the rational request of a person, expressing his or her free choice? If the natural right to one's life is really inherent and inalienable, that is not even remotely possible. If, for the sake of discussion, there were a natural right to be killed on request, it ought to be able to be validated by reasoned argument, it should always have existed, it must apply equally to all who ask, and it must oblige respect. The supporters of euthanasia offer no arguments that such a right has always existed or that it exists now, they do not think it has universal application because they place limitations on those to whom it would apply, and they are careful to disclaim that such requests are binding on others.

Could euthanasia be justified as a genuine welfare right, autonomously requested? Some genuine welfare rights do oblige compliance by others, even without a request. For example, the welfare right of a patient to be sufficiently informed of the significant risks of proposed medical treatment does not depend on the patient asking for the information - it is the responsibility of the doctor to provide it, whether or not there is a request.

If the right to euthanasia on request were genuine, and a doctor was permitted to take the life of a patient who asked for it, the doctor would also be justified, and perhaps obliged out of compassion, in taking the lives of others in similar unfortunate circumstances. This may apply especially when, for any reason, patients could not ask. It could be thought discriminatory and unjust to withhold such a benefit, merely because it could not be requested, if there were also a right to that benefit.

While the right itself may not be established, suppose the power of autonomy were such that the request became valid in the conditions in which it is usually said to be made. Indeed, it appears that this is what is often assumed, since autonomy is commonly discussed as though it was about having whatever is freely, informedly and competently requested. But since no-one is owed anything just because they ask, autonomy must have limits.

What then might those limits be? Leaving that question unasked, let alone unanswered, is one of the many ways in which the relationship between euthanasia and rights is confused. Autonomy refers to one's claim to have what one is entitled to, short of infringing the valid rights of other individuals or of the community. As one American philosopher put it: 'Your right to swing your fist ends at the tip of my nose'.

If autonomy were as unlimited as is commonly supposed when discussing euthanasia, though it is less common to find it so rigidly interpreted in other contexts, a competently self-determined request could never be refused, and a competent request for euthanasia would be justified for any stated reason or none, by any person, sick or not, at any time.

Since the common good is a good for all, not a good for each, proposals for the legalisation of euthanasia must, at the very least, include some attempt to find a balance between individual choice and the community's need for good order, social harmony, and the protection of its vulnerable members. Finding that balance is especially demanding in a society which places high value on respect for persons and their autonomy, but the search for balance is frustrated by lack of an agreed understanding of autonomy. Though the common good presumes moral concerns for arrangements beyond the individual, these are ignored when exclusive emphasis is placed on individual autonomy.

It is extraordinary that, although at least two persons are involved in euthanasia, both of whom will have to make an autonomous decision, only the autonomy of the patient is discussed. The doctor is a separate moral agent, with autonomous responsibility for his or her own actions, particularly those with undoubted moral content, but his or her autonomy totally escapes examination. What makes it extraordinary is that the doctor's autonomy will always be more determinative of the fact of euthanasia than the patient's, since it will not occur without a consenting doctor.

This omission conceals two important issues: first, the means by which the doctor's decision is reached, and second, the great difference between the doctor and the suffering patient in their capacities to make autonomous judgments.

How might a doctor's reasons for agreeing to a request for death be formulated, so as to be objectively tenable? Surely, doctors could not be permitted to take life simply because they were asked; since nobody would destroy something they valued, he or she would necessarily have concluded that that life had lost such value as would require its protection. But there are no objective criteria by which anyone could reach such a conclusion, and certainly none which would indicate when life may be taken. That conclusion could only have been arrived at by having regard to its low quality at that time, and would presume that value resided in the circumstances at a particular time, and was not inherent.

Since it is not possible to suppose that all observers, considering the same factors, would reach the same conclusion, the judgment would relate to the observer's personal values, expressed as an opinion. This could not be objectively tested, and being arbitrary, would lack an essential condition for being just, and being seen to be just. There is no right to behave unjustly.

Patients and doctors do not have equal decision-making capacity. Patients with life-threatening illness often have greatly impaired capacity to make rational judgments about complex matters. Potent emotions, such as fear, anguish or despair, are frequently present, though when they are recognised and treated adequately by competent doctors, the reason for a request to be killed will often disappear. To accept requests for death at face value without providing adequate care would be a form of patient abandonment, by taking advantage of their vulnerability in such states. In so doing, their autonomy would be abused, in the name of honouring it.

By contrast, the doctor must be presumed to be rationally capable of decision-making, prepared to have his or her decisions scrutinised, and prepared to take both moral and legal responsibility for them.

A further major difficulty with the discernment of genuine autonomy in those who are dying concerns the close association between the sincere wish to be dead and mental illness, present in up to 95% of those who wish to commit suicide or who request euthanasia. Numerous articles in the literature of psychiatry reveal that the great majority of patients who desire death during a terminal illness are suffering from a treatable mental illness, most commonly a depressive condition. This is not a diagnosis which can easily be made by the average doctor unless he or she has had extensive experience with depression and suicide, and it is frequently missed even in those already under medical care.

It has been suggested, therefore, that patients will be protected by having a psychiatrist see every person who requests euthanasia. But it is not so simple, since only those psychiatrists with extensive experience of terminal illness and suicide will be sufficiently qualified in this area. Frank Varghese, Professor of Psychiatry in Brisbane, believes that if these patients were always seen by someone with the appropriate experience, 'it is unlikely euthanasia would ever go ahead'. Hendin and Klerman, American psychiatrists with extensive experience with suicide, comment that 'there is still too much we do not know about such patients, too much study yet to be done before we could mandate psychiatric evaluation for such patients and define conditions under which assisted suicide would be legal'.

Depressive illnesses can be associated with a number of cognitive changes, including a significant and measurable decrease in intellectual functioning, diminished concentration, indecision, mild memory loss and sometimes confusion. In fact, serious debilitating illness of any kind can cause degrees of confusion and depression. When to these factors is added the lack of any objective criteria for assessing the degree of mental competence required for different kinds of decision-making, simple assumptions about the presence of genuine self-determination evaporate.

Yet another problem is the question of external influence on those who are ill by subtle, undetectable degrees of coercion which would negate freedom of choice and invalidate autonomy. In its Working Paper Number 28 of 1982, titled Euthanasia, Assisting Suicide and the Cessation of Treatment, the Canadian Law Reform Commission described this possibility as 'a constant danger', and one that could not be protected against. The 1994 Report of the Select Committee on Medical Ethics of the House of Lords concluded 'It would be next to impossible to ensure that all acts of

euthanasia were truly voluntary, and that any liberalisation of laws would not be abused’.

When these difficulties are taken together, the conditions necessary for the genuine exercise of autonomy may be doubtful or absent in an unknown number of requests for euthanasia, possibly the majority. It is unlikely that these problems could ever be overcome by any arrangement of words in a draft bill, since they relate to human variables, unable to be measured or even discerned.

Some of the results of an over-ready resort to claims of rights in preference to a reasoned exploration of all the issues in dispute, already mentioned, will now be examined.

First, discussing individual rights cannot settle questions of right or wrong. Rather, it is a way of avoiding the issue. It is often said that, in a pluralistic society, what is ethical or moral is a matter for private determination. Despite that, there is real community consensus on the morality of most of the actions that are the subject of criminal law, and even the most liberal libertarians are as keen as others to articulate their grievance when they feel have been wronged. If, as a society, we cannot agree that it is wrong to take innocent life, that natural rights need respect and protection, and that the frailties of mind and body imposed by serious illness render the sick peculiarly vulnerable to manipulation by others who may resent them for social reasons, on what can we certainly agree? If we cannot agree on the morality of anything, then the law can be dispensed with, except in so far as it represents self-interest or mob rule.

Second, in any discussion of rights, each person may decide which rights they will enter into the debate, and which they will omit. What may seem to be a fair and reasonable treatment of an issue is easily distorted when important matters are omitted. No better example of this can be found than the near-total neglect of the undoubtedly genuine and equal right of every innocent person to their life, while highlighting only the asserted, but unproven, novel right to die. By this omission, the interests of an articulate select group are promoted at the expense of the vulnerable who will be left to take their chance at the hands of those who, in many instances, are already known to want some of them dead. Nothing could be more hypocritical or callous. If the state will not protect the weak, who will?

Third, when the ways are examined in which human rights are commonly promoted, the powerful are seen to have access to, and influence in, the media where they are argued. At present, the diminished autonomy of vulnerable groups is regularly taken advantage of, even as the egalitarian objectives of individual human rights are articulated. It was the view of the former Australian Human Rights Commissioner, Mr Brian Burdekin, from his experience, that the vulnerable sick were already ‘the most systematically abused and the most likely to be coerced’. Putting sole emphasis on individual rights has a proven record of breeding hatreds and ignoring the consequences for society, and of by-passing processes which show due regard for the interests of every group in the community.

Sociologists at Flinders University in South Australia in 1994 published the results of a survey conducted among doctors and nurses, about their attitudes and practices

regarding euthanasia. The survey discovered that on half the occasions doctors admitted they had carried out euthanasia, there had been no patient consent or request. It also uncovered the view of some of these professionals, the acknowledged guardians of health and life, that poor quality of life, mental disability and physical handicap should be sufficient reasons for active euthanasia, whether or not this was requested.

One of the surveyors, who had previously held no particular view on euthanasia, was moved by these findings to publicly express her disquiet that the very arguments about human rights used to promote euthanasia are in fact abused by its practice. She concluded: 'There is a danger that legalisation of active euthanasia, voluntary or non-voluntary, may expand the potential for further abuses.' I consider legalisation could undermine the value placed on human life, and erode our sense of security. We need to ensure that the state continues to protect people.'

Conclusion.

Euthanasia cannot be considered without reference to human rights, but all relevant rights should be included. These will include the rights of every person to their life and to the standards of health care appropriate to their illness and, where the provision or quality of that care is demonstrably uneven, to the right to distributive justice to protect the equal rights of all the sick. No right should be included unless its existence has been validated beyond question.

It is not acceptable to want the law changed to uphold a spurious right or even a genuine right that has been shown cannot be protected. Whatever arguments may or may not be thought sufficient to support legalised euthanasia, an appeal to human rights has not been shown to be among them. The claimed rights are either unwarranted misrepresentations of rights, or are 'wants' masquerading as 'rights'.