

Chapter 2

Assisted Dying and the Proper Role of Patient Autonomy

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Abstract A governing principle in medical ethics is respect for patient autonomy. This principle is commonly drawn upon in order to argue for the permissibility of assisted dying. In this paper I explore the proper role that respect for patient autonomy should play in this context. I argue that the role of autonomy is not to identify a patient's best interests, but instead to act as a side-constraint on action. The surprising conclusion of the paper is that whether or not it is in the best interests for the patient to die is a morally objective matter. This allows for the possibility that it can be in the best interests of the patient to die even if she autonomously considers it to be in her best interest to continue living. I argue that concerns about 'mandatory' euthanasia can be met when patient autonomy is respected as a side-constraint on action. Ultimately, this means that assisted dying is permissible, not because the autonomous patient views her suffering to be unbearable, but because it is in her objective best interests and she permitted it via her consent.

2.1 Introduction

A governing principle in medical ethics is respect for patient autonomy. It is therefore unsurprising that debates on voluntary euthanasia and physician assisted suicide have focused on the relevance and scope of this principle. The aim of this paper is to argue for the proper role that patient autonomy ought to play in determining the permissibility of these two forms of assisted dying.¹ In the following I recap arguments

¹In this paper I use the umbrella term 'assisted dying' to cover both voluntary euthanasia (VE) and physician assisted suicide (PAS). This does not mean that the distinction between VE and PAS should be, or are being, elided. Indeed, one might argue that there is an important distinction between a doctor intentionally killing a patient (VE) and intentionally helping a patient to commit suicide (PAS). The decision to use this umbrella term is that the argument presented here applies to both VE and PAS.

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against an overemphasis on patient self-determination and argue that self-determination has a subsidiary role in determining whether assisted dying is permissible. I suggest that whether or not assisted dying is in the best interests² of the patient ought to be determined objectively. The role that patient autonomy plays in determining the permissibility of assisted dying is as a permission or constraint on action. The advantage of this account is that it fits well with emerging models of medical decision-making³ that, with good reason, downplay the importance of patient self-determination but do not rule out the importance of patient autonomy entirely. To date, discussion on the moral permissibility of assisted dying has failed to catch up with this movement.⁴ This paper aims to bridge this gap by outlining the proper role of patient autonomy with regard to assisted dying.

There might be good reasons to deny that assisted dying is morally justified, regardless as to whether it is determined to be in the patient's best interests and the patient autonomously consents to it.⁵ I do not address these arguments here. Instead, the focus of this paper is to assess what the argument from respect for patient autonomy amounts to and to outline the role that patient autonomy should play in determining the permissibility of assisted dying.

2.2 Informed Consent and Respect for Patient Autonomy

The central case for the moral permissibility of assisted dying is that it constitutes respect for individual autonomy (see Young 2014a, b).⁶ The argument from autonomy draws upon the claim that a person has a right to shape her own life through her choices and extends this right to *include* the right of patients to choose the manner of their death (Gray 1999, 21; see also Battin 2005, 20). Patient autonomy

²Throughout this paper I use the term 'best interests' to narrowly refer to the promotion or protection of the patient's well-being. A broader usage of the term might include values in addition to well-being, such as financial gains and legal obligations.

³For models and defences of shared-decision making see Birchley (2014), Maclean (2006), Sandman and Munthe (2009, 2010). For defences of various forms of paternalism see Conly (2013), Loewy, (2005), Scoccia (2008), Thaler and Sunstein (2008).

⁴Little has been written on the diminishing relevance of patient autonomy in recent bioethics literature as related to assisted dying. The exception is Varelius (2006), which explores the proper ends of medicine in view of a growing distinction in the bioethics literature on objective characterisations of the goals of medicine and, on the other hand, respect for patient autonomy (Varelius 2006, 121–2).

⁵For a comprehensive overviews of objections to assisted dying see Brock (1993).

⁶This is not the only argument in favour of the moral permissibility of forms of assisted dying. A second important argument focuses on patient well-being and the moral demand to reduce patient suffering (Brock 1993, 206). However, this second argument is often directly linked to the argument from autonomy with the burden of the patient's suffering being determined by the autonomous patient (Brock 1993, 207).

is argued to have a ‘pivotal role’ in end-of-life decision making: “...permitting people the opportunity to decide the timing and circumstances of their own demise if that is what they wish” (Biggs 2001, 96). The ‘right to die’ is thus derived from a more general right to direct the course of our own lives (Chetwynd 2004, 175).⁷

The appeal to patient autonomy in relation to the right to die can be traced to the rise of the doctrine of informed consent (Beauchamp 2006, 644). According to the doctrine, a patient has the right to refuse medical treatment on the condition that she is (A) fully informed of the nature, benefits and risk of each procedure, and (B) her consent or refusal is freely chosen (Declaration of Helsinki 2008). The main justification for informed consent procedures is the importance of respecting patient autonomy (Manson and O’Neill 2007, 17; see also Beauchamp and Childress 1989, 75), protecting: “...the [patient’s] right to decide how one is to live one’s life, in particular how to make critical life-decisions” (Feinberg 1986, 54).

One way in which to unpack the role of informed consent as related to assisted dying is to reflect on the kind of autonomy that informed consent ought to protect. Problematically, the concept of ‘autonomy’ is vague and has various meanings in different contexts. As Faden and Beauchamp have noted, the term has been loosely associated with ideas as diverse as: “...privacy, voluntariness, self-mastery, choosing freely, the freedom to choose, choosing one’s own moral position, and accepting responsibility for one’s choices” (Faden and Beauchamp 1986, 7). The concept has also been used to bear connotations with freedom, independence and self-determination (Schermer 2002, 1; see also Feinberg 1986, 28).

In the following I explore two key ways in which respect for patient autonomy as required by the doctrine of informed consent can be understood. First, respect for patient autonomy, understood as self-determination, may be required since this is the best means of protecting the patient’s well-being (Sect. 2.2). Secondly, respect for patient autonomy could be viewed as a side-constraint on action (Sect. 4.2), regardless as to whether this leads to a decline in patient well-being. Specifically, I argue, that the doctrine of informed consent protects patient autonomy as a side-constraint on action rather than as a means for protecting patient well-being. By making this distinction we get a clearer idea of the role that patient autonomy ought to play in determining the permissibility of assisted dying.

2.3 Autonomy as Self-Determination

Although moral philosophy has conceptualised autonomy in a variety of ways, respect for patient autonomy is commonly equated with respect for patient self-determination (see Foster 2009, 3 and Macioce 2012, 101). On this view, a patient’s autonomy is identified with the patient’s ability to make choices that shape her life

⁷An important caveat to this argument is that respect for patient self-determination does not require health care practitioners to assist in patient dying at the patient’s request (Brock 1993, 207). The argument from autonomy should thus be seen as a constraint on morally permissible assisted dying; it does not amount to the claim that it is morally obligatory to carry out requests for assisted dying.

in accordance with her own conception of the good life (Brock 1993, 205–6). Various reasons have been given for the importance of respect for patient autonomy understood as patient self-determination. These arguments range from the claim that (a) the exercise of self-determination gives our life meaning (see Nozick 1974, 50; Varelius 2006, 379–380; Glover 1990, 81; Buchanan and Brock 1990, 38–9),⁸ to the claim that (b) respect for self-determination is the most effective means for promoting and protecting the patient's well-being.

The argument that (b) respect for self-determination equates to maximal well-being promotion has been defended on the basis that: “[w]hen patients are competent and have access to information, they are the best judge of what is in their interests and whether the expected benefits of a proposed treatment outweigh the burdens” (English et al. 2004, 108).⁹ Such arguments can be traced back to Mill, who argues that respect for individual choice is the best means for maximising utility: “...since the individual's ‘choice of pleasure’ rests with her own judgement” (Mill 2008, 112; see also Erbay et al. 2010, 36; Savulescu 2003, 138–139). The view that individual self-determination ought to be respected because it allows for well-being maximisation has been generally supported within medical ethics, it being argued that we ought to respect patient self-determination because patients have a special expertise regarding their well-being (see, e.g., Veatch 2000, 704; Tännsjö 1999, 16). In the context of the debate on assisted dying, the connection between self-determination and well-being has also been emphasised:

It might seem that individual well-being conflicts with a person's self-determination when the person requests euthanasia [...] But when a competent patient decides to forgo all further life-sustaining treatment then the patient, either explicitly or implicitly, commonly decides that the best life possible for him or her with treatment is of sufficiently poor quality that it is worse than no further life at all...there is no objective standard, but only the competent patient's judgment of whether continued life is no longer a benefit. (Brock 1993, 206–7)

If it is correct that respect for patient self-determination is morally required because this is the best or only means of protecting or promoting her well-being, this means that that the: “...possible courses of action physicians can legitimately take is ultimately determined by the autonomous decisions of their patients” (Varelius 2006, 123).¹⁰ This would further entail that: “the moral acceptability of voluntary euthanasia and physician-assisted suicide is also dependent on the patients' autonomous decisions” (Varelius 2006, 123–4).

Whilst the view that respect for patient self-determination is the best means of protecting patient well-being is widespread, an emerging trend in the medical ethics literature is to question the focus on patient self-determination as a means for protecting and promoting patient well-being altogether. The movement away from an emphasis on the importance of respect for patient self-determination has been

⁸Here I focus on arguments based on the connection between self-determination and maximisation of patient well-being only.

⁹For a detailed overview of defences of the claim that respect for self-determination facilitates the attainment of maximal best interests see Bullock (2014, 4).

¹⁰Varelius (2006, 123) refers to this as ‘subjectivism’ about the goals of medicine.

made on several fronts, ranging from empirical data indicating that the choices patients make are often not self-determined, to models that facilitate shared-decision making, and defences of paternalism. The shared conclusion of these positions is that a policy of respect for a patient's self-determined choices can, in fact, pull apart from the protection and promotion of the patient's well-being.

A key argument for rejecting the importance of respecting patient self-determination, as a means for protecting patient well-being, draws upon evidence from behavioural economics that individuals are poor decision-makers rarely making decisions that direct their lives in a meaningful way (Thaler and Sunstein 2008). Work in behavioural economics suggests that patient decision-making is impaired by a vast number of cognitive influences (Conly 2013). Empirical evidence suggests that people are unable to predict their reactions to future emotional events, or how happy or unhappy an event will make them to the extent that they do not know their own preferences (Blumenthal-Barby 2013, 212). Patient's thereby often lack what the proponent of respect for patient self-determination assumes: "...a set of preferences which are clearly-defined, well-understood, and rank-ordered so that people can make logical trade-offs among them" (Schneider 1998, 69). In addition to the hindrances faced by patients when making 'self-determined' medical decisions, a growing body of work indicates that patients would prefer to rescind their decision-making authority altogether. The desirability of making a medical decision decreases the more severely ill the patient is (Botti and Iyengar 2006, 32), and a number of studies have shown that preferences for decision making are generally weak (see Ende et al. 1989, 26–27; Robinson and Thomson 2001, 134; Strull et al. 1984).

All of the above could simply be seen as a failure to respect self-determination in practice.¹¹ The problem with this response is that influences on patient self-determination are endemic: irrelevant suggestions can alter a patient's assessment of a decision and external influences on a patient's decision are unavoidable (Thaler and Sunstein 2006, 250). Moreover, these cognitive influences are not easily avoided even when the patient is aware that her decision is subject to them (see Schiavone et al. 2014; Thaler and Sunstein 2008). It simply turns out that individuals are rarely, if ever, capable of exercising self-determination in a way that is free from non-self-determined cognitive influences. The argument that patient's often lack self-determination cannot therefore be addressed by facilitating better respect for patient self-determination in medical practice.

In view of empirical research that patients lack self-determination, autonomy (understood as a means for protecting well-being) has been increasingly recognised as something that is overvalued (Conly 2013, 25). This has led to the development of decision-making models that explicitly move away from the focus on patient self-determination. The development of 'nudge' paternalism is one example of a new model of decision-making that reflects the general concern that patient self-determination is overvalued. Nudge paternalism interferes with the individual's choices by making it more difficult for them to choose an option that they themselves judge to

¹¹I would like to thank Jukka Varelius for raising this point in comments on a draft of this paper.

be detrimental to their best interests, and easier to choose the option that they judge to be favourable (Thaler and Sunstein 2008, 5). The position is justified on the basis that patients would probably make different decisions in the absence of their cognitive hindrances (Schiavone et al. 2014, 105). Whilst respect for patient self-determination is still treated as being important, a patient's decisions are not taken at face-value. Rather than viewing patients as experts in the exercise of their self-determination the nudge paternalist argues that health care practitioners are justified in 'nudging' the patient towards the option that is likely to serve their true interests and preferences.

In addition to models of nudge paternalism, 'widely advocated' models of shared decision making in healthcare practice have arisen in order to address similar concerns (see Birchley 2014; Sandman and Munthe 2009, 2010). The claim that the patient necessarily gets the decision right from the start is argued to be 'implausible' (Sandman and Munthe 2010, 73). Instead of 'abandoning' patients to the decision they make: "...regardless of the possibly catastrophic consequences that might follow" (Maclean 2006, 329) medical practitioners are encouraged to advise and support their patients, thereby increasing the chance that the patient will reach a decision that is consistent with the patient's goals and values (Maclean 2006, 337). Once again, whilst still respected, the role of patient self-determination takes a lesser role, the priority changing to making the decision that best protects the patient's well-being (see also Loewy 2005, 464; Callahan 1992).

2.4 A Revised Role for Patient Consent

Acknowledging the limited role that patient self-determination has to play in protecting patient well-being leaves us with at least two options with respect to the argument from autonomy for the moral permissibility of assisted dying. One option would be to deny that assisted dying is ever permissible given a patient's limited ability to make decisions that protect her well-being. A second option is to revise the role that autonomy plays in end-of-life decision making. This option allows for the permissibility of assisted dying on the basis of a principle for respect for autonomy as a side constraint on action, rather than out of respect for patient self-determination. It is this second option that I explore in the following.

I want to suggest the following two necessary (although not sufficient) conditions for the moral permissibility of assisted dying:

- assisted dying is in the objective best interests of the patient
- assisted dying has been consented to by the patient¹²

¹²These are moral, rather than legal, conditions. Advocates for the legalization of assisted dying similarly agree on the importance of determining that the patient is suffering and that she consents to the intervention (Young 2014a, b). This paper focus on the moral framework underlying these legalistic conditions. Specifically, I argue that the *determination* of whether or not the person is suffering or whether her life is overly burdensome is not reducible to the self-determining patient's conception of her best-interests.

Given that we ought to be suspicious that a patient can exercise her self-determination in a way that protects her best interests I argue that the determination of whether it is in the patient's best interests to die ought to be determined objectively. Secondly, I argue that the role patient autonomy plays in determining the permissibility of assisted dying is as a permission or constraint on action. Whether or not assisted dying is permissible thus depends on objective facts about the patient's best interests *and* the presence of the patient's consent. Whilst these conditions do not justify assisted dying, they account for the role that patient autonomy ought to play in end-of-life decision-making. Importantly, they provide a way of thinking about the role of patient autonomy in a way that is in line with the increasingly reduced focus on the importance of patient self-determination as a means for protecting patient well-being.

2.4.1 *Objective Interests*

Given a well-founded and growing unease of treating respect for patient self-determination as a guarantor of patient well-being promotion, a patient's best interests ought to be thought of independently of her self-determining choices. An independent approach for determining the best interests of the patient, and whether or not it is good for her to die, can be drawn from an objective theory of well-being. Such an account identifies a patient's best interests in a way that is not solely dependent upon her preferences and values:

The idea of the objective list is simply that what is intrinsically good for a person is fixed independently of that person's attitudes or opinions; the items on the list for an individual are there independently of whether the individual has favourable attitudes toward them or himself judges that the items are valuable for him (Arneson 1999, 118–119).

Since the objective list account of well-being is independent of the individual's preferences and desires it is possible for the account to determine that something will contribute to an individual's well-being even if it directly *conflicts* with that individual's preferences:

What is essential is that these are theories according to which an assessment of a person's well-being involves a substantive judgement about what things make life better, a judgement which may conflict with that of the person whose well-being is in question (Scanlon 1993, 188).

An objective list account identifies the substantive goods that contribute to the well-being of an individual and holds that they are good for the individual independently of that individual's preferences. Objective lists generally contain more than one substantive good, such as:

- Life, consciousness, and activity
- Health and strength
- Pleasures and satisfactions of all or certain kinds
- Happiness, beatitude, contentment, etc.

- Truth
- Knowledge and true opinion of various kinds, understanding, wisdom
- Beauty, harmony, proportion in objects contemplated
- Aesthetic experience
- Morally good dispositions or virtues
- Mutual affection, love, friendship, cooperation
- Just distribution of goods and evils
- Harmony and proportion in one's own life
- Power and experiences of achievement
- Self-expression
- Freedom
- Peace, security
- Adventure and novelty
- Good reputation, honour, esteem etc. (Frankena 1973, 87–8).¹³

An objective list theory of well-being provides a basis for balancing different substantive goods in different situations beyond relying upon patient self-determination. Accordingly, it is possible that in some instances the medical decision that will be in the patient's best interests might not involve respecting her self-determination.

A central suspicion regarding objective list accounts of well-being is that they are too rigid to account for the differences in individual values and interests: "...as if the same things must be valuable for everyone" (Scanlon 1993, 188). Specifically, it is argued that whatever is included on the list there are likely to be persons who do not want certain things to appear on it, and for others to want to add items that are not already included. In order to illustrate this concern Griffin uses the example of: "[a] group of scholars [who] may, with full understanding, prefer an extension to their library to exercise equipment for their health" (Griffin 1986, 45). In this example, the scholars regard their well-being to rest on increasing their knowledge, rather than improving their health. According to Griffin this is a problem for objective theories of well-being (assuming that health is always prior as a value to knowledge) as it is too rigid to account for what matters to the individual (Griffin 1986, 51).

The supposed difficulty in responding to this objection is finding a way to allow for a variation in individual well-being with an account that identifies well-being *independently* of the individual's experiences and desires. However, it is possible for an account of well-being to include variances in individual preferences and values without the account being reduced to them. Instead, a theory of well-being can be subject-related,¹⁴ assessing the objective well-being for a particular individual, as opposed to individuals in general. The possibility of developing a

¹³The items on this list are not presented in any order of priority.

¹⁴Here, I use the term 'subject-related' in order to contrast my position with such subject-relative views that do not allow the ordering of items on the list to differ between individuals whilst remaining independent of their views on the matter (cf. Varelius 2003, 368 ff.).

subject-related account of well-being that focuses on the well-being of each individual is not ruled out by the adoption of an objective account. Indeed, an objective account:

[...] does not deny that an individual's attitudes may partly determine what is prudentially valuable for her. An individual's attitudes do not determine what items properly belong on her objective list, but among the items that appear, some may include requirements concerning her attitudes and opinions. For example, an objective-list view might well hold that one good thing for an individual is that her important life aims be satisfied, with importance determined by her own subjective ranking of her aims (Arneson 1999, 117).

Thus, even though an objective list is not reducible to a subject's preferences or desires, this does not mean that an objective list cannot accommodate individual aims, goals, preferences and values. One way in which this could be accommodated would be to include self-determination on the list: "[...] claiming that the informed and reflective living of one's own life for oneself itself constitutes a good" (Crisp 2008). Significantly, just because self-determination features on the list this does not concede that self-determination should always be respected. Rather, exercising self-determination is only one element on the list, amongst others, that contributes to overall well-being. Instead of prioritising self-determination, self-determination becomes one good to consider among many.

Furthermore, an objective list can also be treated as being related to circumstantial factors. Imagine, for instance, that Griffin's scholar is in the midst of a heart attack. Given the scholar's preference for furthering her knowledge over protecting her health, would it be right to hand her a rare academic text book to read in her last moments rather than taking her to hospital for treatment? The answer to this question is almost certainly no. The items on an objective list not only vary from individual to individual in terms of their personal preferences, but the ordering of items on the list can also vary from circumstance to circumstance. Such an account is not *reducible* to the subject's preferences but remains *related* to an individual's tastes and circumstances. The objection that objective list accounts are too rigid cannot be sustained.¹⁵

An advantage of a subject-related objective account of patient best interests is that it sits well with some intuitions regarding the permissibility of assisted dying. Take for instance Scoccia's example of an instance in which we are reluctant to assist in a suicide:

Imagine that Frank suffered a shoulder injury a year ago that will prevent him from ever again playing competitive golf, his life's passion. He is no longer depressed about his situation but feels certain that he has nothing to live for and would be better off dead. Legalization with limits rightly denies [assisted dying] eligibility to Frank. To extend eligibility to people like him would, as Daniel Callahan says, be 'self-determination run amok'. [Callahan (1992)] [He] should be denied suicide assistance [because he is] better off alive than dead notwithstanding [his] belief to the contrary (Scoccia 2008, 367).

A benefit of a theory of well-being that determines whether or not it is objectively good or bad for patient to die is that it reflects standard practices and

¹⁵The above discussion on subject-relatedness is adapted from Bullock (2012).

intuitions regarding the permissibility of assisted dying. We are, for instance, reluctant to permit assisted dying in cases where the patient is young or the disease is not terminal *even if* their decision is completely self-determined. This is because we rightly judge that it is not in the patient's best interests. Likewise, it is often recognised that pain and suffering arising from a terminal disease towards the end of a natural life are good reasons for permitting assisted dying.

It is certainly controversial to argue that sometimes it is objectively best for a patient to die, regardless of the patient's wishes.¹⁶ Suspicions arise about how a doctor can possibly judge whether or not assisted dying is in the best interests of the patient. At this point I remind the reader that the aim of this paper is not to provide a justification for assisted dying. Certainly, it might turn out that such objective values cannot be determined and so we might not *know* whether or not assisted dying is ever justified. The purpose of this exposition is instead to determine the role that patient autonomy ought to play in matters of assisted dying, not to determine whether assisted dying is ever permissible.

2.4.2 *Autonomy as a Side-Constraint*

Determining the permissibility of assisted dying cannot end with the claim that whether or not it is in the best interests of the patient to die can be determined objectively. Indeed, such a position could be easily objected to by those who are rightfully worried that the legalisation of assisted dying would lead to mandatory euthanasia. This is where the proper role of informed consent comes into play.

Above I indicated that autonomy is often understood as self-determination. However, a second important way in which patient autonomy can be interpreted is as a side-constraint on the actions of others. Autonomy as a side-constraint prevents others from doing what they want with the individual, even when they correctly judge the interference to be objectively in the individual's best interests. It can thus be invoked as a reason why a medical practitioner should not do something to her patient, specifically: "...that Y should not do something to X because: (a) X has a right to consent to things being done to her; and (b) the appropriate consent has not been given" (Foster 2009, 8–9).

Given the defence of an objective-list account of well-being, it is an interesting question as to why we should care about patient autonomy at all. Those who doubt that there is any additional value to exercising autonomy beyond its contribution

¹⁶Note that this position is different to the claim that there are objective standards for determining the permissibility of assisted dying, such as 'the patient is suffering' or 'the patient has an incurable illness'. Whilst these conditions are relevant for determining the permissibility of assisted suicide, on my account, it could turn out that it is *not* in the objective best interests of a patient suffering from an incurable illness to die. It could equally turn out that it is in the best interests of a patient to die (when suffering from an incurable illness) even if she would prefer to continue living.

to individual well-being might be motivated to adopt a paternalistic approach to medical decision-making. However—without reaching any conclusions on medical paternalism in general—it seems to me that we have a special reason to respect patient autonomy as a side-constraint when it comes to life or death decision making. This is because whilst it is only morally *controversial* to interfere with an individual paternalistically in order to promote her well-being, assisted dying is both morally and legally serious. Arguments opposing the legalisation of assisted dying on the basis that it constitutes murder (see, e.g., Brock 1993, 208; Dworkin 1993, 21; Glover 1990, 45) are far more compelling than the comparatively mundane objection to paternalism that it constitutes unwarranted interference with an individual's decision (see, e.g., Mill 2008, 92; Feinberg 1986). Thus, in cases of assisted-dying we should not only be concerned with patient well-being, but given the gravity of the decision, the patient's consent or refusal.

Justifications for autonomy as a side-constraint are both legal and moral in nature. In moral terms, Nozick argues that: “[s]ide constraints upon action reflect the underlying Kantian principle that individuals are ends and not merely means; they may not be sacrificed or used for the achieving of other ends without their consent” (Nozick 1974, 30–31), expressing the “inviolability of other persons” (Nozick 1974, 32). Others have suggested that autonomy as a constraint on action is justified on the basis that each individual has full ownership of her body and: “...no one else, not even the State, can interfere with the exercise of that ownership, in whatever way it manifests itself” (Macioce 2012, 102).

In legal terms, autonomy as a side-constraint is protected by the laws of battery and assault (Maclean 2006, 323). Manson and O'Neill argue that informed consent procedures can only be successfully justified on the basis of laws of battery and assault. They argue that it is in the nature of medical practice to carry out procedures that would normally infringe upon an individual's human rights. Informed consent permits a doctor to carry out actions that would usually be illegal or unethical and so: “...is a way of justifying action that would otherwise violate important norms, standards or expectations” (Manson and O'Neill 2007, 75). For example, an individual is protected in law from having his teeth removed by another individual. It is, however, sometimes necessary for dentists to remove rotten teeth in order to prevent infection and further pain in their patient. Without the patient's consent the dentist will be breaching ethical norms and laws (Manson and O'Neill 2007, 76). In order to prevent such medical procedures being classified as battery or assault, the patient can thus consent to her rotten tooth being removed without the dentist being prosecuted.

When we understand patient autonomy as a side-constraint on action instead of viewing patient self-determination as a means for protecting patient well-being we get a clearer picture of how assisted dying might be justified on the basis of an appeal to patient autonomy. I have argued that whether or not it is good or bad for a patient to be assisted in her death is to be determined objectively. But whether or not assisted dying is permissible will also depend on whether or not the patient has autonomously consented to the assistance, where autonomy is understood as having the role of a side-constraint on action. Take a case in which it is determined

that it is objectively in the best interests of a patient to be assisted in their death.¹⁷ At this point the patient or her proxy can consent to the procedure or refuse to consent to the procedure as protected under the doctrine of informed consent. The role of patient autonomy as a side-constraint is to permit or refuse the procedure. Whether or not the procedure contributes to the patient's overall well-being is not reducible to her self-determination.

2.4.3 Assisted Dying and the Proper Role of Informed Consent

Given a growing reluctance towards the view that respect patient self-determination is the best means for promoting and protecting patient well-being, I have suggested a new model for determining the permissibility of assisted dying that incorporates a role for respecting patient autonomy. The two necessary conditions for permissible assisted dying are as follows:

- (a) assisted dying is in the objective best interests of the patient
- (b) assisted dying has been consented to by the patient.

Determining (a) will involve communication with the patient and acknowledging her self-determination.¹⁸ However, given growing suspicions of the efficacy and accuracy of patient self-determination the patient's values and views on the nature of her well-being should be used as one piece of information amongst others in the determination of her best interests. Self-determination thus still has a role to play—it is just not the only role, and it is certainly not the central role in determining whether or not it is in the patient's best interests to die.

Condition (b) provides an important restriction on permitting assisted dying and better captures the legal role of informed consent. Patient consent matters, but not because she has the ability to determine what is best for her, but because it protects her from unwanted interference.

Keeping focus on the importance of consent as a side-constraint mutes the worry that overriding patient self-determination as a means for promoting patient well-being will lead us into full blown medical paternalism, and the legitimate worry that patients will be killed against their wishes. Autonomy as a side-constraint on action allows that *even if assisted dying is judged to be in the patient's best interests this does not mean it is permissible*. The absence of the patient's consent as a side-constraint (explicit, or hypothetical in the case of incompetent patients) renders assisted dying impermissible. Ultimately, this means that assisted

¹⁷I do not detail the conditions here but it will plausibly include things like, being near the end of life, having a terminal condition and/or the experience of great suffering.

¹⁸As encouraged by models of shared decision making. See Sandman and Munthe (2009, 2010) and Maclean (2006).

dying is permissible not because it is the patient's preference, but because it is in her objective best interests and she permitted it via her consent.

2.5 Conclusion

The doctrine of informed consent is commonly justified by the claim that we ought to respect patient autonomy. This demand to respect patient autonomy is a central argument used in favour of permitting assisted dying. Specifically, it is claimed that respect for patient autonomy entails respect for a patient's decisions about the nature of her death. An aim of this paper has been to square this argument from autonomy with the legitimate concern that medical ethics has overemphasised the role of patient self-determination in determining patient well-being.

I have argued that respect for patient autonomy can be understood in at least two ways, firstly as patient self-determination and secondly as a side-constraint on action. Whilst there are many reasons to be suspicious of patient consent as self-determination I have shown that this does not mean that assisted dying is never justified, nor moreover that informed consent should be dispensed with. Instead, respect for patient autonomy as *a side-constraint on action* has a fundamental role to play in determining the permissibility of assisted dying. Specifically, I have argued that two necessary conditions for the moral permissibility of assisted dying are:

- (a) assisted dying is in the objective best interests of the patient
- (b) assisted dying has been consented to by the patient.

Whilst these conditions are not sufficient for permitting assisted dying, the model importantly identifies the role that patient autonomy ought to play in end-of-life decision making in view of well-motivated arguments for attributing a lesser role to patient self-determination. The proper role of informed consent in relation to assisted dying is not to protect the patient's self-determined views on the nature of her well-being, but to act as a side-constraint on objective assessments of whether or not it is good for the patient to die.

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