JUSTIFYING PHYSICIAN-ASSISTED SUICIDE*

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Debates about the ethics of euthanasia and physician-assisted suicide date from ancient Greece and Rome. When it emerged into public consciousness in the mid-1970s, the debate got off to a rousing start, as philosophers, doctors, theologians, public-policy theorists, journalists, social advocates, and private citizens become embroiled in the debate. On the one side were liberals, who thought physician-assisted suicide and perhaps voluntary active euthanasia were ethically acceptable and should be legal; on the other side were conservatives, who believed assisted dying was immoral or dangerous to legalize as a matter of public policy.

In ancient Greece and Rome, euthanasia was an everyday reality where many people preferred voluntary death to endless agony. The emergence of this issue reflects a basic shift in the epidemiology of human morality, a shift away from death due to parasitic and infectious disease to death in later life of degenerative disease - especially heart disease and cancer, which now together account for almost two-thirds of deaths in the developed countries. In the earlier periods of human history, physicians could do little to stave off death; now, improvements in public sanitation, the development of immunization, the development of antibiotics, and the many technologies of modern medicine have combined to lengthen the human lifespan, particularly in the developed world. For much of human history, life expectancy hovered between 20 and 40; in the development countries, at the beginning of the twenty-first century, it is nearing 80 and, unless infectious disease becomes more prevalent again, is expected to increase. The result is that, in the developed world, with its sophisticated health-care system, the majority of the population in these countries dies at comparatively advanced ages of degenerative diseases with characteristically long downhill courses, marked by terminal phase of dying.

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On average, people die at older ages and in slower, far more predictable ways, and it is this new situation in the history of the world that gives rise to the assisted-dying issues to be explored here.

This widespread acceptance was challenged by the minority of physicians who were part of the Hippocratic School. The ascent of Christianity reinforced the Hippocratic position on euthanasia and culminated in the consistent opposition to euthanasia among physicians. The proposals for euthanasia revived in the 19th century with the revolution in the use of anesthesia. In 1870, Samuel Williams first proposed using anesthetics and morphine to intentionally end a patient's life. Publication of Williams's euthanasia proposal prompted much discussion within the medical profession. By the 1890s, the euthanasia debate has expanded beyond the medical profession to include lawyers and social scientists. Probably the most notable event occurred in 1906 with introduction of Ohio bill to legalize euthanasia, a bill that was ultimately defeated. Two more Parliamentary bills were introduced; this time in Britain in 1936 and 1969. They never sparked widespread public discussion or concern in the medical profession. The euthanasia issue was like a recurring decimal with periodic reappearances. With the increasing acceptance of patient autonomy and the right-to-die in the United States, the euthanasia debate has once again become a matter of public concern.

Physician-assisted suicide (PAS) generally refers to a practice in which the physician provides a patient with a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life. The patient, not the physician, will ultimately administer the lethal medication. Some other practices that should be distinguished from PAS are as follows:

1. Terminal sedation**:** This refers to the practice of sedating a terminally ill competent patient to the point of unconsciousness, then allowing the patient to die of her disease, starvation, or dehydration.

2. Withholding/withdrawing life-sustaining treatments**:** When a competent patient makes an informed decision to refuse life-sustaining treatment, there is virtual unanimity in state law and in the medical profession that this wish should be respected.
3. Pain medication that may hasten death**:** Often a terminally ill, suffering patient may require dosages of pain medication that impair respiration or have other effects that may hasten death. It is generally held by most professional societies, and supported in court decisions, that this is justifiable so long as the primary intent is to relieve suffering.

The debate over euthanasia and physician-assisted suicide pits arguments about autonomy and about relief of pain and suffering on the 'support side', versus arguments about the intrinsic wrongness of killing, threats to the integrity of the medical profession, and potentially damaging social effects on the 'against' side.

Principal Arguments in Favor of Physician- assisted suicide:

*The Argument from Autonomy***:** Decisions about time and circumstances death are very personal. Competent person should have right to choose death.

Justice: Justice requires that we "treat like cases alike." Competent, terminally ill patients are allowed to hasten death by treatment refusal. For some patients, treatment refusal will not suffice to hasten death; only option is suicide. Justice requires that we should allow assisted death for these patients.

*The Argument from Relief of Pain and Suffering***:** Suffering means more than pain; there are other physical and psychological burdens. It is not always possible to relieve suffering. Thus PAS may be a compassionate response to unbearable suffering.

Individual liberty vs. state interest: Though society has strong interest in preserving life, that interest lessens when person is terminally ill and has strong desire to end life. A complete prohibition on assisted death excessively limits personal liberty. Therefore PAS should be allowed in certain cases.

*Openness of discussion***:** Some would argue that assisted death already occurs, albeit in secret. For example, morphine drips ostensibly used for pain relief may be a covert form of assisted death or euthanasia. That PAS is illegal prevents open discussion, in which patients and physicians could engage. Legalization of PAS would promote open discussion.

Others have argued that PAS is unethical often these opponents argue that PAS runs directly counter to the traditional duty of the physician to preserve life. Furthermore, many argue if PAS were legal, abuses would take place. For instance, the poor or elderly might be covertly pressured to choose PAS over more complex and expensive palliative care options.

Principal Arguments Against of Physician- assisted suicide:

*Sanctity of life***:** This argument points out strong religious and secular traditions against taking human life. It is argued that assisted suicide is morally wrong because it contradicts these beliefs.

The argument from potential abuse: the slippery-slope argument: Here the argument is that certain groups of people, lacking access to care and support, may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage option of assisted death. To protect against these abuses, it is argued, PAS should remain illegal.

*Passive vs. Active distinction***:** The argument here holds that there is an important difference between passively "letting die" and actively "killing." It is argued that treatment refusal or withholding treatment equates to letting die (passive) and is justifiable, whereas PAS equates to killing (active) and is not justifiable.

*The argument from the integrity of the profession***:** Here opponents point to the historical ethical traditions of medicine, strongly opposed to taking life. For instance, the Hippocratic Oath states, "I will not administer poison to anyone where asked," and "Be of benefit, or at least do no harm." Furthermore, major professional groups (AMA, AGS) oppose assisted death. The overall concern

is that linking PAS to the practice of medicine could harm the public's image of the profession.

*Fallibility of the profession***:** The concern raised here is that physicians will make mistakes. For instance there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus the State has an obligation to protect lives from these inevitable mistakes.

Moral and legal framework of the physician:

Physicians vary in their moral beliefs and actions regarding PAS. A non-judgmental stance should be taken despite complex legal and moral issues. In a questionnaire-based study conducted on 2761 physicians, 60% agreed that PAS should be legal in some cases. However, only 46% were willing, if PAS were legal, to prescribe lethal medication. 31% were unwilling to prescribe for moral reasons even if PAS would have been legal. 7% reported having written a prescription knowing that the patient intended to use it to take his/her own life. Some physicians provide lethal prescriptions to terminally ill patients even if jurisdictions where the practice is illegal.

Oregon is the only state in US to have legalized PAS and not euthanasia, and that too under certain circumstances in 1997. There is no moral or legal obligation for physicians to comply with a patient's request for PAS even in Oregon. The Oregon Death with Dignity Act (ODDA) applies only to people who have reached the age of majority (legal age) and have been diagnosed as being terminally ill. It offers the successful applicant assisted suicide; a doctor gives the patient a prescription for a fatal dose of barbiturates that the patient can take. This state legislation has received nod of the Supreme Court of United States opening the door to many more such laws across the United States for ending the lives of the terminally ill. In a 6-3 vote, justices ruled that a federal drug law could not be used to prosecute Oregon doctors who prescribed overdoses intended to facilitate the deaths of terminally ill patients. In Netherlands PAS and euthanasia have been practiced openly for

approximately 20 years. These practices have been codified into law and formal guidelines have been established in 2001.

In the U.S. about doctor-assisted suicide has gradually increased. The question of whether or not a physician should be able to assist in the planned death of a fatally sick person has been argued by many different sides. Assisted suicide advocates, such as Right to Die organizations, argue that human beings that are terminally ill should have the right to end their suffering and die with dignity. For others who oppose euthanasia, fear of a "slippery slope", which involve predictive empirical issues about possible future abuse. The issue of assisted death is widely acknowledged throughout the world.

Is physician-assisted suicide ethical?

Killing is understood as morally wrong in virtually all cultures and religious systems. Judaism, Christianity, Islam, Hinduism, Buddhism, Confucianism, and many other religious traditions prohibit killing; so do the moral and legal codes of virtually all social systems. Since suicide is a form of killing, this argument observes, suicide- and with it assisted suicide- is wrong ('sinful', 'taboo', 'reviled by God', and so on) as well.

We know that the ethics of PAS continue to be debated. Some argue that PAS is ethical. Often this is argued on the grounds that PAS may be a rational choice for a person who is choosing to die to escape unbearable suffering. Furthermore, the physician's duty to alleviate suffering may, at times, justify the act of providing assistance with suicide. These arguments rely a great deal on the notion of individual autonomy, recognizing the right of competent people to choose for themselves the course of their life, including how it will end.

Surveys of individual physicians show that half believe that PAS is ethically justifiable in certain cases. However, professional organizations such as the American Medical Association have generally argued against PAS on the grounds that it undermines the integrity of the profession. Surveys of physicians in practice show that about 1 in 5 will receive a request for PAS

sometime in their career. Somewhere between 5-20% of those requests are eventually honored.

It is important to recognize that euthanasia is not a new concept to medical profession. There is a need to understand and analyze the arguments and counter arguments given for euthanasia so that formal guidelines can be worked out regarding this vital issue, for the primary goal of all the medical practitioners is to infuse control in all patients to live gracefully and to die peacefully.

Surveys of patients and members of the general public find that the vast majority think that PAS is ethically justifiable in certain cases, most often those cases involving unrelenting suffering. If a patient's request for aid-in-dying persists, each individual clinician must decide his or her own position and choose a course of action that is ethically justifiable. Careful reflection ahead of time can prepare one to openly discuss your position with the patient, acknowledging and respecting difference of opinion when it occurs. Organizations exist which can provide counseling and guidance for terminally ill patients. No physician, however, should feel forced to supply assistance if he or she is morally opposed to PAS.

Nevertheless, there are some issues that would make the debate of assisted-dying far more open to resolution. First, the debate needs to enlarge the range within which it is conducted. This involves expanding the scope of the issue or issues that are seen as central beyond slippery-slope concerns to the positive case that is offered for accepting and legalizing physician-assisted suicide. There are basic philosophical issues here about autonomy and self-determination, freedom and control, about the moral issues in suicide: these need direct scrutiny.

The benefits of polarized, *for-and-against* discussion have now been largely gained in ongoing argument about assisted dying; it is time to turn to exploring the possibilities for resolution. Advance personal policy making together with public policy that recognizes a default-with-other-options may

be only one of these, though it is true, that it is a promising combination for both theory and practice. Certainly, there may be other fruitful avenues for exploration, but it is high time to turn to the consideration of such possibilities. After all the majority of people in developed countries will die the kinds of death from diseases with long terminal courses in which these issues arise, and it is crucial to find way of resolving the debates. If these debates continue to fuel public polarization and political controversy, it could make all our deaths worse; if resolution can be found, that would be a gain for us all.

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