

ISSUE 7

*Physician-assisted suicide is/is not morally  
supported by the combined concepts of  
“medical autonomy” and “mercy”*



*The Moral Claim Justifying Physician-Assisted  
Suicide with the Combination of  
Autonomy and Mercy*



In the specific arena of physician-assisted suicide, some have sought to go from rebutting the arguments labeling such a practice as immoral to presenting a position establishing its morality under certain circumstances. This position combines patient autonomy in making medical decisions (perhaps the dominant theme in current medical ethics)<sup>1</sup> and the element of mercy.<sup>2</sup>

I have discussed the notion of individual autonomy at some length. To this point, I have described two possible contexts. In one, autonomy is meant to encompass the notion that it is only by exercising choices (or, from a sectarian perspective, exercising our God-given “free will”) that we can truly define ourselves as individual beings. The second posits autonomy as a prerequisite for putting the philosophy of utilitarianism into practice. In medical autonomy, we now encounter a third context for the concept, one that intersects with my own world of law.

MEDICAL AUTONOMY

Medical autonomy is the product of two other concepts—my right not to be harmfully touched without my consent and what we call “informed

consent.”<sup>3</sup> The right not to be harmfully touched without my consent exists in all aspects of my life. I have a right to expect that people will not push, punch, or slap me; am entitled to insist on the support of the informal and formal (governmental) portions of my community to maintain and protect that right; and am also entitled to seek redress if that right is violated. In the world of medicine, this means that I cannot, for example, be drugged, dragged from my hospital bed, and taken to surgery to remove my leg even if, in the doctor’s opinion, that is the medically best decision. It is my body, my choice.

Informed consent means that (unless I am unconscious, bleeding to death in the emergency room, or such) I must be provided with sufficient information (benefits, alternatives, risks) to make the choice as to what will be done to my body. This means, as all of us are now aware, that I will often be told about some pretty scary, remote risks. Doctors do not want to be sued on the basis that my consent was not informed when that remote risk comes to fruition.<sup>4</sup>

It also means that doctors will not use us as guinea pigs in experiments without our knowledge. This actually happened in the past, when young black men with syphilis were left untreated and discouraged from seeking treatment elsewhere in order to study the progression of the disease.<sup>5</sup> This notable example and others provided specific historical motivation for requiring informed consent. Thus, while the broader notion of autonomy may have been a philosophy born out of the reaction to abuses by governments (e.g., monarchies) and the majority in society (e.g., rejection of the unique, the eccentric, or the rebel), medical autonomy arose in reaction to abuses by the medical profession.

Put these two concepts together (i.e., the right not to be touched and informed consent) and you have patient autonomy. Underlying this concept is the notion that only I can really know what is going on with me. I am a black box, a mystery to those outside me.<sup>6</sup> And it is therapeutic for me to participate in and make these choices about the course of my medical treatment. Some would even say that, as an autonomous being, I have a moral duty to so choose.

On the other hand, while acknowledging these past abuses by the medical profession, there are those who nonetheless dispute what they term the black box premise of medical autonomy.<sup>7</sup> They dispute that I am self-contained, separate from the world, and unknowable from the outside and that no doctor can know me like I know myself.

I can see value in both sides of this debate. As a general proposition, I

do know myself and what's best for me. I also know my own body. I know that better than others because I live every instant of my life with myself, am my primary interest, and have continually studied myself. Yet that is also the problem. I am often too close. My idea of myself, mixed with hope and fear, leads me to construct the world I perceive in ways that may skew what others would consider the "reality" of my situation.<sup>8</sup> Surely, at some time in our lives, all of us have been confronted by friends or family members who force us to face some self-destructive or self-defeating behavior we have chosen not to see. They could "see" us better than we could. Or maybe "we" do understand at some level, but we also have mechanisms with which to delude ourselves, to hide what we do not wish to face. Our health seems to be one of those things. People smoke—a lot of people smoke. What does that say about our capacity to control the effect of outside knowledge on our behavior?

Even when we know best, we don't do best. Maybe that's our choice under the broad philosophy of autonomy as defining ourselves through our choices, but it's different from medical autonomy wherein my supposed superior expertise in my own health is one of the cornerstones of the concept. One could respond that when I say "I know best" I don't mean that I know what's medically better for me than does a doctor. I mean that I know what's best for my life, and medical decisions are only one piece of that puzzle (such as the decision whether or not to amputate a limb). The doctor can tell me that smoking may kill me over time, and I may believe he or she is correct on a purely medical basis, but I may nevertheless feel that, in the specific context of my life, it's worth the risk. That's a plausible position, but I don't think it's what people mean in this debate.

Moreover, under this view of the rationale for medical autonomy, even if I generally think I know what's best for my life that is not always true. And it seems that the more stressful the situation the more difficult it is for most of us to make good decisions.<sup>9</sup> When we are not only under stress but the cause of that stress also affects our physical and cognitive capacities (such as being in the throes of a life-threatening illness), the difficulties with good decision making only increase.

Also, while it may be therapeutic for some to participate in their treatment,<sup>10</sup> in fact that is not what many people want to do.<sup>11</sup> There are a number of reasons for this. Medical autonomy is not limited to "important" choices; it covers all choices.<sup>12</sup> This may be far more than people wish to deal with, especially when they are weak, exhausted, and ill. Many, though far from all, people in these situations just want to be cared for

without having the strain of making more decisions. Medical diagnosis and treatment decisions are extremely difficult even for doctors.<sup>13</sup> Is it any wonder that untrained, desperately ill people would not want to take the lead in the direction of their treatment? Even a very proactive patient like my father generally was more interested in having information and the illusion of control such knowledge imparts than in actually making the decision.<sup>14</sup>

When my father became too ill, he ceded his decision-making power to the family. We did as he did. We wanted information, to know what was happening, but we generally approved the course of medicine (or the option among alternative courses) suggested by the doctors. They were the medical experts. There were exceptions, one of which I discussed in the story of the “shunt and the phantom surgery.” But it was an exception, though surely a vivid one.

There also is an irony when using the concept of medical autonomy as a platform on which to build a moral basis for assisted suicide. Medical or patient autonomy represents more than individual patient rights and protections. It is a metaphor for a dramatic alteration in the physician-patient power relationship. In years past, all the power was with the physician, as was all the trust. Patient autonomy represents a universe in which the doctor works for the patient; it is the patient who has the power, and trust is no greater than when dealing with any other professional.

Yet one could contend that in placing physician-assisted suicide under the banner of patient autonomy one has in effect returned to doctors far more power than they previously possessed.<sup>15</sup> Now they literally have the power of life and death; they will, in effect, decide whether or not PAS is “reasonable” for a particular patient.<sup>16</sup> Ironically, now a concept that was intended to shift the power balance from the traditional doctor-patient relationship, in which all power was in the hands of doctors, to one in which the power is somewhat more evenly distributed is being invoked by patients as the rationale for ceding to doctors a power they never before had—the ultimate power, the power to intentionally kill the patient.

Although, in theory, it is the patient’s choice, as we’ve discussed, with their ability to control information (both the selection of content and how that content is presented) and their professional authority, doctors can manipulate patient choices to a great extent.<sup>17</sup> I understand this from my experience as a criminal defense attorney. It’s the day of trial, and the prosecution offers a plea bargain if my client will forgo trial. Whether or not to accept that offer is legally and ethically my client’s decision. My obligation

is to convey the offer. Yet I am aware that how I choose to characterize and emphasize such factors as the strength of the case, the risks at trial, the likely jurors, personal aspects (such as having to call family members to the stand), and the likely sentence if we go to trial and lose can completely skew the client's decision in one direction or the other. Doctors can use this same power to push patients toward or away from death by assisted suicide.

#### THE ADDITION OF MERCY

Those finding a moral basis for a physician participating in a patient's death do not rely solely on the patient's autonomy.<sup>18</sup> Assisted killing is not solely a matter of consumer preference to be honored upon request. It requires the addition of the further concept of mercy, mercy in the face of suffering.<sup>19</sup> For me, *mercy* is an interesting choice of words. I generally think of mercy as an act motivated by human compassion, an identification with the other person as someone who but for fortune could be us. That act, however, takes place under circumstances in which one has the power and legitimacy to inflict a form of extreme suffering (striking a fallen enemy on the battlefield, sentencing a convicted criminal) but relents. Religious orders such as the Sisters of Mercy metaphorically can be said to be agents of God's mercy.

But that is a funny way to think about a doctor and a patient such as my father. My father's actions did not justify his suffering, as would a combatant on the battlefield or a criminal at sentencing. Nor can a doctor be placed in the position of the victorious warrior or sentencing judge who can legitimately inflict some extreme consequence. Rather, doctors see people suffer all the time and generally are committed to easing that suffering.

What this position seems to be saying is that at some point, when that suffering is heartrendingly great, nothing in the conventional doctor's arsenal can stop it, and the patient begs for death in place of continual agony, then, as a compassionate human (who, due to his or her professional knowledge, is able to help the patient), the doctor may accede to this request. I am completely sympathetic with this view and would fully understand an individual doctor who chose to act under these circumstances, but I have trouble relying on the conjunction of autonomy and mercy (compassion) as a reliable moral beacon.

In the first place, this conjunction of autonomy and mercy would

equally appear to be a justification for any (requested) mercy killing whether carried out by a doctor or a layperson. And, again, the moral basis would be that, if people are suffering enough and request it, we may kill them. Perhaps, however, this is implicitly based on some interpretation of the duty of doctors to alleviate suffering. Fine. If you believe this, you believe this. It hardly offers a clear moral path given that many doctors who embrace the notion that the duty to relieve suffering is part of the doctor's role would, nevertheless, take the position that killing a patient is antithetical to that role. (In fact, some argue that, as a deontological proposition, the very notion of relieving suffering is premised on a surviving former sufferer.)<sup>20</sup>

There are, I believe, even more serious concerns with this concept. Eventually one will face difficulty trying to limit "suffering" to physical pain.<sup>21</sup> Physical pain is, as we've discussed, not an objective, physically perceptible phenomenon. It is only known by its outward symptoms (grimacing, moaning, groaning, screaming). It is a construction created from the physical, psychological, experiential, and imaginative. A child will stub a toe and cry hysterically at the pain. An adult will grimace, swear, and hop around. What accounts for the difference? I don't think the magnitude of the physical impact on tissue and nerves is different (though it may be). I think, rather, that two things explain the difference. We know from experience that the pain will soon subside. The child likely does not. We know that we cannot seek the comfort of others to ease us in our pain from a stubbed toe. Socially, a child is permitted to seek the arms and comforting words of its parents to ease the pain. Pain, thus, is complex, hardly providing a clear line for when or when not to kill another person.

If the notion of suffering is extended beyond physical pain, the limits of physician-assisted suicide become quite broad indeed. Psychological pain can be nearly as excruciating as physical torment. Do we want doctors to give lethal pills to a patient judged to be in mental agony who the doctor somehow determines has no reasonable prognosis of recovery (analogous to a terminal cancer patient)? Once we focus on terms such as *mercy* or *suffering*, we have to recognize that the content of these emotively powerful concepts will be filled in by a process of constructing persuasive analogous narratives. In other words, particularly because they are founded on the depth of compassion and fellow feeling in the human heart, they are far more likely to expand than contract.

Finally, one needs to take into consideration the risk that, given the individual power of the conjoined concepts—autonomy and mercy—in

individual cases an extreme version of one concept may, in practice, suffice.<sup>22</sup> Thus, an articulate, charming person whose suffering may not seem extreme may be so persuasive in his or her request for assistance in dying that autonomy will carry the day. The other possibility is even more troubling, that patients may be in such extreme, uncontrollable agony that, without a clear request, doctors will euthanize them. None of what I've said leads to the conclusion that assisted suicide is wrong in all instances. I have not seen a moral argument that convinces me that this is so. I just do not think that this concept of joining autonomy and mercy adds to my understanding of the circumstances under which assisted suicide is morally justified.