

EUTHANASIA, ASSISTED SUICIDE AND THE PROFESSIONAL OBLIGATIONS OF PHYSICIANS

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Euthanasia and assisted suicide have proved to be very contentious topics in medical ethics. Some ethicists are particularly concerned that allowing physicians to carry out these procedures will undermine their professional obligations and threaten the very goals of medicine. However, I maintain that the fundamental goals of medicine not only do not preclude the practice of euthanasia and assisted suicide by physicians, but can in fact be seen to support these practices in some instances. I look at two influential views of the goals of medicine, one based on the broad guiding principles of autonomy, beneficence and nonmaleficence, and the other focusing on several more concrete aims, concluding that both approaches can be seen to support euthanasia and assisted suicide. I then turn to the popular concern that allowing physicians to carry out euthanasia and assisted suicide will lead to widespread abuse. I argue that the possibility for abuse can be minimised if we make the patient's autonomous consent an essential requirement of the practice.

In ethical discussion of the obligations of physicians regarding voluntary euthanasia or physician-assisted suicide, one concern is ubiquitous: that allowing physicians to kill will undermine their professional obligations and the fundamental moral foundation of medicine (Kass 1993). I will, however, contend that the fundamental goals of medicine can actually be seen to support these practices. Though the promotion of life was originally a more appropriate and understandable overriding goal of medicine, recent technological advances teamed with an aggressive medical intervention have resulted in many people living far longer than they would have previously, and often in a great deal of pain and decrepitude. I will look at two ethical approaches to establishing the goals of the physician and the aims of medicine in general. I conclude that both approaches find physician assisted suicide and euthanasia to be entirely compatible with and perhaps even required by the professional obligations of physicians in some cases. However, the introduction of voluntary euthanasia and physician-assisted suicide could create many problems in public policy, and has potential for allowing the abuse or exploitation of patients. I argue that

limiting euthanasia and assisted suicide to only where it is autonomously requested by the patient will circumvent many of these problems.¹

It is first necessary to define voluntary euthanasia and physician-assisted suicide. By voluntary euthanasia, I am referring to cases where a physician intentionally kills a patient at the patient's autonomous request. By physician-assisted suicide, on the other hand, I am referring to cases in which the physician provides the patient with the means to end their own life, at the patient's autonomous request (Varelius 2006, p.122). Though these two actions are often regarded as being of a different moral order, Dan Brock (1992) forcefully argues that it is not clear that there is any morally significant difference between them. The only difference seems to be that while in voluntary euthanasia the physician carries out the final act, in physician-assisted suicide, the patient carries out the final act. However, this does not seem to be enough to ground a substantial moral difference between the two acts. In both cases, the physician plays an "active and necessary causal role" (Brock 1992, p.10) in bringing about the death of the patient. Brock points out that while physician-assisted suicide is often seen as the patient acting to kill herself, in reality it involves both the physician and the patient acting together to kill the patient. Therefore, I will speak henceforth only of voluntary euthanasia, as it is often regarded as the more extreme or morally suspect case.

Brock also challenges the distinction between 'killing' and 'allowing to die'. This division is also disputed by Tom Beauchamp and James Childress (1983). It is common to deem refusal of life sustaining treatment (for example, food), or removal of life sustaining treatment (for

¹ I am limiting my discussion solely to cases in which the patient is able to make an autonomous request for euthanasia. A consideration of the difficult and borderline cases posed by using proxies to make decisions on behalf of the patient, and the use of advanced directives, goes beyond the scope of this essay.

example, a respirator) as passive, merely allowing the patient (or oneself) to die rather than actively killing the patient (or oneself). However, Beauchamp and Childress maintain that where an *act* of refusing or removing treatment is involved, the death cannot be seen as *passive* (Beauchamp and Childress 1983, p.95). This morally arbitrary distinction serves to deprive many people who are capable of competently choosing to end their own life with the opportunity to do so, for no good reason.

Brock postulates that the distinction between killing and allowing to die is drawn for psychological reasons. By utilising this distinction, responsibility for the death is shifted from the physician to the underlying disease. The necessity for this psychological shift of responsibility results from the fact that killing is seen as intrinsically or as always wrong. However, Brock contends that this is a mistake, and that some killings are, in fact, ethically justified. He suggests that what is wrong with most killings is that they deprive a person of a valued future (Brock 1992, p.14). However, where a person can see no value in their future, and autonomously request to be killed, killing may be ethically acceptable, or even ethically good.

We see a similar argument in Hume's essay *On Suicide* (2006), though Hume attempts to establish that there is no moral failing in taking one's own life, with no mention of assistance. Hume argues that where continued life can no longer yield significant benefits for society, or has come to be regarded as a burden, suicide is morally justified and perhaps even laudable (Hume 2006). This argument cannot ground an obligation for others to help us end our own lives. However, if we accept Hume's argument that suicide is sometimes justified, the obligations of the physician may ground an imperative to assist their patients in this goal.

Though we may claim that taking one's own life, or even killing, is not always wrong, it is a different matter to claim that physicians should assist us in taking our own lives, or that they are obligated to kill us at our autonomous request. It is often argued that allowing physicians to kill has the potential to undermine trust between physician and patient, respect for the medical enterprise, and the value of medicine in general (Kass 1993). Voluntary euthanasia is seen here as going directly against the professional obligations of the physician, and as undermining the very foundational aims of medicine (Brock 1992, p.16). Additionally, it is argued that allowing euthanasia will destroy the self restraint of physicians, causing them to begin killing without the autonomous authorization of their patients (Kass 1993, p.42). It is true that the acceptability of physicians performing voluntary euthanasia rests upon what is involved in the professional obligations of physicians, and upon the aims of medicine (Varelius 2006). However, I believe the aims of medicine and the obligations of the physician can be seen to support, rather than oppose euthanasia.

First, I will look to the guiding principles of medical ethics, as delineated in Beauchamp and Childress' canonical work, *Principles of Biomedical Ethics* (1983). Beauchamp and Childress outline several principles that are designed to guide the conduct of physicians and the course of medicine. The principles that are relevant to voluntary euthanasia are autonomy, beneficence and nonmaleficence.² Physicians are obliged to act according to these principles, though, due to the fact that the principles can conflict with each other, each principle is given only prima facie status, and may be overridden by stronger competing concerns from the other principles.

² Beauchamp and Childress additionally posit justice as a fundamental guiding principle in medical ethics, but as their conception of justice is concerned with the fair distribution of burdens and benefits across society and is thus only indirectly related to the issue of voluntary euthanasia, I will ignore it here.

Autonomy has come to enjoy a very prominent role in biomedical ethics over the last 40 years, and is often touted as the most important guiding principle in medical ethics. It is well established in biomedical literature that the physician has an obligation to facilitate the autonomous choices of her patient (Veatch 1984). Autonomy involves making decisions for oneself, shaping one's own life as a whole based on one's own values and conception of the good. Two primary justifications are given for valuing autonomy in biomedical ethics: that it best increases the well-being and promotes the interests of the patient, as the patient is in the best position to decide what is best for himself, and that showing respect for a person's capacity to make their own decisions is a vital part of showing that person due respect (Varelius 2006, p.124). Autonomy is a vital guiding principle in a pluralistic society in which it is accepted that there can be multiple valid conceptions of the good (Kimsma and Van Leeuwin 1993, p.21). Clearly, respect for autonomy demands that the autonomous choice of a patient to end their own life must be honoured. The refusal to honour this wish involves a refusal to treat the patient with respect (Beauchamp and Childress 1983, p.95). Similarly, it is doubtful that the patient's well-being and interests can be ensured and promoted if he is not shown adequate respect, and a conception of the good which may not match his own is thrust upon him. I will further address the question of well-being under the principle of beneficence, to which I now turn.

Beneficence has traditionally been a vital guiding principle in medicine, demanding an obligation on the part of the physician to act to promote and protect the patient's well-being and best interests (Beauchamp and Childress 1983). Some may be sceptical about the idea that killing a patient could really ever be in her best interests. However, when euthanasia represents the only means of avoiding prolonged and severe suffering, it becomes plausible that the principle of beneficence could endorse voluntary euthanasia in some circumstances. Beneficence is usually

conceived as a principle which involves weighing up the benefits and harms that will result from a given course of action, and taking the route that will maximise benefit and/or minimise harm (Beauchamp and Childress 1983, p.148). Often, when a severely ill patient makes an autonomous request to end their own life, they have come to regard continued life as no longer potentially beneficial, but as a burden (Brock 1992, p.11). Where quality of life cannot be improved, and the patient is in a great deal of pain, ending their life at their autonomous request seems more beneficent than prolonging their suffering. An argument from mercy is often viewed as the strongest argument for allowing euthanasia (Brock 1992, p.15).

Nonmaleficence is the final principle to consider. Nonmaleficence has enjoyed an integral place in medical ethics since the birth of Western medicine, thanks to the famous maxim that is often associated with the Hippocratic corpus; *primum non nocere*, or “above all, do no harm” (Beauchamp and Childress 1983, p.106).³ Beauchamp and Childress suggest that killing violates the principle of nonmaleficence, though they claim that this can be balanced by competing considerations of autonomy and beneficence, which can support voluntary euthanasia in certain cases (Beauchamp and Childress 1983, p.96). However, whether nonmaleficence does indeed oppose euthanasia depends on how strict we take the principle to be, and what we take to constitute a harm. We routinely sanction some harms in medicine due to the benefits that will result. For example, we may allow invasive surgery in order to relieve pain and suffering. Furthermore, it is possible that where a person is dying a prolonged and painful death, a physician acting to make this death less drawn out and agonising does not constitute a harm.

³ Beauchamp and Childress claim that this maxim is not in fact found in the Hippocratic corpus, though similar statements are expressed in the Hippocratic Oath.

It seems, then, that taken together, these three guiding principles, in which, according to Beauchamp and Childress, the obligations of physicians are rooted, in fact endorse rather than oppose voluntary euthanasia. It is clear that autonomy and beneficence will strongly support the practice of voluntary euthanasia in some cases. In terms of nonmaleficence, if we accept Hume and Brock's arguments, we may argue that ending a life does not constitute a harm in some cases. Alternatively, as Beauchamp and Childress suggest, it could be argued that though ending life is a harm, it is offset in some cases by the benefit of relieving pain and suffering, and respecting the autonomous wishes of the patient. Nonmaleficence can be seen to oppose euthanasia, or at best, is neutral to it. However, as a *prima facie* principle, the possible violations of nonmaleficence are offset by strong support from the principles of autonomy and beneficence. This approach, therefore, finds voluntary euthanasia to be entirely consistent with, and perhaps in some cases as even demanded by the obligations of physicians.

An alternative view of the goals of medicine and the obligations of physicians focuses not on guiding principles, but on more specific and concrete goals of medicine. According to this approach, physicians have an obligation to promote these goals, and see to it that they are not violated. However, as these goals can sometimes conflict, it is sometimes necessary to balance considerations from some goals against competing concerns from others, occasionally overriding one goal in order to satisfy the demands of another. Jukka Varelius (2006) takes this approach, listing some goals that are commonly claimed to be the ends of medicine:

1. avoidance of premature death,
2. preservation of life,
3. prevention of disease and injury,

4. promotion and maintenance of health,
5. relief of pain and suffering,
6. avoidance of harm, and
7. promotion of well-being. (Varelius 2006, p.125-6)

It must be noted that some of these terms are evaluative and thus, despite first appearances, it can be difficult to pin down what they actually entail. It is difficult to know what to make of goal 1 (avoidance of premature death), for example. If this relies on a judgment on behalf of the patient as to whether or not death is premature, then it is entirely compatible with the patient autonomously requesting euthanasia when they feel ready for death. However, if this standard relies on some other judgment of premature death, for example, the physician's opinion of what constitutes premature death, it may present a conflict with euthanasia. It is clear, however, that these goals make no sense out of the context of the interests of the patient. As it is generally accepted that the most general goal of medicine is to promote the interests of the patient (Varelius 2006, p.130), interpretation of these principles must take the interests of the patient into account. Additionally, adopting the commonly accepted idea, outlined above, that respect for autonomy provides the most effective way of promoting the interests and well-being of the patient, suggests that promoting the interests of the patient involves taking into account the autonomous desires and decisions of the patient in interpreting what course of action these goals are advocating.

The stance of goal 3 (prevention of disease and injury) on voluntary euthanasia seems to depend on the individual circumstances of the patient. As discussed above, it is an open question whether or not ending a patient's life at their request constitutes an injury. However, if the patient autonomously wishes to end their own life, and does not see this as an injury, this

suggests that we should not regard ending life in these circumstances as an injury. This is supported by the famous medical maxim *volenti non fit injuria* (no injury where the subject is willing) (Manson and O'Neill 2007, p.3). Additionally, where euthanasia is the only means of preventing disease or injury, this goal can be read as supporting euthanasia (Varelius 2006, p.128). Goal 4 (promotion and maintenance of health) is similarly dependent on the circumstances. Where promotion and maintenance of health is possible, this goal would not support euthanasia, as being alive is a necessary condition of promoting or maintaining health. However, where promotion and maintenance of health is no longer possible (for example, because the patient is inflicted with a degenerative, terminal illness), this goal seems neutral to the possibility of euthanasia.

Principles 6 (avoidance of harm) and 7 (promotion of well-being) are again dependent on what we take to constitute a benefit and a harm. If we accept that there can be multiple valid conceptions of benefit and harm, then we would do well to make this judgment dependent on the judgment of the patient. If the patient has come to autonomously view continued existence as a harm, and the relief of suffering that death would bring as a benefit, these goals can be seen to support voluntary euthanasia in these cases.

The goals which are most relevant to voluntary euthanasia are goals 2 and 5 (the preservation of life, and the relief of pain and suffering). It is very clear that accepting preservation of life as a goal of medicine and an obligation for physicians is incompatible with the practice of euthanasia. However, it is questionable to what extent this value should override all other considerations in medicine (Varelius 2006). Too stringent a focus on preservation of life at the cost of all other

values has created many problems in medicine, and has in fact been part of the cause of the growing call for legalisation allowing euthanasia.

A single-minded focus on prolonging life has led to a trend in medical practice which favours the aggressive use of medical life-sustaining technologies. Unfortunately, this has resulted in many people living life of a very low quality, in severe pain or increasingly advanced decrepitude. While adhering staunchly to the value of prolonging life, this practice has neglected another goal of medicine, namely, that of relieving pain and suffering. Indeed, a focus on prolonging life has caused a great deal of pain and suffering. Though the value of preservation of life has its place as a goal of medicine, the adoption of this value as the central goal of medicine, entirely separate from any thought of the benefits to and wishes of the patient seems to contravene, rather than uphold, the aims of medicine and the obligations of physicians (Brock 1992). If we accept Brock's argument that killing is only wrong when it is not autonomously desired by the patient, we can similarly claim that prolonging life is only an appropriate goal when it *is* autonomously desired by the patient. When this is not the case, we must look to the other goals of medicine in order to discern what the obligations of physicians demand.

This brings us to the fifth goal of medicine as suggested by Varelius; the relief of pain and suffering. The relief of pain and suffering is one of the most fundamental aspects of the care to the patient which the physician is obliged to provide (Lanyon 1993, p.543). This consideration seems to clearly advocate voluntary euthanasia in cases in which there is no other way to relieve pain and suffering. Accepting that the competing goals of medicine must sometimes override each other in cases of conflict, it is reasonable to say that in some cases, the necessity of relieving severe pain and suffering will override the value of preserving life.

This interpretation of the above goals suggests that it does not go against the obligations of physicians to their patients to administer euthanasia in some instances. Indeed, the obligations of the physician may be seen to support euthanasia in some cases. Additionally, there are advantages to having physicians as the people who are allowed to administer euthanasia, as opposed to another group in society. The status that comes with being a physician means that an endorsement by physicians of euthanasia could help to remove some of the stigma that surrounds choosing to end one's own life (Brock 1992, p.21). Allowing physicians to carry out this practice will also minimise the chance that people will attempt to take their own life without the assistance of an appropriately trained professional, risking severe harm if unsuccessful. Furthermore, a physician is in an optimal position to judge that the decisions of the patients are autonomous, and that all other medical means to relieve the suffering of the patient have been pursued before euthanasia is considered. The great trust we place in physicians to adhere to their professional obligations and put the good of the individual patient first makes them particularly suitable for this sort of task (Brock 1992, p.21). Finally, confining acceptable practice of euthanasia to a medical environment makes it easier to ensure that stringent regulations are put in place to guarantee that abuse is minimised.

It seems then, that the aims of medicine and the obligations of physicians, whether regarded as established by broad guiding principles or by an appeal to more fixed aims, can actually be seen overall to endorse voluntary euthanasia under some circumstances rather than being fundamentally opposed to it. Additionally, there are advantages to having physicians take on the responsibility of ending life in the circumstances where this can be justified. However, the implementation of a policy which allows doctors to kill is fraught with difficulty. A policy which

allows euthanasia has the potential for abuse, by both physicians and relatives of the patients. Though the obligations of physicians and the goals of medicine are consistent with administering euthanasia under some circumstances, physicians overstepping their boundaries and administering euthanasia where it is inappropriate will erode the essential trust between physician and patient. The transgression of these boundaries is particularly severe, because killing someone who does not wish to be killed is a very severe breach of morality, and thus something which we must go to great lengths to avoid. However, I believe that by limiting access to euthanasia to only cases where it is autonomously requested by the patient, the potential for abuse can be greatly minimised.

An emphasis on autonomy can circumvent many of the problems that it is often feared will arise from allowing physicians to conduct euthanasia. For example, it is often suggested in the literature on bioethics that though euthanasia may be appropriate in some circumstances, allowing its practice only when it is voluntary will inevitably degenerate into allowing its practice when it is nonvoluntary as well (Kass 1993, p.37). However, a focus on the autonomous decision of the patient as the means of legitimating this sort of procedure does in no way implies that euthanasia can be carried out where an autonomous request is not made (Varelius 2006, p.130). This sharp distinction can help to eliminate worries that allowing euthanasia under any circumstances is a slippery slope (Brock 1992, p.20).

Limiting the practice of euthanasia to only cases in which the patient is able to make an autonomous request for the procedure will prevent some people from accessing euthanasia who may have wished to have it, and have a justifiable claim to it. However, preventing the treatment from being accessed by some is offset by a policy which has a greatly reduced potential for

abuse. Public policy is a blunt instrument, and due to the severity of a transgression in this instance, we must err on the side of caution, and work hard to maintain a clear line between acceptable and unacceptable practice of euthanasia. The aim of minimising abuse and mistakes may justify additional safeguards, such as making euthanasia available to only those with a terminal illness. The key is to achieve the appropriate balance between keeping abuse and mistakes to an absolute minimum, while allowing as many of the people who seek euthanasia in accordance with the goals of medicine as possible to access it (Brock 1992, p.20).

A focus on the autonomous request of the patient as the means to legitimating the practice of euthanasia can also address the ever-present worry that allowing physicians to conduct euthanasia will undermine trust. Patients may fear that physicians seek to kill them, rather than cure them (Silverman 1993, p.543). However, when euthanasia is clearly limited to instances in which it is autonomously requested, there is no reason for patients to fear that they will be killed without their explicit request (Brock 1992, p.16). Rather than undermining trust, allowing this option could actually increase trust, as patients could be assured that physicians were committed to carrying out their wishes, rather than overriding their express requests to, for example, not be subjected to aggressive life sustaining treatment. The existence of the option of euthanasia would really give the autonomy of patients the value that it is regularly claimed to deserve in medical ethics (Veatch 1984).

Despite the frequent assertion that allowing euthanasia would undermine the obligations of physicians and violate the fundamental goals of medicine, upon examination, these goals and obligations can actually be seen to support the practice of euthanasia in some circumstances. To guard against concerns that implementation of euthanasia in public policy will lead to mistakes,

abuses, and an erosion of trust, we must focus heavily on an autonomous request as the key to legitimating this practice. This focus enables us to draw a sharp line between inappropriate and appropriate cases of euthanasia, which can guard against 'slippery slope' concerns. Though this hard line may prevent some people who have a legitimate claim to euthanasia from accessing it, it will do a great deal to minimise abuse and strengthen the clear delineation between acceptable and unacceptable cases of euthanasia. In some circumstances, voluntary euthanasia presents a valid and valuable means of meeting the obligations of the physician.

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