Physician-Assisted Suicide: Promoting Autonomy or Medicalizing Suicide?

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Physician-Assisted Suicide

Promoting Autonomy—Or Medicalizing Suicide?

Assisted suicide, many argue, honors self-determination in returning control of their dying to patients themselves. But physician assistance and measures proposed to safeguard patients from coercion in fact return ultimate authority over this “private and deeply personal” decision to medicine and society.

by Tania Salem

Why have physician-assisted suicide and voluntary active euthanasia taken on such vitality in recent years? Some authors stress the conjunction of powerful medical and cultural trends. The advances of modern medicine in association with its overwhelming bias to treat have engendered widespread and increasing fear. More than death itself, what seems frightening is the very real prospect of losing control over one’s own dying process. The reaction to this exorbitant sway of medicine has been nourished since the 1970s: patients’ empowerment or, more generally, the liberal individualism that has vigorously extended into the medical system. In response, advance directives, health care proxies, and other devices founded on the right to forgo medical treatment aim to “protect” patients from physicians, medicine, and hospitals’ institutional imperatives. From the perspective of this recent history, physician-assisted suicide and voluntary active euthanasia are just one more necessary and justified step in this process. It is as if what modern medicine has expropriated from individuals could be returned to them through physician-assisted suicide: control over their own deaths.

These considerations condense two widespread current assumptions in the debate over aid in dying.

The first is that these practices are, for better or for worse, paradigmatic expressions of patients’ autonomy. Although proponents and opponents evaluate very differently the adequacy and the limits conferred to self-determination in this context, they both endorse this general assertion. The second assumption is that physician-assisted suicide and voluntary active euthanasia are ultimate brakes on the unrestrained use of medical technology at the end of life. They are instruments to promote the “demedicalization” of death.

I propose to challenge these assumptions. I want to argue that physician-assisted suicide does not demedicalize death; rather, it medicalizes suicide. By this I mean it transforms a private act (suicide) into a medical event. Indeed, physician-assisted suicide implies not a resistance to but an extension of medical power over life and death. And second, that instead of asserting an individual’s autonomy physician-assisted suicide is in fact an impediment to it.

My analysis accepts the liberal/libertarian presumption that one of the essential attributes of the individual is precisely the liberty to govern oneself free from external constraints. Despite my belief in both the indispensability and inevitability of social constraints, as an analytic device here I will assume radical autonomy to be a moral goal. I will also assume that from the perspective of the physician-patient dyad, more than killing, “assisted suicide” is literally what the phrase states: suicide with assistance, not only because it is the patient who makes the request, but also because it is she who is responsible for the final deed.

Many of those who favor physician-assisted suicide analyze and support it in reference to free choice, individual rights, and moral autonomy. This line of argument rests on a conception of autonomy primarily as “negative liberty”: the right to act and govern oneself in accordance with one’s own private beliefs, values, and choices without interference as long as one’s behavior does not harm others. Proponents assert that this right should encompass patients’ control over the timing and circumstances of death up to and including assistance in suicide. So conceived as a “personal and intimate decision,” the right to aid in dying refers to a sphere of self-determination that should be left free from any paternalistic interference, whether that interference emanates from the state, from doctors, from family members, or from religious or philosophical orthodoxies. Physician-assisted suicide is, in short, advocated as a “natural” extension of the constitutionally protected “right to privacy,” and as a mere specification of the moral right to self-determination.

Opponents of this line of argument contest the pre-eminence conferred on autonomy vis-à-vis other social values and interests. The sanctity of life, the protection of those who are vulnerable to medical or family abuses, the “common good,” and the ethical integrity of the medical professional (that is, the preservation of its ancient vow never intentionally to kill) are variously seen as competing values that in fact outweigh individual autonomy. What is contested is not physician-assisted suicide as an instrument of personal autonomy; critics insist that even if assisted suicide does serve autonomy, limits should be imposed on this value for the sake of other goods. Daniel Callahan’s argument is illustrative: “the acceptance of euthanasia would sanction a view of autonomy holding that individuals may, in the name of their own private, idiosyncratic view of the good life, call upon others, including such institutions as medicine, to help them to pursue that life, even at the risk of common good.”

Thus though they diverge in respect to how far personal autonomy and self-determination should extend, proponents and opponents converge in assuming that these values are ultimately the major forces driving the movement for physician-assisted suicide. A second assumption widespread in the literature—particularly among defenders—is that by enhancing the patient’s control assisted suicide represents just one more necessary step in the demedicalization of death. With the relationship between patients and doctors increasingly seen as a zero-sum game pitting vulnerable patients against the power of doctors and medicine, demedicalization is regarded as a prerequisite to patients’ autonomy and empowerment in the face of death.

Thus proponents uphold physician-assisted suicide as a “natural” and indispensable development of the widely accepted right to refuse and/or withdraw life-sustaining medical treatments. Indeed, Peter Singer argues that the right to refuse is insufficient to grant individuals real control over their dying process. In his own words, “Not killing is not enough. . . . The right to refuse medical treatment can help only in a limited number of cases in which it leads to a swift and painless death. Most cancer patients, for instance, are not in this situation. . . . [This is why] the desire of control over how we die . . . will not be satisfied by the concessions to patient autonomy within the framework of [traditional] ethics.”

**Outer Codes, Inner Individuals**

Incontestably, from a certain perspective physician-assisted suicide is a dramatic expression of autonomy, empowerment, self-determination, and the like. The contemporary debate about death and dying has shifted focus from medical norms to individual rights, choices, and desires, a shift from outer codes to inner individuals. Michel Foucault argues that every moral system necessarily comprises these two aspects: socially stipulated codes of conduct, and a relation to oneself as a moral entity who must evaluate and define a personal stance regarding the proposed conduct. Outer codes and inner individuals thus point not to a dichotomy but to the predominance of one or the other moral perspective: some moral systems emphasize codes (requiring from the individual a strict conformity to them) while others shift the focus to personal “choices.” There is no doubt that the emphasis on inner individuals prevails in contemporary arguments for physician-assisted suicide. Influences from the outside, whether subtle or blatant, are seen as pernicious in subverting the main goal: the “pure” or “true” choice reached from within that at bottom takes account of the interests of the decisionmaker. This self-centered ethics rests on a nonrelational conception of personhood.

The second—and closely related—pillar of this discourse is the insistence that individuals be radically free to exercise their singularities and idiosyncrasies. In pluralistic societies, it is asserted, “there is far from any agreement, or near-agreement, about how one can establish as canonical a particular normative view of life.” Because personal styles, experiences, and beliefs are radically irreducible, it is impossible to suppose a priori that individual choices will coincide; each must find his or her own way of facing dying and death.

Yet there is a paradox underlying physician-assisted suicide. It is conceived of as an intimate, existential act and indeed a response to modern medicine, but at the same time it is a request for the complicity of physicians (and society). In contemporary Western societies the decision to take death into one’s own hands has been construed as an act that is not simply...
personal, private, and solitary, but contrary to social norms and expectations. From a societal perspective, the individual who commits or attempts suicide is in this sense an outsider.

What seems unusual in the debate about aid in dying is the request for public endorsement and legitimation of the act of suicide. Whereas in suicide the individual “drops out” of the social ethos of death and suicide, in the typical physician-assisted suicide scenario, the patient is responsible both for requesting aid in dying and for performing the final deed, and she or he construes the act basically as suicide. Yet as long as the physician is in charge of assisting the patient—either by his or her physical presence or by supplying the medical means to perform the act—physician-assisted suicide entails the medicalization of the act of suicide.

Ideally, for the physician to assist a patient’s suicide the physician must be physically present—as attested in Timothy Quill’s regrets for “abandoning” Diane, leaving her to take the prescribed lethal medication alone. Thus what is intriguing in physician-assisted suicide is not that ventilators, tubes, CPR, and so on are supplanted by “lethal drugs,” but that even in this context the physician and medicine are overwhelmingly present in the setting of death.

Even without the doctor’s physical presence in the last scene, as long as physician-assisted suicide presupposes medical assistance it cannot be conceived as immersed in the realm of self-determination. Unless doctors are reduced strictly to being instruments to fulfill their patients’ desires, physician-assisted suicide enacts what must be seen as a mutual decision. But what kind of questions are at stake in this joint decision? Proponents of assisted suicide suggest that patient and physician discuss the patient’s medical condition and explore alternatives for alleviating pain and suffering. If it comes to it, the physician should provide a prescription for a lethal drug that leads to a “rapid” and “painless” death. That is, the decision to die by suicide is treated precisely as if it were a set of clinical problems to be solved medically—the “private,” “intimate,” “self-determining” decision to commit suicide is translated into a clinical event.

Medicalizing Suicide

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Medicalizing suicide encompasses three different (though interrelated) facets: the medicalization of an act, of a practice, and above all of the social ethos of death and suicide.

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Medicalizing suicide as professional practice. Medicalizing suicide also points to the fact that if legalized, physician-assisted suicide as a legitimate practice would become the prerogative of physicians. Indeed, Jack Kevorkian has seen the exclusive right as the foundation for a new medical sub-speciality of “obitiatry.”

This monopoly leads to the more general question of why aid in dying should be provided only by a medical practitioner. Why, that is, should assistance in suicide be understood as requiring medical authority rather than, for instance, a community of family or friends? The most obvious answer is that physicians—and only physicians—have the necessary technical skills to ensure a “rapid” and “painless” death. But as some critics have noted, “Assisted suicide does not even require medical skill. . . . If freeing up patients truly is the goal, then assisted suicide’s advocates deserve patients when they do not advocate ending the physician’s exclusive power to prescribe medication. Ironically, the advocates of patients’ rights end up empowering doctors more than they do patients.”

Yet even those who maintain that technical knowledge is imperative do not confine their justification of physician-assisted suicide to this reason. Placing suicide under the stewardship of medicine is further defended as a way of “enhancing public accountability of the practice” and “protecting against abuse.” From the patient’s perspective, the request for aid in dying may mean a “desire for companionship in pursuing a difficult course of action, a wish for confirmation of a decision about which the patient is unsure or simply a cry
for help” (pp. 88-89, note 42). Moreover, since suicide is still stigmatized, “seeking a physician’s assistance may be a way of trying to remove that stigma.”20 But inasmuch as cultural preconceptions and loneliness (whatever its source) are far from being exclusively medical issues, we must ask why we expect doctors to respond to them. Two possible answers come to mind: either medicine is moving beyond its proper role, or the scope of medical competence has already been extended beyond appropriate boundaries.

It seems reasonable to conclude that ceding monopoly of assistance in suicide to doctors is anchored in an inflation of the physician’s role, as well as in the extreme idealization of physicians’ character and the relationships they establish with patients. The bond physicians establish with patients is supposedly effective, collaborative, and committed.21 Both this idealization and the willingness to delegate to physicians the exclusive right to assist suicide bespeaks the social and symbolic power already conferred on medicine and medical professionals in our societies. In other words, it is not (or not only) the need for technical expertise that impels us to physician-assisted suicide. Rather, our culture, so impregnated by medicalization, takes for granted that assisted suicide should fall under the control and supervision of medicine.

Medicalizing the morality of suicide. As a legitimate domain of professional practice, then, physician-assisted suicide necessarily involves medicalizing the moral questions surrounding suicide. Physician-assisted suicide presupposes, and ultimately is, a medical judgment about death or suicide; it is a medical evaluation of the fairness and legitimacy of a person’s (not simply a patient’s) desire or choice to end his or her life.

With some few exceptions, even the most radical advocates of physician-assisted suicide recognize the need to establish protocols and guidelines to prevent abuses, protect the vulnerable, guarantee public account-

ability, and even to assure the autonomous character of the patient’s choice. Surely these aims are respectable and the setting up of criteria just and reasonable. Yet establishing medical guidelines also introduces tensions into the value of autonomy in several ways.

The requisites for physician-assisted suicide (must the patient be terminally ill? which medical specialists are best qualified as consultants?) are still being debated. There is, however, agreement about the moral attributes that the patient and his or her request must evince: the decision to die must be “informed,” “rational,” “stable,” and “fully free” or “voluntary.”22 And there is broad agreement that to ensure that these conditions are fulfilled the patient must submit to screening by a team of doctors (the treating physician, a consulting physician, and a psychiatrist) who would evaluate the request for aid in dying.

This requirement assumes that besides undue external influences, some impulses or dispositions emanating from the patient herself or himself—such as depression or guilt—may threaten “pure choice.” “Voluntariness” in this sense must be safeguarded from undue influence stemming not only from outside, but also from within. Ultimately, this is to assume that the inner world may be obscure to the individual, that she or he may be half blind to her or his own choice, desire, or personal truth.

The presumption that the inner world is or may be opaque to the individual suggests a second underlying presupposition: someone other than the person requesting aid in dying has greater expertise in judging the appropriateness of that request. Medical authority, that is, is assumed to have the proper ability to unveil the “real truth” behind the request to die. The patient’s treating physician, along with psychiatric and/or palliative care consultants, is charged to distinguish authentic from distorted choices; that is, to discern whether the request is pertinent or pathologi-

cal (and if so, whether it is “curable” by medical means).

Both these premises obviously collide with the principles of autonomy and self-determination. Both displace the final decision concerning suicide from the patient to the physician’s judgment that the request is appropriate and free from “undue influence.”

The insult to autonomy is not exerted through repression, as was the criminalization of suicide. Rather, it is exercised through what Foucault would call the “normalization” of suicide, the subordination to medical scrutiny of this event and the person making the request.23 The “patient” is subjected to observation, examination, and inquiry to confirm the “rationality” and “voluntariness” of his or her request. Thus medicalizing (assisted) suicide jeopardizes autonomy not only when the patient’s request is denied for one reason or another. Requiring that the patient submit to medical surveillance is, in itself, an outrage to autonomy as this value is classically defined.24

To illustrate how complex is the apparatus through which suicide is normalized, consider guidelines suggested by Frank Miller, Howard Brody, and Timothy Quill, for example. To ensure public accountability for physician-assisted suicide, to guarantee that the procedure is used only as a “last resort,” and to assure that the patient’s decision is genuinely voluntary, the authors suggest palliative care consultants and regional palliative care committees as the core of a whole supervising system.25 Thus the primary physician would be prohibited from providing lethal drugs without prior consultation with a palliative care expert who, based on “examination of medical records and interviews with the treating physician, the patient and the interested members of the patient’s family” (p. 121), would assess the authenticity of the request to die. Patients and their physicians would have the right to appeal the consultant’s denial of requests for assisted suicide to regional palliative care committees. The bureaucratiza-
tion of suicide built into such proposals entails serious constraints on patients’ self-determination.

Subjecting individuals who request aid in dying to this kind of scrutiny further affronts their dignity in putting all such requests under sustained circumstances. Indeed, Ronald Dworkin and others argue precisely that because autonomy must be protected and preserved physician-assisted suicide must be regulated. Under certain conditions the state has the power to override individual rights.

One of the most dramatic aspects of medicine’s extended power over contemporary sensibilities has been precisely medicine’s ability to mold our conceptions about dying.

In the name of protecting individuals from irreparable self-harm all are in principle treated as moral patients rather than moral agents and are presumed to be mentally incompetent. The capacity to make autonomous decisions, which is presumed in all other cases unless demonstrated otherwise, is stood on its head in physician-assisted suicide. Patients must prove their decision-making capacity from the outset.

Subjecting the individual to medical norms in this way also introduces a tension for one of the central questions of liberal philosophers. If, as the liberal argument claims, the morality or immorality of decisions at the end of life rests on the competent patient’s wishes rather than on a distinction between killing and allowing to die,26 protocols that may ultimately deny a patient’s request for assistance in dying assert, in effect, that moral autonomy resides outside the patient’s choice. And if medicine may, morally, reject patients’ autonomous requests for aid, in the context of physician-assisted suicide the value of patient autonomy becomes more rhetorical than real.

Admittedly, even liberal theorists emphasize that there are limits to autonomy, and that like other important rights, the right to physician-assisted suicide is not absolute and can properly be restricted under certain circumstances. Indeed, Ronald Dworkin and others argue precisely that because autonomy must be protected and preserved physician-assisted suicide must be regulated. Under certain conditions the state has the power to override individual rights.

The tension remains, however. In the context of assisted suicide, how is it possible to reconcile the assertion that paternalistic influences are unacceptable with the concept that in some situations the state (or the medical establishment) may deny assistance in suicide in the name of “what it reasonably judges to be the best interest of the potential suicide”?27

Alexander Capron has argued that decisions on behalf of others should rest on a best interest standard of what the “‘average reasonable person’ would do under the given circumstances.”28 Doesn’t this permit the tyranny of the majority over the individual? Doesn’t this menace the right, so praised by liberal theorists, to exercise our singularities in a radical way?

As Yale Kamisar has asked, “[I]f self-determination and autonomy are the major force driving the right to assisted suicide, why should a competent person’s firm conclusion that life has become undurable for her have to be ‘objectively reasonable’? Why should not a competent person’s own evaluation of her situation suffice?”29

To phrase this in terms of the argument I make here, is it ever possible to reconcile medicalizing suicide with autonomy?

It could reasonably be argued that guidelines for physician-assisted suicide do not injure the patient’s self-determination since the request emanates from a patient who supposedly knows the rules of the game in advance. And, the argument would continue, if one does not wish to submit to those rules, “do it yourself” remains a way out. But this seems to admit that ultimately assisted suicide has to do with something beyond strict self-determination, that autonomy is not the primary moral foundation, or at least that if autonomy is to be exercised it demands constant external oversight.

In sum, although advocated in the name of self-sovereignty, physician-assisted suicide ends up reinforcing a power external to the self. It reinforces medical power at the expense of the individual in a very sensitive realm: one’s decision to die.

There are implications for society in this as well.

Not Individuals Alone, But Society Too

There is a certain consensus that the institutionalization of death, its transference from the community to the hospital setting and its medicalization, has extended physicians’ role in regulating death. Today some 80 percent of deaths in the United States take place in health care facilities, while as recently as fifty years ago only a small minority of people died in hospitals or long-term care facilities.

In the wake of the “right to die” movement, today in theory—and to some extent in actual practice—doctors share end-of-life decisions and choices with patients and families. In this sense, all contrive to consolidate “managed death” as the predominant way of dying in the United States. Indeed, the American Hospital Association reported that about 70 percent of deaths in the hospital occur after a decision has been made to withhold treatment.

Despite the space ceded to patients’ autonomous choices, one of the most dramatic aspects of medi-
There Is No Free Lunch

Let us assume that from the point of view of particular patients who will eventually undergo assisted suicide the practice does demedicalize their dying: as long as it hastens death, it liberates them not only from pain and suffering but from the hands of medicine and its paraphernalia as well. This liberation is achieved through torturous ways, however: first, it is precisely physicians who are in charge of freeing patients from medicine. Second, this emancipation presupposes and is achieved at the cost of the individual's submission to medical norms and scrutiny. What the patients' rights movement still struggles to recapture from medicine—control over the decision to die—is being returned to medicine through physician-assisted suicide. Eventually, people will have physician-assisted suicide not only because they want it, but because physicians agree they can have it.

At the societal level too physician-assisted suicide in fact extends the medicalization of death. First, physician-assisted suicide radicalizes the right of the medical profession to make life and death decisions, for now even (assisted) suicide must surrender to its hands. Second, physician-assisted suicide translates one more sphere of personal and intimate meaning into a medical event. Moreover, placing assisted suicide under physicians' control and supervision ends up transforming moral categories (such as "rationality" and "voluntariness") into medical ones.

Perhaps submitting to medical scrutiny individually and to the increasing medicalization of death and dying societally are lesser evils than the agony some people endure at the end of life. Nevertheless, this trade-off should not obscure the price being paid. It urges us, further, to re-examine the claims of honoring personal autonomy and demedicalizing death and dying as the argumentative basis on which physician-assisted suicide rests.

References

2. See, for example, Howard Brody, "Assisted Death—A Compassionate Response to Medical Failure," N E J M 327 (1992): 1384-88. "Failure" in this context refers to the inability of medicine to "arrange a good death."
3. On this perspective, "autonomy" does not mean the absence of social norms; rather, acting "autonomously," "making choices," and similar notions embody a particular kind of social norm, historically engendered.
4. Others stress compassion. Here I focus strictly on justifications for assisted suicide based on self-determination.
8. This is not to deny that some opponents stress intrinsic constraints on autonomy in the circumstances in which physician-assisted suicide is typically requested. The vulnerability and sense of powerlessness so often experienced by a terminally ill patient and the power disparity between doctors and patients is held to make it virtually impossible for the patient to make a truly voluntary decision to die. See, for example, Daniel Callahan and Margot White, "The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village," University of Richmond Law Review 30, no. 1 (1996): 1-83; Herbert Hendin, Seduced by Death: Doctors, Patients and the Dutch Cure (New York: W.W. Norton, 1997); New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context (Albany, N.Y.: New York State Task Force on Life and the Law, 1994).
11. Although he uses a different terminology, Bruce Jennings argues along similar lines. See Bruce Jennings, "Active Euthanasia and Forgoing Life-Sustaining Treatment: Can We Hold the Line?" Journal of Pain and Symptom Management 6, no. 5 (1991): 312-16.
13. H. Tristram Engelhardt, Jr., "Fashioning an Ethic for Life and Death in a

14. It seems ironic that this individualism—which at least in part emerged as a reaction to the power of contemporary medicine—was somehow instigated by medicine itself. As Giles Scofield puts it, "[W]hen medical technology gave us the power to sustain life and permit death to occur, [it transformed] matters of faith into matters of choice." Giles R. Scofield, "Privacy (or Liberty) and Assisted Suicide," Journal of Pain and Symptom Management 6, no. 5 (1991): 280-88, at 285.


17. Jack Kevorkian, Prescription: Medicine (New York: Prometheus Books, 1991). There are indications that the physician-assisted suicide debate is already inciting an internal dispute within the medical establishment over which medical specialty is best qualified to evaluate requests for physician-assisted suicide and to comply with those requests.


25. Miller, Quill, Brody, "Regulating Physician-Assisted Suicide"; see also Miller et al., "Can Physician-Assisted Suicide Be Regulated Effectively?"

26. Dworkin et al., "Philosophers' Brief," p. 45. On this line of argument, see John Arras, "The Right to Die and the Slippery Slope," Social Theory and Practice 8, no. 3 (1982): 285-328. On Arras's interpretation such arguments refuse "to subordinate free choices of individuals to social utilities [and] the most important function of rights is to protect the individual's status as a freely choosing being" (p. 292).


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