The doctor-patient relationship and euthanasia

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Editor's note

The author offers grounds for preferring a 'fiduciary' model of the doctor-patient relationship to either an 'authoritative' or a 'contractual' model. Within this framework he suggests that certain acts of euthanasia could be accommodated not in any way as duties, but as supererogatory acts of kindness to the patient.

Currently there is no general agreement regarding the proper analysis of the physician/patient relationship. It seems that at least three distinct models of the relationship can be discerned. The first of these is what may be termed the traditional authoritative model. According to this view, the physician is the exclusive holder of knowledge. The patient is ignorant with respect to what help he may need and what decisions are in his best interest. Indeed, the patient is seen as an individual who, in the clinical context at least, necessarily does not have complete autonomy as an agent. For example, in the Hippocratic Corpus, especially the Decorum we find:

'... calmly and adroitly, concealing most things from the patient while you are attending him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition ...'

Similar themes are present in the American Medical Association's (AMA) first code of ethics (1847) taken from Thomas Percival's British Medical Code (1803):

'The physician should not be forward to make gloomy prognostications ... but he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger ... and even to the patient himself, if absolutely necessary. ... For the physician should be the minister of hope and comfort to the sick; that by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of these maladies which often disturb the tranquility of the most resigned in their last moments.'

This attitude has been, to a lesser degree, reflected in the behaviour of many modern physicians (1). According to this view, the physician alone should be presumed to have an objective grasp of the patient's situation. The patient, like a child in strange surroundings, may be reasonably assumed to be incapable of making difficult decisions regarding his own treatment, or even negotiating information regarding his state of health. In such a situation, the physician must assume responsibility for deciding which, how much, and in what form information should be released to the patient.

A second, currently more popular model of the physician/patient relationship is that of the contractual relationship (2). According to this model, the physician and patient are simply two strangers who contract for a service. The patient is presumed to be competent and both legally and morally he, or she, has a right to fully informed consent to treatment. As in the contracting of any other service, the physician does not have the right to lie to or withhold any information from the patient that is relevant to his physical condition. Any paternal feelings the physician may have toward his patient should remain personal and not interfere with his performance. The physician should be entirely honest with respect to his fulfilling the terms of the contract, and should answer any questions the patient may have regarding the medical service for which the patient has contracted.

This model, much more than the authoritative model, expresses a profound respect for the personal autonomy of the patient. This respect is reflected in the American Hospital Association's Patients Bill of Rights as well as in the New Code of Medical Ethics promulgated by the AMA. The latter provides that a physician

'... shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception'.

This approach constitutes a radical departure from the
authoritative model. It seems to assume that the physician is either not qualified, or does not possess the right, to violate the patient’s right to informed consent to treatment.

Proponents of the contractual approach note that the authoritative model is excessive in that it infringes upon the patient’s right to informed consent. The general assumption that patients cannot be expected to function autonomously seems to be at best false, and at worst, self-serving. It allows the physician too much discretion regarding the treatment of patients. While such a paternalistic attitude may be justified in certain cases involving individuals who are demonstrably legally incompetent to make decisions regarding their own treatment, as a general policy it represents an abrogation of the rights of the patient.

It may be, however, that the contractual model errs in the opposite direction. Much attention has been paid to the fact that in a clinical setting normally autonomous individuals do indeed lose some ability to make decisions regarding their own treatment. As C Perry has stated:

‘Quite mistakenly, the patient rights approach assumes that the patient is a fully autonomous adult, who can deal with the physician on a legalistic and contractual basis. But once we recognize that illness may dramatically compromise autonomous functioning, a deeper meaning of respect for patient autonomy emerges . . . ’

(3)

Similarly, Ruth Macklin (4) has recently noted that in certain circumstances patients commonly fail to assimilate information crucial to reaching an informed decision regarding their treatment. It seems that the fact that certain patients may have a debilitating or life-threatening medical condition and are (usually) critically ignorant of its causes, aetiology, and treatment tends to lessen their ability rationally to consider alternatives. Therefore it may be that extreme care should be exercised in dealing with these patients. For example, discretion may be needed in informing the patient how serious his condition is. Care may be needed in the language used in discussing the problem; when certain extreme alternatives should be introduced into the discussion; whether certain facts should be often repeated, etc.

A third approach is available, however, which does not embody either the assumption that the patient can function autonomously or that he cannot. The fiduciary or ‘friendship’ model assumes simply that a patient comes to the physician for help. The patient, as an individual, may be entirely autonomous or he may not, due to his illness and psychological factors. The fiduciary model requires that the physician demonstrates concern for the welfare of the patient and attempts to fulfil his needs. No prior assumption of the ability of the patient to make fully informed decisions is made. The physician attempts to provide aid to the patient as one human being to another; the character of the aid will depend upon the condition of the particular patient. If the patient is able to function as an autonomous agent, the physician will treat him as such. If the patient is unable to do so, the physician will attempt to ascertain what is in the patient’s best interest and act accordingly until the patient recovers sufficiently.

The fiduciary model is thus not committed to either assumption possessed by the previous models. It neither assumes that the patient is incompetent nor that the patient is capable of functioning autonomously. The prominent characteristic of this model is the concern the physician has for the patient, who is a fellow human in need. This sentiment is captured by the original Hippocratic Ethic:

‘The physician is, at all times, morally obliged to do that which will secure the well being of the patient.’

According to the fiduciary model, the realistic concern for the well-being of the patient is not restricted to his physical condition but recognises the possible effect of that condition on the patient’s autonomy.

The fiduciary model of the physician/patient relationship thus may be preferable, if only because it is committed to neither assumption made by the other two. If so, certain acts of euthanasia can be conceived of in a way that is readily assimilable to the fiduciary model. In the remainder of this essay it will be argued that if the fiduciary model of the physician/patient relationship is plausible, certain acts of euthanasia can be seen as extraordinary actions performed out of a desire to help those who cannot help themselves. Certain acts of euthanasia will, that is, be argued to be a type of supererogatory act.

To reach this point, however, the relationship between rights and duties must briefly be discussed. The notion of a right and its relation to duty is central to our ordinary moral discourse. It seems clear that if someone has a certain right, others are in general obliged to respect that right. For instance, individuals have a right to life and hence others have a duty not to interfere with the exercise of that right.

The concept of a right, though of crucial importance to our ordinary moral discourse, does not account for all of our moral interaction. It has been argued that persons do not have a right to die and that acts of euthanasia cannot properly be considered to be duties. If this is accepted how can our ordinary moral discourse account for such acts? It will be argued in this section that certain acts of euthanasia can be plausibly considered to be supererogatory acts.

In an interesting essay (5) Peter Williams has argued that while there is a right to life which others have a duty to observe, there is no corresponding right to die that should be taken account of in debates concerning the permissibility of euthanasia. Williams claims that if there were a positive right to choose the time and manner of death, then others would have a corresponding duty to cooperate in the killing. However, it is
never incumbent upon anyone to perform an act of euthanasia; one must consult one’s conscience and render a decision accordingly. Such leeway in the decision to comply with the potential victim’s request is not typical of a performance of a duty. Even if most people would agree in a particular case that a physician should have helped a patient to die, while their indignation at his refusal might be an appropriate response, his action does not call for the opprobrium characteristic of a violation of rights (6). Furthermore in some circumstances a physician administering a drug in order painlessly to end the life of a terminally ill patient who is in terrible pain may be praised for his action (6). If there were a right to death analogous to the right to life, others including the physician would have a duty to observe that right. Indeed, since humane killing would presumably require some medical knowledge, the physician would be the primary duty-holder (6). Thus, the physician in such a case would merely be performing his duty. But mere performance of duties or execution of responsibilities is not generally taken as grounds for praise: when someone performs his duties he is doing what is expected of him, given his commitments and responsibilities (7).

Because of such considerations Williams concludes that a proper analysis of acts of euthanasia cannot be achieved by reference to rights and their corresponding duties. What we ought to do in such cases cannot, that is, be determined merely by knowing what someone’s rights are. Killing another may be the right thing to do in a particular case without it being a response to any right of the victim. He states that:

‘Gracious, loving, charitable, sacrificial, heroic, or saintly acts of killing are of enormous importance and value morally. Though rights are crucially important to our moral universe, there are other constellations. Acts of euthanasia — whether positive or negative — probably fall within these other categories (8).

In what follows I will attempt to show that given their current status in our society certain acts of euthanasia fall within a specific category of acts, and indeed it is a category which is overtly moral in nature. Such acts of euthanasia, it seems, can plausibly be considered a species of supererogatory acts.

A supererogatory act has been analysed as one which is a meritorious, abnormally risky non-duty (9). A common example of such an act is that of a doctor who volunteers to join the depleted medical forces in a plague-ridden city. This act is, of course, meritorious in that it constitutes an attempt to save lives. It is abnormally risky in that there is a high probability that the doctor will contract the disease himself. Finally, it is a non-duty because the doctor has no duty to travel to the city or to treat any victims in it (10). He is simply doing it out of concern for the plight of his fellow humans.

The commission of euthanasia may be meritorious if it releases a victim from needless suffering. Of course an act of euthanasia may not be meritorious — for example if there was a reasonable chance that the patient might have recovered (11). In that case, the physician may be morally censured even though his intentions were beneficent. Furthermore the legal status of euthanasia makes its commission highly risky for the physician, who may be brought to trial under various charges. Thus certain acts of euthanasia, being both meritorious and abnormally risky, qualify as supererogatory acts.

It should be noted, however, that the case of euthanasia differs from the case of the doctor who braves the plague in two respects. First, the risk incurred by the physician who commits euthanasia is not physical, but rather that of transgressing a law. This difference, however, does not seem to be significant. All that is required for an act to qualify as supererogatory is that it be abnormally risky, in some sense, to the agent. The second difference, though not unrelated to the first, may be more significant. It is that what the physician performing euthanasia risks is consequences following a violation of the law, that is, rules governing behaviour which presumably enjoy some degree of social acceptance, rather than a disease which everyone would agree is unfortunate. However, history contains numerous instances of the divergence of law and morality. For example, in Nazi Germany it was illegal to house and protect Jews. Many citizens did so in spite of the illegality of their action and out of sympathy for the persecuted Jews. In the case of euthanasia our moral intuitions may prompt us to wish to override the law in particular circumstances. Thus it seems that this difference is also insignificant.

Indeed, it is the fact that acts of euthanasia are risky to physicians that indicates that euthanasia is a non-duty. If there were some reasonable, generally agreed-upon official policy stipulating when euthanasia was a duty and its commission thus expected, there would be none of the present risk to the physician. It is, indeed, the fact that euthanasia is not a duty which makes justifiable acts of euthanasia praiseworthy. One is generally not praised for performing one’s duties. If euthanasia were a duty in some cases its performance would be routine, as would be an appendicectomy in the appropriate circumstances. In that case, euthanasia would be a responsibility and its commission could not be considered praiseworthy. It may very well be that a physician who commits an act of euthanasia in such circumstances does so out of genuine sympathy. The fact that the act is expected as the performance of a duty would, however, tend to mitigate any basis for praising the physician for the action, just as there would be little temptation to praise a physician for performing a routine operation. All that could be called for, in either case, would be general praise on the basis that the physician performed his duties which benefited persons. In the present climate of opinion, it is reasonable to conclude that justified cases of euthanasia are committed out of an acute appreciation of the victim’s plight, and so are praise-
worthy. This would not be the case if euthanasia were a duty. Thus if euthanasia were institutional, physicians would be relieved of the risk they now face, but only at the cost of removing the essential reason for which its commission may be considered to be praise-worthy.

Benjamin Freedman has argued that professional ethics is to a large degree autonomous from and acts with morality lies professional law (I2). For example, in certain contexts, an ordinary citizen may be morally as well as legally required to divulge certain information, whereas a physician may be bound, by the dictates of his professional ethic, to keep information confidential (II). In other cases, professional morality may conflict with ordinary morality, even if it does not conflict with the law (14). As a result, Freedman conjectures that professional morality lies at the end of a continuum, with acts of the least moral significance at one end and those which are of concern to professional morality at the other, and ordinary morality in the middle (15).

If the discussion in this section is correct, however, then in justifiable cases of euthanasia a physician’s action can be accounted for by ordinary morality. For, as we saw in the case of the German citizens who illegally protected Jews, no special sort of morality was required to describe the moral quality of their actions. Though homicide is in general impermissible except in cases of self-defence, cases of euthanasia can sometimes be justified on the basis that it is the best thing for the victim. These actions can thus be interpreted as an exception to the general rule rather than in conflict with it. Thus euthanasia, considered as a supererogatory act, is consistent with ordinary morality, which allows for both proper exceptions to rules and supererogatory acts. Since the fiduciary model of the physician/patient relationship captures the ordinary concern an individual would feel for another in need, it can easily accommodate the view that euthanasia can be seen as a supererogatory act (16).

References

(3) See reference (2) Perry C.
(6) See reference (5) 142.
(8) See reference (5) 143.
(9) See reference (7) 13.
(10) See reference (7) 10–11.
(13) See reference (12) 3.
(14) See reference (12) 10.
(15) See reference (12) 19.
(16) For a similar argument regarding paternalistic practices by physicians see reference (2) Perry C.