Rethinking Nonmaleficence - Harm, The Media and The Advocate's Obligation

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Introduction

Physician assisted suicide (PAS) represents a contentious social issue at the forefront of public debate in Canada.[1,2] Several high-profile legal cases involving terminally ill and suffering patients have gained national prominence and have helped to sustain public interest in the moral theory behind PAS.[3] In February, the Supreme Court of Canada unanimously decided that Canadians from all walks of life have a right to PAS, overturning a federal decision dating back to 1993.[4] The ruling gives patients suffering from unremitting pain and terminal illness the option to end their life on their own terms, vindicating a philosophy that a majority of Canadians presently adhere to in some capacity.[2] Laws resulting from the decision have not been instantaneous, however, they are forthcoming.[5] Despite the country's support for PAS, ethical arguments against its implementation are often debated. The bioethical norm of nonmaleficence, or 'do no harm' (DNH) is sometimes used within the media to argue against PAS. Here it will be argued that medical professionals offering public opinions ought to present the ethical formula of principlism[6] in addition to the personal and ethical feelings they have with respect to PAS in Canada. The physician's role as public advocate and educator ought to extend to the act of clarifying the principles used in bioethical decision-making. Direct discourse on this topic and on the harm often associated with medical practices in general may allow for more reasonable dialogue on an already complex and emotionally charged public issue.

Nonmaleficence

The bioethical norm of nonmaleficience, colloquially referred to as DNH, has served as a moral scaffold from which physicians have balanced clinical decision-making for decades. DNH is frequently cited as having originated from the Hippocratic Oath, but this theory has been scrutinized, leaving the exact origins of the phrase debatable.[7] In 1970, Beauchamp and Childress[6] presented nonmaleficence alongside the bioethical norms of beneficence (to do good), autonomy (self-governance), and justice to form what would become the foundation of modern bioethics.[8] Strategies aiming to calculate and minimize relative infringements amongst these norms have directed ethical decision making in academic and clinical settings. Since its inception, the framework, referred to as principlism, has remained largely unchallenged and serves as seminal bioethics education in undergraduate institutions and medical schools in much of the civilized world.[8]

Practically speaking, nonmaleficence serves to protect the interests of the patient. Nonmaleficence, according to Beauchamp and Childress, "requires only intentional avoidance of actions that cause harm".[6] By treating DNH as an ethical roadmap, physicians are incentivized to diligently weigh the pros and cons of prospective treatments and resultant harms. However, as Morrison points out, nonmaleficence does not suggest that physicians may never cause harm in order to treat patients but only that the harm caused must not be 'automatic' in nature.[8] The ethics of nonmaleficence and beneficence, therefore, have origins within the philosophical tradition of utilitarianism[8] where options are weighed against one another and decisions that maximize the 'greatest good' are favored over those that do not.[9]

The principles of biomedical ethics set forth by Beauchamp and Childress are not meant to be interpreted as absolute entities in and of themselves. Instead, they have been identified as *prima facie* values in that the worth of any one principle is relative to the context of each case as well as the weight given to the remaining norms. Indeed, as Daniel K. Sokol correctly points out, a literal reading or enforcement of the ethical admonition would actually leave physicians with fewer options in the clinic.[11] Caretakers frequently do harm: whether it's administering ionizing radiation in the form of a CT scan to diagnose a brain tumor or delivering a toxic regimen of chemotherapeutics that may or may not help to shrink that tumor, harm seems to be at the forefront of healing within the domain of the medical profession. The simplistic presentation of the DNH ethic as an absolute medico-ethical principle therefore, is misleading from the outset. The obvious contradiction between the principle itself and accepted medical practice has led Sokol to suggest revising 'do no harm' to 'do no net harm'.[11] The latter terminology may indeed be beneficial to lay discussions on the topic, as it explicitly clarifies the absolutist ambiguity associated with the former.

The Role of the Media and the Social Obligation of the Physician

A brief survey of Canadian news articles related to the PAS debate promotes some cause for worry. Physicians in these articles, arguing against PAS legislation, often provide ethical reasoning to substantiate their positions against the practice. The problem, however, is that in many of these cases only one side of the traditional medico-ethical calculus is provided to the reader, presumably leaving the lay public uninformed or at least less informed than they could be with respect to the

decision-making processes that exist within the medical profession. For instance, one physician reports that "Hippocrates and generations since have recognized that only physicians who pledge never to kill can be trusted with our care when we are most vulnerable."[12] However, the exact basis of this claim proves elusive – exactly what evidence suggests that this is true? In countries where PAS (even euthanasia) has been legalized, there is little evidence to suggest that physicians partaking in the processes are any less trustworthy, capable, or compassionate when it comes to patient care. Furthermore, we know that physicians and caretakers frequently intend to end life, such as in the case of anencephalic newborns and instances in which breathing and feeding apparatuses are removed – the intent on the part of the physician in these cases is unambiguous – it seems unlikely that we would question the capabilities of those practising this kind of medicine.

Identifying the physician's pledge to 'do no harm', another physician asks "How can I teach medical students about healing when I have to prepare them as euthanizers?"[13] After a moment's thought, this statement doesn't survive critical scrutiny. Does participation in the practice of euthanasia leave the participating physicians or healthcare professionals less able to heal? Consider the role of the veterinarian in society and the duty he or she holds to peacefully euthanize suffering animals. In light of the veterinarian's actions as "euthanizer", would we ever suggest that he or she has somehow lost the ability to heal? In the case of veterinarians in training, would we ever perceive their learning proper euthanasia protocols as a handicap in the practice of healing? Canadian medical schools seem to think not, with curriculum changes aimed at making medical students more equipped to meet this medical need already being planned.[14] It seems that describing physicians – who aim only to help the terminally ill and the suffering – as "euthanizers" in this way does little to further the debate at hand. When activist medical professionals use this language they miss the underlying point pro-PAS groups are making. For pro-PAS physicians and caretakers, it's not about somehow wanting to kill on a whim; it's about wanting to heal, to help, and to end suffering in a professional and humane way. To treat their intentions or medical capabilities as anything less would amount to a rueful distraction.

Proclamations, such as those discussed above, ultimately hold back honest discussion on the topic of PAS in Canada. The meaning behind the medico-ethical principle of DNH is riddled with complexity and is far from absolute. To treat the norm any differently is to abandon the very framework from which western healthcare systems operate. Harm is something the medical profession frequently encounters and acting as though this is not true may advance the personal beliefs of a particular physician, but it does nothing to advance honest dialogue on the public issue at hand. To suggest or imply that physicians partaking in PAS would become unable to heal is disingenuous at best and unconscionable at worst. The vast majority of physicians advocating in favor of PAS do so only with the hope of abiding by the wishes of the patient and providing the best possible outcomes associated with a terminal illness, thereby defending two of the four principles of biomedical ethics in their proper context.

Conclusion

The biomedical principle of nonmaleficence or 'do no harm' has obtained much attention in the context of the Canadian PAS debate. Borne out of a desire to provide the best care for the patient, the principle practically serves as a safeguard against overtly risky and non-beneficial decision-making practices that may end up causing more harm than good. DNH has been used as an argument against PAS from the perspective of the clinician but recent Canadian surveys suggest a sizeable swath of the country instead view the forced prolonging of suffering of the terminally ill patient as harmful. If physicians arguing against legislation of PAS believe that death in this case is the real harm, they ought to balance the DNH ethic with the competing biomedical principles as well as the calculus involved in bioethical principlism: an ethic that guides their clinical decision-making practices. Public education and by extension the tone of this debate, could stand to benefit from such explanation.

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