death. It is all good; it can all be redeemed. There is a growing body of opinion in the Anglican Church that we should be thinking again about the Last Sacraments. This is an occasion when as a sacrament the Church unites its members to him who died the good death, *euthanos*, and with him we are one in the Eucharist. Thanks be to God.

Most religions have set their faces against any practice of voluntary euthanasia. This is true not only of Christians but also of Jews and Muslims. There have been, of course, some notable exceptions. Among Protestants individual churchmen have spoken in favour of a swift ending of the suffering in terminal cases of physical illness. Their number has been but few.

What can be said to those who own no religious allegiance? It is here that the concept of natural law appears so valuable. This article has deliberately omitted reference to religious objections; it has argued the case in terms of a consideration of compassion for the dying person. Those who support voluntary euthanasia appear to have little understanding of the complexities that surround fatal illness. Consideration is also due to the relatives, but they are locked in an impossible position of wanting the loved one and yet praying for a swift release. Few relatives would be equal to the task of assisting his suicide or even killing the loved one. Doctors find it abhorrent.

The Case for Voluntary Euthanasia

A Reply to Dr Hugh Trowell

by Benjamin Downing

Chairman of the Voluntary Euthanasia Society

Dr Trowell, with his usual kindness and wisdom, is keen to be fair to the supporters of voluntary euthanasia. Not for nothing is he an experienced physician as well as an Anglican clergyman. All the same some confusion, mixed with medical prejudice, does creep in. It is neither intellectually nor morally adequate to write, as he does, that 'there is . . . an intention to kill in every euthanasia'. That is about as adequate as asserting that death is always an unmitigated evil. Voluntary euthanasia situations are obviously complex, involving rights, judgments, duties and attitudes. They are not to be described in facile phrases.

Dr Trowell is concerned that there is much muddle over 'the right to die', but he does not really do much to clear it up. Since life obviously involves death there can be no conflict between 'the right to live' and 'the right to die', *pace* the British Medical Association in its recent pamphlet (January 1971) *The Problem of Euthanasia*, which

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was prepared by a Special Panel of which Dr Trowell was chairman. The important question is the circumstances of death and dying, and the management of our last days. Dr Trowell recognizes that doctors 'should not prolong biological life indefinitely' and he would presumably agree with Sir Theodore Fox, the former editor of *The Lancet*, who stated in his Harveian Oration in 1965 that if a doctor 'goes on prolonging life that can never again have purpose or meaning, his kindness becomes a cruelty. . . . Some of us hold life sacred, but this becomes a dreadful doctrine when it means that quantity of life is preferred to quality.'

Some interesting remarks about 'The Right to Die' were made by Dr Bernard Towers in *The Tablet* of 28th June, 1969: 'I suggest that the time has come to discuss in all seriousness the relationship between the individual's right to life at any cost and his right to a dignified terminal illness and death, not hounded by doctors with a misguided sense of mission. . . . The right to die when one's time has come, if things were "left to nature", might be called the right to orthothanasia.' We may say that death has its compelling sanctities no less than life. Ordinary people see plainly enough that death is not always and in all circumstances an enemy that must be defeated at all costs. Similarly they also see that life is not necessarily and in all circumstances something good and desirable. It is hard to see what is good and desirable, for example, in the 'life' of a patient, utterly wretched in mind and body and slowly but inevitably dying in a psychogeriatric ward. That patient's situation may be a challenge to the spiritual sensibilities of those responsible for him, though it can hardly be a challenge to the patient himself if he is mentally and physically incapable of responding to spiritual duties. The supporter of voluntary euthanasia contends that this is one of those processes of dying which we have a right to ask our doctors not to prolong, by making known our wishes through a solemn witnessed declaration rationally made before such a condition supervenes. In the words of His Holiness Pope Pius XII: 'The most perfect and most heroic resolution can be found as well as in acceptance as in refusal' (Allocution concerning the Relation of Catholic Doctrine to Anaesthesia, para. 44).

In this era of refined medical technology there is confusion about what we may expect of our doctors in the management of our last days. In their approach to death doctors differ like the rest of us. Some will accelerate the dying process for what seem to them compelling compassionate reasons, with or without the consent of their patients. Some, for reasons of prudence or principle or from other motives, stick strictly to routine procedures without discrimination, even when these only miserably delay the inevitable. The general medical tradition is that the possibility of death is rarely discussed openly with the patient. Indeed there is often deception in the matter for both good and bad reasons, and this deception is more frequently noticed in an observant age.

Central to the objection of many doctors to voluntary euthanasia is the firm traditionally held conviction that the patient never knows best. But this conviction is beginning to weaken in an age when the professions do not attract the same awed reverence and submission as in former times and when the medical ability to prolong or maintain life may often seem more like a curse than a blessing. Deeply ingrained in their professional outlook is the notion that only doctors can decide on matters concerning death. Obviously doctors are unique in their knowledge of dying. They, aided by nurses, know more than anyone else about the management of our last days. But this does not give them the sole right of determination over our own end. The ideal state of affairs is a partnership between the dying person and his doctor—a partnership in which, without legal fears or professional risks, the doctor recognizes and gives what his patient really wants and is best for him, even if what is desired is death itself. If we could attain that state of affairs without legislation there are some of us in the Voluntary Euthanasia Society who would be very satisfied with a considerable achievement. Unfortunately, as we all know, the practice of medicine has become widely depersonalized. Medical team-work and technical expertise, laboratory procedures and narrow specialisms are the order of the day. That is why it becomes important to insert into the heart of all this complexity an insistent assertion of what a patient himself desires or prefers about his own life and its end or continuance.

The chief practical result of the proposed legislation for voluntary euthanasia, which it would be in everybody's plain interest to frame with the utmost scruple and safeguards, would be to impose upon doctors *the duty of at least considering* the wishes of a dying patient, if these are unmistakably and sanely expressed either at the time or by a declaration beforehand if the patient is unconscious or bemused by drugs and distress. Doctors may decide, in their professional judgment on which we must rely, that there is nothing they ought to do to meet such wishes. Some might prefer to hand over the medical management to other doctors more compliant with the obvious wishes of the patient. It could be that no doctor could be found to do anything at all towards euthanasia in the particular hospital or circumstances. But at least, with the proposed legislation or something like it, there would be a publicly recognized and honourable duty upon all concerned to consider a patient's wish for a merciful death. At last a patient could legally ask his doctors for what he really wants in determining his end when his obviously and incurably disabled life has ceased to have meaning or purpose for him. That would be a big step towards the prevention of needless suffering and the enhancement of human dignity in death.

In confronting the case for voluntary euthanasia it is not enough to argue, with Dr Trowell, that all we need to do is to improve and extend the 'institutions which care specially for those dying in great

pain and distress'—a duty which is urgent and inescapable. There are dying patients who want, quite simply, an end.

The question of voluntary euthanasia is undoubtedly difficult, and even harrowing by the very nature of the sufferings and indignities which too often surround death. Dr Trowell is ready to admit, unlike more staunchly traditionalist members of his profession, that there is in fact a human problem requiring new attitudes and perhaps new procedures. But he also firmly implies that if we only leave it to the doctors all will be well, for they know what is best for us. With profound respect it needs to be asserted that the doctor ultimately is the servant of the community. Occasionally the community has to insist on the recognition of new options by doctors, as for example in the Abortion Act which obliged a divided but mainly unwilling medical profession to adopt new attitudes. Supporters of voluntary euthanasia say: 'Change the law, and so change medical attitudes, and the patient will at last dare to ask for what he wants.' It runs altogether counter to historical experience to assert, with the British Medical Association, that 'a change in the law would hamper changes in attitudes'.

In conclusion I must pay a grateful compliment to the Editor of this journal, who has invited me to reply to Dr Trowell. He, and this journal's readers, for the best of religious reasons, may be offended by my point of view. But in our pluralist society people must be allowed to have their own discriminations about death and dying. There can be no Roman Catholic or other religious veto over the evolution of our values. It is widely recognized that euthanasia problems will become more and not less urgent, even possibly acute on demographic grounds alone. The medical profession must necessarily be conservative over its basic values, but it is equally incontrovertible that the doctor derives his ultimate authority from the patient and is his servant and agent as well as his adviser. In an age of growing complexity, increasing options and technological refinement, the doctor is no longer the only arbiter, immediate or ultimate, in the management of our health and illness, life and death. From that plain fact the right to voluntary euthanasia under certain circumstances flows inevitably—and in due course, sooner or later, that right will be recognized by the law.

Footnote
by the Editor

Both the distinguished contributors to our debate have explicitly avoided what they call the 'religious' objections to euthanasia. It is not clear that there are any specifically religious reasons for or against the practice—I mean as there are religious reasons for or

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