

Assisted suicide and voluntary euthanasia: role contradictions for physicians

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ABSTRACT – It is widely assumed by the general public that if assisted suicide (AS) or euthanasia (VE) were legalised doctors must be essentially involved in the whole process including prescribing the medication and (in euthanasia) administering it. This paper explores some reasons for this assumption and argues that it flatly contradicts what it means to be a doctor. The paper is thus not mainly concerned with the ethics of AS/VE but rather with the concept of a doctor that has evolved since the time of Hippocrates to current professional guidance reflected in healthcare law. The paper argues that the most common recent argument for AS/VE – that patients have a right to control when and how they die – in fact points to the involvement not of doctors but of legal agencies as decision makers plus technicians as agents.

KEY WORDS: assisted suicide, voluntary euthanasia, palliative medicine

There is currently a pervasive assumption that if assisted suicide and/or voluntary euthanasia (AS/VE) were to be legalised, then doctors would take responsibility for making the decision that these interventions were indicated, for prescribing the medication, and (in euthanasia) for administering it. In other words, the prevailing view is that AS should be physician-assisted suicide (PAS). But there is significant opposition among doctors to their proposed direct involvement in AS/VE.¹ Analysis of free-text comments in the extensive 2006 consultation by the Royal College of Physicians indicated that physicians seem to believe that doctors should not be the key agents of AS and that, if legalised, AS should instead be delivered by non-doctors.² This paper will attempt to articulate a coherent argument for the doctors' position.

Two preliminary points should be noted. Firstly, the moral rightness or wrongness of AS/VE is not being argued, only that the role of a doctor should preclude doctors from being the decision makers or the agents. Secondly, the arguments are not mainly ethical but conceptual; the authors are not concerned with the practical or experiential consequences of using doctors as decision makers and agents in AS/VE, but only with the role of a doctor and with the meaning of terms such as 'treatment', 'healthcare intervention' and 'best interests'. The two main arguments used in favour of AS/VE – the 'intolerable suffering

argument' and the 'control argument' – will be considered and it is argued that in both the involvement of doctors as decision makers and agents runs contrary to the concept of the doctor's role. Indeed, the 'control argument' actually points towards the involvement of other non-medical agencies.

The 'intolerable suffering' argument

It is commonly said that some patients with incurable illness experience intolerable suffering. It is then argued that (at least sometimes) the only effective way to end that suffering is to cause death. The proposed method is to use substances which have been developed as medications but which in overdose will cause death. Since the cause of the suffering is illness and the method proposed is overdose of a drug designed and used for medical treatment, it is then assumed that doctors should be responsible for making the decision, prescribing the lethal overdose and then administering it (in the case of VE).

The method of assisted suicide/voluntary euthanasia

This argument, however, does not show that doctors must necessarily be involved in AS/VE. It is just a reality of pharmacology that an overdose of some medications will kill. If a method were to be proposed for AS/VE which did not involve the administration of a lethal medication overdose, for example electrocution or cyanide, then there would be no presumption that doctors should make the decision or carry out the act. It seems then that the assumption that doctors should be the decision makers and the agents of AS/VE is based, at least in part, on the method being proposed, ie overdoses of substances developed and used as medications. But there is no inherent necessity to use such methods and so there is no necessity to involve doctors on the grounds of method.

Doctors, suffering and care

It might be replied that since it is the doctor who is treating the illness the doctor is the one who should be called upon to end the suffering humanely when it becomes intolerable. It is argued that this would show continuity of care and compassion through the illness to the patient's death. Yes, but note that 'care and compassion' in this case mean PAS/VE. Is there anything about the core concept of the doctor's role which excludes this kind of activity? How are we to establish the logical limits of a doctor's role?

An early attempt at defining the doctor's role, at defining what it means to be a doctor, can be found in the Hippocratic oath.

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Hippocrates (or his school) exhorts the doctor to do whatever is for the benefit of the patient, and to give no deadly medicine if asked, nor suggest such counsel. This foundation statement of what it means to be a doctor has been picked up and amplified in recommendations from professional bodies such as the General Medical Council (GMC) and British Medical Association (BMA). These bodies define the role of the doctor in terms of the provision of treatment and care in the patient's best interests. Moreover, the documents of these bodies are helpful in analysing the concepts of treatment, care and best interests. For example, the GMC document *Good Medical Practice* begins with the injunction 'Make the care of your patient your first concern'.³ It later instructs doctors that 'You must act in your patients' best interests when making referrals and when providing or arranging treatment or care'. The GMC guidance on consent stresses that doctors must identify which treatments are likely to result in 'overall benefit' for the patient, a concept which is analogous to 'best interests'.⁴ Thus the concept of serving the patient's 'best interests' forms the basis of the initial stipulation that doctors must make the care of their patient their first concern. In other words, that is the defining point of the job. What constitutes 'best interests'?

Best interests

The BMA explains that 'best interests' must include 'clinical improvement' as a key component. The factors which must be considered when making judgements regarding life-sustaining treatment include 'the likelihood and extent of any degree of improvement if treatment is provided; whether the invasiveness, risks and side effects of the treatment are justified in the circumstances; clinical judgement about the effectiveness of the proposed treatment'.⁵ Clinical improvement is of course in relation to the patient's health circumstances, in terms of prolonging life, alleviating suffering, or restoring or maintaining function. An intention to bring about these health improvements provides a positive definition of what it is to be a doctor. But involvement in PAS/VE so as to change the patient's state from being alive to being dead is not in any sense bringing about a clinical improvement. Neither is it alleviating suffering, but instead moves the patient to a state presumed to be beyond suffering. It therefore cannot be seen as serving the patient's 'best interests' in the remit of the doctor's role.

Death cannot be an aim of treatment

The GMC also issues a warning which provides negative limits to the role of the doctor in one crucial respect. Treatments can have adverse outcomes, and the GMC notes explicitly that death is a 'serious adverse outcome' of treatment.⁴ It follows that if a doctor were to prescribe a lethal medication with the aim of assisting a patient to kill themselves then the doctor would be aiming at an 'adverse outcome'. But it makes no sense to say that an adverse outcome could be an aim of treatment. Doctors

treat patients, and aiming at AS/VE cannot fall within the remit of treatment.

To these arguments it might be objected that the role of the doctor is being restricted by tying it to a particular historical tradition, of which the GMC and BMA are the contemporary representatives. After all, the doctor's role has been extended to areas beyond treatment such as health promotion and public health policy. But it does not extend beyond the area of 'health benefit'. Hence, while the role of the doctor has changed and may continue to develop it cannot (logically) extend to intentional killing or assisting with killing. If so extended then the concept of what it means to be a doctor must also radically change, and more than two millennia of settled public and medical opinion must be reversed.

The 'control' argument

It is interesting to note that in popular debate the emphasis has moved from the 'intolerable suffering' argument. This may be because it depends on an empirical premise – that there is suffering which cannot be relieved – and developments in sophisticated methods of relieving symptoms have weakened the force of this premise. However that may be, recent high-profile cases have in fact tended to concern those who wish to determine when and how their lives should be ended. For example, the case might concern someone who is not expected to die within months or even a few years and is not suffering intolerably but sees ahead a degenerative disease and does not wish to live through disability and the perceived indignity of requiring care; someone who has recurrent bouts of distressing mental illness and does not want to continue; or someone who has become quadriplegic through accident and does not want a life of total dependency. In such circumstances the desire to control when, where and how one dies is understandable. The 'control' argument is therefore persuasive and concurs with the current societal emphasis on individual autonomy and the legal emphasis on rights.

In its more radical form the 'control' argument becomes the 'patient choice' argument. In recent years the idea has grown and been encouraged by successive governments and consumer movements that all healthcare decisions should be 'patient led' and thus determined by the patient's wishes. Fearing taunts of 'paternalism' and 'lack of respect for patient autonomy' many doctors have gone along with this. So this radical view has gained ground in all areas of medicine, including palliative care.

Consumer choice plus AS/VE as healthcare interventions: consequences for medical professionalism

The general problems of the patient choice movement have been discussed earlier⁶ and, more recently, the specific issues of choice in end-of-life care have been argued.⁷ If patients are given an unrestricted right to consumer choice, and if doctors

are to be the agents of AS/VE thus making those actions healthcare interventions, then there is no reason to deny patients the choice of PAS/VE providing the legal criteria are met. Indeed, PAS/VE would have to be offered as an option where the qualifying criteria were met. But, if patients are given such a right to PAS/VE then the whole idea of medicine as a profession must radically change. Doctors will simply become the suppliers of goods and services in the free market; the entire responsibility for the choice must pass to the consumer, ie the patient. If the 'service' is PAS/VE then the decision is up to the patient. But such a position is totally incompatible with the age-old and current concept of what it means to be a doctor. Such a position could emerge out of politically-led consumerism, but if it does the price will be the end of medicine as a profession.

The more persuasive and less radical form of the 'control' argument is not concerned with patient choice in general but specifically with those patients who have disabling or terminal illnesses and who do not wish to live through their remaining natural lifespan. Such patients may reasonably feel that through no fault of their own life has dealt them an unfair hand. This appeal to considerations of natural justice seems a plausible argument for AS/VE. But is it an argument which must involve doctors?

An alternative proposal

The considerations outlined against the 'intolerable suffering' argument could apply again – that prescribing a lethal medication overdose cannot (logically) count as a treatment in a patient's best health interests and would in fact make the doctor a decision maker and agent in bringing about what is an 'adverse outcome' of treatment. Does that mean that the 'control' argument must fail because no one is appropriate as decision maker or agent? Not necessarily, for an alternative solution would be the legalisation of AS/VE and its implementation under the jurisdiction of the legal system. After all, some who endure these distressing and incurable conditions do say that it is unfair or unjust that they should have to suffer. Sometimes indeed it is said that they have a human right to AS/VE. If this is so then their cases clearly fall within the jurisdiction of those dealing with matters of justice or rights. A legal tribunal could therefore be established to make the decisions according to the qualifying legal criteria, while the agents effecting the tribunal's decisions would not be doctors but technicians. At most doctors could be involved in confirming diagnosis and expected prognosis and excluding impaired capacity due to illness. This possibility is rarely discussed currently, although a similar idea was proposed in 1993.⁸

Conclusion

Opinions differ on the *ethical* consequences of trying to make AS/VE the responsibility of doctors, but prior to consideration of such ethically relevant consequences the question arises of

whether the provision of AS/VE can *logically* be part of the doctor's role. A doctor's job description is to aim at the provision of treatments with health benefits in the patient's best interests, and to avoid adverse outcomes. Death is not a health benefit and a dead patient has no health interests. Death resulting from treatment is a serious adverse outcome. It is therefore irrational to assume or argue that the provision of AS/VE could be part of a doctor's role.

In this paper a definition of the doctor's role in terms of the aim of providing treatment in the patient's best health interests and of avoiding adverse outcomes has been proposed. But what kind of a definition is this? Ideally a definition should provide necessary and sufficient conditions of what makes something what it is. It must be admitted that this has not occurred; this account could not be a sufficient condition of the role of a doctor because other occupations – nursing, physiotherapy and many more – might have the same aims (and with the same exclusion of AS/VE). There may also be other necessary conditions for exercising the role – such as having an approved training. Nevertheless, a partial definition which includes the necessary condition that rules out AS/VE as possible aims and actions has been suggested.

The decision regarding whether or not to legalise AS/VE is for society, one to be taken after proper democratic parliamentary debate. It is, however, essential that the correct question is posed. It should be whether AS/VE, as part of the justice system and involving a legal procedure including safeguards, should be legalised. The question should not be whether 'physician-assisted suicide' or 'euthanasia by doctors' should be legalised, since it is simply irrational to consider AS/VE as 'treatments' or 'healthcare interventions'. Instead, AS/VE must be debated in a context where they are explicitly excluded from the healthcare domain.

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