Professional Integrity and Physician-Assisted Death

by Franklin G. Miller and Howard Brody

The practice of voluntary physician-assisted death as a last resort is compatible with doctors' duties to practice competently, to avoid harming patients unduly, to refrain from medical fraud, and to preserve patients' trust. It therefore does not violate physicians' professional integrity.

The debate over the ethics of physician-assisted death has suffered from inadequate analysis of professional integrity. Some who would permit it have tended to ignore professional integrity as a source of moral constraints on physician conduct. We contend that the attempt to ground its ethical appropriateness solely on the principles of respect for patient autonomy and relief of suffering fails to do justice to the internal values and norms of medicine, in accordance with which physicians ought to practice. The use of professional knowledge and skill to help a patient end his or her life can be justified only if professional integrity is not violated. However, some who oppose the practice as incompatible with medical norms employ too narrow or simplistic a conception of professional integrity.

Since so little has been written recently on the subject of professional integrity, we can in this paper do little more than introduce and apply some basic concepts; much more work would be necessary to develop a comprehensive theory of professional integrity in modern medicine. We aim to highlight some important features of the concept and to consider their bearing on the perplexing moral problem of physician-assisted death. We set the stage by examining briefly the related concept of personal integrity.

Personal Integrity

Martin Benjamin has provided some very useful observations about personal integrity and its moral importance in his recent study of integrity-preserving compromise. The root meaning of *integrity* refers to wholeness and intactness. Benjamin sees integrity as standing in a strong relationship to personal identity: "[Integrity] provides the structure for a unified, whole, and unalienated life. Those who through good fortune and personal effort are able to lead reasonably integrated lives generally enjoy a strong sense of personal identity." He suggests that the key elements of personal identity and personal integrity are the same: "(1) a reasonably coherent and relatively stable set of highly cherished values and principles; (2) verbal behavior expressing those values and principles; and (3) conduct embodying one's values and principles and consistent with what one says."[1] Thus, for me to have personal integrity at the most basic level requires that I believe in some values or principles, and that I both talk and act as I would be expected to if my thoughts and behavior were indeed guided by those values and principles.

Benjamin observes that integrity, though intimately connected with an individual's personal identity, has an important social dimension. He quotes Peter Winch: "To lack integrity is to act with the appearance of fulfilling a certain role but without the intention of shouldering the responsibilities to which the role commits one. If that, *per absurdum*, were to become the rule, the whole concept of a social role would thereby collapse."[2] Benjamin adds that personal integrity is especially important in complex social organizations, such as health care settings, that cannot function without a great deal of interdependence and coordination. He might have further noted that when those organizations serve vulnerable individuals, who can benefit optimally from the encounter only if they are able to place a good deal of trust in the organization and its members, then integrity—both personal and professional—becomes absolutely critical, since lack of integrity undermines trust.

Benjamin treats integrity as primarily a formal principle; accordingly, it is a necessary but hardly sufficient condition for a morally praiseworthy life. If one's values and principles happen to be execrable, then acting consistently with them obviously will not make one virtuous. He goes on to describe various ways in which people might appear to be acting with integrity, while in fact their behavior is morally questionable. One problem arises from adhering to a narrow, simplistic framework of integrity. Benjamin describes this problem as one of emphasizing one aspect of integrity, consistency, over another equally important aspect, wholeness. A per-

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son may act consistently on the basis of a single value, but this value may be quite insufficient to support or inform a complete life; one can behave consistently with it only by putting on blinders and radically restricting one's self-understanding and views of one's environment. A second problem arises from the challenges to integrity in a modern, pluralistic, rapidly developing society. To maintain integrity in the face of changing social and personal circumstances—for example, evolving conceptions of roles and responsibilities of spouses in the context of family life—one will have to modify one's values and principles, and how one talks and acts upon them, to some degree. If one modifies them too much, one will justly be accused of having lost one's moral grounding; but if one modifies them too little, then one will essentially have abandoned one's social role obligations. Benjamin notes that modern society poses a double threat to living a life of integrity: first, in a pluralistic culture, it is not at all clear what our core value commitments ought to be; and second, even once we have adopted some commitments, changing social circumstances tempt us with a bewildering number of ways to modify them.

Violating Integrity

Consideration of what it means to violate integrity can shed further light on this concept. When contemplating an act that would violate one's integrity, one is apt to say, "I can't do that!" Obviously, this does not mean that the act is physically impossible to perform. Nor does the person of integrity mean that to do the integrity-violating act would be too risky in view of the possible consequences: legal penalties, loss of reputation, etc. Rather, I can't do it because, knowing that it would be improper, unsuitable, or wrong (for anyone or for me), I could not live with myself, or maintain my self-respect, if I did it. For example, why did Socrates refuse the opportunity to leave Athens to escape the manifestly unjust death penalty awaiting him? He refused because it would have been contrary to his integrity as the philosophical gadfly of Athens and his loyalty to the scheme of law under which he had lived and thrived. Being Socrates, it was unfitting to make a clandestine escape. Rather, it fit his sense of integrity to refuse to alter his mission in life and, accordingly, to submit to the unjust sentence of death.

The identity to which integrity is connected is not the sameness or continuity of personhood that makes one the same person from birth until death; nor is it sameness of personality or temperament. Integrity is tied to the moral identity of character. It involves a fit between character and conduct; therefore, it bridges being and doing. Persons of integrity shun conduct of various sorts because it does not fit with the sense of who they are. Professional integrity, which we discuss in the next section, also concerns character; but it relates to the moral identity of those who occupy a distinctive social role, in contrast to the full identity of persons, which characterizes their lives as a whole.

Professional Integrity

Discussions of integrity in the recent literature of biomedical ethics often lack any clear delineation of *professional* integrity. For example, while the fourth edition of Beauchamp and Childress's *Principles of Biomedical Ethics* contains a useful general account of the virtue of integrity and acknowledges its primary importance in health care ethics, integrity is not described in terms of the identity and normative commitments tied to the professional roles of physician, nurse, or other clinicians. "Our argument is that moral integrity in science, medicine, and health care should be understood primarily in terms of the principles, rules, and virtues that we have identified in the common morality."[3] We contend, however, that the common morality, shared by lay persons and professionals, does not provide a fully adequate framework for elucidating and assessing the moral responsibilities that are distinctive of physicians and other clinical professionals. In particular, at issue in the ethical problem of physician-assisted death is not only whether suicide and assistance in suicide can be morally justified. It is also morally significant to inquire whether it ever can be permissible for a *physician* to assist in the death of a patient. In an adequate moral accounting of physician-assisted death, appeal to the internal morality of medicine and the virtue of professional integrity is needed to supplement appeal to the principles, rules, and virtues of our common morality. Beauchamp and Childress add that, "Of course, ours is not the only substantive moral framework for integrity in biomedical ethics, and we cannot wave away all other approaches" (p. 471). We develop here an alternative approach to integrity understood as a professional virtue of physicians, which is distinct from, but not in conflict with, the virtue of integrity in common morality.[4]

Like personal integrity, professional integrity shares a connection with the concept of identity. Professional integrity in medicine represents what it means normatively to be a physician; it encompasses the values, norms, and virtues that are distinctive and characteristic of physicians. Accordingly, the identity to which professional integrity corresponds is tied to a specific social role. The formation of an identity as a physician and commitment to the professional integrity of medicine, learned and internalized through medical education, are aptly described as professional *socialization.* Personal identity also presupposes a social context; it is formed in interaction with others. But personal identity in modern society is not essentially role-defined or role-specific. My personal identity is expressed in the variety of roles that I occupy and in the individual way that I perform them. Professional identity and integrity are much more strongly communally structured. While there remains some free scope for individuality in the practice of medicine, and a good physician may have a unique personal style, professional identity generally constrains individual expression in a way that personal identity does not.

We have arrived at the suggestion that a basic conception of the good of medicine and a core set of moral commitments of physicians can be identified, such that physicians of professional integrity can be expected to practice consistently in con-

formity with them. For example, we might agree that care, accuracy, and reliability in gathering data about the patient's illness is an absolutely essential feature of medical practice. We cannot conceive of someone who took no interest whatever in thorough clinical assessments, but who purported nonetheless to be a competent physician, unless that person was a blatant charlatan. That leads us to the conclusion that falsifying a medical history or physical exam, for instance writing "ears normal" without even examining the ears, would count as a very basic violation of professional integrity.

This point can be made in a slightly different way. Benjamin (partly following Alasdair MacIntyre) insists that the unit of analysis for personal integrity is the complete human life; specifically, we look at human lives organized as narratives to reveal whether or not one's words and actions consistently manifest one's commitment to a set of core values and principles. A profession like medicine, unlike a person, does not have a discrete lifetime; but nonetheless a narrative account of how a profession has evolved over time remains a key mode of discovering elements of professional integrity. As part of that narrative, we routinely ask questions that relate to what sort of practice medicine is: what would count as virtuous or praiseworthy medical practice and as conduct of physicians that falls short of minimal expectations? Such questions point out for us the *internal goods* that make medicine the practice it is.[5] For example, unlike sifting through a puzzling set of signs and symptoms to make an accurate diagnosis, making money through successful medical practice is not an internal good. One can earn money in many other ways besides being a physician, but only a physician can comprehend and experience the peculiar satisfaction that comes from making the correct diagnosis in those circumstances.

The two problems that Benjamin notes with maintaining personal integrity in a complex, changing world also apply equally to professional integrity. First, physicians might misconstrue the requirement of professional integrity if they sacrifice wholeness to consistency. For example, a duty to prolong the life of the patient is certainly one of the general requirements of good medical practice. But one will contravene other important values if one holds that this duty is an *absolute* defining characteristic of medical integrity; such a misperception has led some physicians unethically to disregard patients' competent refusals of life-prolonging medical therapy. Second, the idea of a profession developing over time suggests that what counts as professional integrity should not be seen as absolutely fixed. Otherwise, physicians might hold so rigidly to a certain doctrine of professional integrity that they end up abrogating their social role responsibilities under changed conditions of medical practice. We shall argue that an absolute professional prohibition of physician-assisted death exemplifies this problem.

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Integrity and Conscience

The close connection between integrity and conscience is reflected in the axiom of professional ethics that professionals are not obligated to perform acts that violate their consciences, even if the acts are not contrary to professional norms. A physician should not be required to sacrifice personal integrity in the practice of medicine. For example, abortion is not contrary to the norms of the medical profession, and physicians of integrity perform abortions for a variety of medical and nonmedical reasons. Physicians conscientiously opposed to abortion, however, are not obliged to compromise their personal integrity by performing abortions. If physician-assisted death becomes legalized and recognized by the medical profession as legitimate in some cases, physicians morally opposed to this practice would have a right to refuse to assist actively in bringing about the deaths of patients.

Exercising integrity is not reducible to following conscience for two reasons. First, a person's integrity may involve commitment to nonmoral values, such as artistic creation and scholarship, which are passionately pursued but are not matters of conscience. Second, a person facing a moral dilemma is pulled by conflicting directives of conscience. When faced with such a conflict a person of integrity may lack any clear and certain conviction of conscience about what should be done. Considerable reflection, deliberation, consultation, and study may be required to arrive at a position which is considered reasonable. Analogous to a moral agent's internal conflict of conscience is professional conflict concerning practices that are subject to competing moral evaluations. Whether physicians should be permitted to assist actively in the deaths of suffering patients is an issue that calls for careful analysis of the professional integrity of physicians and a balancing of competing ethical considerations.

The Substantive Content of Professional Integrity

Benjamin treats integrity as a basically formal concept, since the lives, values, and sense of identity of persons of integrity may vary enormously. In the case of professional integrity, however, normative content can be specified, because the identity to which it corresponds consists of a distinctive and relatively stable social role. We offer the following as a brief overview of the substantive content of the professional integrity of modern

physicians. We attempt to elaborate some aspects of professional integrity in the subsequent discussion of physician-assisted death.

Reflection on medicine as a professional practice guides articulation of what professional integrity of physicians involves. Since medicine is a goal-directed practice, conduct that complies with (or violates) the professional integrity of physicians may be understood in terms of an ethical framework of ends and means. The acts of physicians of integrity must serve the proper ends or goals of medicine, and they must be ethically appropriate means to these ends in the light of the values and norms internal to the practice of medicine. As in the case of other skilled practices or arts, there is a conceptual and pragmatic fit between the goals and the means of medicine. The goals of medicine inform practitioners and theorists on the range of appropriate or inappropriate means of medical practice; and the understanding of the proper and improper means of medical practice elaborates the meaning of the goals of medicine.

Medicine is too complex to be oriented toward a single fundamental goal. We believe that most, if not all, legitimate medical practices can be encompassed by three goals: healing, promoting health, and helping patients achieve a peaceful and dignified death. Healing, broadly understood, includes interventions intended to save life, cure disease, repair injuries, restore impaired functioning or ameliorate dysfunction, help the patient cope with irreversible illness, and palliate pain and discomfort. Promoting health includes interventions intended to prevent disease or injury: consultations to encourage healthy behavior (including nutrition and exercise), vaccinations and prophylactic treatments, prenatal care and normal delivery of babies, and so on. Helping patients achieve a peaceful and dignified death may overlap with healing, since providing treatment intended to relieve suffering serves both goals. However, the third goal also includes activities that lie outside the scope of healing, such as helping patients plan for limiting treatment at the end of life and deciding for dying or incurably ill patients to forgo life-sustaining treatments that are more burdensome than beneficial. In addition, we shall argue that this third goal supports physician-assisted death as a last resort, provided that adequate safeguards are observed to assure that the patient makes a voluntary and informed choice and that the use of medical intervention to terminate life is not premature or unnecessary in view of available alternatives.

It might be objected that to cite helping patients achieve a peaceful death as a goal of medicine is an arbitrary and question-begging move, aimed solely at legitimating physician-assisted death. The objection is mistaken, however, since there is no necessary connection between affirming this goal and justifying the practice of voluntary physician-assisted death as a last resort. Daniel Callahan eloquently argues that contemporary medicine has neglected the goal of helping patients achieve a peaceful death.[6] Yet he remains a staunch opponent of physicians' direct involvement in patients' suicides.

Four basic duties of physicians govern ethically appropriate means of medical practice: (1) the duty to practice competently; (2) the duty to avoid disproportionate harm to patients in the effort to provide medical benefits; (3) the duty to refrain from fraudulent misrepresentation of medical knowledge and skills; and (4) the duty of fidelity to the therapeutic relationship with patients.

Competence is the first duty of physicians. The goals of medicine cannot be served unless physicians possess and exercise at least minimal standards of knowledge and skill. Competence includes the ability to communicate with and respond attentively to patients (and family) as well as possessing scientific knowledge, clinical judgment, and technical skill.

Since the power of medicine depends on interventions that invade the body or alter its functions, the maxim "Do no harm" fundamentally constrains medical practice. It is obvious, however, that the goals of medicine are often served by practices that produce harmful side effects or complications, as in chemotherapy for cancer. Therefore, this duty prescribes that physicians avoid producing harms to patients that are not balanced by the prospect of compensating benefits.

The duty of refraining from fraudulent misrepresentation enjoins physicians from unjustified departures from standard medical practice. It prohibits performing acts that pose as medical practice but conflict with the goals of medicine. Fraudulent misrepresentation is conceptually distinct from incompetence, though the two may overlap in particular cases. This distinction is evidenced by venality in medicine. A surgeon who performs unnecessary operations to boost his income may be technically competent. But besides violating the rule against disproportionate harm, he also fraudulently misrepresents the science and art of medicine, since the public may come to think, from his example, that surgery is necessary and proper in a much wider set of circumstances than it actually is.

The goals of medicine are pursued within the context of a therapeutic relationship between physician and patient. The generic duty of fidelity contains two component duties: the duty not to abuse the trust on which a therapeutic physician-patient relationship depends, and the duty not to abandon patients.

Medicine is a complex moral enterprise; it consists both of a body of technical knowledge and skills, and their application to specific sorts of human problems. Physicians can violate the integrity of medicine as a professional practice, then, in various ways: by perverting it to serve medically extraneous or antithetical ends (as in the conduct of Nazi doctors who performed forced sterilizations, engaged in brutal experiments, "euthanized" handicapped children and mental patients, and participated in the operation of the extermination camps[7]); by misrepresenting or debasing the body of knowledge itself; or by applying it in the wrong way or in the wrong circumstances, such as when much more harm than good is caused.

A physician who prescribes anabolic steroids for an athlete who wants to enhance his athletic performance violates professional integrity in a number of respects. Such practice serves no valid medical goals.

The patient may ultimately suffer complications that far outweigh any transitory advantage of increased athletic prowess, thus violating the duty of avoiding disproportionate harm. Also, medical practice is fraudulently misrepresented, because steroids are not medically indicated for the condition of the athlete. Moreover, this practice suggests that it is appropriate medical treatment to provide unfair advantages to one group of athletes by prescribing potentially harmful substances for them. This misrepresentation may be compounded if the mere fact that a *physician* is willing to prescribe steroids leads the credulous athlete, or others, to conclude that the risks are inconsequential. The patient may have given informed consent for steroid "treatment," but this is not sufficient to make it compatible with professional integrity. The physician is not a morally neutral technician available to do the bidding of patients.

We do not interpret professional integrity of physicians as coextensive with the whole of medical ethics. Ethical considerations of respect for patient autonomy, social utility, and justice lie outside the domain of professional integrity, which constitutes the internal morality of medicine.

Is Physician-Assisted Death Compatible with Professional Integrity?

A number of prominent physician-ethicists have argued that physician-assisted death is incompatible with the internal morality of medicine.[8] We agree that the professional integrity of physicians is at stake in ethical assessment of the practice. Doctors have a duty, grounded in the norms of professional integrity, not to kill or assist in the killing of patients. We contend, however, that this duty is not absolute, and that an exceptional practice of voluntary physician assistance as a last resort does not violate professional integrity.

Our argument proceeds in two steps. First, we will show that the practice is compatible with the goals of medicine. Second, after indicating how each of the norms of professional integrity, outlined above, supports a prima facie duty to refrain from assisted suicide and active euthanasia, we will show that, on further analysis, each will permit cases of voluntary physician-assisted death in response to unrelievable suffering. Our aim is to show that this is allowed by professional integrity; accordingly, we offer a critique of a variety of arguments that conclude that physicians should be prohibited from practicing assisted death. Some proponents might argue that professional integrity in some cases *requires* a physician to assist in the death of a patient by prescribing or administering a lethal dose of medication, unless he or she is morally opposed to such assistance under all circumstances. We take no stand here on the duty to assist. In the face of traditional legal and moral prohibitions, it is a sufficiently daunting task to argue that such assistance is not incompatible with professional integrity. Furthermore, we urge caution in moving from the position that it is allowed in some cases to the position that it is required, since this practice should always be seen as problematic and justifiable only as a last resort.

The Goals of Medicine

If medicine is *essentially* a healing enterprise, then physicians should never help patients to die. Leon Kass argues that "being a physician, teacher, or parent has a central inner meaning that characterizes it essentially."[9] For Kass, the essence of medicine—its inner normative meaning and purpose—is healing, which physician-assisted death contravenes. In introducing the concept of professional integrity, we contended above that medicine is too complex to be captured by a single fundamental goal that defines the scope and limits of medical practice. Ludwig Wittgenstein pointed out the problems with such conceptual essentialism in his famous example of the concept of a game.[10] There is no essence of games: no necessary and sufficient conditions for an activity to qualify as a game. There are games of various sorts; and what unifies the class of games is a complex set of "family resemblances" between these various sorts of games. A similar point holds for the range of practices that fall under the scope of clinical medicine. Although healing is a core goal of medicine, the concept of healing cannot be stretched to cover the full scope of legitimate medical practice. We argued instead that there is a plurality of goals of medicine, which includes healing, promoting health, and helping patients achieve a peaceful death.

The critical question is whether administering a lethal dose of medication can ever be a legitimate means of realizing the goal of helping patients achieve a peaceful death. When no healing interventions are appropriate for the condition of a patient who resolutely requests aid in ending his or her life because of intolerable suffering (in spite of careful consideration of comfort care alternatives), then resort to physician-assisted death may become, unfortunately, the best among the limited options available to achieve this important goal of medicine for this patient.

Kass argues that physicians, being concerned with the health of living, embodied human beings, must always refrain from this option. "For the physician, at least, human life in living bodies commands respect and reverence—*by its very nature*"(p. 38). Because the human organism is mortal, this respect is compatible with forgoing treatment when such treatment would be futile; however, it can never be compatible with interventions aimed at ending human life.

We agree with Kass that a norm of respect for the human body follows from the nature of medicine, but we dispute that this moral consideration rules out physician-assisted death. The moral force of physicians' respect for the human body is perhaps best illustrated by considering requests that they perform bodily mutilation. Suppose a modern Oedipus urges his physician to blind him—in a painless way, without otherwise endangering his health—because of his unwitting but terrible sins. Is the physician's reason for refusing simply that such a request would be regarded as deranged and therefore nonautonomous? There is an issue here of professional integrity: bodily mutilation on demand is not within the scope of what physicians properly do. And this consideration is logically

independent of concerns about the decisionmaking capacity of anyone who requests bodily mutiliation. This is even more apparent in the case of requests for female circumcision, which are motivated by traditional cultural beliefs and attitudes and do not evidence mental derangement. Bodily mutilation violates professional integrity because it contravenes the goals of medicine. Furthermore, it harms patients without any compensating medical benefit, and it fraudulently misrepresents medical practice.

Kass seems to be arguing that physician-assisted death is akin to bodily mutilation. Indeed, it constitutes a greater violation than removing or damaging a functioning body part, since it causes the death of the organism as a whole. According to Kass, "Medicine violates the body only to heal it."[11] This statement, once again, reflects Kass's essentialism—that medicine serves only the goal of healing. If there are goals other than healing, then it may be legitimate for physicians to "violate" the body to serve another valid medical goal. Whereas no medical goal supports bodily mutilation, justified physician-assisted death is dedicated to helping a patient achieve a peaceful and dignified death when no other satisfactory option is available.

Consider the case of an eighty-five-year-old woman who has suffered a cascade of health problems and treatment complications that leave her incontinent, bedridden, and increasingly blind.[12] She is now in a nursing home—a fate she dreaded—with no prospect of recovery to independent living and doing those things she most values. She decides that she wants to die and asks her physician for help. Suppose that in response to this request her physician were to say, "I can't help you because I am bound as a physician to respect your body, and if I give you a lethal injection I will be destroying your body as a living organism." The patient might reply as follows: "My body is worse than useless to me, since it now brings me unbearable suffering, and there is no point in continuing to live, given my humiliating and dependent condition. I want you to do this for *me*, since the quality of my life has become intolerable because of my diseased and debilitated body."

An absolute prohibition of physician-assisted death based on respect for the human body represents a mistaken view of medical priorities. Respect for the human body must be accompanied by respect for the person whose body it is. The physician serves the patient via the body; however, in unfortunate circumstances the most appropriate service for the patient requires ending bodily life. Ultimately, respect for the person, who finds his or her continued existence intolerable, takes precedence over respect for the person's embodied life.

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Competence

Standard measures of palliative care, encompassing thorough efforts to relieve pain and discomfort and supportive services to help patients cope with the process of dying, enable most patients to face death without unbearable suffering. Physician-assisted death constitutes incompetent medical practice insofar as palliative care, such as that provided within the context of hospice programs, is capable of relieving patients' suffering to a satisfactory degree.[13] To comply with a suffering patient's request for assistance in causing death without first carefully considering palliative care alternatives violates professional integrity.

Some hospice physicians and ethicists opposed to such assistance have argued that it always amounts to incompetent medical practice, because competent palliative care provided by well-trained hospice clinicians obviates the need to relieve suffering by lethal means.[14] We believe that clinical experience fails to support this claim.[15] Not all patients can receive adequate relief of pain or suffering even under conditions of optimal palliative care.[16] Deep sedation to counteract refractory suffering is a possible option; however, this will not be satisfactory for patients who want to remain alert without suffering intolerably.[17] Some patients may prefer to end their lives at home than to be hospitalized and persist in a sedated state pending death. Furthermore, it is not clear that relieving terminal suffering by inducing unconsciousness, which may hasten death, is morally superior to voluntary physician-assisted death.

Benefiting the Patient and Avoiding Harm

Killing can be seen as the ultimate harm, since ending a person's life deprives the victim of all future benefits and deprives others of that person's services and companionship. Accordingly, we recognize a duty binding on all persons not to kill and a right possessed by all persons not to be killed. In addition to being subject to this general prohibition against killing, physicians have a role-specific duty not to kill and indeed to preserve life. Furthermore, physicians are charged to avoid harms that are not compensated by proportionate benefits. How then can a physician ever be justified in administering lethal medication to a suffering patient?

Although death is prima facie harmful, it is clear that we do not always regard the occurrence of death as a harm. Deaths that bring a peaceful close to a full life may be regarded as merciful. Thus pneumonia was known as "the old man's

friend." The growing power of medicine to stave off death has been accompanied by the ethical recognition that there are circumstances in which it is permissible, if not obligatory, to forgo life-sustaining interventions to allow the patient to die—thus suggesting that in those circumstances death counts as a lesser harm, or even as a benefit.

In contrast to forgoing treatment, physician-assisted death constitutes active intervention: the physician makes death happen, rather than allowing it to happen. Therefore, the practice conflicts more deeply with the duty to preserve life. Can it ever be beneficial, all things considered, for a suffering patient? Kass discerns a logical error in regarding it as benefiting a patient. "To intend and act for someone's good requires his continued existence to receive the benefit."[18] Although the idea that causing death can be beneficial may seem paradoxical, Kass's argument relies on too narrow a conception of benefits. If death is a liberation from unrelievable suffering, then it is a benefit. What removes an evil is a benefit, even if the benefit cannot be experienced. Furthermore, it is important not to ignore the benefit to incurably ill patients of knowing that there is a way out if suffering becomes unbearable.

Respect for professional integrity requires that physicians in performing assisted death must refrain from premature termination of life. If a reasonable quality of life remains available to the patient, with the help of comfort care, then assisted death is not appropriate, regardless of the wishes or requests of the patient. Certainly the patient and physician may differ in their respective assessments of the quality of life available to the patient. The patient's subjective appraisal of his or her situation must be considered carefully and discussed empathically. What is at stake, however, is not a solo act of suicide, which the patient may contemplate and execute without the assistance of a physician. When a physician is involved, a transaction occurs that must be negotiated between physician and patient. In entering into such a transaction the physician should be bound by professional integrity, which excludes physician assistance on demand. The physician is an independent moral agent, committed to the internal morality of medicine, not a tool at the command of the autonomous patient. The patient who wants the help of a physician to terminate his or her life should understand that such help is being sought from a professional clinician, who must be convinced that this course is the best option for the dire situation of this particular patient.[19]

A clear case of when requested death is not compatible with professional integrity was featured in a documentary on euthanasia in the Netherlands, aired 23 March 1993 on the Public Broadcasting System.[20] A forty-one-year-old man diagnosed with HIV, but not yet seriously ill, persuaded his reluctant physician to assist with suicide to avoid the future ravages of AIDS. We believe that the physician's action would be premature in such a case, because the patient, with the help of good medical care, probably can live at least a few years with a reasonable quality of life. To be sure, the patient may decide (not unreasonably) that his life is not worth living in view of what the future has in store. He remains free to undertake suicide on his own. The autonomy of the patient is not sufficient to justify physician-assisted death, which must accommodate respect for professional integrity.

Fraudulent Misrepresentation

Physicians who undertake unwarranted deviations from the standard of care fraudulently misrepresent medical practice; to provide procedures and treatments that are known to offer no benefit amounts to quackery. Professional integrity requires that physicians base their prescriptions for treatment on medical indications. Physician-assisted death is prima facie contrary to this norm of professional integrity, because it is never medically indicated in the sense that the medical condition of the patient warrants lethal "treatment." From a strictly medical perspective, no objective determination can be made that a dying patient needs active assistance from a physician.

To be sure, there are medical preconditions for the appropriateness of such assistance—as when the patient is suffering from a terminal illness or an incurable and debilitating condition and the patient's judgment is not clouded by treatable depression.[21] Physicians who offer assisted death without a careful assessment of the medical condition of the patient and discussion of available palliative care certainly fraudulently misrepresent medical practice. These medical preconditions, while necessary, are not, however, sufficient. The appropriateness of offering this assistance requires in addition the patient's subjective appraisal of his or her condition as intolerable and her or his determination to seek a swift and painless termination of life rather than to await natural death with the help of comfort care. Even then, as it is not medically indicated and involves killing, physician-assisted death lies outside standard medical practice.

If it is not medically indicated and departs from standard medical practice, how can it ever be considered appropriate? Respect for professional integrity does not rule out departures from standard medical practice. Clinical research, conducted by physicians, inherently departs from standard medical practice. It administers experimental treatments that are not proven or accepted as safe and effective, and tests procedures that are not intended for the medical benefit of research subjects. Clinical research is governed by federal regulations, including mandatory prior committee scrutiny by institutional review boards. The analogy to clinical research supports a case for formal regulation of physician-assisted death to assure that it is used only subject to stringent guidelines and safeguards.[22]

Trust

The integrity of medicine as a profession depends on trust. Vulnerability to the consequences of disease or injury and the prospect of death prompts persons to become patients by seeking the care of physicians. Trust makes it possible to assume the patient role, which involves permitting doctors to probe our bodies and submitting to the risks and burdens

of invasive procedures. Whereas our vulnerability as embodied persons gives rise to the need for trust in physicians, this very trust makes patients vulnerable. As Annette Baier points out, "Trust is accepted vulnerability to another's power to harm one, a power inseparable from the power to look after some aspect of one's good."[23] The trust that underwrites medicine reflects a double vulnerability of patients to physical and personal harm. To be a patient is to submit to the ills of the body and the treatment and care provided by clinicians.

Stanley Reiser aptly describes medicine as "this remarkable social institution whose members must daily prove themselves worthy of a crucial trust: that they will never take advantage of the vulnerability that is the hallmark of the patients who appear before them."[24] Patients trust physicians to use their skills to help, rather than to harm; for physicians have the power to produce the ultimate harm of wrongful death by virtue of their access to potentially lethal technology. The vulnerability of patients, the power of physicians, and the trust in physicians' professional integrity must not be abused by interventions that unjustly take (or risk) the lives of patients. Opponents of physician-assisted death commonly argue that legitimation of this practice would undermine trust.[25] How can persons trust doctors who have the socially sanctioned power to kill patients? If physicians possessed the unilateral authority to decide which patients "need" to be relieved of suffering through their help, then trust would be undermined. Yet if the practice is limited to competent patients who voluntarily request to terminate their lives and who are fully informed about available options of treatment and comfort care, physician-assisted death does not constitute an abuse of trust.

To be sure, suffering patients facing progressive disability, imminent death, or continued diminished quality of life and dependence on others are highly vulnerable. They are liable to distorted thinking, fear of pain and humiliation, and depressed mood. As a result, their autonomous decision-making may be impaired. In addition, dependent patients may feel pressured to end their lives to avoid burdening others. Sensitive and thorough discussion of the patient's situation and options for treatment and supportive care can help in discriminating between rational and irrational decisions to terminate life. Being vulnerable, such patients need protection and care. But they also need respect for their considered judgments regarding how to live and to die.

How can persons trust doctors who have the socially sanctioned power to kill patients?

Patients who resolve to end their lives after due consideration and discussion waive their right not to be killed.[26] When the resolution is voluntary, the physician acts as the agent of the patient, not as the arbiter of death. The patient's voluntary request and informed authorization is a precondition for making the provision of lethal medication, from the patient's perspective, not a harm but a benefit. Thus the practice differs fundamentally from typical cases of criminal homicide, in which the person killed is an involuntary victim, and also from capital punishment, which we discuss below.

Abandonment

Physician-assisted death may be considered as abandonment of patients, particularly if it is performed without a careful and thorough assessment of the patient's condition and discussion of available alternatives. Adequate palliative care of the dying is hard work. It is much easier to get it over with quickly by offering "instant oblivion." Recognizing a duty not to kill or assist in the suicide of patients helps guard against a hasty decision in favor of putting an end to suffering by eliminating the patient. Nevertheless, an absolute prohibition of physician involvement in suicide risks abandoning patients to intolerable suffering against their will.

The norm of nonabandonment is relevant not only to whether physician-assisted death may be legitimate but also to how it should be performed. In his narrative of his patient "Diane," which is widely regarded as a paradigm case of justified physician-assisted death, Timothy Quill lamented the fact that Diane, after ingesting barbiturates, died alone: "I wonder whether Diane struggled in that last hour, and whether the Hemlock Society's way of death by suicide is the most benign. I wonder why Diane, who gave so much to so many of us, had to be alone for the last hour of her life."[27] Dying alone in this way raises two issues of abandonment. The physician-patient relationship is arbitrarily ruptured if fears of legal repercussions prevent the presence of the assisting physician at the time of death. Furthermore, there is a risk that the suffering patient may botch the suicide, thus losing control over the process of dying and possibly suffering unwanted medical interventions. If voluntary physician-assisted death as a last resort is a legitimate practice, then the norm of nonabandonment supports physician presence at this moment.

Physician Participation in Capital Punishment

It is instructive to contrast voluntary physician-assisted death with physician participation in capital punishment, in the light of professional integrity. We concur with the prevailing professional standard that considers it unethical for physicians to assist in the execution of convicted criminals.[28] Our stance is not based on a judgment that capital punishment is immoral. Whether or not it can be morally justified, physicians should not be involved as executioners. In capital punishment by lethal

injection, in which the physician operates as an agent of the state, the patient-centered focus of ethical medical practice is lacking.

Suppose, however, that a death-row prisoner has developed a relationship with a physician who provides health care for the inmates of the penal institution. If the prisoner requests that this physician administer a lethal injection in lieu of electrocution and the prison authorities do not oppose this request, is there any basis in professional integrity for the physician to refrain from participation in capital punishment?

Physician participation, though it may be more humane than the standard means of execution, violates professional integrity for a number of reasons. No medical goals are served by the physician-executioner. The act of execution by lethal injection is not a medical treatment or procedure. Typically, it is not initiated by a request for a physician's assistance and, even if such a request is made, the act of execution does not aim at responding effectively to the patient's medical condition. There may be no physician-patient relationship between the medical professional operating as executioner and the condemned criminal. And regardless of whether such a relationship is operative, execution by lethal injection obviously is not intended for the benefit of the prisoner. The prisoner would never have chosen the option of physician-inflicted death had it not been for the prior exercise of the state's coercive power in condemning the prisoner to die. In using his or her medical knowledge and skills to execute the prisoner, the physician does not serve the interests of the prisoner, but the interests of the state, which has determined that the prisoner's life must end.

Limits of the Argument

We have argued that the professional integrity of physicians grounds a prima facie duty to refrain from killing, or assisting in the killing of, patients. This prima facie duty may be overridden, however, in the situations of patients with intractable and intolerable suffering who voluntarily request to end their lives. Voluntary assistance in dying as a last resort is morally problematic but does not necessarily violate professional integrity. By contrast, an analysis of physician involvement in capital punishment fails to turn up any weighty countervailing considerations that can override the prima facie duty not to assist in a patient's death.

It is important to recognize the limitations of our argument in this essay. Professional integrity does not encompass the whole of medical ethics. Moral considerations other than the norms of professional integrity may be appealed to in favor of, or against, permitting a practice of limited physician-assisted death. We have argued elsewhere that an experimental public policy of legalizing the practice should be undertaken, subject to stringent regulatory safeguards to protect vulnerable patients and to preserve the professional integrity of physicians.[29] In this essay we have focused on the narrower question of whether the practice as a last resort can be compatible with the professional integrity of physicians. We believe that an affirmative answer to this question constitutes a necessary condition for legalization.

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Physician-Assisted Suicide and the Profession's Gyrocompass

by Steven H. Miles

In recent years, a substantive ethic for the ends of medicine (one going beyond process values such as honesty) has often been taken for dead—as the scary fossil of Paternalosaurus Rx or the relic of Saint Hippocrates. Vital ethics has been autonomy centered, correcting the abuses of a silent clinician-patient relationship and its arrogant assumptions regarding the values that guide the healing encounter. Autonomy-based ethics, however, has long since moved from empowering persons to refuse or choose any therapy or experiment. It has become a comprehensive ethic in which individually or contractually defined norms for medicine supplant professionally grounded boundaries for medical practice. Miller and Brody's effort to understand how a substantive ethic of medical professionalism applies to physician-assisted suicide is admirable.

A professional ethic is a gyrocompass pointing in a precalibrated direction. Ideally, it forces a prolonged testing of ideas that the present moment would otherwise too quickly accept. It is neither a dead letter nor a scriptural truth. It bears a message of moral reflection from the past and may properly be recalibrated in the evolving dialogue between the profession and the society that values it, about the profession's goals, accountability, and duties. It does not legislate. Constructing professional ethics is difficult in a modern society where internationalism, skepticism, and respect for pluralism are fundamental values. Even so, the influential ethic against physician participation in torture and on human subjects research demonstrates the vitality of these constructions. Amendments must be forged over time in response to the changing relationships between patients, clinicians, and society.

A professional ethic neither trumps all countervailing claims nor capitulates to any state or powerful individual. Its balancing weight is not simply the force of present arguments or powers, but derives from the way the norms have been constructed in the history of the profession. This kind of ethic is cultivated as the prudential voice of a historical community.[1] It is created out of the values of the society, whose political powers it reflects. It speaks from its own practical experience in moral problem solving.[2]

Brody and Miller argue that the exceptional practice of voluntary physician-assisted suicide can be compatible with physicians' professional integrity. To assess their claim, it is necessary to distinguish four different ways of relating a professional ethic to public permission for physician-assisted suicide.

- **Case 1:** A person (who happens to be a physician) in an intimate relationship with a very ill person (perhaps her patient) uses medical knowledge or equipment to assist a suicide.
- **Case 2:** A physician assists a patient with intractable suffering to commit suicide.
- **Case 3:** Public policy is to grant persons the right and means to commit suicide under certain circumstances and permits physicians to assist in this act.
- **Case 4:** Public policy grants physicians the exclusive authority to assist and supervise persons in the

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