Ethical Considerations in Physician-Assisted Suicide

Physician-assisted suicide (PAS) is a topical issue. Neurology, neurosurgery and rehabilitation medicine are very much at the forefront of PAS as patients who request PAS often have untreatable or terminal neurological conditions. In 2010, the Director of Public Prosecution published the policy on assisted suicide following the lack of prosecution of several cases of those assisting others to die abroad. This article will examine the ethical issues that arise when considering PAS.

Autonomy

Respect for the autonomous wishes of patients was established in common law in 1914 when Cardozo J stated in Schloendorf v Society of New York Hospital:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”

There is widespread recognition that as long as the patient has the requisite mental capacity, he/she is entitled to make life-limiting decisions with regard to his/her own medical treatment. However, because assistance for suicide is not considered proper medical treatment, the desire to die often goes unheeded during the dying process. The views of philosophers Immanuel Kant and John Stuart Mill on autonomy have contributed greatly to PAS. Kant supported the notion that autonomy should be governed by rational choice, while Mill asserted that people have a right to self-determination as long as their actions do not harm others. Mill emphasised the importance of preferences and desires, rather than rationality. Everyday physicians and patients negotiate treatment goals. Physicians, with their medical expertise, provide advice and recommendations on treatment options. Patients who are experts about their own lives contribute to the collaborative decision-making by expressing their personal preferences and values. A Kantian view of autonomy would support the physician-patient partnership and relational model of decision-making that integrates mutual respect and reasoned negotiation. The consumer based Millean autonomy emphasises patient preferences and desires, leading to the extension of a patient’s right to demand specific interventions which may deviate from established medical standards. Thus, the physician-patient partnership becomes one-sided, with the emphasis on patients’ desires and demands.

Which view of autonomy is better? A patient with Kant’s view would have to ignore desires and preferences for pure practical reasoning. This is almost impossible in vulnerable patients because of physical or psychological illness. Indeed, Kant himself argued against the permissibility of self-killing claiming that it was against moral law to kill oneself even when continued life promised more evil than satisfaction. Leading Brassington to suggest that autonomy ‘simply peters out at some point before self-killing, so that there is simply no such thing as … assisted suicide’. The Millean view allows the patient to regain control over the dying process. However, patients may not necessarily stand their options for end-of-life care or patients requesting PAS may be depressed or undergoing existential or spiritual crises that cloud the understanding of end-of-life options.

Both Kant’s and Mill’s views fail to consider the social context of the patient. An alternative suggestion of a good autonomy model is one that involves an interactive and interdependent approach to decision-making where patients are empowered by family and physicians to consider the values and commitments of all those involved and directly affected by the patients’ decisions. Here the key consideration is not whether the patient or physician should be given decisional rights but rather how to improve the autonomous decision-making process of patients within their social context.

Dignity

For many patients, the right to die with dignity means dying without having to suffer from severe physical pain, without being dependent on others for hydration, nutrition and bodily hygiene, and without family and friends having to witness their suffering.

Three concepts of dignity suggested by Schroeder are applicable to PAS. The first, Kantian dignity is the intrinsic dignity in every individual rational being with life plans that is an end in itself. International laws have stressed the inviolability of this human dignity and expanded it to encompass all human beings. Secondly there is comportment dignity, defined as ‘the outwardly displayed quality of a human being who acts in accordance with society’s expectations of well-mannered demeanour and bearing’. Finally, there is meritorious dignity, which builds upon Aristotle’s thinking that dignity is something that is desired rather than inherent and that one deserves it through being honourable.

Kilimaster simplified the concepts of dignity to...
two. First is the universal Kantian dignity which is the inviolable status one holds simply by being a human being; the other is an aspirational dignity which encompasses both comportment and meritorious dignity. This alliance can be brought together by considering the dignities and norms, rather than an upholding of external standards and norms. Therefore, aspirational dignity is the quality held by individuals who are living in accordance with their principles.7

Supporters of PAS appeal most closely to aspirational dignity.8 Consequently, what standards and principles one has tried to adhere to during life, one may not be able to achieve in death if PAS is disallowed.9 Opponents of PAS describe life as a divine creation and gift, and invoke religious and natural law arguments to protect it before natural death. They also promote medical interventions for the prolongation of life. However, Hume points out that while we may be infringing God’s prerogative by taking life and thus altering the divine timing of death, we may similarly be infringing divine prerogative when intervening to save a life.10 Resistance to PAS is based on the prudential value judgement that life is always better than death. However, life does not necessarily have a value judgement that life is always better than death. Opponents of PAS describe life as a divine creation and gift, and invoke religious and natural law arguments to protect it before natural death. They also promote medical interventions for the prolongation of life. However, Hume points out that while we may be infringing God’s prerogative by taking life and thus altering the divine timing of death, we may similarly be infringing divine prerogative when intervening to save a life.10 Resistance to PAS is based on the prudential value judgement that life is always better than death. However, life does not necessarily have a value judgement that life is always better than death.

Sanctity of life
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Slippery slope
Keown argues that if PAS is legalised, this will inevitably lead to the acceptance of non-voluntary and involuntary euthanasia because of the loss of ‘effective regulation’.11 Keown also suggests that PAS may initially be regulated as a last resort measure, but eventually become more accepted and preferred.12 Smith evaluated these arguments in several countries and concluded that there was no concrete evidence to support these claims.5 Keown states that it is the physician that is the deciding factor in PAS, not the patient. This physician justification could just as easily be applied to situations where the patient cannot make the request, as in non-voluntary euthanasia.13 Lillehammer’s counterargument is that Keown wrongly implies that only either the physician’s opinion or the patient’s autonomous choice is required for PAS to be permitted.14 Lillehammer emphasises that both the physician’s judgement and the autonomy of the patient are required to provide sufficient justification for PAS to occur.15 Therefore, the physician does not determine the value of the patient’s life; this is done by the patient voluntarily and autonomously. The physician’s role is considered to be the beneficial to prevent suffering.

Vulnerable patients
Opponents of PAS feel that vulnerable patients may start to consider death as a possible option for releasing family members, carers and the society at large from the responsibility of having to provide them with care.16 Furthermore, depression may cloud the view of vulnerable patients.

Proponents of PAS accept the real possibility of abuse of PAS laws. Nevertheless, the mere potential of abuse should not prevent the legalisation of PAS. What is needed are stringent safeguards to minimise or prevent abuse. Physicians should also be trained to spot signs of depression which can occur in terminally ill patients.

Involvement of physicians
Some believe that PAS is contrary to the role and professional duty of physicians. Patients may trust physicians less and be fearful of hospitals if PAS is legalised. Too little trust between physicians and patients could compromise the physician-patient relationship. In PAS, it would be superficial to say a physician’s interest is merely to kill; rather physicians have a duty to ease the suffering of patients, do what is in the best interests of patients and respect the autonomy of patients. There are concerns that the involvement of physicians in PAS could curtail improvements in palliative and terminal care.17 However, there is evidence that palliative care treatment has in fact improved where PAS is legal.18 The availability of PAS may also encourage physicians to address other end of life concerns such as decreasing ability to participate in activities that make life enjoyable, loss of autonomy and loss of dignity more effectively.19 Conclusion
It is hoped that this article has provided some fundamental insights into the ethical arguments for and against PAS. It is important that society embarks on a full and informed debate on this issue as it is likely to get more relevant with patients increasingly willing to travel to jurisdictions that allow PAS to seek PAS.
Ethical considerations in physician-assisted suicide: a comment

The Association of British Neurologists has recently sought its members’ opinions on physician assisted suicide. The response, available through the ABN’s website, was very much (but not unanimously) against. In this article, Dr Sathasivam, a neurologist and ethicist examines the issues.

Dr Sathasivam has written a learned account of the arguments around physician assisted suicide. Through it, we encounter the precision of thinking and clarity of language that characterise the ethicist’s approach to such a complex problem. We are reminded, also, of the centuries of careful deliberation on the moral nature of humanity; we should not forget that the definition of autonomy has been debated far longer than motor neurone disease has been recognised. I anticipate that most readers of ACNR will not be aware of the range of arguments that Dr Sathasivam expounds, and will find their own position on physician assisted suicide challenged and nuanced.

Four points in response: first, how does one negotiate a final position on physician assisted suicide, with so many conflicting arguments? How does one choose which ‘trumps’ which? This is difficult enough as an individual. But it is even more problematic when a group of people, such as the Association of British Neurologists, seeks a consensus. And it is almost impossible to conduct a debate on a nationwide basis. Philosophers have described ‘middle ethics’, themes common to religious and non-religious worldviews, to assist such enterprises. But more often than not, the lowest common denominator prevails and all that happens is that anecdotal grenades are lobbed from the barricades: pantomime stories of suffering patients and impotent doctors, of interfering officialdom and scheming families. Curiously, people with a religious view are often dismissed from public debate, as though possession of a settled set of values is a ‘prejudice’.

Second, Dr Sathasivam’s review fails to include that most philosophical organ: the gut. Sooner or later, as people mull over this or that position on physician assisted suicide, they will find their rationalism bumps up against a visceral ‘that’s it’ or ‘that’s not right’. The reasoning behind these colicky interruptions may be unconscious, but deny them at your peril. For so we meet our ‘deontological ethical principles’ or natural moral law. Somehow these ‘bottom lines’ need to be captured and respected.

Thirdly, as we consider some patients’ requests to die, we should not forget that our responses shape our society as a whole. How do we want neurologists, or the ABN, or England, to be perceived in its approach to illness, dependence and the end of life? And if our position shifts on physician assisted suicide, how would that affect the way society views other suffering, dependent people? Do we edify humanity by allowing physician assisted suicide or do we corrode it?

Finally: for what it is worth, my position is that there are a very few people, in awful irreversible situations, whose request to die has integrity; but the cost of assisting them, to the idea of who a doctor is, what it means to be dependent and, ultimately, to how we revere all life, is simply too great.

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ACNR would welcome responses!

REFERENCES
1. Mary E. Schleiermacher, Appellant v The Society of the New York Hospital, Respondent. (1914) 105 NE 92.
10. According to Wikipedia, moral agency can be defined as ‘a person’s responsibility for making moral judgments and taking actions that comport with morality’. http://en.wikipedia.org/wiki/Moral_agency