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## Why Euthanasia and Physician-Assisted Suicide are Morally Permissible

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Why Euthanasia and Physician-Assisted Suicide are Morally Permissible

Key words: euthanasia, physician-assisted suicide, moral, ethic, bioethics

Abstract: Although there has been much debate about the immorality or moral permissibility of physician-assisted suicide and euthanasia separately, there is little discussion encompassing both debates together. I argue in favor of the moral permissibility of these two topics. The major arguments addressed include some that are frequently addressed such as models of correct use of physician-assisted suicide, quality of life, and individual rights, as well as a few that arguments that have gotten little to no attention such as the utilitarian argument of less suffering and a thought experiment comparing the common euthanization of animals to the controversial euthanization of humans. I next address the major objections that opponents of physician-assisted suicide and euthanasia claim, these include: corruption of the doctor's role as a healer, slippery slope and fear of abuse, and that there are alternatives to euthanasia. Lastly, I respond to these objections with further evidence to support my claim that these acts are morally permissible. The aim of this paper is to make a comprehensive argument in favor of physician-assisted suicide and euthanasia, which are frequently addressed in separate debates.

There has been much argument as to whether physician-assisted suicide and euthanasia are immoral or morally permissible, I will argue that physician-assisted suicide, in which a doctor prescribes a lethal dose of medication to a patient upon their request so that they may end their life, as well as voluntary active euthanasia, in which a doctor directly administers lethal drugs to the patient, are morally permissible and should be legalized.

Acts of euthanasia are categorized as “voluntary”, “involuntary” and “non-voluntary.” Voluntary euthanasia is performed at the request of the patient. Involuntary euthanasia describes a situation in which euthanasia is performed without the patient’s request. Non-voluntary euthanasia relates to a situation in which euthanasia is performed when the patient is incapable of consenting (Bartels, 2010).

Euthanasia is further categorized as active and passive. Active euthanasia refers to the deliberate act, usually through the intentional administration of lethal drugs, to end a patient’s life. Passive euthanasia is used to describe the deliberate withholding or withdrawal of life-prolonging medical treatment resulting in the patient’s death (Walsh, 2009). Passive euthanasia is accepted as morally permissible by much of the population because many see this as leaving the death of the patient to “God’s will”. Passive euthanasia has become an established part of medical practice and is relatively uncontroversial (Walsh, 2009). Critics argue that active euthanasia is not ethical because a doctor directly participates in the patient’s death. Considering that passive euthanasia is legal and is not seen as unethical, I will take the more radical argument in favor of voluntary active euthanasia.

I will make several arguments in support of physician-assisted suicide and active voluntary euthanasia. Within both practices, the people who facilitate the process remain constant (the patient and the doctor together), the only difference between the two is who administers the drug,

the physician or the patient; I see this difference as irrelevant to my arguments. When I speak of euthanasia I am referring to active voluntary euthanasia unless otherwise noted and for the purposes of this paper, euthanasia is synonymous with physician-assisted suicide. I will also address several common objections to these practices.

Plato recommended abandoning the sick people to death, the Hindus entrusted the elderly suffering patients to the Ganges River, and the elderly Eskimos exposed themselves to the cold when they became dependent on the community (Diaconescu, 2012). Euthanasia is not a modern manifestation but the idea was born along with human consciousness of suffering and death (Diaconescu, 2012).

## **ARGUMENTS:**

### *Models of Correct Use For Physician-Assisted Suicide*

Although euthanasia is not legal in any states, physician-assisted suicide is currently legal in Oregon, Montana, Washington and Vermont. In the states of Oregon, Montana, Washington, and Vermont. Laws require that a physician diagnose a terminally ill patient as having a life expectancy of six months or less and a second doctor then must concur with the diagnosis (Worsnop, 1997). Patients must request the lethal prescription twice verbally and once in written form with a waiting period of at least two weeks between the first and last request (Worsnop, 1997). Lastly the doctor who writes the prescription must believe the patient is mentally competent to make the decision. The law also requires that patients be able to take the pills on their own (Worsnop, 1997). Further restrictions exist for the state of Vermont. Drugs have to be prescribed by doctors in Vermont for state residents only. Patient's request for drugs have to be witnessed by two impartial people who are not relatives or potential heirs, employees of health care facilities where the patient is being treated, nor the patient's doctor (Worsnop, 1997). The

trends occurring in these states can project what could transpire if physician-assisted suicide were legalized elsewhere, as well as allow a glimpse into what could happen if euthanasia was legalized. Oregon passed its Death with Dignity Act through a voter referendum in 1994 and started permitting the practice in 1998. Oregon has the lengthiest record of legal physician-assisted suicides so it is frequently used as research for the effects of legalization. The number of Oregonians who choose physician-assisted suicide has been slowly climbing; 673 cases were recorded between 1998 and 2012 and in 2012, the 77 cases reported to the Public Health Division amounted to about 0.2 percent of the total deaths recorded in the state (Worsnop, 1997). In Washington, where the law was established in 2009, 70 people took lethal doses of prescription medicine in 2011 (Worsnop, 1997). The number of individuals requesting the prescriptions is higher in both states, but in Oregon a little more than a third haven't used the drugs after obtaining them (Worsnop, 1997). "I think it's a peace-of-mind thing," says Peg Sandeen, executive director of the Death with Dignity National Center. Assisted-suicide laws merely illuminate what has been going on in the shadows for years.

*Quality of Life: What is Life and is this Different than Living?*

What is the definition of life? Most medical professionals consider a human being alive if there is brain activity, however, I argue that being alive is different than living. Although someone may still be breathing and their brain may still be functioning, if their life is full of suffering without any hope of happiness, is that truly living? Living a full life is multifaceted but most would agree that autonomy is essential. A person's ability to control their own body and do what they like, as long as it doesn't harm anyone else, is crucial to the human existence. But what happens if a person can no longer do what they love? For example, hiking or even eating? What happens when loss of autonomy is taken to the extreme and they can no longer clean

themselves after use of the restroom or breathe without a machine? This loss of autonomy directly impacts the human sense of dignity. Critics argue that embarrassing matters such as this are simply a part of aging, however, terminally ill patients do not feel this way. According to statistics from the Public Health Division of Oregon, terminally ill patients who went through with physician-assisted suicide were asked what their end of life concerns were: 93.5% reported loss of autonomy, 92.5% reported that activities were no longer enjoyable, and 77.9% felt a loss of dignity.

### *Individual Rights*

In the eyes of Oregon's governor, former emergency room physician John Kitzhaber, the answer to the euthanasia controversy is simple: "I believe an individual should have control, should be able to make choices about the end of their life. . . . As a physician, I can tell you that there's a clear difference between prolonging someone's life and prolonging their death," (Worsnop, 1997). Most would agree that each person has the right to control what happens to his or her body and his or her life, then following this logic, why doesn't this right carry over to the right to control how one dies? Values such as privacy, freedom, and autonomy are highly regarded in our society and are frequently protected and yet these rights are not applied to one of the most personal moments of a person's life – death.

Although these arguments are valid and thus used frequently, there are other arguments that receive little to no attention in the intellectual conversation about physician-assisted suicide and euthanasia. These arguments include the utilitarian argument of less suffering and comparing animal euthanasia to human euthanasia.

### *The Utilitarian Argument: Less Suffering*

Jeremy Bentham made an argument for an innovative conception of morality, known as the

utilitarian approach, which is not about pleasing God or being faithful to theoretical rules, but rather is focused on increasing happiness and decreasing suffering as much as possible. The utilitarian approach would argue that euthanasia is morally acceptable because it decreases the misery of everyone involved: the patient, the caretakers, and the family and friends of the patient. Flaws do exist in the utilitarian principle when applied to certain situations, for example: the utilitarian approach would argue that a peeping tom is not immoral if he is not caught, meaning that if his victim was unaware, no suffering would occur and his pleasure would be all that mattered. However, most people would agree that other values such as individual rights, justice, and freedom are equally important. The safeguards that exist in the laws of states that legalized physician-assisted suicide protect patients' rights and maintain justice. Not allowing a patient to decide when his life should end is in fact denying him his freedom. In the case of physician-assisted suicide, the utilitarian approach would state that when a terminally ill patient is kept alive only to die slowly and painfully, suffering is greatly increased for everyone involved. Rather than taking the radical utilitarian approach and killing anybody who is in pain or suffering, I argue for the more moderate utilitarian approach in which the physician-assisted suicide is conducted justly (at the wishes of the patient whose rights are not violated and by a doctor whose moral convictions do not go against the act), then the act alleviates unnecessary suffering and only the suffering of losing a loved one (that will occur no matter the circumstance of death since the patient is terminal) will occur for the family and friends of the patient.

#### *Animal Euthanasia as a Case for Human Euthanasia: A Thought Experiment*

Think about why we euthanize animals: we euthanize them because we feel remorse for their pain and suffering. Furthermore we are aware that in their old age, matters will only worsen. We might feel conflicted when euthanizing our pets because we cannot explain to

them why we are going to kill them. We love these animals and we don't want to kill them, but we know it is in their best interest. Now what if the animal could give consent or could beg you for death? You would still be sad because you are losing a loved one, as is natural, but the responsibility of the decision would be lifted and you would feel less conflicted about the issue. Now if this logic can be applied to animals, why not humans? One may state that this thought experiment is disanalogous. Some argue that human beings are superior to animals because of their mental capacity, morality, or simply by virtue of being human and thus cannot be paralleled to animals. I will not argue that animals and human beings are equal in all aspects but both are sentient beings and thus should be regarded equally in respects to suffering and the relief of this suffering. On the basis that voluntary euthanasia is completely at the request of the patient because of intractable pain they are experiencing, if we can show animals mercy, then why can't we show fellow humans mercy?

### **OBJECTIONS AND RESPONSES TO OBJECTIONS:**

#### *Corrupts Doctor's Role as a Healer*

Opponents of euthanasia argue that there is a moral distinction between actively ending a patient's life and withdrawing or withholding treatment which ends a patient's life. Letting a patient die from an incurable disease may be seen as allowing the disease to be the natural cause of death without moral culpability (Kerridge, 2009). Critics of physician-assisted suicide as well as euthanasia believe that if a doctor takes on the role of the "executioner", his role as a healer will be corrupted and the trust that exists between patient and doctor will be violated. Opponents use the Hippocratic Oath which states "I will never give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect," as evidence of a doctor's ultimate rule not to administer lethal drugs.

*Response to Corrupts Doctor's Role as a Healer*

In response to the use of the Hippocratic Oath as evidence against euthanasia, the next sentence of the Hippocratic Oath states "I will not give to a woman an abortive remedy." If the Hippocratic Oath was followed close to its original text, then abortions would be illegal for doctors to perform as well. The Hippocratic Oath has undergone significant transformations since its conception. Today, there are many interpretations of the original Hippocratic Oath, some following a stricter interpretation and some allowing a looser interpretation. As medicine advances and evolves, it is important to also reconsider the thinking behind medicine. A physician's role should always be to keep the best interest of the patient at the forefront of their practice, but what if the patient believes it is in their best interest to end suffering and die peacefully?

Although some physicians feel that it is not ethical to help their patients die, other physicians believe fulfilling a patient's wish to end his suffering at the end of life is part of the responsibility a physician accepts when caring for the person. Dr. Eric Kress, a family practitioner and hospice care worker, reports an experience with one patient that persuaded him of the existence of this responsibility: The patient was terminally ill with ALS; he had lost 100 pounds, couldn't walk and was being fed through a tube. "He used to be a vigorous guy, but now he was wasting away, and there was no question where he was headed," Kress recalls. His patient, whom Kress considered of sound mind, felt very strongly that he did not want to wait a few more weeks for the disease to end his life. He requested lethal medication. Kress told him he couldn't provide it. A few weeks later the patient had stockpiled enough pain medication to kill himself anyway. But before he died, Kress says, "He called me a coward and said, 'Who are you treating here? Are

you treating yourself or are you treating me?' And he got me thinking, what kind of doctor am I? Am I going to do what I want or what my patients' needs?"(Worsnop, 1997).

The experience that this doctor had counters the main issue with doctors assisting patients with death. One vow a doctor makes is to "do no harm", but if more harm is being done by keeping the patient alive against his wishes, then why is it not within a physician's duties to relieve that patient of suffering? One may object that more harm is done by ending the patient's life, believing that death is the greatest harm that can be done to a person, however, I argue that this objection is false in this situation. Death can be frightening and when death occurs at the hand of another person, it can be murder. The reason why life is so valued and death is so dreaded is because people have ambitions, goals, dreams, and expectations for the life ahead of them. When this future life is abruptly taken away from a person, it is considered a great loss. What if the person knows fully that they have no future and that the little life they have left will be full of extreme suffering? When a patient receives a diagnosis of terminally ill, he will begin to grieve for his life before death is actually near; death may not seem as daunting to this person when it does come. This is why persons with terminal diseases should be allowed to avoid suffering, they have stared death in the face and know it is coming. If a person can overcome the strongest human drive, to live, then the suffering and hopelessness must be so great that it would be immoral to not grant them the mercy of a peaceful passing.

### *Slippery Slope and Fear of Abuse*

Another concern of critics is that the legalization of physician-assisted suicide and/or euthanasia would open patients to exploitation by relatives or others and could lead to widespread euthanasia of the sick, old, and vulnerable (Worsnop, 1997). Opponents note the current laws don't require an independent witness present when a person is taking the

prescription, so there is no way to be sure every dose is self-administered or taken by free will (Worsnop, 1997). Opponents also point out that the law does not require an outside psychological evaluation of patients who request the drugs (Worsnop, 1997). Misdiagnosis of a patient as terminally ill also creates concern. Critics state that persons with disabilities may be at increased risk in the context of legalized assisted suicide and at increased risk of discrimination (Golden, 2010). In essence, these people with disabilities have suggested that euthanasia or assisted suicide will victimize them by devaluing their lives (Golden, 2010). One last issue that deserves noting is the worry that terminally ill patients may be inclined to use euthanasia because of high medical costs and the burden these costs place on their families.

#### *Response to Slippery Slope and Fear of Abuse*

Critics argue that embracing death with dignity would be a risky departure from the value we place on prolonging human life — that allowing death with dignity would invite horrible abuses (Mayo, 1992). Dr. David Mayo, board member of Death with Dignity, impels these critics to consider several aspects of medicine today: current law and medical practice already recognize the right of competent adults to refuse life-prolonging therapies, however trivial (for example, an antibiotic to end a life-threatening pneumonia), and even feeding tubes and hydration via IV. The law also recognizes a terminal patient's right to adequate palliative care, even if this requires doses of powerful pain relievers high enough to hasten death by suppressing respiration. Dr. Mayo suggests that “the fundamental proviso is that the earlier death must not be intended, but merely foreseen by the physician”. In practice this often means the line between “optimal palliative care” and culpable homicide is drawn in terms of the invisible intentions of the physician (on which even he may not be clear). Few patients or family are informed (or ask) whether lethal doses are administered. If ever there was a situation ripe for abuse, this is it.”

In addition, Oregon's 15-year record of legalized Death with Dignity provides convincing data that these abuses have not materialized. Supporters point to a study published in the *Journal of Clinical Ethics* that found no unreported cases of physician-assisted suicide in Oregon, concluding that the laws in place to prevent unjustifiable and illegal physician-assisted suicide are working. In addition, the researchers found that terminally ill people in Oregon were no more likely to consider assisted suicide than people in states where the procedure was illegal (Worsnop, 1997).

The concern that patients may choose the physician-assisted suicide option simply because it will relieve their families of the financial burden of their medical costs is simply not supported by data. According to the Public Health Division of Oregon, only 3.9% of patients that chose physician-assisted suicide reported financial issues being a major end of life concern.

#### *Alternatives to Euthanasia*

Some opponents support, in the most extreme cases, palliative sedation (in which a patient is drugged into semi consciousness to escape pain until he dies) (Worsnop, 1997).

The intention of palliative sedation is to relieve refractory symptoms, never to kill the patient. When killing the patient or hastening the patient's death is the intention, what is done is not palliative sedation but slow euthanasia. In order to achieve symptom control during palliative sedation, the right medication is given at the right dose (Broeckeaert, 2011).

The American Medical Association, along with most opponents of assisted suicide, supports the removal of life-sustaining devices in the last stages of life (passive euthanasia), if patients have indicated such a preference, rather than active euthanasia.

#### *Response to Alternative Care*

In cases where palliative care is effective, I completely agree that it is a suitable alternative

to death, however this is not always the case. Pain medication is often regulated, only allowing for a certain dosage over an allotted time span. When this dosage is not effective, patients are either in excruciating pain or abuses of the drug occur due to increases in the dosage. This increase in dosage can cause adverse side effects. Thus, palliative care is not effective in all cases and alternatives such as physician-assisted suicide or euthanasia should be available to patients as an option.

Palliative care and caring for the dying are often not stressed in the training of physicians. Only six of the nation's 125 medical schools have a separate course on death and dying, according to Barbara Barzansky, director of the AMA's Department of Medical School Services (Worsnop, 1992). A relatively sizable proportion of physicians see palliative care as a last resort, as if they have failed at their practice. Meaningful change may come only through reform of medical education. Physicians must be persuaded, writes Cassel, that "excellent palliative care is a rewarding professional activity, worth the involvement of their time and effort, and that the dignified and gentle death of a patient can be seen as a medical accomplishment of considerable merit rather than as a failure," (Worsnop, 1992).

Another argued alternative is the use of passive euthanasia rather than active euthanasia, asserting that this is a more ethical choice since direct killing is not taking place at the hands of a doctor. But is this really more ethical? Is removing a respirator and allowing a patient to suffocate to death or removing artificial nourishment and allowing a patient to starve to death really more ethical? James Rachel states that active euthanasia is more humane than passive euthanasia as it is "a quick and painless" lethal injection whereas the latter can result in "a relatively slow and painful death."

I have argued that physician-assisted suicide as well as voluntary active euthanasia do more

good than harm. On the basis of respect for quality of life as well as individual rights, persons should have the freedom to decide how they die. After all, these practices do not cause an unseen death, they simply bring an inevitable death quickly and mercifully. The existence of working systems of legal physician-assisted suicide serve as a model to muffle the fears of possible abuse. The main goals of these practices are to reduce unnecessary suffering and to allow a peaceful passing for those who never would otherwise.

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