Canadian Journal of Bioethics
Revue canadienne de bioéthique

An Ethics Journey: From Kant to Assisted Suicide

Michael Gordon

Volume 6, Number 1, 2023

URI: https://id.erudit.org/iderudit/1098567ar
DOI: https://doi.org/10.7202/1098567ar

See table of contents

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

Explore this journal

Cite this document

Gordon, M. (2023). An Ethics Journey: From Kant to Assisted Suicide. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *6*(1), 106–108. https://doi.org/10.7202/1098567ar

Article abstract

Most of us would agree with the almost trite saying that “life is a journey”. Of course it is, unless it ends tragically at birth, and even then it is a very short journey. All of us can describe how we got from one stage in life to another, whether personal, family, education or career. Many journeys seem to be in an almost straight line while others meander from one place to another, changing direction and alternating goals, sometimes zigging back and forth. I have had many wonderful journeys in my life; the choice to change career aspirations from engineering to medicine, the choice the study in medicine in Scotland, the choice to focus on geriatrics and then the choice to branch out into medical ethics to add more depth to clinical medicine. The early undergraduate study of philosophy planted the seed that eventually grew into my completing a Master’s in Medical Ethics; and then expanding my teaching and practice to include palliative care and end of life-decision-making, to most recently participating in the assessment of those requesting medical assistance in dying (MAID in Canada).

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

M Gordon. *Can J Bioeth / Rev Can Bioeth*. 2023;6(1):106-108

TÉMOIGNAGE / PERSPECTIVE

An Ethics Journey: From Kant to Assisted Suicide

Michael Gordon[a,b]

Résumé
La plupart d'entre nous sont d'accord avec l'adage presque banal selon lequel « la vie est un voyage ». Bien sûr, c'est le cas, à moins qu'elle ne s'achève tragiquement à la naissance, et même dans ce cas, le voyage est très court. Nous pouvons tous décrire comment nous sommes passés d'une étape à l'autre de notre vie, qu'il s'agisse de notre vie personnelle, familiale, scolaire ou professionnelle. De nombreux voyages semblent se dérouler en ligne presque droite, tandis que d'autres serpentent d'un endroit à l'autre, en changeant de direction et en alternant les objectifs, parfois en faisant des zig-zig. J'ai connu de nombreux voyages merveilleux dans ma vie : le choix de changer d'orientation professionnelle pour passer de l'ingénierie à la médecine, le choix d'étudier la médecine en Écosse, le choix de me concentrer sur la gériatrie, puis le choix de m'orienter vers l'éthique médicale pour donner plus de profondeur à la médecine clinique. L'étude de la philosophie au début du premier cycle a planté la graine qui m'a permis d'obtenir une maîtrise en éthique médicale, puis d'étendre mon enseignement et ma pratique aux soins palliatifs et à la prise de décision en fin de vie, et plus récemment de participer à l'évaluation des personnes demandant une aide médicale à mourir (AMM au Canada).

Mots-clés
Kant, éthique médicale, AMM, suicide assisté, médecine

Abstract
Most of us would agree with the almost trite saying that "life is a journey". Of course it is, unless it ends tragically at birth, and even then it is a very short journey. All of us can describe how we got from one stage in life to another, whether personal, family, education or career. Many journeys seem to be in an almost straight line while others meander from one place to another, changing direction and alternating goals, sometimes zigging back and forth. I have had many wonderful journeys in my life; the choice to change career aspirations from engineering to medicine, the choice the study in medicine in Scotland, the choice to focus on geriatrics and then the choice to branch out into medical ethics to add more depth to clinical medicine. The early undergraduate study of philosophy planted the seed that eventually grew into my completing a Master's in Medical Ethics; and then expanding my teaching and practice to include palliative care and end of life-decision-making, to most recently participating in the assessment of those requesting medical assistance in dying (MAID in Canada).

Keywords
Kant, medical ethics, MAiD, assisted suicide, medicine

Affiliations
[a] Department of Medicine, University of Toronto, Toronto, Ontario, Canada
[b] Joint Centre for Bioethics, University of Toronto, Toronto, Ontario, Canada
Correspondance / Correspondence: Michael Gordon, Michaelgordon6200@gmail.com

I recall lying on my bed in the little bedroom we'd carved out of a small bungalow on the border between Brighton Beach and Manhattan Beach in Brooklyn, New York. I was in my first year of university at Brooklyn College which eventually became part of the City University of New York, a marvelous campus, which at the time charged no tuition.

Even though I had a major in Chemistry, as a liberal arts institution I was required to do a number of the so-called "101 courses", of which philosophy was one of the core areas of study. My professor was, as I learned over time, a German refugee who had escaped the holocaust. The topic was Emanuel Kant, an 18th century German philosopher. I loved the course and the professor, with his thick German accent. I was trying to unravel the concept of his famous *Categorical Imperative*, which initially proved to be a bit of an enigma to me. Perhaps it was partially due to the way his ideas were translated into English, from the original German.

As I curled up on my single-sized bed, with the text lying next to me I had that light-bulb moment when I understood it Since then, Kant has been one of my favorite sources of ethics teaching to medical and other health care students.

I studied medicine at Scotland's University of St. Andrews, Dundee campus, because I wanted the opportunity to travel, which I did extensively during my almost six years in Scotland, including my first internship (house job) in Aberdeen. Without realizing it, I was informally getting my early education in ethics, as many of the cases had an important ethical dimension to them. At that time (1961-1967), the main reference source for doctors for medical ethics was Hippocrates, with the dictum (*primum non nocere: first do no harm*). When one thinks of that ethical obligation in the face of modern medicine, it would be impossible to practice, as much of what we do causes some harm. Surgery causes pain, bone marrow aspirations are not innocuous and anyone that has had a colonoscopy would attest to its discomfort – just the preparation is challenging. So, until one uses the concept *on balance* with the possible benefit, the dictum is meaningless. Yet, every time a physician prescribes a drug, the patient/family asks about side effects. Doctors then have to describe the benefits and risks of the medication in order to get the proper consent to use the drug – that brings us to one of the contemporary pillars of medical ethics: *autonomy*.

ISSN 2561-4665

I changed my plans for post-graduate studies from engineering to Medicine after I read the book *The Citadel* by A.J. Cronin (1). In it, the protagonist faces a monumental ethical dilemma – he acts appropriately but almost loses his medical license, although he is eventually exonerated. It had a powerful effect, and in many ways changed my whole life and my career trajectory.

After training in a number of countries, including the United States during the latter days of the Vietnam war, I chose to emigrate to Canada – probably the most important decision of my life. I then moved from Montreal where I was doing a medical residency to Israel, with my Israeli wife. That country was a wonder and at the same time a shock to me. Not only did I have to master a new language (Hebrew), I had to fulfill my military service, which I did as an Air Force physician, after which I undertook two years of training in internal medicine. Working in a religious affiliated hospital, I had to learn the basics of Jewish medical ethics and what is termed *Halacha* (literally, the way to behave).

My first position was in Pathology prior to going into the Air Force. There I learned in real time the conflict between the need for post-mortems to enhance medical knowledge and its prohibition by observant Jews. I recall vividly the door to the post-mortem room being pounded on by distraught family members who opposed a post-mortem on a loved one even though administrative permission had been obtained – but not permission from the family.

I eventually ended up in Toronto where I undertook my geriatric medicine career – which I realized early on fitted my personality. I took and succeeded in the first exam for the Geriatric specialty and my career progressed with a special focus on individuals with cognitive decline. I moved up the administrative hierarchy until I became chief of medicine (geriatrics) at Toronto's renowned Baycrest Centre. In my administrative and clinical roles, I would be confronted with many challenges that implied ethical rather than purely clinical issues.

With a new mandate that required publicly funded hospitals to have ethics committees, my CEO asked me to find and appoint a chair. After weeks of enquiring among those of my staff who I thought were up to it, I found no takers. I made a deal with my CEO, if he would send me to the one-week intensive course on Medical Ethics at Georgetown University, I would take on the role for a year and get things started.

I loved the course but noticed that the American students seemed to be especially interested in the issues as part of a risk-avoidance strategy – in fact many of the students were from law rather than medicine. On my return, I realized very quickly that the Georgetown Mantra of *autonomy, beneficence, non-maleficence and justice* did not get the committee very far as we tried to grapple with some of our "ethics" referrals. Thus began what became a decades long education as to what ethics was all about, and most important how to get those concerned to understand the issues.

We were a clinical ethics committee and left the research domain to another group of people – although there is some overlap, they are really different domains in many ways. Research participants are not the same as patients, and the risk tolerance of untoward outcomes is by the nature of the enterprise, much lower. Research is to provide knowledge rather than treat patients, thus bad adverse events are to be avoided whenever possible (2).

I found some of my greatest challenges were ethical issues rather than clinical conundrums, although the latter often led to ethical considerations. One of great joys was teaching trainees and non-physician health care professionals, the essence of clinical ethics. The first thing I tried to have them internalize is that when you ask for advice about an ethics problem, do not expect "an answer" as one might when a cardiac consultation is provided. To me, the important thing is to identify the players, the issues, the difference in opinions among the players, and then the process of deliberation. I sometimes go over the *Mantra* with those asking advice but alert them that those principles do not provide answers, but rather a framework by which the issues should be addressed. Of course, they do not make up the full repertoire of ethics deliberation. I have heard clinicians who hear about problem say, "oh that's an issue of *autonomy*" and case closed.

I have many examples of cases I saw on request where the initial assumption of *autonomy* was based on some view of the person's situation and the psycho-social factors in their lives. The Canadian controversy about the evolution of medical assistance in dying (MAID) legislation (Physician Assisted Suicide or PAS in the US) is an example of how polar opposite views can affect the law and the citizenry's views about end-of-life options.

As with other jurisdictions that have one form or another of assisted dying (the Benelux countries, for example), the so-called "guardrails" are always part of the process. Someone who knows me very well, and I know respects me as a physician, told me that I was acting as an executioner (the word used was murderer) for doing assessment as to supplicants' request for MAID. I look at the various views as likened to religion – strong beliefs are not up to logic or convincing. For example, those who are very religious (whichever sect) may consider abortion as murder and rarely take into consideration the often-devastating effect that an illegal abortion can have on the life of the pregnant woman. I saw the results of an illegal (back street) abortion on an adolescent when I was a medical student doing a summer rotation in Beth Israel Hospital (now Brookdale Hospital Center). I was called to the emergency room. The girl was febrile and gushing blood. They managed to save her life, but I remember one of the senior nurses saying, "well there goes her chance of ever having children".

I firmly believe that my change of course in my profession to include medical ethics turned out to be one of most important career choices I made, next to choosing geriatrics as my specialty. With the burgeoning older population world-wide but especially in North America, policy and resource allocation choices are a constant source of discussion. The concept of *justice*

(distributive justice) is front and centre in that dialogue. Is it “ethical” to discharge so-called *bed blockers* (almost all elderly) to a nursing home that is a dozen or more kilometers away to free up hospital beds? How does one measure the amount of benefit or suffering by two groups affected, such as someone getting hip surgery versus someone whose family cannot readily visit them and who suffers profound loneliness and depression?

I often advise physicians who are looking to expand their educational journeys beyond the usual clinical medical specialty-based formats. I suggest they explore undertaking a Master’s degree in areas such as education, policy develop and of course my favorite, bioethics. Kant (3), Cronin (1), and the Jewish scholar and physician Moses Maimonides (4) captivated me and I am forever grateful for their wisdom.

Reçu/Received: 10/03/2023
Publié/Published: 06/04/2023
Conflits d’intérêts
Aucun à déclarer
Conflicts of Interest
None to declare

Édition/Editors: Hazar Haidar & Aliya Affdal
Les éditeurs suivent les recommandations et les procédures décrites dans le Code of Conduct and Best Practice Guidelines for Journal Editors de COPE. Plus précisément, ils travaillent pour s’assurer des plus hautes normes éthiques de la publication, y compris l’identification et la gestion des conflits d’intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d’excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Code of Conduct and Best Practice Guidelines for Journal Editors. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal’s standards of excellence.

REFERENCES

1. Cronin AJ. The Citadel. Back Bay Books; 1983
2. Piasecki J, Dranseika V. Research versus practice: the dilemmas of research ethics in the era of learning health-care systems. Bioethics. 2019;33(5):617-24.
3. Encyclopaedia Britannica. Categorical imperative. Updated 10 Feb 2023.
4. Seeskin K. Maimonides. In: Zalta EN, editor. The Stanford Encyclopedia of Philosophy (Spring 2021 Edition). 24 Jan 2006 [rev. 4 Feb 2021].