

In “Do No Harm,” Ian Ochs explores physician assisted suicide from a principlist perspective. In particular, he claims that an unwillingness on the part of a physician to help a suffering, end-stage patient die in a controlled, peaceful, painless manner, can violate the principle of nonmaleficence.

## **Do No Harm**

**By Ian Ochs**

Nonmaleficence – doing no harm – stands as one of the four core principles which inform doctors’ decisions under principlism. It also provides a large obstacle against the legalization of physician-assisted suicide, because most people see death as the ultimate harm. In this paper, I will argue that not offering euthanasia to a terminally ill patient who wishes to die not only violates the principle of autonomy, but also of nonmaleficence itself. In addition, I will argue that in certain situations it may be more ethical to euthanize a terminally ill, suffering patient who does not explicitly request euthanasia.

Because the issue of physician-assisted suicide is emotional and polarizing, it often raises irrational responses which make logical discussion difficult. Therefore let us perform a related thought experiment:

It is back in the Middle Ages. John’s friend, Robert, has been accused by the Inquisition of heresy. Guards took him in the middle of the night to the dungeons, and began to torture him. John, however, has managed to find Robert’s window, and looks in at him through the bars. He knows that there is no chance the Inquisition will allow Robert to live, but will continue to torture him until he is dead. John cannot save Robert, but he can slip him some poison through the bars, which will make his death quick and painless. He asks Robert, and Robert says he wants to take it. Should he give Robert the poison?

Some principlists argue that to allow John to effectively poison his friend would be a direct violation of the doctrine of nonmaleficence, despite the fact that John specifically requests it.

These theorists, then, apparently believe that nonmaleficence takes priority over autonomy, a concept I will return to later.

First, however, I would challenge the idea that “doing no harm” implies preserving life at all costs. Robert, in this scenario, would argue that he will die either way – one form of death is simply more drawn-out and painful than the other. Although people may object that if John allows the Inquisition to kill Robert, he himself will be blameless in the death, I would support James Rachels’ position that killing and allowing to die are morally equivalent. Rachels used a thought experiment which involved two situations: in one, an uncle forces his infant nephew’s head underwater to claim his inheritance, while in the other, seeing that the child has fallen unconscious in the bath, he allows the child to die without raising a finger. Rachels argues that in both situations, the uncle is “killing” the child, rendering meaningless the doctor’s doctrine of simply “allowing” a sick patient to expire.<sup>i</sup> Likewise, whichever action John takes will result in his friend’s death – but if John withholds the poison, he effectively forces his friend into a painful rather than a painless death, which seems opposite to “doing no harm.”

Although this argument might be considered utilitarian, the principle of nonmaleficence itself relies on utilitarianism. The Belmont Report, drafted by the US Department of Health, Education, and Welfare to prevent abuses of subjects in medical research following the Second World War, first outlined the principles of medical principlism. With respect to nonmaleficence, the report states:

“Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm and (2) maximize possible benefits and minimize possible harms.”<sup>ii</sup>

We have already seen that point (1) leads inevitably to questions of what constitutes harm; now point (2) explicitly asks the doctor to defend his actions with some form of utilitarian analysis. The commission, which addressed the rights of patients in experimentation, wanted doctors to weigh the benefits of specific research to society against the harm it did to their patients. However, should not a doctor also weigh a patient’s happiness against the simple goal of prolonging a miserable existence? At what point in protecting a patient’s life do we begin to harm the patient himself?

Many doctors will shy from making such decisions by hiding behind the Hippocratic Oath,

which they say forbids them from taking a human life. However, the idea that doctors must continue to follow to the letter an oath that was written thousands of years ago is absurd. Consequently, the Oath has been rewritten many times over the centuries, the most current and commonly used version in 1964. While it is true that the original Hippocratic Oath does ban both physician-assisted suicides and abortions<sup>iii</sup>, the modern version of the oath (which medical students today mostly take, if they take an oath at all) takes a much more thoughtful approach to the subject of taking human life:

“But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.”<sup>iv</sup>

I make this reference only to show the ambiguity with which the medical profession itself approaches end-of-life issues. A vague warning against “playing at God” hardly seems a fitting way to prepare someone for a profession in which their job is to prevent His world from killing people off – but that is a topic for another essay.

So if we return to our thought experiment, I think we can see that (a) Robert has clearly expressed a wish to die, which falls under the principlist doctrine of autonomy, and (b) in refusing Robert’s request, John would actually do Robert harm by forcing him into a more painful death, violating the doctrine of nonmaleficence. Therefore, under a principlist system of ethics, John would be *obligated* to provide Robert with the poison. Similarly, a doctor who denies a suffering, terminally ill patient’s request for a painless death should be considered in violation of principlist ethics.

However, what if Robert did not request the poison? What if John, on the pretext of giving his tortured friend a glass of water through the prison bars, simply poisoned him? Would his actions still be considered ethical?

Anyone who opposes physician-assisted suicide from a principlist framework has already ruled that autonomy, in the form of a patient’s wish to die, is overruled by nonmaleficence, the doctor’s prohibition against doing harm. Now, however, we have switched the tables; nonmaleficence demands that the doctor put an end to the hopeless patient’s suffering, while autonomy demands that the patient be informed of his condition and allowed to make the decision. Should nonmaleficence still overrule autonomy in this situation?

Under certain conditions, I would argue that the answer to this question is “yes.” Several circumstances might make it hard for a patient to request a course of action that is in their best interest, and I will try to address at least several of these in the context of our thought experiment.

The first and most obvious reason Robert would not voice his wishes is if he could not. Perhaps, during the course of his torture, his ears have been permanently damaged. All he can see is his friend at the window holding out a glass of water to him and mouthing words. Even if John tries to explain his intent, Robert will not understand, and John’s repeated gestures in an effort to communicate can only cause him anxiety. In this situation, autonomy has been compromised: Robert is clearly incapable of comprehending his options, and thus cannot make the decision for himself. Whether John provides him with the poison or does not, he will still be ignoring Robert’s autonomy, because Robert does not have the capacity to exercise his autonomy. Thus, John must fall back on the principle of nonmaleficence, and to minimize harm must poison his friend. Such would be the case with suffering, terminally ill patients suffering from dementia or some other form of sickness which compromised their reasoning faculties. As the Belmont Report states:

“Not every human being is capable of self-determination. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty.”<sup>ii</sup>

The situation becomes less clear, however, when the course of action the patient demands conflicts with what will cause them the least amount of suffering. In such a case, an action prescribed by autonomy is not absent, but actively opposes the action prescribed by nonmaleficence. As an example, suppose John offers Robert the poison, but Robert refuses. He believes that he will likely be released the next day, and looks forward to rejoining with his family.

John is now faced with a huge ethical dilemma. He knows that there is absolutely *no possibility* that Robert’s fate will be anything less than that of a painful death, but Robert maintains hope, and thus the principle of autonomy demands that Robert be allowed to live. It would seem that John is caught between principles.

However, the principle of autonomy, as outlined in the Belmont Report, is not absolute. Doctors must “give weight to autonomous persons’ considered opinions,” but they are not required to act on that basis alone. Additionally, and perhaps more significantly, it requires autonomous decisions to be made “voluntarily *and with adequate information.*” Robert’s belief that he will live to return to his family reflects a lack of adequate information, and thus should be granted less weight than if he expressed an understanding of his inevitable fate. If John kills him, on the other hand, he will be able to maintain his optimistic delusion, thus dying happily with thoughts of reuniting with his family rather than torturously in despair. In many cases, it would therefore be better to end the life of a suffering, terminally ill patient while they are still optimistic, rather than causing them the pain of recognizing inevitable, imminent death.

These cases where autonomy conflicts with nonmaleficence are by no means meant to be blanket doctrines, to be wholeheartedly applied in every similar case. Obviously such incidents, where doctors are forced to choose between conflicting principles, must be considered on a case-by-case basis. Perhaps the suffering man who refuses euthanasia wishes to say goodbye to his family – would it be ethical to end his physical suffering and thus deprive him of the emotionally satisfying sense of closeness with his family at the end? Certainly not, such could only increase his total suffering. If, however, you knew that his family had died in a plane crash, perhaps it would be more ethical to tell him they were coming and then euthanize him in his sleep, content with the thought of seeing his family the next day rather than dying alone. I only wish to impress the idea that euthanasia, even when it seemingly violates autonomy, cannot always be shunned as “murder.” Too often in principlism, the life becomes valued over the person living it. By applying the principles with more thought to the patients’ welfare and less to their continued vital signs, the medical community could help make the end of life much less painful and terrifying.

## References

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- <sup>i</sup> Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine* 272.2 (1975): 79-80. Print.
- <sup>ii</sup> United States. Department of Health, Education, and Welfare. *Belmont Report*. 1979. *Family Health Ministries*. Web. 29 Oct. 2010. <<http://www.familyhm.org/Belmont%20Report.pdf>>.
- <sup>iii</sup> Hippocrates. "The Oath." *National Library of Medicine*. National Institutes of Health. Web. 29 Oct. 2010. <[http://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html)>.
- <sup>iv</sup> Lasagna, Louis. "Hippocratic Oath: The Modern Version." *NOVA*. PBS, 1964. Web. 29 Oct. 2010. <[http://www.pbs.org/wgbh/nova/doctors/oath\\_modern.html](http://www.pbs.org/wgbh/nova/doctors/oath_modern.html)>.

## Further Reading

- "It's Over, Debbie." *Journal of the American Medical Association* 259.2 (1988).
- Quill, Timothy E. "Euthanasia and Physician-Assisted Suicide." *New England Journal of Medicine* 324.10 (1991): 691-4.