Autonomy in assisted suicide

Assisted suicide is a topical issue. Autonomy plays a central role in arguments for and against assisted suicide. The Kantian and Millean views of autonomy greatly influence our thinking of this area in assisted suicide. An understanding of autonomy in relation to assisted suicide would allow us to evaluate the opposing views of this often controversial issue.

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Assisted suicide, defined as any act that intentionally helps another commit suicide, is an increasingly topical and controversial issue.1,2 It is not a crime in several European countries including Belgium, Luxembourg, Netherlands and Switzerland, where medical assistance to die is provided by carefully drafted legislation. In the United States, the state of Oregon has passed a law permitting physician assisted suicide. In England, the law appears to be inching towards the legalisation of assisted suicide.

In 2002, Diane Pretty, who was suffering from motor neurone disease was the first to challenge the status quo of assisted suicide when she legally sought an undertaking that the Director of Public Prosecution (DPP) would not prosecute her husband for assisting in her suicide. The case eventually reached the European Court of Human Rights. Although the judges of the English courts and European Court of Human Rights were desperately sorry for her predicament, they did not find in her favour. In 2010, the DPP published the policy on assisted suicide in England. It followed the lack of prosecution of several cases of those assisting others to die abroad. Therefore, from the complete criminalisation of assisted suicide, there is now evidence that it may be regarded as almost a right and lifestyle choice.

Legal cases

Autonomy is derived from the Greek autos meaning self, and nomos meaning rule or law. In medicine, respect for autonomy is commonly interpreted as giving a competent adult the right to make his or her own decisions with regard to that individual’s medical treatment. Respect for patient autonomy is one of the fundamental principles of medical ethics which underpins the ethical debate on the legalisation of assisted suicide.4 The concept that respect must be given to the autonomous wishes of patients was firmly established in common law when in 1914, Cardozo J stated in Schloendorff v Society of New York Hospital: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body”.

More recently in England, in Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital,6 Lord Scarman promoted individual autonomy by asserting that “the patient’s right to make his own decision ... may be seen as a basic human right protected by the common law.” Numerous subsequent cases have upheld this right. In addition, there is widespread acceptance that if a patient has the requisite mental capacity, then he or she is entitled to make life-limiting decisions with regard to his or her own medical treatment. However, since assisted suicide is not usually considered as medical treatment, these wishes of mentally competent patients are often ignored during the dying process.

Assisted suicide

Proponents of assisted suicide argue that every competent person should have the capacity to act in a self-determining manner, including the right to put an end to their own lives, and that
this capacity is worthy of respect. However, opponents of assisted suicide assert that because one has a final say over what happens to one’s body does not imply that anyone else has the right to go along with one’s preferences or accede to one’s requests. Thus, the paradox of autonomy in assisted suicide—it has been used to support arguments both for and against assisted suicide.7

The views of the philosophers Immanuel Kant and John Stuart Mill on autonomy have contributed greatly to the sphere of assisted suicide. Kant supported the idea that autonomy should be governed by rational choice.8 On the other hand, Mill argued that the right to self-determination should be upheld as long as it did not cause harm to others.9 Thus, while Kant emphasised the importance of rationality, Mill was more concerned with the importance of preferences and desires.

On a day to day basis, doctors and patients constantly discuss and negotiate treatment options and goals. Doctors, armed with their medical expertise, provide advice and recommendations on treatment options, including expectations of benefits and risks. Patients are experts about their own lives, psychosocial wellbeing and spiritual circumstances, and thus contribute to the collaborative decision-making by expressing their personal preferences, beliefs, and values. In a doctor-patient partnership, patients may veto recommended but unwanted treatment, and doctors may veto excessively harmful, futile, or useless treatments and procedures. A Kantian view of autonomy, with an emphasis on rational choice, would support this partnership and relational model of decision-making that incorporates mutual respect, dialogue, and reasoned negotiation between doctors and patients. The Millean autonomy is a consumer based autonomy with emphasis on patient preferences and desires, extending a patient’s right to demand specific interventions which may deviate from established medical practice or standards. In the Millean context, patient choice or demand will often be divorced from expertise, judgment, recommendation, and autonomy of the doctor. Doctors become instruments or tools for carrying out patient preferences, being obliged to provide the desired or demanded service. Patients’ preferences and wishes override reasonable and rational considerations and medical judgments about burdens, benefits, and outcomes. The doctor-patient partnership becomes lop-sided, favouring patients’ desires and demands.

Let us now consider the two different views of autonomy in relation to assisted suicide. A patient with Kant’s view of autonomy would have to overlook desires and preferences in favour of pure practical reasoning.10 This is of course difficult, if not impossible, in patients who are vulnerable because of the confounding factors of physical or psychological illness.11 Furthermore, Kant himself produced arguments against the acceptability of self-killing, claiming that it was against moral law to kill oneself even if
the continuation of life brought more evil than satisfaction. Nevertheless, Velleman argued that it was sometimes justifiable to destroy an object of value, if it would otherwise degenerate in ways that may diminish that very value. For example, a terminally ill patient who is about to lose autonomy and dignity from the distress and suffering of the incurable illness may be justified in seeking assisted suicide to die with dignity. Mill’s view of autonomy allows the patient to take back control over the dying process, and is often described as presenting the idea of autonomy as a personal prudential value—as something that benefits us and improves our lives. However, it may lead to several problems—in particular, patients may misunderstand their options for end-of-life care (eg. good pain relief) or patients requesting assisted suicide may be depressed or be undergoing existential or spiritual crises that cloud cognitive clarity and interfere with the proper understanding and appreciation of end-of-life options. It has been argued that patients capable of choosing to end their lives are also capable of making other important decisions; therefore, assisted suicide would be unacceptable because it removes all the latter choices. However, it is difficult to envisage how any future autonomous decision is going to carry more weight than the central wish of a person wanting to end his or her own life.

Both the Kantian and Millean views of autonomy involve individual choice, but may not take into account the social context of the patient. It has been proposed that a good model of autonomy should involve an interactive and interdependent approach to decision-making where patients are empowered by family and doctors to consider the values, duties, and commitments of all those involved and directly affected by the patients’ decisions, including, but not exclusively, the views of the patients. In this model, the key consideration should not be whether the patient or doctor should be given decisional rights but rather how to enhance the autonomous decision-making process of patients within appropriate social considerations.

Conclusion

Autonomy is a central concept in arguments for and against assisted suicide. A better understanding of this complex issue is important when we are evaluating the pros and cons of assisted suicide. The applicability and relevance of the Kantian and Millean views of autonomy will undoubtedly continue to fuel the debate on assisted suicide. It is important to recognise the social context of the patient when decisions are made with regard to assisted suicide, as social context can sometimes be overlooked in arguments related to autonomy.

Conflict of interest: none declared

References

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