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The Compatibility Between Physician-Assisted Suicide and an Internal Morality of Medicine

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I. Introduction

Three well-known explanations attempt to identify the origin of morality in medicine: (1) the internal morality explanation, external morality explanation, and a composite explanation composed of various parts from the first two. While the composite explanation circumvents issues that the internal/external explanation experience, it ultimately generalizes medicine's norms, values, and goal(s). That is not to say that the composite explanation is worthless or inadequate in general. However, various physicians, lawyers, medical groups, and the general public tend to recognize either the historical values, practices, and traditions of medicine or take a more progressive understanding of medicine. When new practices emerge, such as with physician-assisted suicide, a large divide tends to occur with individuals finding themselves on either the internal or external morality side. For instance, Edmund D. Pellegrino, a famous American bioethicist, supports an internal morality of medicine. While there is nothing inherently wrong with supporting an internal or external morality of medicine, there seems to be a misunderstanding when examining physician-assisted suicide. In "Some Things Ought Never Be Done: Moral Absolutes in Clinical Ethics," Pellegrino explicitly states that a physician must never kill a patient and that such an action is contrary to the end goal of medicine (Pellegrino, 2005, p.475). In this paper, I argue that physician-assisted suicide is compatible with medicine's internal morality because it does not: obscure the moral norms central to medicine, alters the role and duty of a physician or agitates medicine's end goal. In the first section of my paper, I will lay out Pellegrino's notion of medicine's internal morality and address why such morality needs to originate internally rather than externally. In support of the internal argument, I will use Pellegrino's article "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." In the second section, I focus on defining physician-assisted

suicide and euthanasia to show their difference. In the third section of my paper, I will show how physician-assisted suicide is compatible with medicine's internal morality by showing how it does not: obscure the moral norms central to medicine, or alters the role and duty of the physician, or agitates the end goal of medicine. In the fourth section, I will provide one counter-argument in regards to the compatibility of physician-assisted suicide and the internal morality of medicine, specifically focusing on physician-assisted suicide as a radical expression of the patient's autonomy. Finally, I will conclude with a summary of my paper.

II. Internal Morality

Pellegrino's notion of medicine's internal morality draws inspiration from different individuals such as John Ladd's, Leon Kass', and Alasdair Macintyre's work (Pellegrino, 2001, p.562). However, Pellegrino heavily leans on MacIntyre's work to justify his stance, explicitly relying on MacIntyre's revitalization of the Aristotelian concept of ends in his book *After Virtue*. MacIntyre applies the Aristotelian concept of ends to a practice or profession and states that a practice is a cooperative arrangement between one and others that seek goods that are internal to it through excelling at said practice (MacIntyre, 2007, p.187). What's important to note here is that MacIntyre's concept of practice applies to all professions such as law, medicine, gymnastics, etc., and that internal goods are goods achieved through achieving excellence in those professions. For instance, Pellegrino provides the example of the practice of medicine and how excellence in healing is an internal good while making money from the practice of medicine is an external good (Pellegrino, 2001, p.562). Although Pellegrino heavily relies on MacIntyre, he also departs from MacIntyre's work by noting that MacIntyre emphasizes milieu and social construction (Pellegrino, 2001, p.562).

Nevertheless, Pellegrino uses MacIntyre's concept of practice to support his claim that the practice of clinical medicine aims towards various goods that reside internal to it such as the (1) medical good, (2) the good for humans, and (3) the spiritual good. First, the medical good occurs when the physician properly uses their medical knowledge to treat a patient. (Pellegrino, 2001, p.569). Second, the good for humans ensures that a patient's perception of the good ultimately rests on what is good for a human as a human, such as preserving a patient's dignity (Pellegrino, 2001, pp.569-70). Third, the spiritual good allows a physician to understand a patient's values, beliefs, and choices in order to assist in treatment (Pellegrino, 2001, pp.570-1). When examining all of these goods, one comes to identify the moral norms that guide clinical practice, such as not harming other, helping others, truth-telling, respecting others, etc. (Pellegrino, 2001, p.576). With all this in mind, one might wonder what is the end goal of medicine is? In the article, "The Goals and Ends of Medicine: How Are They to be Defined?" Pellegrino states that the end goal of medicine is healing (he states various goals that essentially fall under the umbrella of the word healing, such as the words "cure" and "help") (Pellegrino, 1999, pp.62-3). After all, when a patient seeks the help of a physician, they expect a recovery or a "healing process."

However, some claim that a morality internal to medicine cannot correctly function because there are multiple end goals. In the article, "The Impossibility of an Internal Morality to Medicine," Robert M. Veatch provides various counter-arguments against the internal morality that Pellegrino supports. For instance, Veatch claims that there are various end goals in medicine aside from healing, such as prolonging life and hastening death (Veatch, 2001, pp.630-1). Veatch argues that even if an internal morality exists, it might conflict with the individual and society's morality and goals. In other words, Veatch states that the morality of medicine must originate

externally, specifically with consideration of the social culture of the area, in order to properly function (Veatch, 2001, pp.637-8). Veatch's arguments against medicine's internal morality certainly make it appear that the internal morality model is outdated.

In response to Veatch's argument against medicine's internal morality, Pellegrino would note that the practice of medicine is not socially constructed because medicine is a universal experience (Pellegrino, 2001, p.563). Similarly, to have an internal morality of medicine means that an essence exists. If one were to have a morality that originates externally from the practice of medicine, then its essence would ultimately be unknown. Without medicine's essence, the risk of moral relativism—an individual's belief or their culture's belief dictates what is right and wrong—becomes a real threat to the practice of medicine by removing the moral bedrock from medical practice. Therefore, an internal morality of medicine is essential to the universal experience of medicine found around the world and provides moral bedrock for the practice of medicine.

III. Euthanasia and Physician-Assisted Suicide

In *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life: Revised and Expanded Second Edition*, The Hastings Center defines physician-assisted suicide and euthanasia a unique way that clearly distinguishes them from each other. They define physician-assisted suicide as "...a practice...that permits terminally ill residents under certain conditions to obtain from a physician a prescription for a lethal dose of medication for voluntary self-administration" (Berlinger et al., 2013, p.205). On the other hand, they define euthanasia as "...the intentional killing of a patient by a physician, as through the physician's administration of a lethal dose of medication" (Berlinger et al., 2013, 204). What is important to note here is the notion that physician-assisted suicide merely permits a patient to

end their life. At the same time, euthanasia is the intentional killing of a patient. Similarly, the physician who practices physician-assisted suicide has a limited role in the death of the patient. More specifically, the physician merely provides the lethal medication for the terminally ill patient to ingest; on the other hand, the practice of euthanasia, according to The Hastings Center, refers to a physician killing a patient.

It is important to note that this distinction is relatively new. It is impossible to say how many physicians and medical organizations use and support this distinction, but it is certainly gaining traction. For instance, *The Free Dictionary's* medical dictionary states that there was once a distinction between active and passive euthanasia; However, now all euthanasia is considered active ('euthansia'). Active euthanasia refers explicitly to the intentional killing of a person; while passive euthanasia generally refers to the termination of extraordinary treatment—meaning treatment beyond standard medical treatment such as the prolonged use of a ventilator—when death is inevitable, and treatment only prolongs life (American Medical Association, 1973, p.140). Regardless, it appears as though the active and passive distinction is phasing out to better clarify the difference between physician-assisted suicide and euthanasia.

Although The Hastings Center's distinction between physician-assisted suicide and euthanasia greatly helps in showing how the practice of physician-assisted suicide is compatible with the internal morality of medicine, using this distinction runs the risk of contradicting an internal morality of medicine. In other words, it is only because of social change that a clear distinction has arisen between physician-assisted suicide and euthanasia. Supporters of medicine's internal morality would most likely hold onto the distinction between active and passive euthanasia. Additionally, not all physicians and major medical organizations recognize this clear distinction for one reason or another. For instance, in the *Code of Medical Ethics*, the

American Medical Association states that physician-assisted suicide is inherently incompatible with the physician's role as a healer (Opinions on Caring, 2007). Even though the American Medical Association does not mention that physician-assisted suicide is a form of euthanasia (specifically in their book, *Code of Medical Ethics*), it does acknowledge that such a practice violates the end goal of medicine and the role of the physician. In harmony with the American Medical Association's stance on physician-assisted suicide, Pellegrino notes that euthanasia runs the risk of violating human good and/or spiritual good (Pellegrino, 2001, p.572). Meaning that it ultimately violates the practice of medicine and the internal morality of medicine.

IV. Physician-Assisted Suicide and the Internal Morality of Medicine

Some may argue that there is no possibility of compatibility between physician-assisted suicide and an internal morality of medicine. However, the key to the compatibility between the two lies in the bioethical principle of beneficence.