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DOSSIER ''DESIRES TO LIVE AND DIE'' / *Thoughts*

An argument for physician-assisted suicide and against euthanasia

Un argument pour le suicide médicalement assisté

R. Cohen-Almagor

School of Politics, Philosophy and International Studies, The University of Hull, Cottingham Road, Hull HU6 7RX, United Kingdom

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Summary The article opens with the hypothesis that the default position that should guide healthcare providers when treating patients at the end-of-life is that patients opt for life. In the absence of an explicit request to die, we may assume that patients wish to continue living. Thus, the role of the medical profession is to provide patients with the best possible conditions for continued living. The article makes a case for physician-assisted suicide legislation. It examines the 'quality-of-life' argument, and the issue of the patient's autonomy and competence. It is argued that (1) quality-of-life is a subjective concept. Only the patient can conclude for herself that her quality-of-life is so low to warrant ending it, and that (2) only competent patients may request ending their lives. Patients' lives should not be actively terminated by the medical team without the explicit consent of patients. The article then probes the role of physicians at the end-of-life, arguing that medicine should strive to cater to the wishes of all patients, not only the majority of them. Physicians should not turn their backs to justified requests by their patients. Physicians are best equipped to come to the help of patients at all stages of their illness, including their end-of-life. At the same time, in ending life, the final control mechanism should be with the patient. Thus, physician-assisted suicide is preferred to euthanasia in order to lower the possibility of abuse and of ending the lives of patients without their consent and against their wishes. As matters of life and death are grave, they should be taken with utmost seriousness, requiring the instalment of ample checks against abuse and facilitating mechanisms designed to serve the patient's best interests. The article concludes with 19 careful and detailed guidelines for physician-assisted suicide. These are necessary measures designed to ensure that the best interests of the patients are served as they wished.

E-mail address: R.Cohen-Almagor@hull.ac.uk

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Résumé L'article commence par l'hypothèse que la position par défaut qui doit guider les fournisseurs de soins de santé lors du traitement de patients à la fin de la vie est que les patients optent pour la vie. En l'absence d'une demande explicite de mourir, nous pouvons supposer que les patients souhaitent continuer à vivre. Ainsi, le rôle de la profession médicale est de fournir aux patients les meilleures conditions possibles pour poursuivre la vie. L'article fait un cas pour la législation du suicide assisté par un médecin. Il examine l'argument « qualité de vie », et la question de l'autonomie et de la compétence du patient. On fait valoir que (1) la qualité de vie est un concept subjectif. Seul le patient peut conclure pour lui-même que sa qualité de vie est si faible pour justifier y mettre fin, et (2) que les seul le patient compétent peut demander de mettre fin à sa vie. Il ne devrait pas être mis fin activement à la vie des patients par l'équipe médicale sans le consentement explicite des patients. L'article explore ensuite le rôle des médecins à la fin de la vie, en faisant valoir que la médecine doit s'efforcer de répondre à toutes les attentes des patients, pas seulement à la majorité d'entre elles. Les médecins ne devraient pas tourner le dos aux demandes motivées de leurs patients. Les médecins sont les mieux équipés pour venir en aide à leurs patients à tous les stades de leur maladie, y compris en fin de vie. Dans le même temps, en fin de vie, le mécanisme de réglage final doit se faire avec le patient. Ainsi le suicide médicalement assisté est préférable à l'euthanasie pour réduire les abus comme mettre fin à la vie des patients sans leur consentement ou contre leur volonté. Comme les questions de la vie et de la mort sont graves, elles doivent être prises avec le plus grand sérieux. L'article conclut sur 19 directives précises et détaillées concernant le suicide médicalement assisté. Ces mesures nécessaires visent à assurer le meilleur intérêt des patients.

Introduction

During one of my conversations with Isaiah Berlin we discussed end-of-life issues. Isaiah told me a personal story about one of his friends who, at that time, experienced some health problems. Later, he reflected on our discussion in writing. Isaiah wrote:

> *My friend did indeed collapse, his leg was cut off, he did not eat because he could not. He expressed no wish to die. The doctors saved him; he is still in a bad state but is unaware of it, and is quite cheerful. He proposes to go on living, but this is unlikely to last long [1].*

This letter encapsulates some of the major concerns at the end-of-life. These concerns can be formulated in questions:

- what is the patient's condition?
- what are the patient's wishes?
- what do we mean by ''quality-of-life''?
- what is the significance of the patient's autonomy and competence?
- what are the roles of the medical profession at the end-of-life?

In this article, I will unfold these questions, addressing two additional questions:

- whether we should have end-of-life legislation, which includes euthanasia and/or physician-assisted suicide?
- what might be the impact of such legislation on society?

This article makes a case for physician-assisted suicide legislation. Such legislation should be put under close scrutiny and examined on an annual basis. If the alarm sounds of the opposition prove to be justified, then it will be the task of the medical profession and the legislature to secure remedies against premature killing. In France, the Conseil national de l'Ordre des médecins (CNOM, the National Council of the College of Physicians) has endorsed euthanasia [2], and the French parliament has opened a debate on euthanasia in January 2015 [3]. In the past, President François Hollande affirmed his aim to legalise voluntary euthanasia and called for a national debate on the issue [4,5]. Indeed, in France and other parts of the world the discussion should continue in earnest, reflecting on changes in reality and always aspiring to protect the patients' best interest.

The patient's condition and wishes

Discussions about the appropriate treatment at the end-of-life should be reserved to patients who are suffering from an incurable disease, whose quality-of-life is deemed by the patients themselves as low, when death becomes for them an attractive proposition. In most cases, such discussions are reserved for cancer patients. Cancer is a very painful condition, and some patients find it intolerable [6—8]. Unfortunately, current medical knowledge has not mastered adequate treatment for many forms of cancer. When a patient's life is saturated with pain, when her entire existence is focused on her suffering and on the means to provide relief from suffering, the normally high value ascribed to life deteriorates, and thoughts about the alternative to life might become dominant.

Most patients would like to continue living. As in the Isaiah Berlin story, empirical research has shown that the yearning to live is very strong. I have visited more than thirty hospitals in Israel, England, Canada, USA, Australia, New Zealand, the Netherlands, and Belgium. Most patients, even in the most dreadful conditions, opt for life. This is more so