

Ethical Argument_Physician Assisted Suicide

Ethical Arguments Surrounding Physician Assisted Suicide

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The increase of medical advancements has led to a greater ability to save lives causing healthcare providers to be faced with the great responsibility of holding people's lives in their hands. While medical innovation is aimed at saving lives, the debate about physician assisted suicide asks whether or not providers can also use their influence to aid in ending the lives of those suffering with terminal illnesses or chronic, debilitating diseases. Before discussing the ethical arguments for or against physician assistant suicide (PAS), one must differentiate between different aspects surrounding end of life care such as refusing life sustaining treatment or euthanasia. Today, refusing life sustaining treatment has been legalized through advanced directives such as the MOLST form. The ethical basis for this is that patients have the right to accept or refuse treatment under the Patient Self-Determination Act based on patient autonomy (Bomba & Karmel, 2015). With regards to euthanasia, however, the provider is actively ending the patient's life by means of an injectable drug, creating strong moral arguments against euthanasia.

Physician assisted suicide (PAS) falls in a grey area between these two end of life treatments. Because the provider has somewhat of an active role, and is not just withholding treatment, physician assisted suicide has been a subject of controversy for many years, with some states legalizing it while others are vehemently against it. The ten states that allow physician assisted suicide, also known as "death with dignity", including California, Oregon, and New Jersey, require a waiting period between requests and two physicians to verify the patient's residency, prognosis, mental competence, and voluntariness (*Death with Dignity Acts - States That Allow Assisted Death*, 2021). These states argue that PAS falls under the patient's autonomy, as well as the idea of beneficence, that the provider must do good to the patient rather than allow them to suffer from pain. Those against PAS base their arguments on the foundation

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of the patient-physician relationship. Allowing providers to aid in ending the lives of patients will ultimately decrease trust in providers and also contradict the ethical principle of “nonmaleficence”, of doing no harm. With patient’s lives on the line, and a great moral conflict at hand, the ethical principles behind each argument must be thoroughly studied before creating new legislation either for or against physician assisted suicide.

Proponents for physician-assisted suicide (PAS) often cite patient autonomy as a main reason for PAS to be made accessible. To force someone to participate in a prolonged painful dying process when the option of permanent pain relief is available is unjust (Dykhuis, 2020). Patient autonomy can be defined as “the right of a competent adult to make informed decisions about their medical care” (General Medical Council, 2020). Pain medication, however well managed, cannot alleviate all pain. PAS can also give back some control to the dying patient when it comes to the end of their life. They can choose where they will die, when they die and who they will be surrounded by when the moment comes (Dykhuis, 2020). These are all choices that are taken away from patients when the autonomy or option to choose PAS is not available.

There are arguments against PAS in regards to the patient’s decision-making capacity. They question the patient’s ability to make such a permanent decision when diagnosed with a terminal illness or while dying in pain. However, patients can still have the capacity to make their own medical decisions at the end of their life. In states in which PAS is legal, such as Oregon, it is a requirement that two physicians separately determine the patient’s capacity before PAS can be requested (Dykhuis, 2020). Autonomy cannot happen without capacity, as autonomy requires the ability to discern, understand and decide among options without coercion from others (Spence et al., 2017). There are formal assessment tools used by physicians in order to safeguard against a patient making a decision without capacity (Barstow et al., 2018). In Oregon,

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in addition to a patient being assessed by two separate physicians, the patient must request PAS twice verbally at least fifteen days apart as well as produce a written request for PAS witnessed by two non-relative individuals (Dykhuis, 2020). The argument of diminished capacity could be made for any patient under medical duress which is why standardized assessment tools and safeguards such as more than two physicians are used in PAS.

The ethical principle of nonmaleficence or “to do no harm” and beneficence or “to do good” can both be upheld in physician-assisted suicide when viewed as a legitimate last option for terminally ill patients. Physicians have a duty to act in the patient's best interest. When a patient’s pain is unmanageable even with the highest doses of pain medication, the physician has a duty to offer relief from this. In order to do good and alleviate the insurmountable pain, the physician should honor the patient’s request of physician-assisted suicide. A physician is not inflicting pain or suffering upon the patient, therefore they are not contradicting the principle of nonmaleficence. They are still in line with beneficence by prescribing a medication that can relieve the pain. Physicians are healers of pain and providers of comfort, even when they cannot cure a disease and physicians-assisted suicide reinforces this concept.

Arguments against physician-assisted suicide are rising as the practice is becoming progressively widespread. A specialty of the medical field that is particularly involved in patient end-of-life care and dying is oncology, as patients can suffer from terminal cancers that not only have no cure, but worsen in severity over time. An article in the Journal of Oncology Practice cites the various reasons why physicians in the field of oncology oppose the practice of PAS. One major reason against PAS includes the diminishment of the physician-patient relationship and the potential for medical errors. The imbalance of safety, knowledge, and power between the physician and patient is a major problem when the patient considers PAS. Providers worry that

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the decision to die can be made by the patient erroneously in a time of suffering (O'Rourke et al., 2017). Fear, worry, and pain can cloud the judgement of ill patients and have their decision-making abilities distorted, which makes them arguably unable to give adequate consent.

Prognosis for cancer diagnoses are ultimately averages that can potentially be wrong, and if the patient elects for death under a time of duress, they could mistakenly shorten their lifespan (O'Rourke et al., 2017). Lastly, the physician is not directly aiding the patient in administration of the lethal medication, which leaves room for error in usage.

The second major argument against performing physician-assisted suicide is that assisting in the dying process conflicts with the trainings of a physician, which is to serve as healer and improve patient health. The first tenant of the Hippocratic oath is "First, do no harm"; this teaching is incongruent with aiding in patient death. Alternatives to physician-assisted suicide include the utilization of effective palliative care, and which allows the provider to care for their patients until the time of their passing. Widespread access to quality palliative care is present throughout the United States; patients have the autonomy to decline unwanted treatment with advanced directives and do not resuscitate (DNR) or do not intubate (DNI) orders (Sulmasy & Mueller, 2017).

Physician-assisted suicide continues to remain an ethically controversial issue nationwide where various jurisdictions have made this practice legal under specific circumstances. Those in favor of physician-assisted suicide place emphasis on the ethical principles of autonomy and nonmaleficence, stating that this should be a permissible option for patients and physicians that are willing. A patient's right to make medical decisions about their care should be respected and includes relieving and not extending suffering from pain. However, those against argue that the practice undermines the integrity of physicians and medicine overall, seeing that the profession is

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dedicated to providing care for those with progressive illnesses and not eliminating life or hastening death. There is belief that this will eventually wear away the trust that patients place in their physicians which includes the thought that physicians are dedicated to prolonging and protecting life.

Practicing physicians themselves are divided as well in their beliefs about legalizing the practice of physician-assisted suicide. A study was done where 1000 randomly selected physicians in the US were chosen to question their thoughts on the topic. 60% of physicians thought it should be legalized, however, 13% of the 60% replied “yes” when asked if they would perform PAS if legal. Physicians stated “outside their scope of practice” and “lack of training” as the most common responses as to why they would not be willing to perform PAS despite thinking it should be legal. The next common responses were religious teachings, legal consequences and ethical or moral disagreement to the practice. Relating to the current safeguards in position for PAS, 58% of physicians believe they are adequate and acceptable for protecting patients. Furthermore, 49% concurred that the main reason patients pursue PAS is pain (Hetzler et al., 2019). From these findings, it is clear that there is inconsistency between inclination to support PAS and willingness to practice where ethics and morals can play a significant role in a physician’s decisions.

Recommendations on how this ethical issue in healthcare can be addressed include emphasis on palliative care where an effective and appropriate system is available to all patients with terminal illnesses at the end of life. According to the World Health Organization, palliative care is a widespread approach that improves and betters the quality of life for patients and their families encountering issues associated with life-threatening illnesses. It is done by preventing, treating and alleviating suffering of pain and other difficulties whether it is physical, social,

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psychological or spiritual (World Health Organization, 2020). It allows prescribing pain medications that may have a small risk of quickening death, however, that is not the intention of the clinician but rather treating pain and relieving discomfort which is how it differs from PAS.

Resources can be diverted to improving palliative care as well as nursing homes, at home capabilities and hospitals so that there is effective pain management for patients which makes the process of nearing end of life as comfortable as possible. Acceptable and appropriate relief of pain can be provided to 95-98% of patients nearing end of life with palliative care (Jackson et al., 2019). Patients with advanced fatal diseases or illnesses should be able to receive and expect reliable, consistent and skilled care, where patient education about end of life is a crucial responsibility for clinicians, hospices and support teams. Patients should be made aware that support services are available to them where their goals and needs are addressed. Additionally, it is essential that physicians and other healthcare professionals continue to dedicate themselves into improving care for patients near death as well as use their current and updated knowledge to prevent and relieve pain and associated symptoms effectively.

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