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# THE AMA ON EUTHANASIA AND ASSISTED SUICIDE

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STEVEN LUPER

**ABSTRACT** The American Medical Association (AMA) criticizes physician-assisted suicide (PAS) and physician-facilitated euthanasia (PE) chiefly on the grounds that they would ultimately cause more harm than good. This essay rebuts the AMA's case, by drawing upon recent work in the philosophy of death that is concerned with the notion of harm and the harmfulness of death.

THE AMERICAN MEDICAL ASSOCIATION (AMA) opposes physician-assisted suicide (PAS) on the grounds that it “would ultimately cause more harm than good,” because it is “fundamentally incompatible with the physician’s role as healer,” and because it “would be difficult or impossible to control and would pose serious societal risks” (AMA 2016, Opinion 5.7). It condemns the practice of euthanasia as conducted by physicians (PE) for these reasons as well, and adds, by way of clarifying the serious risks at hand, that “euthanasia could readily be extended to incompetent patients and other vulnerable populations” (Opinion 5.8). In this essay I will attempt to rebut these charges. I will devote most of my attention to the first one, concerning the harmfulness of PAS and PE. Here the AMA appeals to the moral principle that physicians should not act in ways that

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will ultimately cause more harm than good, which we can call the “*more-harm principle*.” However, I will start by discussing another argument against PAS and PE, one that appeals to (what I will call) the “*no-harm principle*.” While the AMA does not appeal to the no-harm principle in its opinion statement, discussing it is useful for two reasons. One is that the no-harm principle features in many formal and informal criticisms of PAS and PE (e.g., Boudreau and Somerville 2013). Another is that clarifying the no-harm principle will help me to bring the more-harm principle into focus, which in turn will make it easier to assess the AMA’s case.

### NO-HARM PRINCIPLE

As based on the no-harm principle, the case against PAS and PE can be formulated as follows:

1. Physicians should never harm patients (the no-harm principle).
2. Physicians who engage in PAS or PE will harm patients.
3. So physicians should not engage in PAS or PE.

My first task is to consider whether this argument is any good. To do that, I will need to clarify the notion of harm.

Harm can be understood as a sort of adverse effect on a person’s well-being or welfare (as many theorists have claimed; see, for example, Feldman 1991; Luper 2009; McMahan 2002), but exactly what sort will take some explaining. We can begin by distinguishing between something’s being intrinsically good for an individual, on the one hand, and its being overall good for that individual, on the other. Something is *intrinsically* good for her if and only if it is good for her in itself, rather than because of its further effects. A relatively uncontroversial example is pleasure; another, more controversial example might be fulfilled desires. We can add that something, such as pain (and perhaps thwarted desires), is intrinsically *bad* for an individual—and in that sense “harmful”—if and only if it is bad for her in itself. An individual’s level of welfare (or well-being) over a particular stretch of time is determined by the intrinsic goods and evils she accrues over that time. The goods boost her welfare, while the intrinsic evils lower it. If the evils she accrues outweigh the goods, she will have a negative level of welfare for that period of time, whereas her level of welfare will be positive if the goods she accrues outweigh the evils. Her *lifetime welfare level* is the sum of the intrinsic goods and evils that she accrues over the course of her life. Whether something is *overall good* for her is a matter of whether it makes her lifetime welfare higher than it otherwise would have been; it is overall bad for her (and “harmful” to her in this sense) if it makes her lifetime welfare level lower than it otherwise would have been.

More formally stated: An event or state of affairs is overall good (bad) for an individual if and only if, and to the extent that, her lifetime welfare level would be higher (lower) if that event occurred than it would be if that event did not occur.

At this point it is possible to distinguish between two ways in which the no-harm principle may be understood, as the term *harm* might be used in either of the two senses just set out. It is no abuse of language to say that you “harm” me if you prick me with a needle, since, at least informally, we can say that an act “harms” me when, as a result of it, I suffer to some degree, or I accrue some other intrinsic evil or evils. The practice of medicine is replete with such pro tanto harms. They occur when an injection is given, for example, and in much greater measure when a burn patient’s dead skin is scrubbed off, or when a bone is broken and reset. We may also speak of harm as that which is overall bad for a person. The two sorts of harm are quite different. Treatments involving pro tanto harm may well be overall good for patients, while treatments that are overall bad for patients may not involve any pro tanto harm at all, as acts may be overall harmful wholly by virtue of reducing the amount of intrinsic goods a patient accrues in life.

Should we interpret the no-harm principle as an injunction against causing pro tanto harm? Surely not, since then it would exclude a great many perfectly acceptable medical procedures that involve at least some discomfort. Let us add that, so interpreted, the no-harm principle might not rule out PAS or PE anyway: it would not exclude them assuming that the killing involved in PAS and PE is painless, since being killed eliminates the very possibility of incurring pro tanto harm. (Here I ignore the possibility of retroactive or global goods and evils; for discussion, see Luper 2012a, 2012b). What matters is what harms patients in a second way—namely, by being overall bad for them. It is true that, other things being equal, it is important to avoid causing patients to incur pro tanto harm, but causing pro tanto harm will be justified if it is overall good for the patient (and done with the proper consent). Hence it seems best to understand the no-harm principle as an injunction against those actions that would be overall bad for a patient. We might state it as follows: Physicians should treat no patient in a way that will be overall bad for her.

Would it be overall bad for a patient to be euthanized by a physician, or assisted with suicide? Well, that depends, of course, on the patient and the mechanism whereby death is brought about, but being killed (whether by a physician or with the help of a physician) quickly and relatively painlessly would be overall good for many people. (By the same token, *not* being killed would be overall bad for them.) At least theoretically, these people are easily identified: they are those whose welfare levels, as assessed over the period of time otherwise left to them, are negative. They are the people who, if not helped to die, will fare ill over their remaining lives.

I said that, theoretically, the group of people whom PAS and PE would not “harm” is easily identified, but I would quickly add that for many individuals it is

impossible to know whether they are in this group. In particular, the availability of palliative care complicates matters, since palliative care will improve the prospects of many people who would otherwise fare ill over their remaining lives. For some persons, but certainly not all, a regimen of pain management can make the difference between a positive and a negative welfare level (Hudson 2015). In any case, we would want to facilitate a person's death only if it is relatively clear that she will benefit, so it is reasonable to impose various restrictions on who is to have access to PAS and PE. Still, we will not want to be overly restrictive. It is important to keep in mind that few if any medical procedures are risk-free. Even the use of antibiotics or anesthesia will end up being overall bad for some. It would be a mistake to exclude a procedure just because it might or will be overall bad for some small number of people.

To guard against this possibility, let us reformulate the no-harm principle. A better version is this: Physicians should treat no patient in a way that is likely to be overall bad for her.

As stated, the no-harm principle seems quite reasonable. However, it is useless to opponents of PAS and PE, since it excludes neither of these practices, assuming that these are appropriately restricted. I will not attempt to craft suitably restricted policies, but a good starting point is to require that the persons who request assistance be competent and properly informed about treatment options (including any palliative care that is available), at least 18 years old, and that they be diagnosed with an illness that is likely to be terminal within six months. These restrictions appear in the PAS policies in those U.S. jurisdictions where it is legal, and could be included in a policy for euthanasia. In time, the requirement involving a terminal illness might be relaxed, for predictions about how long it takes an illness to kill are not especially reliable (Christakis and Lamont 2000), and, more importantly, many persons who will not die within six months would fare badly no matter how much longer they live, even with palliative care and other kinds of intervention. It might be possible to identify conditions that are strongly correlated with faring ill during the final segment of life, even with appropriate intervention; in that case, a better policy could be extended to patients diagnosed with one of these conditions who request help in dying after fully understanding their prognosis and treatment options and who judge that further life would not be worthwhile.

### **MORE-HARM PRINCIPLE**

Next we may consider the AMA's own case against PAS and PE, as based on the more-harm principle, according to which physicians should not act in ways that ultimately cause more harm than good. On its face, it is not clear how to interpret this principle, so we will have to consider various possibilities.

The idea, at least in part, might well be that PAS and PE would (probably) be overall bad for the patients who die. However this claim was rebutted in the previous section.

A better interpretation is that the AMA is concerned about the effects of PAS and PE on the utility of everyone who would be affected by PAS and PE. “Utility” may be construed narrowly, to mean the sum of the pleasure and pain accrued by these people, or more broadly, to mean the sum of the intrinsic goods and evils accrued by them. The AMA’s fear may be that this sum would be lower than it would be if PAS and PE were avoided. If so, however, the worry is easily overcome. A powerful (if depressing) case can be made for the conclusion that PAS and PE would not lower utility.

In outline, the case is this: as pointed out above, painlessly killing people (or their killing themselves) eliminates their ability to accrue pain or other intrinsic evils, so dying would be against a person’s interests only if she would have fared well had she lived. Killing people when it is against their interests would indeed reduce the net utility, but such detrimental killings would be rare, assuming that well-designed policies of PAS and PE are on offer, especially if these are restricted to cases of terminal illness. For nearly everyone who dies under such policies, there will be a boost in the net utility, as the individual’s *disutility* is avoided. Hence any significant lowering of utility would have to be due to the ways other people—those whose deaths are not hastened—are affected. There is no doubt that the hastened death of a family member or friend is a terrible blow, both because it causes devastating grief and because the further benefits of a shared life will be lost, but in the present context, the benefits of that shared life should not be exaggerated, given the dire condition of people for whom further life is detrimental. What is more, the cost borne by surviving family members is offset: for each grieving survivor, there is someone who will be spared considerable misery by a well-designed policy of PAS or PE. Choosing to receive assistance in dying can even help one’s relatives to cope with what is to come (Ganzini et al. 2009). Hence it is difficult to see any reason to think that the benefits accrued by people whose deaths are facilitated by PAS and PE would be outweighed by the harms incurred by family members and friends who are left behind.

### UNCONTROLLABLE PHYSICIANS

Perhaps the AMA has more in mind when it says that PAS and PE would cause more harm than good, for it also claims that PAS and PE “would be difficult or impossible to control, and would pose serious societal risks,” and that PE “could readily be extended to incompetent patients and other vulnerable populations.” Here the concern appears to be that if physicians are permitted by the AMA or by law (or both) to euthanize or assist in the suicides of any group of persons, no matter how carefully circumscribed that group is, it would be difficult or impossi-

ble to stop them from killing or helping to kill people in a great many cases where it is clearly unacceptable. They might even kill people because they are mentally deficient or because they are over 60.

Two things should be emphasized about this line of criticism. First, the AMA's concern is of little significance if it is merely that physicians could not be *stopped* if they were to abuse the privilege of assisting in death once it is granted to them. The concern must also be that physicians *would* abuse their privilege. Arguably, the privacy and intimacy of physician-patient encounters would shield physicians who decided to engage in large-scale abuses. It might be difficult to catch them if they decided to kill people who cannot walk or to brow-beat the elderly into submitting to euthanasia. But even if it would be "difficult or impossible" to police such abuses, the point is not relevant unless there is reason to predict that the feared abuses would occur.

Something else needs emphasizing: as I have understood it, the charge we are discussing does not support the conclusion that it is morally objectionable for physicians to help people die. The suggestion is that even if in certain cases PAS and PE are morally acceptable, condoning it (even if in those cases and no others) would prompt physicians to act in ways that are clearly unacceptable.

Thus clarified, the AMA's charge is rather baffling. One might have thought that physicians could be permitted, for certain compelling reasons, to help people to die in various clearly described cases, and forbidden, for other reasons, to help people to die in other cases. One also might have thought that the force of reason, together with the threat of professional and legal penalties, would suffice to make egregious abuses extremely rare. According to the AMA, one would be mistaken. However, it is difficult to see why the AMA believes that physicians would become abusive. In this matter the AMA bears the burden of proof: it should explain why it predicts wide-scale abuses in places where PAS or PE is permitted. Meanwhile, let us note that the AMA cannot base its case on the fact that a growing number of intrepid physicians violate the existing AMA code (Quill and Greenlaw 2008), as it is far from clear that the AMA's blanket condemnation of all forms of PAS and PE is reasonable, or that what maverick physicians like Timothy Quill have been doing is morally inappropriate. Nor will it be easy for the AMA to base its case on the way physicians have actually behaved in places where PAS or PE have been permitted, as the data reveal no grounds for concern (Prokopetz and Lehmann 2012).

### DEFINING ROLE ARGUMENT

What, finally, about the claim that PAS and PE are "fundamentally incompatible with the physician's role as healer"? This objection is easily rebutted, once it is made sufficiently clear.

The charge might be that physicians ought not to *supplement* their role as healers. They should not use their medical expertise for any purpose other than healing, and in particular, they should not use it to assist people who wish to die. This charge, I take it, is clearly unmerited. If the additional purpose (beyond healing) is itself morally inoffensive, no one (including the AMA's ethics committee) would object if a physician pursued it. Indeed, it is commonplace for physicians to do things that have little if anything to do with healing. Some use their expertise for entertainment purposes, say by writing certain sorts of novels. Some use their expertise to fight crime, either on a part-time basis (as consultants) or full-time (as coroners and forensic pathologists). Some use medicine to enhance people's appearance (by helping to develop beauty products, or by performing certain sorts of elective cosmetic surgery). Conceivably, in some unusual case a plumber could use his expertise to save a person's life. Would it be reasonable to condemn him on the grounds that saving lives is beyond the role that plumbers play?

A more plausible charge is that physicians ought not to use their medical expertise in any way that *precludes* healing. This would be grounds for them not to help patients die, assuming that they cannot provide such help if they are healers. (According to Boudreau and Somerville [2013], helping patients die and healing them are "simply not miscible" [62].) However, it is clearly hyperbole to say that physicians cannot do both. It is true that physicians cannot prolong a particular person's life and assist in the death of that very person at the same time, but they can help prolong the lives of people who seek that kind of attention and help other people who wish to die, just as veterinarians can meet the needs of people who want their animals healed even while accommodating those who want their suffering pets euthanized.

Obviously, physicians *can* do both, but perhaps a weaker charge is intended, namely that it is objectionable for physicians to use their medical expertise in any way that *interferes with* their role as healers. Here the worry might be that people would come to distrust physicians and to make less use of their expertise if PAS or PE becomes part of their practice (Boudreau and Somerville 2013; Steinhäuser et al. 2000). However, even if some distrust developed for a time following the introduction of PAS and PE (as it might; see Hall, Trachtenberg, and Duggan 2005), there is no reason to think it would be substantial or that it would persist, as long as physicians did not assist in death in unwelcome or otherwise inappropriate ways. No one worries that veterinarians will euthanize animals willy-nilly, and that is largely because veterinarians *don't*. If they began to euthanize animals inappropriately and without permission then, no matter how slyly they went about it, eventually they would create distrust.

So in the final analysis, the charge seems to be that physicians should not be trusted if they assist in death. The worry is something I addressed earlier: namely, that if physicians euthanize or assist in the suicides of any group of persons, no matter how carefully circumscribed that group is, they would kill or help to kill



people in clearly unacceptable cases, and I have already pointed out that this concern is unwarranted.

Note, finally, that even if helping people die did interfere substantially with the physician's efforts to heal, it would not follow that it is inappropriate for anyone to use her medical expertise to help people die. As has been pointed out by others, people looking for help in dying could be accommodated without the involvement of professional healers (Sade and Marshall 1996). A new occupation could emerge, featuring specialists who use their medical expertise to help end the lives of those who request assistance. However, in my judgment there is no need for anything of the sort, any more than there is a need to stop veterinarians from euthanizing animals so that that task can be turned over to the practitioners of a new occupation.

### **QUALIFICATIONS AND CONCLUSION**

In the preceding, I took harm to be some sort of adverse effect on welfare. In closing, I must acknowledge that it is possible to understand harm very differently, in which case new ways of arguing against PAS and PE open up. I also acknowledge that even if we do not tinker with the notion of harm, it is possible to come up with criticisms of PAS and PE which I have not addressed. I will elaborate briefly.

According to many theorists, most of them followers of Immanuel Kant, moral agents have a kind of status which Kant (1785) called "dignity," which is not determined by their welfare, either at a time or over time. Killing moral agents takes away their dignity by ending their existence. Although dignity is lost at death, it has a kind of importance that overrides all considerations of welfare, so boosting welfare by any degree, no matter how great, can never justify any loss of dignity, however slight. Hence it is possible to say that taking away a subject's dignity is a kind of harm of a very weighty sort. The consequences for PAS and PE are clear, as both are motivated by considerations of welfare: both involve helping someone die because dying is in her best interests. Assuming that dignity is always more valuable than welfare, and that losses of either are forms of harm, then the more-harm principle automatically rules out PAS and PE.

I think that the Kantian critique of PAS and PE can be effectively rebutted, but I will not attempt to do so here (for discussion, see Hill 2014; Luper 2009; Velleman 1999). Still, as the Kantian approach illustrates, there are ways of criticizing PAS and PE to which I have not responded. What has been accomplished in this essay must therefore be appropriately qualified. What has been shown is that if the AMA's more-harm principle is concerned exclusively with welfare-based harm, as I took it to be earlier, then the case against PAS and PE, as grounded on this principle, fails. I think we can also conclude, on the strength of the argument in the previous section, that physicians may participate in well-designed PAS and PE policies with no fear that this will preclude them from healing their patients.

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