

# Voluntary, or Compulsory?



by Theodore Dalrymple

A 2021 [Canadian law](#) on assisted suicide contains a provision that will allow doctors to provide assisted suicide to the psychiatrically ill starting next year. Given that severe psychiatric disorder tends to cloud the judgment of those who suffer from it, one wonders who will benefit most from this law, if passed. Certainly, it might remove from society people who are often difficult, unproductive, and expensive for others. They might be encouraged to shuffle off this mortal coil as a service to their relatives or even to their county. The distinction between the voluntary and the compulsory might become blurred.

The law is a logical extension of the right to a dignified death procured by others—that is, a mode and time of death of a person's choosing with the aid of doctors and nurses.

Originally, the right was conceded to those already dying, but why should the dying have all the best deaths? Either a man has a right to dispose of himself, or he doesn't; whether he happens to be dying (as, in a sense, we all are anyway) is irrelevant. If a man has a right to kill himself, it is only humane to give him the opportunity to do so in comfort, surrounded by his loved ones, with soft music playing, free of the messy outcomes so often associated with unassisted suicide.

Many of those currently determined to exit this life are obliged to travel to Switzerland, but doing so is expensive and creates a further social division: those who can afford assisted suicide and those who can't. What does equality of rights mean if people are unequally able to exercise those rights? The supposed equality becomes a dead letter. Therefore, not only should there be a law permitting assisted suicide as and when people desire to die, but in the name of equality, it is the duty of the state to ensure that people have access to it as part of general social security.

The slippery-slope argument, of course, has long been one of the principal objections to the legalization of assisted suicide and euthanasia. Not every slippery slope is slid down, but we have reason to suppose that, at least in some jurisdictions, it is happening. In 2017, a research letter in the *New England Journal of Medicine* reported (with a sense of pride) that, in the Netherlands, 92 percent of those euthanized had serious illnesses. No explanation of the other 8 percent's circumstances was forthcoming—the editors evidently did not think it polite to ask. The numbers were not small: as many were euthanized without serious illness as are murdered in the Netherlands in four to five years. The state, one might surmise, is complicit in more killings than all the criminals in the country combined.

Moreover, serious illness is not the same as fatal illness. An illness may be serious but not fatal; it may be bearable or

unbearable, but whether it is the one or the other is not simply a technical question that can be answered by ticking a few boxes on a form. An easy way out will always tempt people to take it who might otherwise have carried on. And in times of economic stringency, they might well be encouraged to take it. Our hospitals, after all, are full, and often urgently in need of beds for those who can be helped.

On the other side of the question is the fact that everyone can easily imagine circumstances in which he would rather die than carry on and would appreciate an easeful death. The principle of double effect, according to which doctors are permitted to prescribe drugs intended to comfort the dying but that will also shorten their lives, has long been in operation. It is not a perfect solution to the dilemma—but then, there is no perfect solution.

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