An Interdisciplinary View on the Legalization of Physician-Assisted Suicide

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Introduction

When an individual has a terminal illness, death may not always come rapidly or peacefully. More times than not, the individual with a terminal illness goes from being a well, able-bodied individual, to then slowly degenerating into an individual living with unbearable chronic pain and dependence on others to survive. This process of degeneration may be rapid such as in an individual with brain cancer having severe migraines, unrelieved by common pain medication. Soon after, this individual may lose all feeling in their lower limbs and subsequently be bound to a wheelchair for the remainder of their life. Although the onset of symptoms may be rapid, the struggle of waking up every morning just to endure these agonizing symptoms is prolonged and debilitating. Due to the unbearable way chronic illness can take someone's life, a procedure called Physician-Assisted Suicide was adapted to give individuals with a terminal illness the right to die without struggling to stay alive. Physician-Assisted Suicide, otherwise known as PAS, is where individuals with terminal illness receive a prescription from a physician for a self-administered lethal medication to end their life at their expense (Chin et al., 1999). For someone in the state of a terminal illness, who cannot bear the pain of waking up every day and who knows that they will not get better, are essentially forced to slowly deteriorate until their bodies cannot compensate for their illness.

Currently only eight states in the U.S. (Oregon, California, Colorado, Hawaii, Maine, New Jersey, Vermont, Washington, as well as the District of Columbia) have legalized Physician-Assisted Suicide for the case of those with incurable illnesses. However, in every other state, letting someone die in the way that they wish is legal, so what is our moral justification for not legalizing PAS? Currently, those individuals' legal options are limited to choices such as signing a Do-Not-Resuscitate (DNR) order, committing to hospice or pain

management interventions, or even gruesome ways of dying such as starving oneself to death. If this is the case, there is no morally significant reason as to why society should not expand our options to be inclusive of those who desire to die peacefully using a lethal drug, rather than slowly wither away in pain. In this paper, I will argue that if we lack a morally relevant justification for denying death with dignity, then it ought to be legalized. Since there is no morally relevant justification for denying the legality of this procedure, Physician-Assisted Suicide should be legalized in all 50 states.

Supposed Morally Relevant Justifications

As a society, we lack a morally relevant justification for respecting "letting someone die" but not Physician's Assisted Suicide. With this, many people will claim that there is a morally relevant difference between killing an individual and letting them die. Additionally, others will claim that a doctors' oath to "Do no harm" is another morally relevant distinction. In this section, I will argue that these distinctions are in fact not morally relevant and cannot be used as an applicable justification to oppose the legalization of Physician-Assisted Suicide.

Killing v. Letting Die - The Equivalence Thesis

Without hesitation, most individuals may think to themselves, '*It is much worse to kill someone than to let them die.'* With this being said, what is the morally relevant difference between these two concepts? Philosopher James Rachels discusses how there is no morally significant difference between killing someone vs. letting someone die for various reasons. Rachels uses the "Equivalence Thesis" to defend the idea that the difference between killing and letting die does not *itself* present with a moral difference (Rachels, 2001). He makes it clear to not confuse the Equivalence Thesis with believing that every individual case of dying is equally as bad as every individual case of killing, as this is discernibly not true. However, he explains

this theory in such a way that depicts a situation in which killing and letting die, are equal in their corruptness. Rachels describes a situation in which a woman wants her uncle dead, so as a result decides to put poison in his coffee. On the other hand, another woman who also wants her uncle dead is about to give him poison, when she notices him unknowingly drink poison from another source and watches him die while withholding the antidote in her pocket (Rachels, 2001). Here, it is evident that neither woman's actions are better than the other. Therefore, if the only noteworthy difference between killing and letting die is that one is direct murder and the other is indirect, Rachel argues that the second woman's behavior then would be better, however it is not (Rachels, 2001). This concludes that there is no morally relevant difference between killing and letting die.

With the verification that there is no morally significant difference between killing someone and letting them die, one might ask, *'How does this pertain to Physician- Assisted Suicide?'* And with this, the answer is quite simple. As a society, we extend our respect and acceptance to situations of death such as a hospitalized individuals who wish to sign a DNR or in other words, a Do-Not-Resuscitate Order. This medical order essentially instructs health care providers to **not** provide CPR to a patient who stops breathing, ultimately letting them die. Although there is a plethora of possible reasons as to why an individual may wish to sign this document, as a society we will openly respect and consent to this individual's wishes.

Similarly, many patients will also choose to take part in hospice care, particularly those with six-months or less to live, in which the care they receive is comfort based rather than curative. In this case, these individuals for example would receive medication that manages their pain, rather than treating or curing their illness per say. On the other hand, some may choose to reject care altogether, meaning that they may not want to take a life-saving medication or go

through a life-saving surgical procedure. Whatever the reason may be, this individual essentially chooses not to take the pertinent steps in saving their life, such as opting for refusal of treatment for their specific condition.

Lastly, we as a society will even respect the wishes of an individual who chooses to starve themselves to death, in which this death could and would be extremely grueling, painful, elongated, and devasting. Nevertheless, we will accept the wishes of an individual who chooses this route as society has a deep-seated *respect* to understand and accept an individual's wish to die. If all these cases of letting die are appropriate and accepted, and there is no morally relevant difference between killing and letting die, why will we not accept Physician-Assisted Suicide? Why are we so against respecting those who wish to die with dignity? Individuals who desire PAS have a terminal illness in which their one desire is to not prolongate their agony with medications and procedures that have no use in their diagnosis. Their desire to leave the earth in a way where their last memories of life are not memories of crippling pain and the wretched faces of their loved ones, is seemingly not a strong enough justification for society.

Instead of allowing an individual to feel in control of their death and provide some form of comfort in their lasting days, society would rather be against and criminalize the use of providing a safe, lethal dose of a drug to end an individual's life. It is apparent that there is no valid or even excusable reason as to why society legally and morally accepts situations such as DNR orders, hospice, refusal of care, gruesome means to death, and much more, yet are so quick to disapprove and even reprimand the legalization of a safe, effective way of dying.

The Hippocratic Oath

In addition to the argument of Killing v. Letting die, another dispute that concerns itself with the legalization of PAS is the Hippocratic Oath. This oath is known as one of the most

notable pledges made by medical personal that is widely known by many as a physician's oath to "do no harm." This essentially means it is a physician's duty to protect his patients and inflict no intentional harm upon them. Many may argue that the Hippocratic Oath, a body of ethical statements that have traditionally guided a physician's professional responsibilities, directly goes against Physician-Assisted Suicide. One statement within this Oath that opposes Physician-Assisted Suicide goes as follows: "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect" (Hajar, 2017). It is evident that many may reject PAS as they will claim that giving a lethal drug to an individual to end their life is the biggest form of harm that one can inflict upon another.

However, if this notion is true, would allowing someone to die such as by starving oneself to death truly be considered "no harm?" Starving oneself to death is a process that is incredibly painful, extensive, and inhumane. Although no one other than the individual who chose to starve themselves is *actively* inflicting harm, both the medical and legal personnel within our society are allowing that individual to slowly and painfully deteriorate, which in turn, is one of the biggest forms of harm.

To furthermore prove that the Hippocratic Oath is not morally relevant, this was a code of ethics that was composed over 2500 years ago (Hajar, 2017). Due to this fact, when we ultimately view this pledge today, can anybody say with complete honesty that allowing someone to slowly starve to death is not a form of harm? Whereas giving someone a safe and controlled lethal dose of a drug, is? It can be viewed that with this type of logic, our concepts of harm are backwards as it seemingly appears that prolonging pain and suffering is not a form of harm, but Physician-Assisted Suicide is. Many forms of dying that society have not placed a criminal regulation on has caused more harm to an individual than PAS, in which this procedure

would permit the opposite of harm but instead a peaceful death to that individual. It is more harm to allow for a slow, painful death than to give someone a lethal dose of a drug that will not prolong their pain and subsequently meet their wishes. Therefore, the Hippocratic Oath is not a morally relevant distinction.

Virtue Ethics: Compassion

Furthermore, after discussing two morally irrelevant distinctions regarding PAS, one moral consideration that does matter and is in support of legalizing Physician-Assisted Suicide is compassion. However, when discussing compassion, we must first discuss the overarching foundation for compassion which is virtue ethics.

Virtue ethics is essentially a group of ethical theories concerned with the virtues that an individual possesses (their moral character), rather than placing emphasis on duties, roles, or consequences of actions (Hursthouse & Pettigrove, 2018). Furthermore, virtue can defined as such: "The concept of a virtue is the concept of something that makes its possessor good: a virtuous person is a morally good, excellent or admirable person who acts and feels as she should. These are commonly accepted truisms" (Hursthouse & Pettigrove, 2018). Essentially, to have a morally righteous character, you must possess certain qualities that allow you to act in such a way that is considered virtuous (morally right).

Moreover, compassion may be defined as "The ability to identify with the suffering of another or to imagine ourselves in a similar state" (Saunders, 2015). A person may be described as compassionate when they regard another's pain with courtesy, empathy, and dignity. According to virtue ethics, individuals have a moral obligation to develop certain virtues that lead to a good character, ultimately leading to compassion. In regard to PAS, compassion demands that we as a society must accept an individual's wish to die peacefully. This is because

we accept situations in which a person may refuse to keep themselves alive by harmful means. For example, it is compassionate to respect an individual's wish to sign a DNR, but it is truly not compassionate to require other people to degenerate into pain and disability, if they do not wish to choose one of the current options for end-of-life care.

Additionally, one vice that coincides with the disapproval of PAS is selfishness. According to philosophers Rosalind Hursthouse and Glen Pettigrove, "Virtues and vices will be foundational for virtue ethical theories and other normative notions will be grounded in them" (Hursthouse & Pettigrove, 2018). With this being said, one cannot be considered a compassionate person if they accept the current options for palliative care but not Physician-Assisted Suicide. Instead, they would be considered selfish for being against an option to mitigate a person's pain over slowly starving to death for weeks. This is because we as a society are allowing the suffering of others to occur as we do not feel morally responsible for that individual's death. Since we are not a direct factor in that person's death, we do not feel morally obligated to advocate for practices such as PAS, making us selfish. Ultimately, this shows that we as a society have more concern for our own moral worthiness, than the well-being of terminally ill individuals.

Overall, compassion shows what is truly relevant in the situations of suffering due to terminal illness. In contrast, it is not compassionate towards the individual that is dying nor to their respective friends and family to go by the words of for example, a more than a thousand-year-old oath, rather than dealing with the current matters at hand. Compassion would mean offering an individual the chance to obtain a drug to comfortably end their life by their means, not prolonging their pain. Consequently, it is imperative that to be considered a virtuous person,

one must advocate for the ceasing of struggle for individuals at the end of their life, in other words, implementing PAS.

The Need for Change

Given the arguments described above, I have shown that because there is a lack of morally relevant justification towards denying the legalization of Physician-Assisted Suicide, there needs to be parity in options for those with terminal illnesses. We must advocate for the changing of our laws to decriminalize PAS in the states where they are currently not legal, as it is not fair to allow for the harmful deterioration of those with terminal illness when more suitable options are available. Through education of what PAS is and entails, as well as the collective cooperation of individuals within our society, it is entirely possible to make the legalization of Physician-Assisted Suicide in all 50 states a reality.

Objection towards PAS- Slippery Slope Argument

As stated previously such as with the Hippocratic Oath, some individuals may go against the legalization of PAS for a variety of reasons. Another opposition towards PAS can be seen with the Slippery Slope Argument and how some individuals believe that the legalization of this practice may lead to the uncontrolled spiraling of future authorization of dangerous medical procedures.

With the legalization of any law or regulation, it is always a thought that if one act gets legalized, there may be the possibility that another act may become legal as well. The “Slippery Slope Argument” explains how if PAS is legalized, this will ensue a “slippery slope” with other procedures being legalized as well, ultimately ending with the legalization of euthanasia for anyone for any reason (Sulmasy et al., 2016). One argument that hinders the reason for why PAS should be legal is in the case of the Dutch government in the Netherlands. The Dutch

government essentially ceased the prosecution of physicians who voluntarily euthanized their patients in the 1980s, resulting in the legalization of euthanasia in 2001, then moreover the legalization of euthanasia of children in 2004 within the parameters that these individuals' suffering is intolerable or their illness is incurable (Sulmasy et al., 2016).

Although the slippery slope argument has seen to take effect such as in how the Dutch government allowed for what appears to be a rather lenient ruling regarding euthanasia, the exceptionally controlled and extensive testing process to even obtain consent and be qualified for PAS in the U.S. will prevent the unnecessary legalization of other medical procedures. Using the example of Oregon's Death with Dignity Act, the first state to legalize PAS, the extensive process of obtaining these lethal drugs prevents the act from reaching beyond its intended purpose.

To begin, to obtain a prescription for one of the lethal medications, the patient must first be an adult resident of Oregon who is deemed capable of communicating his own decisions about his or her health care and who also has a terminal illness in which their remaining life expectancy is deemed by a medical professional to be within six months (Chin et al., 1999). Following this, the individual must give both a written statement, as well as two oral requests to his or her physician deeming that they understand and desire these lethal medications to end their life. The patient's physician then must confirm the diagnosis of the terminal condition as well as its prognosis, to ensure that the individual does in fact have a limited (approximately 6 months) life expectancy (Chin et al., 1999). The physician must then refer the patient for counseling if they find any evidence that he or she believes the patient's judgment may be impaired by some type of psychiatric or psychological disorder, essentially disqualifying them from obtaining these medications. Additionally, they must also inform the patient of every possible alternative such as

comfort care and other forms of pain management (Chin et al., 1999). Lastly, the physician must also report all prescriptions for the lethal medications to the Oregon Health Division once the medications are given to the patient. This allows for both the physician and the patient to be protected from criminal prosecution (Chin et al., 1999).

It is imperative to understand the notion that the Oregon Death with Dignity Act does not permit *euthanasia*, which is the physician administering a lethal medication to a patient rather than giving it to the patient to administer themselves. Due to the fact that both Oregon and other states in the U.S. which have legalized PAS have such extensive and controlled measures in regard to this process, the slippery slope argument is deemed an invalid opposition towards the legalization of this procedure.

Conclusion

After discussing how both arguments of killing and letting die, as well as the Hippocratic Oath are not morally relevant distinctions, it is evident that there is no morally relevant justification for denying someone death with dignity. With the only morally relevant distinction that is in favor of PAS being compassion, those cannot consider themselves compassionate if they are not able to see how letting those with terminal illness decline is not compassionate, but more so selfish. Additionally, dispelling the concern of PAS leading to legalization of euthanasia for all, furthermore proves that there is no morally significant reason as to why the remaining states in the U.S. cannot legalize this practice.

Moreover, I personally feel that as a future nurse, it is also my duty to advocate for the legalization of this medical procedure as I believe compassion as well as medical equality for all are very significant moral obligations within my future profession. I hope that as I enter the

medical field in the very near future, I am able to be a part of the changes that progressively lead towards the legalization of Physician-Assisted Suicide in all states.

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