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Death on Demand: Proper Medical Treatment?

Richard Huxtable

1. Introduction

Although the message is sometimes lost in translation, English law proclaims death-on-demand to be unlawful. Various Parliamentarians have pled the merits of a different message, that the unlawful should be rendered lawful. Their efforts have (yet?) to prove successful. Equally unsuccessful (again, so far) have been numerous attempts to petition the courts to lift the ban. Despite the Houses’ ongoing resistance, the courts continue to insist that only Parliament can pull apart the prevailing prohibition. So constrained, the judiciary is left to re-state the basic message: assisted dying is not lawful.

According to Lord Mustill, the principled basis for resisting assisted dying is that “the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy”. Mustill is not alone in pointing to the state interest in upholding the sanctity of human life. Keown suggests that the principle, which opposes the intentional ending of innocent human life, has long been a feature of English law (and, on his account, rightly so). This is no mere theistic and anachronistic hangover: article 2 of the Human Rights Act 1998, the right to life, expresses the same essential idea in a secular tongue.

The sanctity of life may dominate whenever death-on-demand enters the courtroom, but it is occasionally united with suggestions that vulnerable citizens must be protected and dangerously slippery slopes avoided. The public interest seems, therefore, to comprise various (potentially overlapping) interests. Yet, these are not always spelt out. In this chapter, I outline those indications we have from the lawmakers, focussing specifically on the proclaimed integrity of medicine and what the claim could – or should – mean in relation to death-on-demand.

It becomes apparent that medicine is protected in and by the law; “proper medical treatment” is exempted from some of the rules that might otherwise inhibit its practitioners. Should medically-assisted dying also be exempt? I suggest that medicine’s “internal morality” appears not to provide a necessary answer to this question and, indeed, that any such answer would be insufficient, since we need also to look to the wider public interest. But we will see that this too is a contested concept. Ultimately, we cannot escape a values choice, such as that between autonomy and the sanctity of human life.

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1 See R Huxtable, Euthanasia, Ethics and the Law: From Conflict to Compromise (Routledge-Cavendish 2007).
2 “Death on demand” refers to requests for (active) voluntary forms of assistance in dying (i.e. voluntary euthanasia and assisted suicide), which are motivated by a desire to avoid current or anticipated suffering.
3 E.g. Lord Joffe’s Assisted Dying for the Terminally Ill Bill and, more recently, Lord Falconer’s Assisted Dying Bill.
4 E.g. R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions [2014] UKSC 38 (SC).
5 E.g. Nicklinson (n 4) [116] (Lord Neuberger), [343]-[344] (Lord Kerr).
7 See Huxtable (n 1) 131-133.
9 E.g. Nicklinson (n 4) [228]-[232] (Lord Sumption).
10 E.g. protecting the vulnerable might be connected with upholding the sanctity of life.
I do not here seek to specify the “right” choice of values which should guide our laws or even the “right” combinations thereof (whatever these might be). I do, however, hope to show why appeals to the integrity of medicine, “proper medical treatment”, and the public interest cannot do the necessary moral work: this remains work for us to do, collectively, as members of a society which is contemplating – and may be edging nearer towards – the legalisation of assisted dying.

2. Proper Medical Treatment and the Public Interest

When the demand before the court is “help me to die”, the sanctity of life tends to dominate. Yet, other state interests evidently occupy the judges’ minds, although these are rarely spelt out. In Robb, however, the demand was “allow me to die”. Thorpe J ruled that hunger-striking Mr Robb could not be forcibly fed, as his decision had been competently reached. Thorpe J was refreshingly open about the state interests in issue in the case: “(1) preserving life; (2) preventing suicide; (3) maintaining the integrity of the medical profession; and (4) protecting innocent third parties”. In this particular case, autonomy triumphed, since it was judged to outweigh the obligation to protect life; furthermore, the refusal of food was not considered equivalent to suicide, the integrity of the medical profession was not found to be directly engaged, and there were no (pertinent) third parties judged to be in need of protection.

Thorpe J is not alone in citing these particular state interests. In Brady, Kay J referred to the same list, albeit reaching the opposite conclusion about the legitimacy of force-feeding this particular (notorious) prisoner. He hoped that the law had not reached the point “where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing” Both judges had acquired their lists from a US authority, Thor, in which, as in Robb, the patient’s right to refuse even life-sustaining intervention had been upheld. In such cases, provided that the patient is indeed autonomous, autonomy will outweigh any state interests in protecting people or protecting a particular profession. Of course, the possibility remains that the order of priority will be reversed in other cases – which is precisely what happens when the patient seeks active assistance in dying.

Given the apparent role that they play in denying death on demand, these different state interests invite further investigation, not least the idea that the integrity of the medical profession merits protection, including from the autonomous claims of some patients. Medicine, it seems, is special, and it deserves special protection. The law has accordingly created a special exception, by which doctors can avoid the taint of criminality that might otherwise impede their practices. As, again, Lord Mustill famously put it:

“Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability. Actual consent ... is an essential element in this immunity; but it cannot be a direct explanation for it,

12 Robb (n 11) 131.
15 Brady (n 13) 367.
since much of the bodily invasion involved in surgery lies well above any point at which consent could even arguably be regarded as furnishing a defence. Why is this so? The answer must in my opinion be that proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own”.  

His Lordship had made similar comments in Bland, while earlier, in Attorney-General’s Reference (No 6 of 1980), Lord Lane had referred to “the accepted legality of … reasonable surgical interference”, which he judged to be “needed in the public interest”.  

The law therefore suggests that proper medical treatment should be afforded the (legal) space to thrive. Notice, in the above passages, that respect for patient autonomy (and thus consent) does not wholly determine the propriety of medical treatment. Autonomy is a component of proper medical treatment but it does not do all of the heavy lifting; quite what does, and therefore what is to count as proper medical treatment, and who is to say so, are nevertheless open to interpretation. To a significant extent, the law seems content to leave the identification of the precise parameters and their policing to the profession itself. The medical profession accordingly has the freedom to self-govern, with the General Medical Council (GMC) setting the relevant standards and overseeing doctors’ compliance therewith.

Doctors who fail to satisfy the GMC’s standards of good medical practice can be disciplined and removed from the profession where necessary. Notably these standards themselves refer to the importance of integrity: individual professionals are instructed to behave with integrity, so that public trust can be maintained, in order to sustain the integrity of the profession itself.

The scope afforded to doctors’ views of good doctoring in the quasi-law of the GMC is further replicated in the law itself, not least in the all-conquering Bolam standard.

According to this standard, which originated in the civil law of clinical negligence, a doctor will satisfy the standard of care expected of her if she acts in accordance with a practice accepted as proper by a responsible body of professionals skilled in that particular art. So far, so good, perhaps, at least insofar as this phrase appears simply to translate the “reasonable person” standard into the “reasonable doctor” standard. Bolam’s reach – indeed, the Bolamisation of medical law – has nevertheless caused alarm. Doctors’ views about what doctors (should) do has certainly proven determinative of all manner of medico-legal dilemmas, from the provision of information in the consent process, to judging the best interests of incapacitated patients, to the withdrawal of life-sustaining treatment therefrom. But it is not merely the case that the law allows doctors to determine how they should do what they do; it is also apparent that doctors are legally entitled to do that which the rest of us cannot. The suspension of otherwise general rules does not only

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17 R v Brown et al [1993] 2 All ER 75 (HL), 109-110 (Lord Mustill).
18 Bland (n 6) 891 (Lord Mustill).
20 Medical Act 1983, s 35.
21 General Medical Council, Good Medical Practice (General Medical Council 2013).
22 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
24 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 (HL).
25 Re F (Mental Patient: Sterilisation) [1990] 2 AC 1 (HL).
26 Bland (n 6).
empower surgeons.\(^{27}\) in life-or-death situations, exceptions are also made,\(^{28}\) such that doctors – but not non-doctors – can refrain from providing the necessities for life,\(^{29}\) and can run the (admittedly, small) risk of shortening patients’ lives when relieving their symptoms.\(^{30}\) The freedom also extends to decisions \textit{not} to do certain things. The courts appear resistant to prescribing for doctors: they will not \textit{order} doctors to act contrary to their clinical judgment.\(^{31}\) The judges will declare the law: they will not prescribe the course.

Doctors are therefore protected and empowered, but they are not entirely free from oversight or constraint: the courts will still peer over the shoulders of the doctors and, indeed, of the GMC.\(^{32}\) Indeed, the propriety of proper medical treatment is not wholly determined by the profession itself. This should not be surprising because, as Thorpe J and Kay J indicated, the state’s interests encompass more than the integrity of the medical profession. As agents of the state, the judges (and, of course, Parliament) will erect boundaries around what even doctors can do, presumably by reference to other important state interests. There will sometimes be external, and critical, scrutiny of doctors’ practices: \textit{Bolitho},\(^{33}\) for example, issued a reminder that the courts ultimately assess the defensibility of doctors’ chosen standards.\(^{34}\) The law has also moved on from a \textit{Bolamised} view of information disclosure and the best interests of patients.\(^{35}\) Sometimes accepted practices must be modified in the wake of court rulings,\(^{36}\) and, occasionally, medical personnel might be at greater risk of liability or culpability than the rest of us. For example, prosecution guidance on complicity in suicide appears to render doctors particularly vulnerable.\(^{37}\) As such, even if doctors are willing in principle to offer this (or any other) form of assisted dying, the law currently instructs them not to do so in practice, unless they are willing to accept the adverse consequences.\(^{38}\)

The continued illegality of death-on-demand might rest, albeit partially, on doctors’ own views of the demerits thereof. Many such professional organisations oppose a permissive repositioning of the law, and research reveals a strong palliative care ethos in this jurisdiction (doctors in this specialty, at least in this country,\(^{39}\) appear

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  \item E.g. Female Genital Mutilation Act 2003, s 1(2).
  \item \textit{R v Adams} [1965] Crim LR 365.
  \item E.g. Medical Act 1983, s 40.
  \item \textit{Bolitho v City and Hackney Health Authority} [1998] AC 232 (HL).
  \item See e.g. \textit{Chester v Afshar} [2004] UKHL 41 (HL), \textit{Re A (Medical Treatment: Male Sterilisation)} [2000] 1 FLR 549 (CA), and Mental Capacity Act 2005, s. 4.
  \item See e.g. Miola (n 23) 173-185.
  \item Director of Public Prosecutions, \textit{Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide} (Crown Prosecution Service, February 2010); General Medical Council, \textit{When a Patient Seeks Advice or Information about Assistance to Die} (General Medical Council, January 2013).
  \item Although, for whatever reason, prosecutions and convictions are in fact scarce: Huxtable (n 1).
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resistant to such a development). More often, however, the courts explicitly refer to protectionist norms, and particularly to the need to uphold the sanctity of life, when they rule against assisted dying. In Bland, Lord Keith opined that the sanctity of life “is the concern of the state, and the judiciary as one of the arms of the state, to maintain”. These sentiments echo those of the judge in Thor, who usefully identified “two separate but related aspects” to this “paramount concern”: “an interest in preserving the life of the particular patient and an interest in preserving the sanctity of all life.”

So much for what the law happens to say: what should be said? In order to assess the appropriateness of the legal prohibition, we need to take a more critical look at the apparently prohibitive principles, and particularly the integrity of medicine.

3. Death-on-Demand and the Integrity of Medicine

Permissive proposals for assisted dying typically empower physicians as providers, so surely their professional integrity, and any impact thereon, is a crucial concern? However, integrity is a complex concept. Personal integrity can be characterised in terms of an individual’s deep desires or her identity-conferring values. It can also be tethered to general moral constraints: maybe a person only has integrity if she stands for something that is objectively morally worthwhile. Benjamin tries to unite the accounts: a person of integrity will strive for consistency, in the sense that she honours her own values, and also wholeness, since she will be responsive to other external values and will, where appropriate, yield to these. Balancing these competing commitments might prove difficult on occasion but the individual must somehow seek to preserve her integrity, if she is to maintain her self-respect.

These same concepts – and same challenges – can be encountered amongst groups. Any group with a particular identity can be said to possess (or judged to lack) integrity. Miller and Brody, for example, suggest that:

“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.”

So what, then, is the distinctive identity of medicine and what are the moral considerations to which it gives rise, as well as those with which it should engage? In seeking to answer these questions, various commentators have contemplated the “internal morality” of medicine, along the lines first explored by Fuller, in his

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41 Bland (n 6) 859 (Lord Keith).
42 Thor (n 16) [8].
45 M Benjamin, Splitting the Difference: Compromise and Integrity in Ethics and Politics (University Press of Kansas 1990).
46 See e.g. DP Sulmasy ‘What is conscience and why is respect for it so important?’ (2008) 29 Theoretical Medicine and Bioethics 135, 136.
examination of the internal morality of law. Fuller sought to identify the nature of the particular practice and the norms its practitioners should observe, if the practice is to succeed (or even be labelled) as such a practice. This was a conceptual quest, not an empirical enquiry, and we too are interested here in what medicine involves and entails by definition, irrespective of the values its practitioners happen in fact to espouse.

The basic structure of Fuller's account is as follows. For Fuller, law (making) is the enterprise of guiding people's behaviour via rules. From here arises an overarching obligation, implicit in the nature of the enterprise: there must be rules, which are capable of guiding the relevant subjects. From this end, there then arise more specific instrumental obligations: the lawmaker should issue rules (as opposed to specific edicts), which should be clear, constant, non-contradictory, promulgated, prospective, possible of performance, and administered in a manner that is congruent with their official articulation.

Accounts of the internal morality of medicine can be re-constructed along Fullerian lines. First, consider Pellegrino's account, which builds on work by MacIntyre, and (especially) Kass. For Pellegrino, (clinical) medicine appears to be the enterprise of promoting and protecting the good of the whole person of the patient, with particular reference to his or her health. From here arises an overarching obligation: to serve the patient's good, the clinician should promote and protect the medical good (which requires technical competence), the good as perceived by the patient (which requires respect for their autonomous wishes), the good for the patient as a human being, and the spiritual good. From this end, there then arise more specific instrumental obligations, which Pellegrino depicts as virtues that should be exhibited by the medical practitioner, if she is to serve the end of the person's (overall) good: fidelity to trust; suppression of self-interest; intellectual honesty; compassion; courage; and prudence (so that the best means are chosen).

Miller and Brody offer an alternative account, according to which (clinical) medicine is a multi-faceted enterprise, which encompasses healing, promoting health, and helping patients to achieve dignified and peaceful deaths. From here arise the overarching obligations on medicine's practitioners: to heal, promote health, and help patients to achieve dignified and peaceful deaths. From these ends arise instrumental obligations on the practitioners: to be competent; to avoid harms when conferring benefits; to avoid fraudulent misrepresentation (and departure from accepted standards); and to maintain fidelity to the therapeutic relationship (thus maintaining patients' trust).

There are striking differences between these accounts. First, there is a significant difference between, on the one hand, Fuller's internal morality of law and, on the

49 Similar distinctions between what is and should be the case feature in analyses of the Bolam (n 22) standard: e.g. Miola (n 23) 11-12.
50 Veatch (n 48) 623-5, 627. Of course, these elements can be difficult to disentangle: as an autonomous individual, I can presumably choose my values, and perhaps so can a profession, if we link integrity to identity or desires. Big shifts in the values might mean that I, or the profession, become something other. I will leave such disentanglement to others.
52 Although particular theorists might disagree, Veatch suspects that such accounts commonly look to an "end" or "goal" for medicine: Veatch (n 48) 627.
54 A MacIntyre, After Virtue (3rd edn, University of Notre Dame Press 2007).
55 LR Kass, 'Regarding the end of medicine and the pursuit of health' (1975) 40 Public Interest 11.
other, both of the attempts to specify the internal morality of medicine. Fuller had positioned himself amongst jurisprudence’s natural lawyers, rather than its legal positivists. As such, he believed there to be a necessary connection between law and morality. Fuller suggested, for example, that his desiderata provided the ground-rules for social co-existence, and that their observance “affects and limits the substantive aims that can be achieved through law”, which thereby made them moral.56

Critics like Hart disputed the “morality” of Fuller’s internal principles.57 Certainly, Fuller seemed to stop short of supplying any substance to the ends of law; his account has a degree of moral content and orientation,58 but it is less substantive than other natural law theories.59 Of course, neither Pellegrino nor Miller and Brody are so reticent about stipulating the substantive ends of medicine. Fuller’s definition of law, and his ensuing norms, appeared to leave open important questions about the appropriate moral content that the rules should capture. The theorists of the internal morality of medicine, however, appear to beg such questions – they seem to insist that there are particular moral messages that medicine should be imparting about particular activities. These accounts, therefore, beg the specific question about the moral permissibility of physicians offering death on demand. But here a second difference emerges: Pellegrino insists that assisted dying is written out of medicine (as unacceptable by definition), while Miller and Brody take the opposite view. Pellegrino’s prohibitive position is initially apparent from his alignment with Kass. According to Kass, medicine is an inherently ethical practice, which is orientated towards the end of health. Its internal values are explicitly said to encompass the injunction: “do not kill”.60 Pellegrino follows Kass’ Aristotelian approach, explicitly adopting an essentialist, teleological and realist position.61 His promotion of a transcendent and spiritual account of the good, rather than one autonomously chosen by the individual, ultimately reveals his fundamental allegiance to Roman Catholic values: “What the patient describes as good for himself – cloning, let us say, or self-mutilation, human embryo research, euthanasia – may violate the good for humans or the spiritual good. The good perceived as good by the patient is not to be a moral law in itself”.62 Since medicine is aimed at the good, which on this definition excludes assistance in dying, physicians’ provision of assistance in dying would violate the integrity of medicine.

While Pellegrino and Kass evince Hippocratic beneficence,63 and postulate a prohibitive position on assisted dying, Miller and Brody point to a permissive position. Miller and Brody anticipate an allegation of question-begging, for including in medicine’s goals the provision of a dignified death.64 They, quite reasonably, note that some advocates of this goal nevertheless resist the allure of assisted dying,65 so they see no necessary connection between this goal and that activity. But they still

56 Fuller (n 51), 184.
58 See R Huxtable, Law, Ethics and Compromise at the Limits of Life: To Treat or not to Treat? (Routledge 2012), 18-20.
60 Kass (n 55).
61 Pellegrino (n 53) 560.
62 Pellegrino (n 53) 572.
64 Miller and Brody (n 47) 11.
happen to think that the activity can be considered compatible with the medical enterprise – so, presumably, they perceive some sort of necessary connection. Admittedly, they do not place any doctor under a duty to assist in dying; instead, they leave this to the doctor’s discretion, suggesting at most that it can be “justifiable only as a last resort”.66

As such, Miller and Brody critique the prohibitionists (specifically, Kass) and they argue that medicine’s core concern with respect for the person need not rule out assisted dying.67 The willing doctor will still need to be competent: she should not, for example, offer assistance in dying, when palliative care “is capable of relieving patients’ suffering to a satisfactory degree”.68 But such care should not be imposed on patients.69 Nor should death always be regarded as more harmful than beneficial. However, the physician is no mere technician or tool of the patient: professional integrity “excludes physician assistance on demand”,70 so the physician must still “be convinced that this course is the best option for the dire situation of this particular patient”.71 Miller and Brody admit that assistance in dying will lie outside mainstream practice, so willing professionals might plausibly be charged with fraudulent misrepresentation. Despite this, they suggest that departures from accepted standards can be justified (as is the case with research), provided that there are suitably robust qualifying criteria, which encompass medical indications (such as the patient’s suffering and their mental capacity), as well as the patient’s subjective appraisal of their situation. They finally submit that trust need not be abused, nor patients abandoned, if a policy that permits assisted dying is formulated along such careful lines.72

Momeyer works towards similar conclusions. He finds Kass’ promotion of Hippocratic ideals to be too vague, general and selective: for example, robust adherence to a Hippocratic ethic would also require physicians to honour a panoply of Ancient Gods.73 Momeyer does join Kass in suggesting that medicine’s end includes healing; unlike Kass, however, he believes the end to be stipulated by humans, rather than by nature,74 and he thinks that there are other important values also to be served in and by medicine, such as “respect for patient values, or preservation of patient dignity”.75 For underplaying such values, Momeyer charges Kass with favouring an illiberal, paternalistic prioritisation of the doctor’s view of the patient’s good.76 He admits that respect for autonomy is sometimes taken far and, like Miller and Brody, accepts that external arguments will have a bearing on the legitimacy of assisted dying.77 Ultimately, however, Momeyer rejects the idea that assistance in dying “is incompatible with the very nature of medicine or the essential identity of physicians as healers.”78

66 Miller and Brody (n 47) 12.
67 Miller and Brody (n 47) 12-13.
68 Miller and Brody (n 47) 13.
69 Miller and Brody (n 47) 13.
70 Miller and Brody (n 47) 14.
71 Miller and Brody (n 47) 14.
72 Miller and Brody (n 47) 15.
74 Momeyer (n 73) 17, 19.
75 Momeyer (n 73) 20.
76 Momeyer (n 73) 21.
77 Momeyer (n 73) 22-23.
78 Momeyer (n 73) 23.
4. The Integrity of Medicine: Neither Necessary nor Sufficient?

Traditionalists therefore claim that assisted dying is incompatible with the integrity of medicine, but others maintain that, whilst not mandatory, neither is it incompatible. Both sides appear to reach these conclusions by writing assisted dying into or out of the essence of medicine from the outset. In so doing, each side begs the question as to whether assisted dying can be compatible with the integrity of medicine. Maybe this is not entirely problematic, if one or other of these accounts captures the essence (and internal morality) of medicine. As it is, however, we can dispute the necessity of each account and, correspondingly, each of the different answers given about medicine’s compatibility with assisted dying. Indeed, the fundamental question about the permissibility of assisted dying will still remain open even if a necessary account can be settled upon: we cannot hope to arrive at a sufficient answer to that question merely by reflecting on the nature and internal morality of medicine. Let us consider each of these problems in turn.

First, we cannot establish which, if either, of the rival accounts is superior, in the sense that it offers a necessary view of the nature of medicine. Veatch identifies three problems with the entire enterprise of identifying an internal morality: first, medicine encompasses many roles and many ends; secondly, even within a single medical role, there may be more than one end being served; and, finally, even if we could determine a single end for medicine, an outside view will still be needed on the appropriateness of that end.79 Veatch’s first two allegations initially undermine Miller and Brody’s position. Miller and Brody saw medicine as encompassing different goals and its core values as susceptible to evolution. Miller and Brody’s openness to the fact of change suggests that they are not directly concerned with the essential nature of medicine – unlike Pellegrino and, importantly, Fuller. Fuller wanted to capture the essence of law, whatever its rules happen to say and wherever they happen to be said. Like Miller and Brody, Veatch appears troubled by the complexity – and apparent impossibility – of the task of describing the goals of medicine. Notice, for example, how he comments: “The awful truth is that different cultures seem to shape the terrain of medicine very differently”.80 Mapping medicine – and its morals – seems, on this view, to be too vast a task, so we cannot hope to specify a single secure answer as to the rightness or wrongness of a particular activity like assisted dying.

Veatch has a point but perhaps he, like Miller and Brody, is wrong to embark down this empirical avenue. The mere fact that, in practice, medicine has many goals and can accordingly encompass many means arguably tells us nothing about whether medicine, by definition, has any particular goal or goals, such that it should encompass only particular means. However, Veatch does appear to recognise that the alternative to the empirical avenue is a contestable conceptual cul-de-sac. As such, even if we seek to glean the essence of medicine, like Pellegrino, we still encounter difficulty. A more charitable reading of Veatch’s position would suggest that he disputes the feasibility of arriving at a suitably agreeable concept of medicine.81 Pellegrino, of course, offered a particular take on the essence of medicine. Perhaps, if we extend our charity to Miller and Brody, they too were seeking some sort of conceptual essence (albeit one that would be open to

79 Veatch (n 48) 628.
80 Veatch (n 48) 631.
81 We might similarly ask whether Fuller provides a defensible definition of the essence of law.
evolution). Both accounts do at least converge, albeit partially, on medicine’s concern with health and healing. The problem with even this essence is that it is still difficult to see what medicine, by definition, should therefore say about the legitimacy of assisted dying.

“Medicine”, says Beauchamp, “is a vague and inherently contestable concept”.82 “Health” seems no less elusive,83 since it can align with very different versions of value theory: perhaps health is about quality of life; perhaps it should be considered as, or in light of, an objective good (like life itself); or perhaps it requires reference to people’s own preferences.84 Pellegrino favours an objective account of health, which forbids the intentional ending of life; autonomy matters, but it is not the fundamental value. Miller and Brody, meanwhile, allow more room for preferences, although, in doing so, they skirt a very fine line between defending values internal to and external from medicine.85 Although they depict autonomy as a value outside the internal morality of medicine,86 these authors additionally suggest not only that it would be contrary to the endeavour to impose unwanted treatment on patients,87 but also that trust, which is essential to the endeavour, requires reference to patients’ considered judgments.88 In making these points, Miller and Brody either smuggle in values from outside medicine or they implicitly allow that the goals of medicine do include due regard for the patient’s autonomy. Certainly, their enthusiasm for autonomy is not unbridled: for example, they do not support death-on-demand as such.89 Yet, whatever role autonomy is playing in their particular argument, it still seems plausible that health and healing might require recourse to the patient’s own preferences; but, at the same time, we might also think that Pellegrino has a point about medicine’s concern with health as a more objective end.

If medicine has an essence, we might suppose that one of these rival readings must be superior. Of course, determining the victor has proven – and will likely long prove – difficult.90 But maybe we do not need a single victor; perhaps, indeed, a dose of agnosticism can salvage the very enterprise of specifying the internal morality of medicine. Fuller, you will recall, restricted the concept of law to guiding action via rules, from which end particular norms then arose. He left open the question of the substantive content of the rules themselves. Perhaps we can do the same for medicine, for example by saying that medicine is all about health (from which particular norms will flow), but then declining to give any particular content to the concept of health. Leaving ourselves open to variation, somewhat akin to Miller and Brody, would allow us to focus on form as opposed to substance. Then, however, we would confront a new problem: we would be left with little (perhaps no) idea about what medicine should involve or require and, accordingly, about the legitimacy of assisted dying as judged from within medicine. And there is a bigger problem here: resolving the rightness of the different views thereon, and more specifically the right

85 Beauchamp suspects that they ultimately prioritise external values: Beauchamp (n 82) 605-7.
86 Miller and Brody (n 47) 12.
87 Miller and Brody (n 47) 13.
88 Miller and Brody (n 47) 15.
89 Miller and Brody (n 47) 14.
90 DeGrazia (n 84) and Beauchamp (n 82) make similar points about the varieties of value theory and moral theory, respectively.
answer to the question of death-on-demand, is not something we can achieve merely by looking to, and in, medicine.
It appears that, even if we could resolve the end or essence of medicine, and thereby its means, this alone cannot tell us whether the end, essence or means, are good. As Dixon comments, “Whether a doctor’s participation in active euthanasia is a violation of her integrity depends on whether the act is wrong, so we cannot without circularity use the concept of integrity to prove that it is wrong”. Dixon here appears to adopt an external view on integrity, in which integrity is not merely about one’s identity or deep desires, but is instead about standing for the (objectively) right things. Since, on this view, rightness is prior to (and constitutive of) integrity, we cannot reverse the order of priority and use integrity to establish rightness or wrongness. Of course, we might depart from Dixon and prefer to see integrity as tied to identity or desires. But even the individual (and, by extension, the group) that is integrated on such a basis cannot avoid external appraisal: I may sincerely cleave to certain values and ways of being, but I can still legitimately be subject to moral censure.

Here we reach Veatch’s third criticism, that even if we could determine an end for medicine, we will need an outside view on the appropriateness of that end. “The ends of promotion of health and healing”, says Veatch, “are themselves meaningless unless one turns outside medicine to know whether the ends are worth pursuing”. Beauchamp joins him, in suggesting that an internal “morality is not self-justifying by its own internal norms”. Medicine’s ends, Veatch continues, are “inevitably derived from the ends of the human as seen – imperfectly – by the broader society”. We therefore need to look beyond medicine in order to judge its practitioners’ activities. Implicit in the indications of Thorpe J et al is the idea that medicine is protected because it provides something of social value. Freedman would seem to endorse this interpretation, as he suggests that a profession – and therefore its internal morality – is granted a privileged position in, and by, society.

“The internal morality of law …, as the internal morality of medicine, rests ultimately on society’s commitment to preserving and ensuring continuation to a value through allocating it to be especially safeguarded by concerned professionals in society. By adopting a profession with its central value, society has given warrant to corollaries of that value to be pursued irrespective (sometimes) of, for example, simple considerations of utility”. On this account, society wants medicine to protect its core values, whatever these happen to be.

Here we return to where we began. Perhaps the judges had it right: the integrity of medicine, as a component of the public interest, deserves protection. Veatch, of course, would not want the purported integrity of medicine to do any heavy moral lifting. However, we should remain mindful of the aforementioned problem of (self-) disrespect. Maybe some room should be allowed for the profession’s self-conception. But now our familiar problems also return: we cannot resolve what the

92 To think otherwise would mean that anything goes, which would allow a particularly impoverished account of autonomy (and/or liberty) to triumph.
93 Veatch (n 48) 635.
94 Veatch (n 48) 607.
95 Beauchamp (n 82) 639.
96 Freedman (n 63) 17.
97 Furthermore, identity might consequently alter, such that the entity becomes something other.
internal morality of medicine requires, allows or prohibits, as the necessary core is too amorphous and, even if we could, a view from within will be insufficient to resolve the general moral questions about what should be required, allowed or prohibited. If, then, we are seeking to resolve a general question about the legitimacy of assisted dying, we must look to the source of medicine’s purported legitimacy i.e. to morality and to the society in question. In short, we must turn to the public interest.

5. Death-on-Demand and the Public Interest

Unfortunately, the “public interest” is another amorphous concept. The sorts of claims that are usually advanced, in law, in the name of the public interest can be distinguished according to whose interests are in issue: my interests, your interests, or our interests. Sometimes (as we see in mental health law) my liberty will be limited in order to protect my welfare. Alternatively, there might be a public interest in protecting you from me – this is certainly a theme of the rulings denying death-on-demand. Finally, the public interest will sometimes be said to protect us collectively, such as when a purportedly objective ethical principle, like the sanctity of human life, operates to prevent contrary demands from being met.

Yet, the law appears to lack a consistent or clear approach to the public interest. Although life sometimes trumps choice, in-roads have been made into the sanctity of life, and sometimes choice does trump life (specifically if the claim is “allow me to die”). Neither is it clear how the particular interests – in autonomy, say, or welfare – are being conceptualised or even the level at which they operate. For example, some judges depict autonomy as a private interest, whilst others see respect for autonomy as part of the public interest:

“There are some moral values, of which the state is the proper guardian, with no rational or utilitarian justification, but which are nevertheless accepted because they are fundamental to our humanity and to our respect for our own kind. The principle of autonomy is one of these values”.

On this account, autonomy stands shoulder-to-shoulder with the sanctity of life. The problem, of course, is that each happens in fact to compete with the other, with neither emerging wholly victorious in law. Can a victor be found in principle? In order to determine a victor, we need an account of what the public interest should encompass, and how it should resolve the different claims that are advanced by different individuals and groups. According to Held, accounts of the public interest tend to fall into three categories: preponderance (or aggregative) theories; unitary theories; and common interest theories. Each deploys a different concept of “interest” and differs in its conception of the relationship between the public interest and the interests of individuals.

Preponderance theories adopt a subjective account of “interests”, in which individuals determine their interests according to their preferences. The public interest therefore aggregates these preferences, in a utilitarian fashion, and the

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99 E.g. Huxtable (nn 1 and 58).
100 Nicklinson (n 4) [267] (Lord Hughes).
101 Nicklinson (n 4) [208] (Lord Sumption).
103 This aligns with one version of value theory: see DeGrazia (n 84).
general will dictates matters of social policy. According to such an approach, the public interest requires respect for autonomy – or, at least, respect for the autonomous choices of the majority. This leaves the account susceptible to the charge that no practicable mechanism exists “for determining what is in the interest of a preponderance of individuals”. Furthermore, the minority – whoever these are – seems doomed to lose out. We see these sorts of difficulties arise in relation to assisted dying. Do a majority of people genuinely want the option of death-on-demand? And, even if they did, can the interests of the minority be sufficiently protected if such a policy is adopted?

Unitary theories take a different approach. Here, the public interest is an overriding interest, which is tied to objective accounts of the good, and thus to what people should want or should receive. The problem with this approach is that it will be difficult to determine that which serves – or pleases – everyone. Specifying the objective good is notoriously difficult: for example, life might generally be worth protecting, but not everyone will want such protection at all times. There are echoes, here, of the problems that Momeyer detected with Kass’ position on the internal morality of medicine, since we run the risk of affording too little room to autonomous choice.

Perhaps common interest theories can fare better. Here, the interests in question are those that all individuals have in common. Barry, for example, combines subjective and objective positions. Individuals should be free to pursue their own conceptions of the good life and it is in the public interest to ensure that they have the opportunities to do so. People will advance quite different claims, but Barry recommends looking to the elements that are common and universalisable: these make up the distinctive public interest. For Barry, the public interest refers to the promotion of collective welfare (broadly defined), but it is not the only consideration when designing public policy. Sometimes the public interest will conflict with other considerations. So, for example, there might be a public interest in ensuring public safety. If one individual is to benefit from such an interest, then so must everyone else. Certainly, some will fall foul of a rule designed to ensure public safety; they might feel, for example, that they should not be imprisoned. Such concerns can be addressed in the ways in which the rules are designed or applied. As such, there might be other goals which the public will occasionally choose to prioritise over the collective good; equally, sometimes, subjective preferences will give way to other important goals. As McHarg clarifies, “The balance struck between competing interests and goals in any situation will inevitably reflect a value choice, but not one which purports to eradicate the initial conflict”. McHarg admits, however, that a common interest theory might still be of limited application, since people will not agree about the goals that society should adopt or the best means of achieving these goals. Identifying the group’s goals will also be complex, although democratic processes seem to offer the best chances.

105 See P Saunders, ‘Support for UK assisted dying bill plummets to 43% after hearing opposing arguments’ (2014) http://www.lifesitenews.com/pulse/support-for-uk-assisted-dying-bill-plummets-to-43-after-hearing-opposing-ar
106 This aligns with another version of value theory: see DeGrazia (n 84).
107 B Barry, Political Argument (Humanities Press 1965).
108 See McHarg (n 104) 677.
109 McHarg (n 104) 677.
How might a common interest theory apply to the case of assisted dying? If we follow McHarg, we might see a prima facie case for allowing the practice, if this reflects the public will. Yet, the question will remain about whether the practice contributes in some way to the collective good. As McHarg noted, a value choice must ultimately be made. So which values should dictate our appraisals of, and policy responses to, assisted dying?

6. Conclusion

Determining the proper content of, and role to be played by, the public interest will therefore involve a value choice – about the interests in issue and also about the proper balance to be struck between protecting individuals and protecting others (including society at large). We well know that the values associated with death and dying remain hotly contested. Determining the legitimacy of assistance in dying involves a genuine moral dilemma, in which it is difficult to know which way to jump. The integrity of medicine seems not to offer a secure answer. Resolving the question by reference to what doctors happen to think seems to be an insufficient basis for determining policy, given the wider interests at stake. At the same time, no single answer appears (necessarily) to emerge from the concept of medicine – but, even if one did, this too would be insufficient. The integrity of medicine is therefore part of, but by no means exhausts, the public interest. Unfortunately, when we widen the pool of interests, we find that we are still required to make a value choice.

Perhaps the right choice will one day be revealed, and a principled answer will be found to the enduring euthanasia question. But perhaps that is a pipe dream, given that the different answers – which alternately emphasise choice, suffering, and the intrinsic value of life – continue to be both commended and condemned. Maybe, as Hoffmann LJ once indicated, the law can live with the conflicts:

“A conflict between the principles of the sanctity of life and the individual’s right of self-determination may ... require a painful compromise to be made...

There must be an accommodation between principles, both of which seem rational and good, but which have come into conflict with each other”.

The law achieves this accommodation in a variety of ways: in some situations, autonomy triumphs; on other occasions, the sanctity of life wins out; and, although the law purports to prohibit assistance in dying, ways are usually found to secure humane disposals for those who do so.

In such endeavours, the law reveals itself to be open to different accounts of the good life. Indeed, the judges admit that they will have regard for the different values present in society, and that they will adapt the law as society evolves:

“The determination of the public interest is a matter for the courts, applying, subject to any statutory provisions which may be relevant, the common law...

[T]he common law is capable of moving with the times to meet changing

110 But see Saunders (n 105).
113 Huxtable (n 1).
114 Bland (n 6) 827 (Hoffmann LJ).
115 Huxtable (n 1).
conditions so that as far as possible it reflects the acceptable standards of the
day".116

Maybe there is a case for such value pluralism or "value agnosticism" in the law.117
Maybe, too, there is a principled case for the adoption of middle ground positions,
given the considerable complexity and uncertainty which cloud practices like
assistance in dying.118 Indeed, even if the law does edge towards embracing death-
on-demand,119 it must remain not only appropriately "moralised",120 but also alert to
the need to secure an "appropriate pay-off between allowing so much liberty than an
excess of harm results, and such restricted liberty that people have too little control
of their lives to make them worthwhile".121 At the same time, the law must also work
as law: it must be clear and consistent, and thus observant of criteria like those of
Fuller’s "internal morality", if its rules are to guide people as they should. These are
matters for elsewhere.122 For now, I hope to have shown that appeals to the integrity
of medicine, "proper medical treatment", and even the public interest cannot resolve
the values choices we must make whenever death-on-demand is in issue.

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