# An Ethical Debate: Physician-Assisted Suicide


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Physician assisted suicide is a prevalent issue facing healthcare providers and consumers in the United States today. The following research investigates arguments supporting and opposing the utilization of physician assisted suicide in relation to healthcare ethics. First, ethical principles will be defined, focusing on the most common principles that will be utilized as arguments in the following literature. Those principles will then be contextualized and evaluated in the literature review, focusing on the relationship between physician assisted suicide and common ethical values. The literature presented is based on information from the United States to keep data consistent with the national healthcare system and common American ethical values. The findings of this review will then be summarized and reflected to reiterate the arguments for and against physician assisted suicide. The paper intends to provide readers with impartial ethical considerations pertaining to the topic of physician-assisted suicide.


**Introduction**

The practice of physician assisted suicide (PAS), or medical aid in dying, is one of the most controversial topics in the healthcare industry. Physician assisted suicide, or the act of a physician administering lethal drugs to a terminally ill patient to end their life at their request, confronts many ethical dilemmas. The four main ethical principles of healthcare--autonomy, nonmaleficence, beneficence, and justice--are all used in support of or against the utilization of this practice. Furthermore, the principle of sanctity of life examines the correlation between ethics and common American religious values.

Autonomy, or as defined by Eileen Morrison in *Ethics in Health Administration: A Practical Approach for Decision Makers,* is the "ability to make individual decisions based on freedom from external controls and take action for oneself" (Morrison, 2020, p. 27). The principle of autonomy is the most common basis of argument for those in favor of PAS and serves as a fundamental principle in ethics. Autonomy focuses on a person's right to self-governance, and the ability to make their own decisions regardless of external influences. Arguments for physician

assisted suicide often integrate autonomy through the focus on the ethical right of patients to make their own choices and have control over their healthcare decisions.

Nonmaleficence is the "ethical and legal duty to avoid harming others" (Morrison, 2020, p. 47) and beneficence is the duty of "acting in charity and kindness" (Morrison, 2020, p. 45). These correlated principles often serve as implied duties in which physicians and providers abide by in order to provide the best quality care for patients. The principles of maleficence and beneficence are most often stressed when terminally ill patients request PAS on the basis of removing or preventing unnecessary harm. Frequently, physicians confronted with this request feel obligated by these duties to fulfill a patient's request of assisted suicide in order to prevent the patient from experiencing unnecessary harm. Conversely, nonmaleficence may also serve as reasoning for providers to refrain from physician assisted suicide. While PAS appears to some as being an act to prevent further harm to a patient, some physicians see it as administering further harm, and contradicting their duty to serve as a healer.

Justice, or the "principle of ethics that addresses what is fair or what is deserved" (Morrison, 2020, p. 57), can be used to argue for the rights of both patients and physicians. Patient justice and staff justice are both vital principles of healthcare, and when confronted with physician assisted suicide, these rights risk being violated. Patient justice raises the concern of patients requesting PAS due to external influences that in turn contradict their personal justice. If patients request aid in dying based on external influences such as societal beliefs or physician opinions, their patient justice is being violated. Furthermore, staff justice for physicians and providers who are being confronted with the request to participate in PAS can often be violated. If physicians' ethical and moral beliefs do not align with the idea or act of assisted suicide, their right to refuse participation is supported by staff justice. Furthermore, physicians are often referred to as the "healers" of society, and arguments often claim that the role of healers should not be associated with the involvement of assisted suicide. It is claimed that a healer should promote healthy lifestyles that lead to longer, healthier lives. If physicians are contributing to the act of assisted suicide, they may be insinuating that they are incapable of "healing" and instead believe the only viable option is death. Furthermore, it is often perceived that the duty of a physician is to provide high-quality care until it is no longer feasible. If physicians choose to impede on their duty to provide care by instead

assisting in patient suicide, their duty and role as a provider may be questioned. Not only do the arguments of physician assisted suicide revolve around the patient, they often concern the moral and ethical pressures facing involved providers.

The principal of sanctity of life is the basis of the final ethical argument regarding physician assisted suicide. The sanctity of life is prevalent in Christianity and Judaism and often serves as a gateway between religion and ethics. This belief argues that the beginning and ending of life should be controlled only by God, and any other entity should not have a say in when or how a life should end. Due to this, the act of a physician performing assisted suicide contradicts the meaning of the sanctity of life and ultimately impedes on the duties of God.

Upon reviewing several arguments for and against physician-assisted suicide, it is clear that there are various viewpoints on the topic. By incorporating several perspectives into the literature review, the goal of this paper is to inform readers of the ethical implications of assisted suicide in an impartial manner.

**Literature Review**

Throughout the article, "Patient Rights at the End of Life: The Ethics of Aid-in-Dying," Mary Atkinson Smith, Lisa Torres, and Terry Burton argue that the four main ethical principles of healthcare are compelling reasons to support the implementation of physician assisted suicide. They claim that patient autonomy should be automatically granted to a patient and should continue through the end of their life. According to this idea, terminally ill patients should be able to continue to implement their right to self-governance when given the option to request PAS. Similarly, abiding by the principle of justice would consist of treating patients 'fairly' by respecting their autonomy, focusing on patient-centered care, and giving them the ability to control their own deaths. Therefore, if autonomy and justice are taken into consideration, "terminally ill patients in their final phase of life should have options available promoting dignity and alleviating suffering while allowing them to make their own autonomous choices when it comes to how they die" (Atkinson Smith & Burton & Torres, 2020, p. 79). In conjunction with this, the principles of nonmaleficence and beneficence should be granted to patients and practiced by their respective physicians. If terminally ill patients believe that death would prevent or eliminate their current state of harm or distress, then nonmaleficence and beneficence grant physicians the right to end or prevent this harm.

Despite arguing that the four ethical

principles of healthcare defend the right to request aid in dying, the authors of this article also acknowledge and discuss opposing arguments. They recognize that two of the most common fears of the implementation of PAS is that it will be hard to control and could impose risks to society. Those who have this fear often claim that if physician-assisted suicide is permissible, any person who requests aid in dying will be granted assistance. This also invokes the fear that people will make rash decisions to participate in assisted suicide if they are not aware of all their options. As a rebuttal to these arguments, they observed data from states that have successfully legalized PAS in their healthcare systems. According to the article, each patient who requests physician-assisted suicide in the United States is legally required to have a two-week waiting period after submitting two oral requests, a 48-hour waiting period after a written request, and the patient must have a terminal illness with a prognosis of 6 or less months to live. This challenges the argument that PAS will be hard to control due to the fact there are multiple requirements that must be met before healthcare organizations give authorization. Furthermore, data proves that there is very low utilization of assisted suicide throughout the United States and not every request for it is granted. In an evaluation of patients in the U.S, Canada, and Europe that chose PAS, it can be observed that there is a commonality in the type of patients that are granted authorization. Over 70% of patients had terminal cancer, were older, and were well-educated. Additionally, their reasoning for making this choice all related to "the fear of losing autonomy and dignity, lack of quality of life, and avoidance of mental and emotional distress" (Atkinson Smith & Burton & Torres, 2020, p. 81). This data supports the argument that authorization for assisted suicide is highly selective, regulated, and often requested on the grounds of maintaining and supporting patient autonomy.

While Atkinson Smith, Torres and Burton use autonomy and information from prior cases of physician-assisted suicide in support of the debate, Cynthia Geppert and Ronald Pies use these same points to argue against such practices. In the article "Two Misleading Myths Regarding 'Medical Aid in Dying,'" Geppert and Pies determine that autonomy coincides greatly with physician-assisted suicide. Rather than taking the approach that autonomy supports medical aid in dying by giving patients freedom of choice, they argue that by succumbing to the act of requesting aid in dying, the patient is "surrendering control to 'the other,' be it physician or government" (Geppert & Pies, 2018, p. 5). In this perspective,

the patient is actually sacrificing their autonomy by giving the last control they have over their life to someone else. More specifically, the utilization of PAS actually "extends medical control over personal conduct, especially at the end of life; and diminishes patient autonomy" (Geppert & Pies, 2018, p. 4). In this perspective, the autonomy of patients is not being preserved, but rather this self-governance is being exchanged for bureaucratic decision making.

The authors further argue the violation of patient autonomy when they bring into question whether or not patients faced reasonable evaluations prior to requesting aid in dying. Factors that influence a patient's wish for physician-assisted suicide may go far beyond their chronic illness, and instead can be due to mental health or family issues. Given that Oregon is one of the few states to legalize physician-assisted suicide, Geppert and Pies refer to the Oregon Death with Dignity Act to support their argument. In 2016, out of the 204 patients that were prescribed lethal drugs by their physicians, only 5 of them were given psychological evaluations. The absence of mental health assessments provides a gray area in why patients may be requesting PAS, and prevents said patients from getting alternate psychiatric care. Similar to the lack of psychological evaluations, there are no procedures done to ensure that the patient's family life has no influence on the patient's decision to request aid in dying. Geppert and Pies emphasize that certain questions should be raised, such as "does the patient have a family member who stands to gain from the patient's suicide—by, say inheriting a large sum of money, or being freed from the burden of caring for the patient?" (Geppert & Pies, 2018, p. 7). If patients feel that they are too much of a burden to family members or that the financial incentives for their loved ones are more valuable than continuing end of life care, that might give them reason to request aid in dying. In this case, these external influences obstruct reasoning behind a patient's choice, which in turn, challenges autonomy.

In continued debate regarding physician-assisted suicide, the ethical theories of Immanuel Kant serve as the framework for various arguments. The philosophical work of Immanuel Kant applies to modern ethical dilemmas with regard to personal autonomy and morality. One of Kant's most distinguishable principles is the concept of autonomy, or self-regulation. He stresses that autonomy serves as a basis for human dignity and allows for the ability of self-governance, even if it contradicts natural instincts. The principle of autonomy is supported by Kant's good-will theory, or the belief that the will of an

action is only inherently good if it is derived from a sense of duty. This indicates that the intent of a person strongly influences the moral integrity of their decisions. In relation to assisted suicide, the intent behind a patient's request for aid in dying has a vast impact on whether this decision would be ethically acceptable. In most instances, patients who request assisted suicide are sufferring physically and mentally from terminal illnesses. In these cases, the intent behind requesting assisted suicide is based on the autonomous right to end one's personal suffering. In accordance with Kantian principles, the duty of these patients is inherently good, as its intent is to minimize pain and suffering. Therefore, the ability of patients to request assisted suicide is morally acceptable as it is in compliance with Kant's principles regarding autonomy.

In an opposing perspective, Kantian theories may also be used to dissent physician-assisted suicide. Dinh refers to Kant's "means to an end" principle to argue against the morality behind assisted suicide. This principle is composed of several guidelines, with one being that a person has a duty to do good, as long the action does not serve as a means to an end. The "end" depicts the desired outcome of an action and the "means" are the actions done to reach this outcome. In the case of assisted suicide, the "means" would be ending one's suffering, and the "end" would be death. Kant explains that one's "end" represents the sanctity of their life, which holds intrinsic value and worth. Due to this, the 'means' must somehow hold higher value than life itself. In this case, the occurrence of pain and suffering does not hold greater value than one's life. Therefore, if the "means" of assisted-suicide is based on the intent to end suffering, it does not justify putting an end to one's life. Furthering this argument, it may be speculated that along with themselves, patients requesting assisted-suicide are also treating their physicians as a means to an end. Dihn argues that if "he destroys himself in order to flee from a burdensome condition, then he makes use of a person merely as a means" (2017, p. 480). Following this principle, the patient would solely be using the physician for their ability to end their suffering.

In compliance with Kantian ethics, Kant's categorical imperative furthers the argument against assisted suicide. The categorical imperative states that an action or duty is only ethical if it can be imposed widely as a universal law. This would require the act to promote a duty in which all individuals would be expected to follow. Dihn states that "for Kant, because universal laws of nature serve to impel the furtherance of life, the maxim of ending one's life when life seems to

bring more ill than happiness cannot become a universal law of nature" (Dihn, 2017, p. 480). Since the universal laws of nature encourage the continuance of life, the request of assisted suicide contradicts these basic principles and therefore could not be seen as universally good or in alignment with the categorical imperative.

In a further look into the principle of sanctity of life is also necessary to take into consideration when discussing physician-assisted suicide. In the article, "Euthanasia and Assisted Dying: What is the Current Position and What are the Key Arguments Informing the Debate," the authors dive into the importance of patient autonomy, the sanctity of life, and the effects that PAS may impose on society. Patient autonomy supports the idea that patients should preserve their own self-determination and "should have a choice in whether or not they wish to continue living with a condition that undermines their inherent dignity and personal identity, without violating the principle of sanctity of life" (Fontalis et al., 2018, p. 409). In other words, it's believed that autonomy should be respected, but should not infringe on the sanctity of life. The principle of sanctity of life is founded on cultural and religious beliefs that the value of life is prevailing, and God is the only one who can determine the beginning and end of human life. Since PAS involves both a patient and physician, it's important to consider both individuals' moral and ethical beliefs. If a physician believes that aiding in a patient's death doesn't comply with their belief in the sanctity of life, their rights to staff justice may be violated. Staff justice, as defined by Morrison, "is a form of justice that deals with the fair or deserved treatment of staff members" (2020, p. 59). Furthermore, the involvement of a physician aiding in a patient's death may then raise societal concerns. Since physicians serve as the 'healers' of society, their role in PAS may be seen as a way to "relieve the social and economic burden of a patient's illness" (Fontalis et al., 2018, p. 412). While this may not be the case, it leads to the possibility of society questioning the integrity of physicians.

Other forms of justice, such as patient justice, also pose the risk of being violated through the implementation of PAS. One of the biggest arguments that Fontalis, Prousali, and Kulkarni explore is the "slippery slope" debate. This means that if physician-assisted suicide is permissible, then patients may request and be granted PAS for reasons other than the end of suffering. This considers the possibilities of assisted suicide being utilized in morally impermissible cases, such as patients suffering from mental illnesses or patients who are coerced by external

influences. In this case, external influences such as financial obligations to continue end-of-life care, mental illnesses, or fear of interdependency may be a reason for some to request PAS. If patients believe they are a burden to their loved ones, financially or mentally, physician-assisted suicide may look like a viable option. Since they would not be requesting PAS solely as a way to end their suffering, the external influence of their fear of interdependency is now an impeding factor. Furthermore, if patients continue to request PAS under these circumstances, it could "potentially lead society toward an attitude that suffering should not be a part of life, interdependency is a burden and the lives of disabled or terminally ill individuals are not worth living" (Fontalis et al., 2018, p. 410). If these external influences serve as a means to request aid in dying, patient justice and autonomy may be disrupted.

After continuous debate on the ethical standpoint of physician-assisted suicide, it is also important to consider alternatives that can be implemented instead. In "Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper," the American College of Physicians discusses the ethical dilemmas providers face during assisted suicide and what alternatives could be enacted instead. Lois Sulmasy and Paul Muellar state that the duties of providers to practice beneficence and nonmaleficence require physicians to embody the role of a healer by acting in the patient's best interest and preventing unnecessary harm. Sulmasy and Mueller argue that if physicians aid in patient death, they're challenging their role as a healer and therefore the main principle of healthcare. Instead, the American College of Physicians takes an opposing position on the issue which emphasizes alternatives to PAS in the form of patient-centered care during end-of-life treatment. They suggest that physicians be present and compassionate, discuss patient care goals, recommend advanced care options, assess pain levels, and coordinate patient centered care options. By utilizing these strategies, "requests for physician-assisted suicide are unlikely to persist when compassionate supportive care is provided" (Muellar & Sulmasy, 2017, p. 10). Although it is not guaranteed that these protocols will prevent all requests of physician-assisted suicides, it ensures that physicians are complying in their duty to act with beneficence.

Sulmasy and Mueller also discuss that "control over the manner and timing of a person's death has not been and should not be a goal of medicine" (2017, p. 11). While death is often inevitable in certain medical cases, the responsibility of when and how it occurs should

not lie in the hands of physicians and patients. It is the physician's duty to provide high-quality care until death, and by assisting in the advancement of the dying process, physicians are challenging this duty as a healthcare provider. If physicians continue to endorse and participate in assisted suicide, it may cause society to question their integrity and sincerity regarding their role as a healer.

**Insights, Reflections, and Commitments**

The implementation of physician-assisted suicide continues to be a debate that affects both leaders and consumers of the healthcare industry. When related to ethics, the principles of autonomy, nonmaleficence, beneficence, and justice are the backbone of most arguments for and against PAS. In support of aid in dying, Kant's good-will theory argues that autonomy protects the rights of patients to make their own choices regarding end-of-life decision making. Furthermore, nonmaleficence and beneficence support the idea that providers should engage in aid in dying if it is believed that this decision will end suffering for and act in the best interest of the patient. On the other hand, arguments against PAS state that autonomy, Kantian principles, and staff justice may be violated during the participation of aid in dying. In terms of autonomy, patients are succumbing to bureaucratic, rather than autonomous, decision-making when handing their final control over to their physician. Furthermore, external influences such as fear of interdependency, mental health issues, or financial incentives obstruct the autonomy of a patient's decision to end their life. In relation to external influences, patients are violating Kant's principle of deontology by making a decision that has a "means to an end" based on external influences rather than their own personal duty. These personal desires then become so prevalent that it disrupts the categorical imperative and eventually violates staff justice by using a physician for one's own personal benefits.

While the utilization of physician-assisted suicide may never be agreed on, there are countless reasonings as to why it should and should not have a place in our healthcare system. Regardless of the issue, the four ethical principles of healthcare should always serve as a basis for all healthcare organizations. Furthermore, administrators and providers should continue to prioritize high-quality, patient-centered care in their facilities. Whether in support of or against aid in dying, physicians and leaders should not let this personal belief affect the overall goal of their institute. In light of this, it is critical that providers and consumers stay true to their ethical beliefs while respecting the viewpoints of others.

Not all physicians may believe their morality aligns with the act of PAS, it is important that patients acknowledge and accept that. Contrarily, if physicians do participate in aid-in-dying, their efforts should not result in society stripping them of their "healer" status. Those who partake in physician-assisted suicide contribute just as much to society as physicians who do not. It is crucial that society finds a balance between physician, patient, and religious ethics. Although there may never be a consensus, it is just as important that these opinions are understood and respected.

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