Assisted suicide and the killing of people? Maybe. Physician-assisted suicide and the killing of patients? No: the rejection of Shaw's new perspective on euthanasia

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Received 4 September 2009
Revised 6 January 2010
Accepted 8 January 2010

ABSTRACT

David Shaw presents a new argument to support the old claim that there is not a significant moral difference between killing and letting die and, by implication, between active and passive euthanasia. He concludes that doctors should not make a distinction between them. However, whether or not killing and letting die are morally equivalent is not as important a question as he suggests. One can justify legal distinctions on non-moral grounds. One might oppose physician-assisted suicide and active euthanasia when performed by doctors on patients whether or not one is in favour of the legalisation of assisted suicide and active euthanasia. Furthermore, one can consider particular actions to be contrary to appropriate professional conduct even in the absence of legal and ethical objections to them. Someone who wants to die might want only a doctor to kill him or to help him to kill himself. However, we are not entitled to everything that we want in life or death. A doctor cannot always fittingly provide all that a patient wants or needs. It is appropriate that doctors provide their expert advice with regard to the performance of active euthanasia but they can and should do so while, qua doctors, they remain hors de combat.

David Shaw[1] presents a new argument to support the old claim that there is not a significant moral difference between killing and letting die and, by implication, between active and passive euthanasia. He concludes that both should be legal and that doctors should not make a distinction between them. Whether or not one accepts his new argument, his conclusion is resistible. The assumption that killing and letting die are morally equivalent is not pivotal to the case for the legalisation of active euthanasia or of assisted suicide. Proponents of the two need not deny and opponents need not assert that there is a moral difference between killing and letting die. There can be good reasons for a legal rule that treats some particular actions differently even if they are, morally, very similar or even the same. Good reasons these might be, but they need not be moral ones. One can justify legal distinctions on non-moral grounds. Furthermore, one might, with regard to professional propriety, make distinctions between particular actions on grounds that are unrelated to moral or legal considerations.

Shaw follows the conventional practice of taking a narrow view of the issues involved by focusing on the relevant deeds as forms of medical treatment and concentrating on active euthanasia as performed by doctors on their patients and on assisted suicide exclusively as physician-assisted suicide. However, the issues are more complex and the views that a reasonable person might reasonably hold are more numerous than Shaw allows. For instance, one might oppose the legalisation of physician-assisted suicide and yet be in favour of legalising some other sorts of assisted suicide. One might support the legalisation of active euthanasia under certain circumstances in which these circumstances do not include the killing of patients by their doctors. Furthermore, even if one thinks that, under certain circumstances, doctors should be legally permitted to kill their patients or to help them to kill themselves, one might also think that they should not do so. As Bosshard *et al*[2] say 'A society striving for an open approach towards assisted dying should carefully identify the tasks that should be assigned exclusively to medical doctors and those that might be better performed by other professions'. However, we need not assume in advance that only members of particular professions should be allowed to kill people or help them to die if such things were to be legalised.

SHAW ON ACTIVE AND PASSIVE EUTHANASIA: THE BODY AS UNWANTED LIFE-SUPPORT

According to Shaw: 'If we regard the body of someone who requests VAE (that is voluntary active euthanasia) or AS (that is assisted suicide) as providing unwarranted life-support, it is clear that there is no substantive moral difference between turning off a ventilator (eg), and providing or administering a lethal drug'.[1] To switch off a ventilator can be legally permissible and, as Shaw notes, this sort of so-called voluntary passive euthanasia (VPE) is commonly considered to be ethically permissible. He concludes that there should not be a legal distinction between active euthanasia, assisted suicide and passive euthanasia and that doctors should not make a distinction between them. He thinks, mistakenly, that: '…if there is really no moral difference between VAE and VPE, it follows that doctors have a duty either to perform both or to perform neither.'[1]

To illustrate his position he asks us to imagine two cases, involving Adam and Brian:

'In the first, Adam is dying of lung cancer and is on a ventilator. He is in constant pain and needs help eating, drinking, washing and going to the toilet. He regards his life as no longer worth living and, with the consent of his family, requests that the

doctor disconnects the ventilator. In the second case, Brian is dying of stomach cancer. He is in constant pain and needs help eating, drinking, washing and going to the toilet, although he can breathe easily. He regards his life as no longer worth living and, with the consent of his family, requests the doctor to administer a medication that will end his life.'[1]

According to Shaw, brain death constitutes the death of a person. He writes: 'Brian is not his body; he is his mind'.[1] His body, and the bodies of us all should be regarded, according to Shaw, not only as life-support systems but merely as such. Both Adam and Brian are, morally, in the same position in Shaw's view. They are asking for something that is keeping them alive against their wills to be switched off. According to Shaw: 'This… implies that the distinction between artificial and natural (bodily) means of life-support is a false one…. Although there may be a difference between their situations in medical and legal terms, this is the true moral status of the situation: both Brian and Adam are dying, are in pain, and are requesting the deactivation of something that is keeping them alive against their will.'[1]

MORALITY, THE LAW AND PUBLIC POLICY

I do not share Shaw's basic assumption that we, as persons, are our minds. I am not sure that the notion is coherent. We have brains, bodies and minds but it does not follow that we, as persons, are one or other of these things. Nonetheless, I am happy to go along with him in accepting that Brian's body can be regarded as a provider of unwanted life-support. However, acceptance of this view does not commit one to an acceptance of the rest of Shaw's account of the ethics of euthanasia and assisted suicide or of an acceptance of his proposed public policy. It does not follow that there is no moral difference between switching off a ventilator and administering a lethal injection. Even if there is no moral difference, it is not necessarily unreasonable to choose to make a legal difference. For instance, as Randall makes clear, we might consider that there is no moral difference between succeeding and failing in trying to kill someone and yet think that, for non-moral reasons, it is appropriate that we make a distinction in law between murder and attempted murder and treat the convicts differently (see Randall, p 374).[3]

In my view, to kill is not morally the same as to let die, despite the similarity of the outcomes: it can matter how and why what is done is done, who does it and to whom it is done.[3–7] However, we can set that particular issue aside. Not all crimes are such that, were they not illegal actions, they would still be immoral ones. We often choose to make legal distinctions that do not reflect moral differences. We can have good enough reasons for making legal distinctions and for choosing to distinguish legally between particular actions whether or not the reasons are moral ones. For instance, there is no inherent moral difference between driving on the left or on the right side of the road. There are good reasons, not all of which appear to be moral ones, for choosing to have a legal preference for the driving of motor vehicles on one or the other side of the road. It is no worse morally to kill or assault someone because of a hatred of the religious, racial or ethnic category that one believes the person is a member of than to kill him for fun, because one hates him personally or for some inscrutable motive. Nonetheless, we choose—whether wisely or not—to require the courts to make a difference and to punish the latter sorts of crimes more leniently than the former.

There is no significant moral difference between having sex with someone who is 16 years of age and someone else who is 15 years and 364 days old. Nonetheless, there is a hugely significant legal difference made in some jurisdictions. Furthermore, it is not for any obvious moral reason that we draw a legal line at 16 years rather than, say, 16 years and a day or, say, 16 years and 6 months or, say, 15 years and 9 weeks or, say, 17 years.

We might choose to make a legal distinction between active and passive euthanasia whether or not there is a moral difference between them. Similarly, we might choose, on whatever grounds, to make a legal distinction between what doctors and non-doctors are permitted to do with regard to euthanasia and assisted suicide.

Even if we choose to make active euthanasia and assisted suicide legal in some circumstances, we might, for whatever reasons, choose to say that doctors should not be permitted to take part. This is the path I favour. I think that euthanasia and assisted suicide are contrary to the role and professional duty or, at the very least, the central role and professional duty of doctors. It is in the general interests of both doctors and patients that the legal position is clearly maintained that doctors are not entitled to kill patients or help them directly to kill themselves. Otherwise, there is a danger that some patients will trust doctors less than they do at present. The status and reputation of doctors might be endangered if their roles appear to be ambiguous. Furthermore, the issues concerning trust are complex and confusing. Some doctors and some patients have an unhealthy, inappropriate, inflated, grandiose view about the role of doctors. It could be inflated even further were doctors—and particularly if doctors alone—were allowed to kill people or help them to die. Doctors can be trusted too much as well as too little for a proper relationship between doctors and their patients to obtain.

In relation to trust in this context, what is at issue is not merely confidence that doctors will do good things for good motives, but that they will do only those good things, which, as doctors, it is appropriate for them to do and to do them for motives that are appropriate ones for doctors to act upon qua doctors. The deeds of Dr Shipman cannot be ignored in this context but my unease over physician-assisted suicide and active euthanasia performed by doctors pertains mainly to envisaged instances in which doctors would be acting benevolently.

There is a danger that doctors would be placed frequently in morally hazardous situations. The current law on abortion and the way that it seems to operate gives an indication of the problem. For an abortion to be legal, two doctors must affirm that, in their opinion, one or other of certain particular conditions are met. Do we believe that doctors typically conscientiously and strictly apply the letter and spirit of the abortion legislation or, rather, that they do in the circumstances what they think is morally the best thing to do? If we do not trust them to adhere scrupulously to the abortion legislation, why should we trust them to adhere scrupulously to any future legislation with regard to legalised assisted suicide and active euthanasia?

If doctors were permitted to kill their patients, would they be placed under pressure to practice active euthanasia in order to save money? I do not think so. Nonetheless, some people might entertain such a niggling fear, which could be corrosive to the delicate bond of trust between medical practitioners and us.

EUTHANASIA AND PROPER PROFESSIONAL CONDUCT

Often, what are actually considerations of appropriate professional conduct are called matters of 'medical ethics'. This is unfortunate. Considerations of professional propriety can be important and they should be treated as such. Not all important considerations are ethical ones. For instance, some people might

think that it is preferable that, say, university lecturers do not have sexual relations with their own students and/or that doctors do not have sexual relations with their own patients even if such relations are not inherently unethical and should not be illegal.

Even if voluntary active euthanasia were legal and even if it were morally the same as voluntary passive euthanasia, doctors might have good non-moral reasons pertaining to appropriate professional conduct for choosing not to perform it. Apart from any other considerations, the BMA would be a laughing stock if it were thought to permit doctors to kill their own patients but not to have sex with them. What would be the sense in that? Wherein would lie the ethics?

DR ANDREWS, DR BENNET AND ME

Suppose, for the sake of the argument that both Brian and Adam have different doctors—Dr Bennett and Dr Andrews, respectively. Because Brian is Dr Bennett's patient, Dr Bennett, unlike Dr Andrews and me, might be said to be morally obliged to provide him with appropriate health care but not necessarily to provide him with everything that he might want or need. Not all that Brian wants or needs takes the form of healthcare treatment. Not all that might be thought of as healthcare treatment will be appropriate treatment for Dr Bennett to provide. Similarly, Dr Andrews will have obligations with regard to the treatment of Adam, which neither Dr Bennett nor I will have with regard to Adam.

Suppose that Brian asked Dr Andrews, Dr Bennett and me to pray with him. Each one of us would, I think, be morally permitted, to comply with his wishes. However, there might be constraints—pertaining to professional propriety rather than to ethics or legality—on a doctor's behaviour towards his patients that renders such compliance problematical for Dr Bennett, or so at least some people might think. If Brian also had, say, a strong urge to bet on a particular horse race, Dr Bennett might be reluctant to place it for him whether or not he would gladly do such a favour for Adam and other bed-bound people. Not all of our physical, psychological and other sorts of wants and needs can be met by health care, far less by actions that it is appropriate for our doctor to perform for us.

Suppose that Adam asked Dr Andrews, Dr Bennett and me to switch off his ventilator. Dr Andrews would be morally and, I think, legally obliged to comply with Adam's wishes. He is responsible for Adam's treatment and is justified in providing it only if Adam consents, if Adam is able to do so. As Adam has indicated that he does not any longer want to receive the treatment provided by the ventilator, Dr Andrews is morally obliged to cease to impose it upon him, although, previously, the treatment was not an imposition.

I am not morally obliged to comply with Adam's wishes and neither, I think, is Dr Bennett. If Adam, as a fellow human being rather than as a hospital patient, asked me to switch off his television set, it would be morally permissible (although not morally obligatory) to do so. It is not clear that it would be morally permissible for me to switch off his ventilator. I suspect that it would be wrong for me to do so. It is none of my business. When faced with this request, it seems to me that I should not consider Brian merely as a fellow human being but, rather, as a patient about whose condition, interests and wellbeing I am ignorant and towards whom I have a duty of non-interference. Similarly, Dr Bennett is morally obliged not to switch off Adam's ventilator. Dr Bennett should regard Adam as someone else's patient rather than merely as a fellow human being. He too should not interfere.

Suppose that Brian were to ask Dr Andrews, Dr Bennett and me to shoot him. I can see no grounds for suggesting that either Dr Andrews or I would be morally obliged to comply. Nonetheless, I think that it might well be morally permissible (were it not illegal) to shoot the poor man. I think, but I am not sure, that it is irrelevant in this case that Dr Andrews is a doctor because he is not Brian's doctor. We are both acting qua human beings towards another human being, and in this case we can be thought to have the same moral duties, whatever they might be.

Suppose that it were legal for Dr Bennett, as Brian's doctor, to kill Brian as a patient. Dr Bennett might reasonably be reluctant to do so. I do not think that it would be morally compulsory for him to shoot Brian. Even if he considered it to be morally permissible, there might well be other good non-moral grounds—were grounds to be required—for refusing to comply with Brian's request. Dr Bennett might think, as I do, that shooting patients is the same as giving them lethal injections. Neither constitutes an appropriate form of medical treatment. It is the job of doctors to try to heal their patients and also to try to comfort them in particular ways by, for instance, alleviating particular sorts of pain in particular sorts of ways. Euthanasia and assistance in committing suicide are not forms of healthcare treatment. They are called for only when healthcare treatment has become futile or unwanted by the patient.

If Brian were to be shot or otherwise killed, it would be better if he were, as a person, killed by another person such as, say, me rather than by another person who was also his doctor, because the relationship between doctor and patient might be compromised, adulterated, blurred and distorted were Dr Bennett (whether as a doctor or in his private capacity as a person) to kill Brian (whether as a patient or a person). Even if it is morally permissible for Dr Bennett as a person to kill Brian, as a person it might, on non-moral grounds, be wise were he to stand aside and let someone else perform the deed. Not all good reasons are moral ones; reasons pertaining to professional demarcation, status and reputation can be good enough.

CONCLUSION

Shaw asks: 'No medical technology is involved in Brian's case, but what moral reason can there be for differentiating between a ventilator that keeps the brain working and a body that keeps the brain working?'[1] Even if, from the point of view of Adam and Brian, their positions are the same, from the point of view of those who interact with Adam and Brian—the moral agents concerned—the situation is far more complex. An agent can have different duties with regard to Adam than he has with regard to Brian. Different agents can have different duties from each other.[3–7]

Nonetheless, we can leave this issue to one side. It is not true that if one accepts Shaw's new perspective and views Brian's body as the provider of unwanted life-support one will be led to accept Shaw's conclusions. It is not inherently irrational to treat circumstances, instances or occurrences that are morally the same differently in law, nor to treat legally the same that which is morally different. For instance, some people might say that voluntary active and passive euthanasia are morally the same, and yet, without inconsistency, claim that the latter should be legal and the former illegal. My own view is that we should give serious, sympathetic consideration to the legalisation of voluntary active euthanasia and assisted suicide whether or not voluntary active euthanasia is morally identical to voluntary passive euthanasia (and although I am convinced it is not).[3 5 i]

[i] Asscher[7] presents a similar sort of argument to mine, which demonstrates that to kill is not the same as to let die.

Furthermore, whether or not the killing of patients by their doctors is morally the same as the killing of people by people, I think there are good reasons of public policy for legally forbidding doctors to kill their patients even if we choose to legalise euthanasia in some circumstances.

Although attempted assisted suicides and attempted active euthanasia can go horribly wrong, it does not follow that they should be legal only when carried out by a doctor. Doctors could offer expert advice, as they might do with regard to sex, without playing an active part. We do not say that, for instance, suicide should be a criminal offence unless the deed is expertly performed. When executions were legal, we did not say that the convicts' doctors, far less that only they, should be legally permitted to carry them out. If assisted suicide and active euthanasia were to be legalised, it would be a good idea if medical assistance were available within easy and speedy reach. If the job is botched, the potential suicide becomes, without ambiguity, a patient in need of the sort of treatment that a doctor can, quite properly, provide.

Even if one thinks that it should not be illegal for doctors to kill their patients or to help them to kill themselves, one might argue that, on the grounds of professional propriety, they should not do it. For this, and for other reasons we have considered, it is not true that: '… if there is really no moral difference between VAE and VPE, it follows that doctors have a duty either to perform both or to perform neither'.[1] The issues are more complex than Shaw allows.

Acknowledgements The author would like to thank Colin Gavaghan and Kerry Lynn Macintosh for helpful comments on an earlier version of this article.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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J Med Ethics 2010 36: 306-309
doi: 10.1136/jme.2009.033118