www.cmf.org.uk
CMF files no:70
Christian Medical Fellowship
Winter 2019

Neutrality in bioethics

By David Randall

'Neutrality is a negative word. It is a word that does not express what America ought to feel... America has promised the world to stand apart and maintain certain principles of action which are grounded in law and in justice. We are not trying to keep out of trouble; we are trying to preserve the foundations upon which peace can be rebuilt.' [1]

So argued Woodrow Wilson, the 28th President of the United States of America, as he desperately tried to maintain American neutrality during the First World War. His ultimately, unsuccessful efforts were born from the best of motives: a horror at the carnage of the Western Front, a deep commitment to peace, and a desire for America to act as peacemaker between the warring parties. Yet his words capture the ambiguities inherent in any policy of neutrality: issues matter; right and wrong exist. To what extent is it appropriate for an individual or body to stand apart from controversy, and when does neutrality start to become complicity with one side or the other?

Neutrality in bioethics

A position of neutrality is possible on a wide range of bioethical issues – for instance, the Royal College of General Practitioners (RCGP) polled its members in 2019 on whether to adopt a position of support, opposition, or neutrality towards the full decriminalisation of abortion, with members coming out in favour of supporting decriminalisation. [2] However, it is in the recent debate around assisted suicide that the issue has been particularly contentious, and this is where this *CMF File* will focus its attention.

assisted suicide
In this article, 'assisted suicide' is used instead of the more euphemistic and inaccurate term 'assisted dying', except where referring to the positions of medical institutions, which generally use the latter term. 'Assisted dying' was defined by the Royal College of Physicians during their 2019 poll on the issue as referring to *'the supply by a doctor of a lethal dose of drugs to a patient who is terminally ill, meets certain criteria that will be defined by law, and requests those drugs in order that they might be used by the person concerned to end their life.'*

Whilst neutrality has historically been viewed with suspicion, it is increasingly being advocated as the most appropriate stance for medical bodies to take on the issue of assisted suicide. In March 2019, the Royal College of Physicians moved from a position of opposing legal change to a position of neutrality after polling their members on the issue, saying: *'"Neutral" means the RCP neither supports nor opposes a change in the law. By remaining neutral, the RCP can reflect the differing views of its fellows and members in discussions with government and others.'* [3]

The President of the RCP, Professor Andrew Goddard, went on to explain that *'neutral means the RCP neither supports nor opposes a change in the law and we won't be focusing on assisted dying in our work.'* [4]

This move by the RCP mirrors similar moves by other organisations:

- The Royal College of Radiologists (RCR) declared itself neutral on assisted dying on the same day as the RCP.
- The Royal Australasian College of Physicians (RACP) declined to take 'a single position' on assisted dying in a new statement adopted in November 2018, based on the report by a working group it had set up. [5]
- The Royal College of Nursing (RCN) moved from opposition to neutrality on assisted dying in 2009. [6]
- The *British Medical Journal* adopted an editorial position to campaign in favour of neutrality by medical bodies on assisted dying in 2012. [7]

By contrast, the British Medical Association (BMA), [8] Royal College of General Practitioners (RCGP), [9] Royal College of Surgeons, [10] British Geriatric Society, [11] and Association for Palliative Medicine [12] all oppose the legalisation of assisted suicide, and the World Medical Association strongly reaffirmed its opposition in 2019. [13] The BMA and RCGP have each announced that they are to poll members on their respective public positions on assisted dying during late 2019 and early 2020, with the option of moving to a position of neutrality.

The purpose of this paper is not to discuss how any given organisation might fairly reach a corporate position on a complex issue such as assisted suicide. Rather, its aim is to examine the issue of neutrality itself: Why might institutions be keen to adopt such positions? What are the implications of neutrality on the assisted suicide debate? What are the implications more widely for medicine and society?

What does neutrality *actually* mean?

Neutrality as a concept can be used in several different ways. It has a mathematical or scientific meaning which may be almost synonymous with the term 'balanced' (for example, a neutral solution is neither acidic nor alkaline, or an innovation that minimises or offsets emissions may be described as 'carbon neutral').

When used to describe the stance of an individual or corporate body, it may be used to express several different underlying attitudes:

- **Impartiality** – Here an individual determines not to assist either side in a conflict (regardless of their own views about an issue), because they have chosen to act as an arbiter. Examples would be the referee in a game of football or the chair of a debate.
- **Non-imposition** – Here an individual does not express their own feelings about an issue because they do not wish to be seen as imposing their own opinions on others. The recent trend towards adopting 'gender-neutral' pronouns, titles and even toilets is based on a reluctance to impose a binary choice of gender options on individuals who

may define themselves in other ways.

- **Maintaining a consensus** – An organisation may avoid adopting a corporate position on a contentious issue, in order to represent opposing elements of their membership even-handedly.
- **Spheres of responsibility** – An individual or body may consider a decision unimportant or not relevant to their objectives and express that view in the language of neutrality. The British Government, for example, adopts a policy of strict neutrality on the domestic politics of Britain's allies; this is not the British Government's concern.
- **Uncertainty** – An individual may recoil from the complexity of a problem and describe themselves as 'neutral' on it; they may further explain that they 'see both sides' of the problem or are 'struggling to pick a side'. For example, someone who defines themselves as agnostic might say they are neutral on the existence of God: they might declare themselves unconvinced by traditional arguments for God's existence but lack the certainty to be an atheist.

These different descriptions of neutrality carry very different moral implications. **Impartiality** is unambiguously positive for an individual acting as an arbiter or referee; the opposite of neutrality would be bias. **Non-imposition** is a modern virtue, reflecting the prevalence of moral relativism in the developed world. Yet a failure to make any judgments treats all parties in a dispute as morally equal: the US Government's Neutrality Acts in the 1930s made no distinction between Nazi Germany and democratic Britain and France.[14] Modern campaigns such as '*Kick it out!*',[15] '*Stand up to sexism!*'[16] or the *#MeToo* movement attack a culture of tolerance that has allowed racism, sexism and sexual abuse to flourish. Whilst **maintaining consensus** within organisations is generally desirable, seeking to appease all minorities can create institutional inertia and prevent progress.

Reasons for neutrality on assisted suicide

The commonest reason given by bodies that have moved to a position of neutrality is that such a position best reflects the lack of consensus within their membership on the issue. Professor Goddard of the RCP explained that '*It is clear that there is a range of views on assisted dying in medicine, just as there is in society. We have been open from the start of this process that adopting a neutral position will mean that we can reflect the differing opinions among our membership*.'[17]

A second common reason given to justify a position of neutrality is that the legalisation of assisted suicide is an issue for society, and not for medicine, to decide. Claire Gerada, former Chair of the RCGP, wrote in 2013 '*The RCGP's "collective" view should not trump the view of the man on the Clapham Omnibus... At the heart of the case for neutrality is that the decriminalisation of assisted dying should be a matter for society as a whole to decide, using established parliamentary processes.*'[18]

A third argument has its basis in the move to moral relativism and the overriding concern for individual autonomy: that medical professionals (or indeed elected politicians) have no right to interfere with an individual's right to choose the time of their death. Neutrality respects this choice; opposition to legal change undermines it. As a former President of the RCP wrote, '*There is little doubt that a substantial majority of the public is in favour of measures to permit assisted dying. If they had the support of the medical profession, it is likely [legislation] would be passed; our professional resistance is one of its strongest obstacles. Is our opposition really justified?*'[19]

Common to each of these arguments is the concept of non-imposition: medical bodies should not impose a corporate position on their members, on society, or on individual patients.

Why shouldn't institutions be neutral?

Whilst adopting a position of neutrality on a complex and controversial issue may seem entirely reasonable, on closer scrutiny several problems become apparent: some are philosophical, and others are intensely practical.

Philosophical problems

Neutrality requires a secular materialist worldview

One key argument made by opponents of assisted suicide is that actively shortening life is morally wrong (because of the fundamental and absolute value of human life), aside from any negative practical implications also associated with its implementation.

However, implicit in the adoption of a position of neutrality is the idea that moral choices are personal and best kept private. According to this view, a doctor who opposes assisted dying on moral grounds is fully entitled to hold this belief personally but should not seek to impose it on others. A position of neutrality (with consensus around basic safety standards, and protection of individual conscience), is viewed as acceptable to all.

This implicit assumption of a separation between the practical effects of assisted suicide ('facts', which can be scientifically studied), and moral objections to it ('values', which rest on a person's ethical worldview), were anticipated by Christian philosopher Francis Schaeffer, who described a line running through Western culture, dividing the 'rational' concerns of science (below the line) from the subjective concerns of 'faith', above it.[20] In the assisted suicide debate, the 'rationality' of safeguards and professional guidelines is neutral ground around which everyone can work, whereas moral notions about the value of life are best kept personalised in the upper storey of 'faith': important for the individual, but not relevant in public debate.

Accepting neutrality as the default position in bioethics cements into place a secular worldview that views any claim to the unique moral value of human life as being inherently faith-based and subjective. Far from being neutral, it implicitly endorses a materialist system of ethics in which concepts of morality and values are relegated to the subjective.

Christian writer Nancy Pearcey develops Schaeffer's ideas by showing that there are certain moral constraints that everyone is glad to see imposed on others, rather than being left to individual choice, such as the prohibition of murder or slavery. '*We understand that granting private individuals the right to murder and enslave people inescapably implies a worldview – one that says some people's lives are expendable, not worthy of legal protection*.'[21] In the same way, accepting the legalisation of assisted suicide implicitly accepts a worldview in which not all lives are of equal value, and some lives can acceptably be brought to a premature end.

Neutrality is not the middle ground

Neutrality is often painted by its advocates as a happy medium, between idealists on either

side who are otherwise unreconcilable – for instance, Raymond Tallis wrote, in a piece advocating a position of neutrality for the RCP that '*a neutral stance would allow the RCP to respect the diversity of views without alienating significant numbers of members and fellows*.' [22]

However, the fierce reaction against the RCP's declaration of neutrality on assisted dying [23] suggests that neutrality is in no way a position acceptable to all. Perhaps neutrality is best seen not as the midpoint of a line, but rather as the third point of a triangle. An advocate of neutrality does not believe in a hodgepodge combination of oppose and support; rather they have a definite position on the stance that should be adopted on an issue: one of keeping out of the debate, and implicitly of viewing any outcome as morally acceptable. Indeed, both those supporting and opposing a change in the law might object to neutrality because both groups believe doctors should be actively involved in framing and leading public debate, rather than sitting out of it.

Neutrality implies that medicine is not a moral pursuit

Underlying the position of neutrality, along with the assumption that human life is of relative value, comes another assumption – that medical practice is a technical rather than a moral pursuit. Doctors simply deliver services sanctioned by the state, rather than forming independent, professional judgments based on a code of professional ethics.

If key professional bodies governing medical practice are neutral on bioethical issues, the profession is opting out of its ethical obligations, and handing over responsibility for its ethical regulation to Parliament (whilst at the same time, failing to provide professional guidance to politicians). Rather than leading and shaping the public debate on key issues, such bodies abdicate their regulatory responsibilities and downgrade the ethical status of the profession. This may have long-term implications for public trust in doctors and compromise the profession's ability to challenge government wrongdoing.

Practical problems

Neutrality means silence

A policy of strict neutrality means that medical bodies are unable to comment on any aspect of proposed legislation relating to assisted dying – for instance, as noted earlier, the RCP's policy on assisted dying includes the commitment that '*the RCP neither supports nor opposes a change in the law and we won't be focusing on assisted dying in our work*'. [23] This means that the RCP is unable to comment on areas of great concern to most practising doctors, such as over future protection for conscientious objection (should legislation be passed), or safeguards for vulnerable patients. A large measure of medical opposition to assisted suicide centres on patient safety concerns: it is impossible ever to say with certainty that a patient's request for an assisted death does not arise from a treatable mental health disorder, from coercion, undue pressure from family members, financial worries, or in patients lacking the mental capacity to make such decisions. Doctors are likewise keen to maintain conscience provisions to allow those objecting to ending patients' lives to be exempt from having to do so. A position of non-engagement with the debate prevents these concerns from being expressed. The fact that an issue might be contentious or divisive does not mean that neutrality is a correct response.

In 2005, the BMA briefly adopted a position of neutrality on assisted dying that was reversed the following year. The Chair of the BMA's Ethics Committee, John Chisholm, wrote recently that '*This created several problems for us. It made it difficult for us to lobby on or engage with the issue. This risked the BMA and the profession being excluded from the assisted dying debate altogether. If legislation were to be introduced in the future, a position*
of neutrality could make it difficult for us to intervene and advocate on behalf of doctors about their role in the process and the safeguards they would like to see.' [24]

Moving from opposition to neutrality actually encourages legal change

It might be that a medical Royal College newly established in 2019 would decide not to adopt a position on assisted suicide. Such a decision would not be newsworthy. By comparison, when the RCP moved from opposition to neutrality on assisted dying, headlines proclaimed that the College had '*dropped its opposition to legal change*'. [25]

One group of writers have concluded that '*Neutrality is not neutral. To change from opposition to neutrality represents a substantive shift in a professional, ethical, and political position, declaring a policy no longer morally unacceptable; the political effect is to give it a green light. Logically, neutrality implies, "We are not opposed."*' [26]

Achieving medical neutrality has been identified as a key goal in the campaign toward legalisation of assisted suicide by its proponents, such as Professor Ray Tallis. In a lecture in 2012, he said: '*I am an optimist and I believe that we shall bring these bodies round to an appropriate stance of neutrality and that, with this obstacle out of the way, Parliament may indeed come to support legislation in favour of assisted dying.*' [27]

The gap between the Canadian Medical Association adopting a position of neutrality on assisted suicide and the Canadian Parliament voting to legalise it was a mere three years. [28] As Williard Johnson writes: '*Few Canada doctors foresaw that "going neutral" would guarantee the arrival of euthanasia, or that promises of a shot in the arm for palliative care would be forgotten. Even fewer realised they would have no option but to cooperate with providing death on demand. It has become all too easy to end patients' lives. Learn from our mistakes*.' [29]

Biblical reflections

Within a biblical worldview, nothing is morally neutral. We should '*hate what is evil*' and '*cling to what is good*'; [30] we are told that people are either with Jesus or against him, [31] and that '*friendship with the world is enmity towards God*'. [32] Christians have freedom to choose a range of different courses of action, but only between options that are in themselves good. [33] The basis of wisdom is learning to form correct judgments about what is right and wrong. [34]

This is applied particularly to those in positions of power. Throughout the Bible there is praise for those who judge diligently [35] and condemnation for those who are indifferent or unconcerned about the needs of those around them. [36] Job asserts his righteousness in his final defence before his friends by showing his concern to intervene on behalf of the needy, [37] and the godly king in Psalm 45 is told to '*ride forth victoriously in the cause of truth, humility and justice*'; [38] he is lifted up because he '*love[s] justice and hates wickedness*'. [39] In the Book of Acts, Roman officials such as Gallio who remain 'neutral' on issues of justice, allowing the mob to rule, are criticised; [40] whilst those

who intervene and form good judgments are presented positively. [41] There can be no more poignant example of dereliction of duty in adopting a position of neutrality than that of Pontius Pilate, who washed his hands as Jesus was led off to be executed. [42]

Although there is obviously no direct guidance in the Bible for how medical institutions should arrive at position statements, it is clear that rulers have a responsibility to act on behalf of those they serve, rather than using power to advance their own agendas. [43] The basis of good judgment is in establishing what is morally right and wrong, and acting accordingly. There is a particular need to defend the weak and to '*speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy*.' [44]

Conclusions

There may be perfectly good reasons for an institution to adopt a position of neutrality on an issue, for example if the issue is unrelated to its core purposes, or if the institution needs to remain neutral in order to adopt the role of an arbiter. One example in medicine might be the Royal Society of Medicine (RSM), which does not hold a position on assisted suicide and maintains impartiality in order to facilitate education and debate within the profession. The RSM defines itself as independent and apolitical; it does not make submissions to parliamentary enquiries or claim to be a voice for the profession. [45]

However, deciding to be neutral based on a desire not to impose a view on others is much more morally ambiguous. There is no such thing as neutrality: dropping opposition to assisted suicide implies that it is morally acceptable.

As well as providing implicit support for a secular worldview, such a position of neutrality fails to represent key concerns around patient safety, delivery of care and trust in medical practitioners. Real harm might be done, as the expert concerns of doctors are no longer expressed in the public debate. There is truth in the oft-quoted aphorism attributed to Irish statesman and philosopher Edmund Burke, that '*all that is necessary for the triumph of evil is that good men do nothing*'. [46]

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