Guest editorial

The medical ethics of physician-assisted suicide

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Absolute prohibitions of physician assistance in suicide have long been canonical in medical ethics, but a powerful reformation of views on euthanasia and physician-assisted suicide is now underway in several countries. The law on physician-assisted suicide in the state of Oregon, social approval of euthanasia in the Netherlands, and the (in principle) legality of active euthanasia in Japan are clear signs of the future. The key moral issue that will drive discussion is the liberty to choose the means to one's death and the justification, if any, for limiting that liberty.

Until very recently the consensus view in most countries was that a passive euthanasia of letting die is acceptable, but an active euthanasia of killing is not. An extraordinary transformation in our conception of the role of patient autonomy had occurred to bring about this consensus. We migrated from a fear of any form of intentional hastening of death to a confidence that it is permissible under a variety of conditions intentionally to forgo life-sustaining technologies of all types, knowing that death will ensue.

This history is now shifting from *refusal* of treatment—where the consensus was originally formed—to *request* for aid that involves physicians (or other second parties). The issues of first-party refusals of life-sustaining technologies are behind us. The issues are now about how patients will be able to request aid. My concern here is not with issues of legalisation or appropriate public policy. I want to suggest why certain acts that have traditionally been considered mercy killings are better framed as forms of requested aid-in-dying. The term “killing” has done more to confuse than to clarify thinking about these matters. None the less, killing remains the centrepiece of the current discussion.

Killing and letting die

The influential distinction between killing and letting die is essential to the traditional view that killing (even at another's request) is prohibited

and letting die permitted under specified conditions. However, the multi-purpose term “killing” does not entail a wrongful act or a crime, and there are several generally accepted justifications of killing, such as killing in self-defence and killing to rescue a person endangered by the immoral acts of other persons. Correctly to apply the label “killing” or the label “letting die” to a set of events will therefore not determine whether the set of events is morally acceptable or unacceptable. This is as true in medicine as elsewhere. Killing may typically be wrong and letting die rarely wrong, but this conclusion is contingent on the features of particular circumstances, not merely on whether the act is a killing or a letting die.

This result is not surprising inasmuch as killings are rarely authorised by appropriate parties (excepting capital punishment), whereas cases of letting die generally are authorised appropriately. Be that as it may, the *frequency* with which one kind of act is justified, by contrast to the other kind of act, is not relevant to the moral (or legal) justification of either kind of act. Forgoings that let a patient die can be both as intentional and as immoral as actions that involve direct interventions to bring about death (and both can be forms of killing).

Furthermore, the killing/letting-die distinction is largely irrelevant to today's mainstream issues about physician-assisted suicide, because the cases are not ones in which physicians are involved in either killing or of letting die. For example, a physician who prescribes a lethal medication at a patient's request does not thereby cause the patient's death and neither kills the patient nor lets the patient die, whether or not the patient voluntarily ingests the medication and dies.

A common thesis is that “letting die” occurs in medicine by “ceasing useless medical technologies”, but “letting die” actually occurs in medicine under two circumstances: one is the cessation of medical technology because it is *useless* and the other is the cessation of medical technology

because it has been *refused*. Honouring a refusal of a useful treatment knowing of a fatal outcome is letting someone die, not killing the person. The type of action—a killing or a letting die—can thus depend entirely on whether a valid refusal justifies the forgoing of medical technology. If there is no valid refusal, the act is an unjustified killing; if the act is of an identical type but is underwritten by a valid refusal, it is a justified letting die.

The received account of letting die in both law and medicine relies on a doctrine about the causation of death. The thesis is that intentionally forgoing a medical technology qualifies as letting die, rather than killing, if and only if an underlying disease or injury causes death. Despite its venerability, this received view is unsatisfactory. To obtain a satisfactory position, it must be added that the forgoing of the medical technology is validly authorised and for this reason is justified. Otherwise, allowing a “natural” death would be a killing. Again we see the absolutely central conceptual and moral role of valid authorisation.

In many cases of justified withdrawing or withholding of a medical treatment, death is not caused by an underlying condition of disease or injury. For example, an act of removing a nasogastric tube to abate hydration or nutrition leads to death from malnutrition, not death from an underlying condition of disease or injury. The disease or injury motivates and justifies the decision to forgo treatment, but does not cause death.

From both a legal and a moral point of view, one reason why physicians do not injure or maltreat patients when they withhold or withdraw medical technology (often with the intention of bringing about death) is that physicians are morally and legally obligated to recognise and act upon a valid refusal, irrespective of the causal outcome of doing so. Since a valid refusal of treatment obligates the physician to forgo treatment, it would be absurd to hold that these legal and moral duties require physicians to cause the deaths of their patients—in the legal and moral sense of “cause”—and thereby to kill them.

The particular form or mode of causation of death is not therefore the material matter in the justification of assistance in dying by forgoing treatment. As long as a refusal of medical technology is valid, there exists no problem about responsibility for the death that ensues or about the justification of the action.

Valid refusals and valid requests

The issue of valid requests for active assistance in dying is more difficult than these issues about valid refusals of treatment, but consider the logic

of the law on physician-assisted suicide in Oregon: a valid request for assistance removes legal culpability for the death that is arranged, but in the absence of a valid request, the same act is one of killing, indeed murder. This logic is why opponents of that law so deeply abhor it. It underwrites the principle that valid requests for assistance legitimate responses by physicians to such requests.

Of course, refusal and request are not so alike that the physician must act on whatever the patient or family wishes. Whereas a health professional is obligated to honour a refusal, he or she is not obligated to honour a request. Valid refusals obligate a physician to do something (or forbear from doing something) that leads to death, whereas valid requests only make it permissible for a physician (or some other person) to lend aid in dying. A physician who in principle accepts the permissibility of assistance in bringing about death may still refuse to honour a particular request if there is good moral reason for doing so.

Causing a person's death is morally wrong when it is wrong, not merely because the death is caused by someone, but because an unauthorised and unjustified harm or loss to the person occurs. The death is bad for the person only if there is an unauthorised and unjustified deprivation of opportunities and goods that life would otherwise have afforded. If a person freely elects and authorises death and sees that event as a personal benefit, rather than a setback, then meeting the person's request involves no clear harm or moral wrong.

If letting die based on valid refusals does no harm or wrong persons or violate their rights, how can assisted suicide or voluntary active euthanasia harm or wrong a person who dies? In each case persons seek what for them in their bleak circumstances is the best means to the end of quitting life. Their judgment is that lingering in life is worse than death. The person in search of assisted suicide, the person who seeks active euthanasia, and the person who forgoes life-sustaining technology to end life may be identically situated. They simply select different means to the end of their lives.

Looking to the future

In the twenty-first century we can expect the following to happen: the laws or precedents permitting physician-assistance in death will prove manageable and even be improved in the Netherlands, Oregon, Japan, and other locations. In the meanwhile, law, ethics, and medicine will struggle to find more conservative alternatives.

One option will be the cultivation of a wider array of circumstances under which competent patients are allowed to refuse nutrition and hydration in order to end their lives. The refusal of nutrition and hydration appears to encounter no legal or moral problems in many countries, despite the fact that there is no clear distinction between starving oneself to death and suicide or between a physician's starving a patient to death at the patient's request and physician-assisted suicide. The other option that is certain to come into increased favour is a dramatically improved style of palliative care. There is already a consensus that better end-of-life care, including palliative care, is needed, and we can expect to see more resources and training in support of this commendable goal.

No one of these three different options: (1) provision of fatal means to death, (2) planned forgoing of nutrition and hydration, and (3) improved palliative care will necessarily be best for each patient. The presentation of these options is also consistent with the larger argument I have presented, which is that these issues of euthanasia, physician-assisted suicide, and aid-in-dying are primarily about increased liberty, not about killing and letting die.

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News and notes

Fifth World Congress of Bioethics

The International Association of Bioethics has announced that the Fifth World Congress of Bioethics will take place at Imperial College, London from 21-24 September 2000.

Associated organisations are: The British Association for the Advancement of Science; the British Medical Association; the European Association of Centres of Medical Ethics; the Institute of Medical Ethics; the Millennial Festival of Medicine; the Nuffield Council on Bioethics; the Royal College of Nursing; the Royal

College of Psychiatrists, Philosophy Special Interest Group; the Society for Applied Philosophy; the UK Forum for Healthcare Ethics and Law, and the World Health Organisation.

For further information please contact: Sara Hassen, 5th World Congress of Bioethics, 1 Riverside, St Anne's Road, Bristol, BS4 4ED or email: enquiries@inanyevent-uk.com or use the Congress Website at <http://www.uclan.ac.uk/facs/ethics/fifthcon.htm>