

Sometimes a case can be made for physician-assisted suicide

YES

Arguably this side of the moot is the easier; provide only one instance and the case is made, whilst arguing 'no' means anticipating all possible cases. Moreover, the ethical principle of patient autonomy implies the need to provide good reasons for refusing. Indeed, given a default position of autonomy, it is not actually necessary to make a case, merely to refute any potential objections to physician-assisted suicide (PAS).

Weak objections

Objecting that the Hippocratic Oath forbids PAS has little force, given the routine ignoring of other aspects of the oath (one could object to abortion on these grounds) and the ludicrousness of imagining that ethical problems of the twenty-first century should be solved by guidelines from the ancient Greeks. Similarly the objection that 'a doctor's job is to save life, not to end it' is neither necessarily true (fields like cosmetic surgery are rarely lifesaving) nor immutable.

Other objections might appear more compelling. It is certain that PAS would affect the doctor-patient relationship, but it is questionable whether this would be a change for the worse.

In countries where PAS and euthanasia are available, there is no evidence of this, although those whose enthusiasm outweighs their rigour sometimes produce apocryphal and unsubstantiated scare stories of frightened people worrying that their doctor will kill them. Elsewhere the extension of autonomy appears to produce better patient well-being and relationships with professionals,¹ and there seems little reason to believe that this would be any different for PAS.

Perhaps the most persistent is the so-called 'slippery slope' argument.² According to most versions of this, a procedure such as PAS, whilst acceptable in itself, would later lead to some unacceptable future scenario such as the mass execution of the old and infirm. As a purely logical argument it need not be taken seriously—indeed logicians usually refer to the 'slippery slope fallacy',³ only ceasing to be fallacious when the intervening steps are inevitable. Such steps could of course occur—for example, we may find that deaths through PAS are more peaceful, and thus more opt for it, or maybe those who would have committed suicide alone may welcome assistance. If these can be demonstrated, then the argument can have real status, although one might question whether the examples given are undesirable.

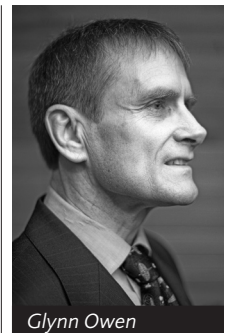
Unfortunately the data cited are typically correlational and highly selected.⁴ Rarely are counter-

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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.



Rod MacLeod



Glynn Owen

BACK TO BACK this issue:

examples given—as with the United Kingdom Abortion Act of 1967, which was introduced among fears that the 28-week limit might ‘slip’ to full-term but in fact went in the other direction and later was reduced to 24 weeks.

PAS and palliative care are not, as some claim, mutually exclusive. Like many working in end-of-life care, I have heard, and accepted, claims that we are able to deal adequately with pain in around 95–98% of cases, and have no argument with this. But even these figures imply that around one in 50 of our patients may suffer unacceptably and it is important to remember that pain may not be the only or even the main reason for wanting to end one’s life.⁵ The suggestion that PAS is unnecessary where palliative care is available contrasts with our own New Zealand data showing illegal euthanasia to be as likely when there is access to palliative care services as not. PAS and palliative care can peacefully coexist, and indeed liberalisation in Holland has been paralleled by a marked increase in provision of palliative care.⁶

Potentially strong objections

One of the more compelling arguments concerns not the patients but the practitioners. Typically fears are raised that providing PAS may lead to ending life being seen as an easier or cheaper option than good palliative care, but Kay Mitchell’s interviews with Dutch doctors performing euthanasia suggest quite the opposite—doctors finding it extremely difficult and going to great lengths to find alternatives.⁷

Also persuasive is the argument of ‘mistakes’; we might mistakenly allow PAS when someone could be treated and allowed to enjoy their last days before dying naturally. Proponents, however, conveniently forget mistakes in the other direction—where someone is compelled to suffer because the present systems cannot work properly. Consider the following account of a myeloma patient in the USA who, saying that she did not ‘have the energy to go another round’ decided to refuse food and drink from the Sunday evening ‘...only to find that the process wasn’t at all quick... by midnight Thursday she was already beginning to choke on the liquid in her lungs... during the height of her struggles in the early

morning hours of [Friday] she sweated, produced tears and manifested physical contortions while moaning... her body writhed despite a displaced hip fracture and lack of bone definition in the long bone of one arm...’ (account from patient’s husband). Of course it could have been handled better—but mistakes happen under all policies, and, if comparing policies, we need to look at the mistakes on both sides.

Finally there is the argument that ‘many ask for help in dying, but typically only once’. Of course many patients may ask only once because the ‘no’ is so resounding as to discourage repetition. But, in any event, no-one is suggesting legislation to permit PAS without evidence of an ‘enduring request’, as seen in such legislation in other countries. For those who change their mind, this requirement provides safety and protection, whilst allowing those who do have an enduring wish to control their own lives.

The picture that emerges, then, is one of our perpetuating the old ‘doctor knows best’ myth, depriving patients of control over their own lives without any sound justification. Perhaps the most telling argument comes from my colleague Professor Rod McLeod. After one of his very impressive lectures, a student said he’d been very impressed by Rod’s asking (and my apologies if he’s misquoted) ‘Who are we to decide that someone else’s life isn’t worth living?’. Of course we have no right to do so, any more than we have the right to insist for them that it is when they know otherwise.

References

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