

**No To Assisted Suicide (NTAS) comment on draft of new UNHRC general comment on ICCPR article 6**

**5 October 2017**

‘No To Assisted Suicide’ (NTAS) submits this comment to the UNHRC to ask that it radically rephrase its comments in paragraph 10 of the draft General Comment on Article 6 of the ICCPR. This paragraph as currently written has elements that are profoundly troubling, as they include remarks that are implicit affirmations of assisted suicide, and possibly even euthanasia. These undermine rather than further human autonomy, especially for the most vulnerable citizens.

The text of paragraph 10 mentions “the central importance to human dignity of personal autonomy”, and the concept of ‘dignity’ is brought up again in the context of describing those “who experience severe physical or mental pain and suffering and wish to die with dignity”. The problem with the usage of this language is that it is nowhere defined as to its meaning in the General Comment. What exactly, then, is ‘dignity’ and who defines it? The concept of ‘death with dignity’ begs the question: are other deaths necessarily without dignity?

Historically, the term ‘death with dignity’ was used by Representative Dr Walter W. Sackett, Jr., who introduced proposals using the term during the 1960s and 1970s in the Legislature of the U.S. State of Florida. Dr. Sackett acclaimed his legislation as being a means of allowing the severely retarded in Florida’s institutions to ‘die with dignity’ simply by refusing to treat infections and pneumonia[[1]](#footnote-1).

Such slippery terms mirror the slipperiness of the concepts being employed here, and the lack of concrete clarity in such an important area is unhelpful, if not actively counterproductive, in giving prescription to the Governments of States parties as to how they should act on these issues. What is being sought, or the grounds on which it is sought, is simply not explicated.

When applied, as in paragraph 10 of the General Comment, to “medical treatment or the medical means in order to facilitate the termination of life of [catastrophically] afflicted adults, such as the mortally wounded or terminally ill”, the employment of “dignity” often gets packaged up as the so-called ‘right to die’, as if what is driving the advocacy for such practices is the ideal of moral autonomy, of individual control over our bodies and our destinies. This, however, is the dressing-up of a misanthropic political position in the language of freedom and autonomy. Recognising that the old idea of euthanasia, of seeking to solve social and cultural problems through recourse to the killing of ‘problematic’ human beings, is for very good reason held in low esteem in the twenty-first century, campaigners for that practice have instead appropriated the more acceptable language of rights for their promotion of assisted suicide.

Strip this language away, however, and it soon becomes clear that the drive for assisted suicide is actually underpinned by an anti-humanist outlook whose similarity with the euthanasia lobbies of old is uncanny. Very old, very sick and very incapacitated people who have a short period of time left to live must be given the ‘freedom’ to kill themselves and to have someone assist them in this task, claim supporters of assisted suicide. They claim their campaign is about individual freedom of choice, the exercise of personal sovereignty against legal and medical establishments that would force unfortunate people to carry on living against their will.

Contrary to this, and to the implied message of paragraph 10 of the General Comment in its current draft form, we see the affirmed extension of assisted suicide or euthanasia to “[catastrophically] afflicted adults, such as the mortally wounded or terminally ill” as contrary to the good of those vulnerable people targeted for their use, motivated fundamentally by social concerns, particularly by the social concern that we can no longer cope with the growing numbers of elderly, frail people, rather than by a passionate attachment to the ideal of individual autonomy, of which it has a false view.

Autonomy simply means the freedom to do on the part of the individual. This of course has limitations in terms of the social effect individual actions can have on others, but the good of self-determination is a generally accepted value. Neither medically-enabled suicide or active euthanasia however, have any relevance to this concept, After all, one can autonomously want or try to end one’s own life, but this does not entail that one has the right to have another assist one in doing so. Similarly, the right to request assistance in suicide is already there (just as the right to request just about anything, whether reasonable or unreasonable, should remain) but the problem comes with the response to such a request.

It is not coercive, or paternalistic, or a denial of a ‘right’, to deny a person a right to assistance with a task they can accomplish unaided. Even if the task is impossible for the person to accomplish unaided, no one is obligated to help that person. The whole connection between autonomy, rights, and assisted suicide or euthanasia is therefore illusory.

In fact, autonomy and the article 7 right to privacy are threatened by institutionalising assisted suicide / euthanasia. Introducing either practice means ‘professionalisation’ of the killing of patients or the involvement in their deaths through a settled process of procedural safeguards. What this means in practice is that our most intimate reasons for wanting to die would be subject to scrutiny. The ‘deathbed scene’ would become one where suspicions would only be allayed by total transparency. The ‘checks for abuse’ called by, *inter alia*, the UNHRC in paragraph 10 so that “medical professionals are complying with the free, informed, explicit and, unambiguous decision of their patients, with a view to protecting patients from pressure and abuse” is a suspicion of all that happens behind closed doors.

Freedom from state intrusion into the deathbed scene is important in several ways. First, the deathbed scene should remain private. Death is not a medical procedure that must be monitored. Funerals may be public events but the approach of death is a time for intimacy, of close friends and family, for emotions, personal goodbyes, forgiveness, humility, reflection and sadness. Once the last will and testament is completed, legal matters should no longer concern the dying person. If a doctor attends, it is simply to make the patient comfortable. Already, there are medical reports to file; if assisted suicide ever became institutionalised, the situation would become formal, all those making up the deathbed would have to justify their relationships with the dying person so that ulterior motives might be crossed off, and the deathbed scene would need to be recorded. Dying would, in short, become a public event.

As Hannah Arendt observed, emotions displayed in public risk being shallow, false and perverted. We might also observe that for some time all elements of birth and death have hitherto been private events.

The term ‘palliative’ derives from the Latin term *pallium*, which was a cloak. We hide birth and death from the public glare also to protect the public, to shield others from impenetrable mysteries that will not be resolved. By thrusting its unwelcome attention into the deathbed scene, legalisation of either assisted suicide or euthanasia would, ironically, jeopardise spontaneous acts of kindness by doctors in the last few hours, days or weeks of life.

At the moment in countries where physician involvement in the death of patients is illegal, an act of euthanasia is unlikely to come to the attention of authorities unless the doctor, family or others in the medical team choose to report the action. When patients are desperately and hopelessly ill and suffering in their death throes, doctors occasionally take such actions and few will or do report them. According to a study published in 2009[[2]](#footnote-2), which polled doctors anonymously, around three thousand of these final acts of kindness occur each year in the United Kingdom, more than projected assisted suicides should the act become legal. The composite number in the United States would be around 15,000 deaths per year.

Such acts of kindness are threatened by paperwork and safeguards to protect the vulnerable. Given that death would become part of the business of physicians, they would, for their own protection, be unwilling to lend a hand in cases where the patient has not completed the paperwork properly.

There is the assumption that many ‘vulnerable’ people are being killed today simply because there are no established procedures to control the situation. Doctors, at the moment, perform this occasional but necessary task not as doctors but as human beings, just as if, in warfare, any of us might dispatch a mortally wounded friend because we have the means and opportunity to do so. If we made death a treatment, kindness would be secondary to established procedure, paperwork will have to be kept and the whole thing subject to inspection.

Most disturbing, however, is the tendency of the state in assisted-suicide laws and similar proposed laws, to pronounce upon the reasoning behind an individual’s decision to die. Legalising assisted suicide would also involve judgments about the value of someone’s life by defining those with (e.g.) less than six (or 12) months to live as not having value and those with more of having value. By no stretch of the imagination can this constitute individual autonomy.

We would argue that it is essential that we draw a thick line between the right to refuse medical treatment and assisting a suicide. In the midst of the professionalisation outlined above, individuals would be losing this important right as their motives for refusing medical treatment would be constantly scrutinised and judged. We need to insist that in this decision made by a competent adult (and not one judged incompetent only at the time of and in light of their decision) the doctor does not get any say in the matter. Patients should be able to discharge themselves and request an end to treatment even if a judge does feel that they are special and their lives are valuable. The right to bodily integrity and freedom from unwanted force upon the person is the basis for many other rights and should be defended.

Legalising assisted suicide would also reduce the value with which we hold certain members of our society. The misanthropic idea that the mere existence of some people is undesirable to the rest of us haunts the assisted-suicide discussion. Changing the law – much as we can agree that few people will be affected in the short term – opens a Pandora’s box. As its justification is suffering, more and more categories will seek recognition of their suffering by demanding assisted suicide for themselves. The categories have a tendency to expand and those who insist that it should only be those with terminal illnesses had better be ready to answer these demands from those who, on good grounds, can demonstrate their own suffering. It is not that large numbers will come forward but that those determined few who do undoubtedly have a good case if we allow that suffering as the basis for requests.

The assisted suicide discussion did not emerge in a vacuum. It has come at the same time as a discussion about sustainable development, aging populations, limited resources and how the elderly use far too many of them, particularly health-related resources. The categories may well expand because of these sorts of pressures.

The so-called ‘right to die’ sought by proponents of legalisation of assisted suicide is not a right or a freedom at all. It is a heavily regulated process that will undoubtedly become more and more regulated with so many safeguards that those who suffer at the end of life will be worse off. Only those with two doctors testifying that the patient has less than six months to live, with checks made for competence and to ensure the decision is not made out of depression or impulse, would have the ‘autonomy’ that many think legalisation will bring.

Compassion would fare no better. The deathbed scene would have to be regulated if it is to be ‘transparent’. The actions of relatives and doctors alike may have to be monitored. The time-honoured tradition whereby doctors occasionally bring relief to suffering patients in their last few hours or days will be brought under official control. If we were to officialise the whole process whereby doctors occasionally dispatch patients in order to prevent needless suffering, we threaten the tolerance with which we viewed and still view these actions.

Once bureaucratised, there will be no real space for compassionate deeds; all, in the name of transparency, will have to be accounted for and a paperwork trail established. Doctors may well be increasingly reluctant to go down an unofficial route. Thus, ironically, legalising assisted suicide may well be worse for the dying. Whereas we might impute the noblest of reasons to those campaigning for a change in the law, the devil is in the details. Such safeguards and checks, as we have demonstrated, destroy our freedoms.

If the basis for affirming involvement in the death of patients is to be made on the basis of autonomy then, NTAS submits that it is a foundation that does not survive close scrutiny. Even if assisted suicide or euthanasia were demanded by the principle of patient autonomy, and neither are, they would both undermine that autonomy in practice. Even if ‘dignity’ were properly defined by the current draft of the General Comment (and it isn’t), it seems that a colloquial understanding of dignity would not be served by assisted suicide and euthanasia.

The Committee should therefore not include the current language of paragraph 10, but omit it entirely, and restrict its comments to encouraging States parties to further efforts of suicide prevention, and also to expand and support palliative care and analgesic medicine. This would truly enable patient choice, and still allow for the informal practices between doctors and patients that maintain patient privacy and true autonomy at the end of life.

1. Cited in Germain Grisez and Joseph M. Boyle, Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate (London: University of Notre Dame Press, 1979), p. 7. [↑](#footnote-ref-1)
2. Clive Seale, ‘Hastening Death in End-of-Life Care: A Survey of Doctors’, Social Science and Medicine, vol. 69, no. 11 (2009), pp. 1659–1666. [↑](#footnote-ref-2)