

### **Kious and Battin's dilemma resolved: outlaw Physician-Aid-in Dying**

Kious and Battin (2019) are right to assert that there is no distinction of substance between physical and psychiatric suffering, and that the presence of psychiatric suffering does not necessarily connote incapacity (although in practice it often will).

They are rightly concerned that these two assertions, taken together, create an intellectually uncomfortable and practically embarrassing dissonance between the availability of physician-aid-in-dying (PAD) in cases of intractable physical suffering on the one hand, and intractable psychiatric suffering on the other.

It is not entirely clear what they suggest should be done, if anything, to resolve the dissonance. They identify three possible courses of action. The first is to do nothing, maintaining permissive PAD laws applicable to cases of physical illness, but maintaining too the psychiatrists' default position that suicide prevention in cases of psychiatric illness is a moral and should be a legal obligation. The problem with this, the authors observe, is that it wrongly assumes that physical and mental suffering are materially different, and fails to give to psychiatric sufferers relief allowed by the law to physical sufferers. 'The *status quo*', they summarise, 'might seem callous'. Since the main point of their article is to highlight the problems inherent in treating physical and psychiatric suffering differently, it seems likely that they regard this as the least acceptable solution. Indeed their abstract appears to make this clear: 'If PAD in terminal illness is permissible [and nowhere in the article do they canvass the possibility that it is not], it should also be permissible for some who suffer from non-terminal psychiatric illness...'

The second possible course of action identified is to give access to PAD to anyone who wishes to pursue it, if they have the capacity to make the decision in an appropriately informed way, whether their diagnosis is physical or mental, terminal or non-terminal. The authors appear to commend the *ethics* of this course: their only reservations are empirical: although a person with mental illness may not always be incapacitous because her illness alters her values, '...we are still confronted by Gupta's and Desmarais's worry: how can we tell when she is and when she is not?' (see Gupta and Desmarais 2016). That question, agree the authors, demands an answer if the second course is to be safely adopted.

The third possible course, into which the authors acknowledge, rightly, the second might ultimately collapse, is to 'devise a metric for suffering in both physical and mental illness and to allow PAD (and, likewise, suicide) for persons whose suffering exceeds some threshold designated as "unbearable"...' That, as is elegantly demonstrated, is easier said than done.

I gratefully adopt much of the analysis in this article. I have some reservations. I don't dismiss as peremptorily as they do, for instance, the idea that terminality is useful as a safeguard against proceeding dangerously down a slippery slope. On the contrary, it can be very useful. But that and other caveats should not obscure the substantial degree of agreement. Yet, if I am right to suggest that the authors' instincts are for the second/third option, they have reached precisely the wrong conclusion using, in part, precisely the right reasoning. The right conclusion is not that the ambit of legally sanctioned PAS should be widened, but that it should be narrowed: indeed PAS should be unlawful.

There are three broad reasons for this conclusion. The first rests squarely on the authors' identification of the difficulties associated with courses two and three. The abstract notes that to adopt either of these courses 'would present a serious philosophical challenge.' Quite right. And not only a philosophical, but a technical challenge, as demonstrated in the body of the article.

The preamble to the second reason is wholehearted agreement with the authors that the dissonance (see above) is deeply unfortunate. Lawyers should live less even less happily than ethicists with such a dissonance. The dissonance stops (and the article's main complaint is resolved) as soon as PAD is taken off the statute book.

The third reason relates to the different functions of law and ethics. The article, supremely clear though it is in most respects, conflates those functions. This is a besetting sin of modern discourse in medical ethics (Foster and Miola 2015). The authors here consider only the individual patient. The resolution of the dilemma exposed by their dissection depends, they say, on a 'deep and difficult question: when is it worse that someone die, whether from suicide or with physician assistance, who could have been helped, and when is it worse that someone whose suffering could only be alleviated by death continues to suffer?' That is the correct question, but it cannot be satisfactorily answered *for the purposes of the law* by reference only to the patient in question. Considering only that patient is a simplifying philosophical indulgence not available to legislators.

The evidence (after a long time in which it might have been, and was, said that the evidence from the Netherlands and elsewhere was equivocal) (Lewis 2007a; Lewis 2007 b) is now clear enough: to allow PAS to unequivocally capacitous patients mortally endangers incapacitous constituencies (Keown 2018). This should be enough to dispose of PAS laws. If it is not, add in the distortion of the doctor-patient relationship and the expressivist consequences, far from the immediate context of PAS, of allowing state-sponsored killing, and the wider societal case for a ban on PAS is clear. One reaches the same conclusion by substituting for the ruling atomistic model of human identity a more biologically and sociological plausible (and politically satisfactory) picture of humans as quintessentially relational entities. We bleed into one another. Our shapes are determined by the pressure of the bodies that surround us (Foster and Herring 2018).

All this entails the answer to the authors' dilemma. The legislature has an obligation to keep alive (wretchedly and reluctantly and painfully if necessary) a number of patients who would like PAS, because the assisted deaths of those patients would endanger others. The patients who are kept reluctantly alive are casualties of the social contract to which they are parties. This sounds cruel in this context. It sounds like torture in the name of a principle. It is neither of those things. It is simply a stark result of the wholly conventional process of balancing individual and societal benefits and detriments. This is the everyday business of lawmakers and judges. The law, to a first degree of approximation, *is* the truncation of individual rights for the greater good. This stand-off between individual rights and societal considerations is expressly acknowledged in the text of the article of the European Convention on Human Rights (Article 8) under which challenges to the prohibition of PAD are conventionally couched in Europe (e.g in the UK Supreme Court case of *R (Nicklinson) v Ministry of Justice* (2014)).<sup>1</sup> It is an explicit acknowledgement

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<sup>1</sup> Article 8 reads: '1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

of the danger of the tyranny of the minority. That danger is particularly acute if the situation of the minority is tragic.

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