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Ethics of Euthanasia and Physician Assisted Suicide

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Abstract

A highly debated topic in the healthcare industry has been the morality behind Physician Assisted Suicide and other end of live care options. PAS and euthanasia have been around for decades, however not until 1997 was it legally permissible in the United States. Oregon's "Death with Dignity Act" allows doctors and physicians to legally prescribe patients who qualify with lethal drugs for the sole purpose of ending their life. This bill created much controversy and is still a heated topic of discussion today. I will be outlying the PAS processes seen in three countries, including the United States, The Netherlands, and Canada, along with exploring the qualifications and statistics for each. I will then explore the bioethical approaches of three philosophers, them being Immanuel Kant, David Velleman, and Frances Kamm. I will offer my own thoughts and opinions on the differing approaches along with exploring what each philosopher has to say. I will finish off this discussion by connecting the thoughts gathered with the present day Hippocratic Oath and determining in my opinion whether PAS should be considered morally permissible.

Introduction

The Hippocratic Oath is an oath sworn upon by physicians that outlines the ethical standards and guidelines one must follow as a healthcare professional. With this oath, doctors and physicians swear to do no harm or injustice, benefit the sick, and respect the confidentiality of all patients. Most notably however, the oath states the following: “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan.” Physicians are to respect a patient’s autonomy and beneficence, and according to the classical Hippocratic Oath any sort of euthanasia or Physician Assisted Suicide (PAS) will violate the patient’s rights. However, there is debate as to whether physicians still follow the oath as it is very dated and medicine has evolved. Therefore, this poses the question as to whether physician assisted suicide and euthanasia violates the Hippocratic Oath, or if it can be understood as a way to respect the autonomy and beneficence of the patient.

Physician Assisted Suicide, or Physician Assisted Death, is the act in which a physician provides medication to intentionally end a patient’s life at the explicit request of the patient (Emanuel, 2016). With PAS, the medication is supplied by the physician and self-administered by the patient. In other words, the physician gives the patient the life-ending medication, however they do not administer it. That final decision is entirely up to the patient.

Along with PAS comes euthanasia, which differs slightly but has one main difference. In these cases, the physician both provides and administers the medication to the patient, thus ending their lives rather than the patient ending their own. Euthanasia has three subsets: Voluntary Active Euthanasia (VAE), Involuntary Active Euthanasia (IAE), and Nonvoluntary Active Euthanasia (NAE). The medications used in these scenarios are typically sedatives or neuromuscular relaxants that slowly decrease and eventually cease all bodily functions.

Voluntary Active Euthanasia occurs when there is a mentally competent patient who explicilty requests a physician to administer medication to intentionally end their life (Emanuel, 2016). Involuntary Active Euthanasia is when a physician administers medication to intentionally end a patient's life without the request of a mentally competent patient. In other words, this is when a patient who is coherent and competent receives medication without their own request(Emanuel, 2016). Nonvoluntary Active Euthanasia is when a physician administers medication to intentionally end a patient's life with a *noncompetent patient* who was unable to give consent due to the fact that they have a disease that compromises their decision-making capacity (Emanuel, 2016). Situations in which this may arise is when a patient is too young that they cannot consent for themselves, or the patient has a mental deficit such as Dementia or Alzheimer's.

Section I: PAS & Euthanasia Around the World

PAS and euthanasia can be seen all throughout the world and practices vary depending on the location. As early as 1942, Switzerland became the first country to decriminalize assisted aid in dying, as long as there was no selfish motive in doing so such as obtaining inheritance (Hurst 2013). In the United States, there are 10 states that have legalized PAS, including the District of Columbia (ProCon, 2021). Like previously mentioned, each country deals with PAS and euthanasia in a different way, whether that may be different requirements, processees, or overall different frameworks. The countries discussed here will be the United States, Canada, and the European approach in the Netherlands. Each of these three countries have different paths as to how they got to the legalization of PAS and what the process is like to request highly controversial end-of-life treatment.

In 1997, Oregon became the first state in the United States to legalize physician assisted suicide in an act called the Death with Dignity Act. This act allowed terminally ill, but capable

adults who reside in Oregon who have received a prognosis of 6 or fewer months to live to obtain medication for the sole purpose of committing suicide (Landry 2015). This act however, is not equivalent to euthanasia and is only a legal framework for PAS. Therefore, by no means should a physician be administering the medications to the patient. The physician is to be the supplier of the medications, while the patient self-administers the lethal dose. Under the act, there is a strict set of rules and requirements one must follow and meet in order to be a candidate for PAS. To start, one must be 18 years or older in order to be considered. No child or anyone under the age of 18 can qualify or participate in PAS, no matter the health status of the patient. If the age requirement is met, a prognosis of 6 or less months is given, and the patient is deemed suitable to make personal decisions, then the patient can continue on to the next step. The patient must put forth two oral requests and one written request that has to be witnessed by two separate, independent individuals. No less than 15 days must elapse between the patient's first oral request to when the physician writes the prescription. During this time, the physician must seek a second opinion to confirm that their patient meets the needs and requirements to qualify for the lethal treatment. The three requirements checked by a secondary physician are as follows: the patient is capable of making the decision to request assistance in dying, the patient must be making an informed decision, and the physician informs the patient that they have an opportunity to rescind the request at any time and in any manner (Landry 2015). If, by any means, the secondary physician deems the patient to be unfit due to psychological or psychiatric complications, then the process will be delayed, a prescription will not be written out, and the patient will seek counseling to determine if they truly are fit or unfit to proceed. If the secondary physician sees no wrongdoing, then the attending physician can proceed to write a prescription for the patient and carry on the process.

It is important to note that in the state of Oregon, no healthcare provider is under any duty whatsoever to participate in PAS with any patient. However, they are obligated to help that patient find a physician who is willing and able to take on such a case. In databases collected in Oregon and Washington State over a span of 18 years, PAS accounts for less than 0.4% of all deaths (RTE, 2015). Out of those deaths, about 75% were dying of cancer, while 15% were suffering from neurodegenerative diseases (RTE, 2015). That same study determined that a typical patient who utilized PAS was older, white, and well-educated. Out of those patients, pain was not the main motivation as to why they wished to receive PAS. In fact, less than 33% of patients were experiencing some sort of inadequate pain control. The dominant reasons included loss of autonomy, loss of dignity, and the inability to enjoy life activities (Emanuel, 2016). Patients who wish to receive PAS do not have to be in or experience unbearable pain or symptoms related to their disease or illness. However in other countries, that is not the case.

The Dutch Termination of Life on Request and Assisted Suicide Act is an act established by The Netherlands that lays out requirements and regulations in regards to end of life care. This law was passed in April of 2001 and was put into place exactly one year later in 2002 (Nicol, 2013). Unlike the United States which requires a 6 month or less prognosis, this law requires patients to have "unbearable physical or mental suffering" with no vision of improvements in order to qualify rather than being deemed terminally ill. Also, a big difference between the Netherlands and the United States is that PAS *and* euthanasia are both considered legal, whereas just PAS is legal in the US. Patients as young as 12 years old can request end of life treatment if they are accompanied and receive consent by a parent, guardian, or proxy. If a patient is between the ages of 16 and 17, they are able to make decisions themselves with no parental consent,

however they have to be accompanied by a parent at all times and must be included and involved in discussions and decisions.

Along with the age requirement, there are certain criteria physician's must follow in order to properly determine if a patient is fit for euthanasia or assisted suicide. To begin, the physician must be satisfied that the patient's request is voluntary and well-considered, and that the patient's suffering is considered "unbearable and that there is no prospect of improvement." They have to inform the patient of their situation and future prognosis, and discuss the situation with the patient and reach the conclusion that there is no other reasonable solution. After doing so, they must consult at least one other physician and state in writing that they have seen the patient and determined that the physician has satisfied and met all criteria. At any point however, it is important to note that patients have no absolute right to euthanasia and doctors no absolute duty to perform it. Doctors can refuse to perform any end of life procedure and can pass the case onto another willing physician. In fact, nearly two-thirds of euthanasia requests are refused by doctors (Guide, 2018). This can be due to multiple reasons, including it going against their personal beliefs, the threat of a malpractice suit, or that they believe it goes against the duties of a physician. This debate, along with more in depth ethical approaches, will be discussed later.

The main reasons why euthanasia is requested in the Netherlands is because of pain, degradation, and the longing to die with dignity (Emanuel, 2016). Cancer accounts for more than 70% of call cases of euthanasia and PAS, while loss of dignity is a motive for 61% of cases. Only 6% of patients have neurodegenerative deficits, compared to 15% in the US (Onwuteaka-Philipsen, 2012). Patients who experience depression are more than 4 times as likely to request euthanasia than those who are not, and depression is the root for nearly 7% of cases (Jansen-van der Weide, 2005). However, one of the main differences that have emerged

with respect to euthanasia and PAS in The Netherlands is that the patient does not have to be deemed terminally ill. If doctors agree that the patient's condition will not improve, the patient and the doctor must discuss every possible alternative treatment before settling with euthanasia. If there is a treatment option, then there is prospect for improvement. However, if all treatments have been exhausted, there is no room for improvement, thus making the patient a candidate for euthanasia. A doctor's duty is to preserve life, however when there are no treatment options left, their focus shifts to ending the suffering of a patient. The Netherland's focuses more on the mental well-being of their patients when it comes to assisted death, contrary to the United States which focuses on the physical state and well-being above anything else.

The third and final country being assessed is that of Canada, specifically the province of Quebec. This province's procedure is similar to the United States, as their focus is on those who are near the end of their life and suffering from constant and unbearable pain that can no longer be treated or relieved. Approved in June of 2014 and later placed into effect in December of 2015, Bill 52: An Act Respecting End-of-Life Care established rules and criteria for continuous palliative sedation and medical aid in dying in Canada (Landry, 2015). According to the bill, the main purpose is to "ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy and to recognize the primacy of wishes expressed freely and clearly with respect to end of life care" (Hivon, 2013). In regards to the rules and requirements, all patients who wish to receive end of life care must be 18 years of age or older. There has to be a 10 day waiting period between the written request and the provision of end of life care. Also, patients have to be insured, suffering from an incurable illness, experiencing constant and unbearable physical or psychological pain, and suffering from an advanced state of irreversible decline in capability (Landry, 2015). If all of these criteria are met, then the patient qualifies for

medical aid in dying (MAiD). However, this bill does not allow for MAiD to be conducted under an advanced directive. In other words, a patient must request aid in dying themselves through an aid in dying form rather than simply putting it in their will. However, if it has reached a point in which the patient is unable to sign the form themselves, they can appoint a proxy or a third party to sign the form for them if they have given consent.

In Canada, the reporting of MAiD cases is much more strict than other countries discussed, as all institutions are required to develop some sort of policy and report to the board of directors about their cases. Reports should include the number of requests for MAiD, the number of times aid was administered, and the number of times aid was not administered along with reasoning as to why it was not given (Landry, 2015). From 2016 to 2020, there has been 21,589 total deaths due to MAiD, with 7,595 occuring in 2020. They account for roughly 2.5% of all deaths in Canada, and are slowly on the rise in all provinces in Canada. Cancer accounts for 69.1% of cases involving MAiD, followed by cardiovascular conditions (13.8%), chronic respiratory conditions (11.3%), and neurological conditions (10.2%) (Canada, 2021). These leading causes for MAiD are seen all across the board, with cancer being the leading cause for both the United States, Netherlands, and Canada.

Section II: Ethical Issues andAnalysis

After discussing and exploring PAS and MAiD in three different countries, one of the main differences seen was that European countries often shift their focus away from the term "terminal" and more on the incurable aspect of illness. For the United States and Canada, one must be in the terminal stage of their life in order to qualify for PAS or other end of life care. The topic of debate however is what classifies as "terminal" and at what point is it deemed acceptable for someone to qualify for end of life care. No one can measure pain other than the person

experiencing it, therefore it is difficult to determine when someone has entered the terminal stage of life and no other treatments or cures will be beneficial. Is it morally permissible for a physician to reject a PAS patient because they deemed them not terminal or incurable?

For instance, let's say a patient has been on the transplant list for 10 years waiting for a kidney. During that time, she has been on dialysis three times a week, every week. They have recently come to the conclusion that they no longer wish to continue dialysis treatment due to the fact that it is burdensome and is continuing to make their life more and more difficult. During the next visit, the patient has decided they have had enough and requests to end their life via physician assisted suicide. They believe that stopping dialysis and having the risk of their organs shutting down will be too painful for them to go through, therefore they wish to end their life via PAS. However, the doctor believes more can be done for the patient besides euthanasia. They believe that the combination of pain medications and at home care with the end goal of hospice is the best option for the patient. However, the patient insists on PAS as choosing to stay alive will induce more suffering on themselves. Due to the fact that the physician thinks more can be done, the patient is not deemed "terminal", therefore does not qualify for PAS. Physicians take an oath to always respect a person's autonomy and dignity, however does rejecting their wishes go against that oath? There are three ethical approaches that will be examined in regards to this debate: the Kantianism view, the Velleman view, and the Kamm view.

The first view being explored is the Kantianism view, which openly opposes PAS, euthanasia, and Voluntary Active Euthanasia (VAE). The basis behind this view is that if an action fails to respect the dignity of a person, then it is morally impermissible (Kerstein, 2019). Dignity is the right a person processes to be valued, respected for their own sake, and to be treated ethically. Deciding to end your own life for the sole purpose of relieving suffering fails to

respect your dignity, which in turn makes this scenario morally wrong. It is believed that if a person's worth is unconditional, the person would have positive worth in every context in which they existed. In other words, worth does not diminish in any circumstance. As long as a person maintains their personhood or their quality of being a person, their worth does not diminish. The Kant approach believes that if you are human and you are alive, you have value. He claims that "as long as one has rational nature, a decline or rise in one's sense of self worth does not affect one's worth as a person" (Kerstein, 2019).. Kant believes that your own life experiences do not determine your worth. Human dignity is a natural status that every person is born with, and it cannot be forfeited or earned. Therefore, Kant believes that forfeiting one's dignity and worth is unacceptable. If they maintain their worth and have rational nature, then hastening their life is considered morally impermissible.

For example, if an individual decides to end their own life simply to benefit themself because they do not want to suffer through the last few months of their life, they are thinking more with emotion than they are with rationality. They are using themselves as a means to ending their own suffering, which can be deemed impermissible. A person who chooses to end their own life is choosing what is convenient for them rather than what is right. Therefore, the individual has disrespected their rational nature and their actions are considered morally impermissible. However, if we go back to the Hippocratic Oath, specifically the line in which doctors are to "do no harm", the idea of declining someone MAiD or PAS and instead having them continue suffering could be seen by some as harm. On the other hand, explicitly and intentionally ending someone's life could also be seen as harmful. If all treatment is exhausted and the wellbeing of the patient has deteriorated, I believe it is in the best interest of the patient to have the option to end their own life in a respectable, safe manner. It is better and safer to have

a medical procedure set in place to help aid the patient in a peaceful death rather than have them resort to self destruction and suicide.

David Velleman rejects the idea that a person can justify ending his or her life simply on the basis of benefits and the ending of suffering and harm. Instead, his main argument against euthanasia is that if it were to be legal, patients will be deprived of the default option of staying alive. With the option of ending their own life, they are now responsible for their continued existence. Velleman states “Once a person is given the choice between life and death, he will rightly be perceived as the agent of his own survival” (Symons, 2019) With this responsibility, Velleman argues that if a person has the choice between life and death, not only are you responsible for your own decision, but you have to justify whatever decision is made. He claims that that is a burden to the patient, calling it unjustifiable (Symons, 2019). Overall, he claims that the best policy for euthanasia is simply no policy at all.

In a way I agree with Velleman on the idea that having the option of euthanasia can place some sort of burden on the patient. I believe that having an open option to end their own life could potentially cause them to give up hope quicker, as there is a solution on the horizon which is ending their own life. However, everyone is entitled to their own autonomy and decision making, and I believe that if someone wants to put an end to their suffering, they have the right to do so. Two big concepts for doctors to follow are the ideas of beneficence and personal autonomy. They are to respect the wishes of their patients and the decisions they make, while also keeping in mind what is best for them. Some may argue that performing PAS goes against the benevolence of the patient, as death is not a form of treatment. Some physicians view the practice of medicine as healing and treating their patients, while others focus more on the patient’s health and well being. The latter is what I believe should be followed. All treatments

should be exhausted before the topic of euthanasia comes to the surface. If death is the last option, and if I believe it will most benefit the patient, then that is what I will do. The well being of the patient, along with the autonomy and decisions made by the individual, should be heavily weighed in scenarios involving PAS and euthanasia.

A contrasting view that can be seen is that of Frances Kamm. This view supports the idea of euthanasia in that if a patient is in "intractable pain but has not lost his rational nature", then it is acceptable for them to engage in VAE (Kerstein, 2019). Unlike the Kantian view which focuses on the worth of a person, this view focuses on the distinction between the worth of a person and the worth of their continued existence. It also builds off the idea of rational nature as seen in the Kant view. Kamm claims that if one were to engage in PAS for the purpose of eliminating pain, the person treats the value of relieving? pain as greater than the value of their continued existence, but not their rational nature. Doing so respects their worth, therefore engaging in PAS is deemed appropriate. It is when someone disrespects their rational nature that PAS would be unethical and unacceptable. If someone were to end their life because they simply no longer want to exist, that is in no way justified in this view.

One who objects to this view would claim that there is no way death can be seen as a benefit for a patient due to the fact that they are ending their life. Benefiting a patient means treating them for diseases, taking care of them, and providing the best care possible. However, there comes a point in people's lives where treatment is not enough and rather than providing benefits to the patient, it is doing quite the opposite and making their suffering worse. Consider this thought: If people claim that killing a patient causes more harm, how can a patient who desired death due to their terrible suffering continue to be harmed if their life has ended? In other

words, can a person be harmed by their own death even though they are no longer around to suffer harm?

To an extent, I would argue that this view is the most practical when it comes to PAS and euthanasia. It respects a person's autonomy in that if they wish to end their own life in order to end their suffering, then they are permitted to do so. Most people associate death with negative connotations and see it as always bad, while life is viewed as a positive and what people strive to continue every single day. However, if you are suffering more while you are alive than you would if you respectfully ended your life, I do not believe death would be considered bad for you at that point. Experiencing chronic and life altering pain every day of your life, or being unable to do every day activities because you are bedridden, could make life very bad for you as well. There comes a point in some people’s lives where their suffering gets to be too much that death turns into the lesser of two evils. That is what I believe Kamm is getting at. If there is practical reason to believe that engaging in PAS will most benefit the patient due to the fact that the suffering is too much, then it is morally and ethically permissible. The value of the patient’s pain is greater than that of the person’s worth, therefore respecting the patient’s wish to follow through with euthanasia should be respected.

Section III: Conclusion

Euthanasia and physician assisted suicide is a very controversial topic of discussion. At what point is it morally permissible to end a person’s life because they can no longer deal with the suffering they are enduring? Is it ethically wrong to end a patient’s life if a physician’s main duty is to do no harm? Does performing PAS go against the Hippocratic Oath? I believe that every situation is unique when it comes to end of life care. There comes a point where treatment

no longer is beneficial, so the debate is whether PAS and euthanasia would be an acceptable end of life care option. Doctors pride themselves on doing whatever possible to treat their patients and make sure any decision made is to the benefit of the patient. However if there is no treatment left, PAS PAS should be considered a treatment.

Looking at the revision of the Hippocratic Oath, the main line that I was focusing on throughout this argument was as follows: “I will remember that there is an art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemists drug” (Webicina, 2021). I believe that in an ideal world, if someone is experiencing so much suffering that continuing to live will prompt more discomfort than ending their life, then they should have the option to request PAS. If they are in a state where it is legal, the doctors and physicians agree, and they see the patient as fit, then they should respect the wishes of their patients. I believe that Kamm has the strongest argument on this discussion, in that in most cases involving PAS death is the lesser of two evils.

Physicians want to do anything to make sure their patients remain healthy, are healthy, and continue to be healthy after they receive care. Sometimes, I believe they get so wrapped up in doing whatever possible to treat a patient that they can disregard the well being of the patient during the treatment process. Physicians are seen as problem solvers and they will do anything in their power to solve whatever comes their way, whether it may be treating basic diseases and injuries, pioneering research, or in extreme cases, finding ways to cure the incurable. I think that they get so engrossed in solving problems that they can sometimes forget about what a patient is going through during such a grueling and often painful process. They can forget about the “warmth, sympathy, and understanding” and focus more on the “surgeon's knife or the chemist's drug.” Evaluating all options and exploring different possibilities, along with respecting the

choices of others is all that is asked in a scenario like this. Saving a life is always a goal for those working in healthcare, but sometimes choosing the lesser of two evils is what's most beneficial.

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