

PHYSICIAN-ASSISTED SUICIDE:

**the right to life or
the right to death?****MARIA ALISHA GABRIEL**

offers a view on the issues surrounding this most contentious subject.



End-of-life issues are at the forefront of moral and political debate as medical technology advances and our population ages. Recently, Kathleen Gilderdale was acquitted of charges of assisting the suicide of her 31-year-old daughter, who had suffered from myalgic encephalomyelitis.¹ On January 20, 2010, Frances Inglis was given a life sentence for injecting her brain-damaged son with lethal amounts of heroin in order to perform “an act of mercy”.² Arguments surrounding physician-assisted suicide (PAS) are morally complex and have caused great controversy in the United Kingdom (UK).

Clarification of terminology

Tom Beauchamp, a leading bioethicist, defines PAS as a patient’s voluntary choice of death with the assistance of a physician.³ The World Medical Association (WMA) identifies PAS as “knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs”.⁴ In other words, the physician provides the means for death but the patient administers the lethal medication, thus committing suicide. Beauchamp makes a distinction between PAS and euthanasia on the basis that PAS patients do not need to be acutely suffering or terminally ill to request to die.³ The bioethicist Gregory Pence describes euthanasia as “the killing of one person by another

for allegedly merciful reasons”.⁵ The term euthanasia has also been defined as knowingly and intentionally performing an act or practice that ends a person’s life in order to release the person from an incurable disease, intolerable suffering or undignified death.⁴ Euthanasia can be further distinguished from PAS by the fact that the physician directly causes the death of the patient by administering a lethal injection or by withholding treatments in order to bring about the death of the patient.

Euthanasia can be further classified into non-voluntary, involuntary, voluntary, active and passive. Non-voluntary euthanasia occurs when “the person killed is not capable of making or refusing to make such a request”, whereas involuntary euthanasia occurs “when the person killed is capable of making such a request but has not done so”.⁶ Voluntary euthanasia occurs when the patient is fully competent and requests that the physician end his/her life. Active euthanasia entails an act in relation to end of life that has as its organised objective the termination of life.³ An omission can be defined as neglecting to do something that is vital to the survival of the patient. Therefore, by omitting treatment, life support or resuscitation, the physician is theoretically letting the patient die naturally. In end-of-life cases, this is termed ‘passive euthanasia’, and an important distinction is made between overseeing a refusal of treatment and assisting in a suicide.⁷

The principle of double effect

Although the active–passive distinction is used as a moral guideline to separate acceptable practices from condemnable practices, one must ask if there is a conceptual distinction between the two. It can be argued that there is fundamentally no distinction between active and passive euthanasia since the aim and end result of both are the same. Therefore, one may argue that the distinction between the two is only a moral fiction – are not killing and letting die of the same substance? Alternatively, there is an argument that actions and omissions are distinct entities. This draws on the principle of the double effect, whereby each action can be seen to have two outcomes – one ‘good’ and the other ‘bad’. According to this principle, the action is permissible if the ‘bad’ outcome is only foreseen, and not intended. Therefore, giving a high dose of pain medication with no intention to kill but with an awareness of the possibility of the medication hastening death is morally justified under the double effect.⁸ Nevertheless, common opinion seems to be that passive death at a patient’s or family’s request, that is, with intention, is acceptable, but the active hastening of death is not.^{3,7}

The slippery slope argument

As pointed out by Beauchamp, a practice or policy that allows physicians to intervene to cause death runs the risk of abuse and may cause more harm than benefit. This argument is not based on the fear that serious abuses will occur immediately, but that they will grow incrementally over time.⁷ A system that does not have clear-cut boundaries may be open to abuse. Additionally, legalising PAS would effectively cause a decline in the quality of palliative care, and vulnerable patients may be manipulated into ending their lives against their original wishes. Although there is no extensive evidence to support this argument, Beauchamp alludes to the precautionary principle that counsels us that it is better to be safe than sorry. He cautions against taking the chance of eroding the general attitude of respect for life in our society, and alerts us to the risk of inadvertently causing unwarranted deaths, reducing the quality of palliative care or causing mistrust of physicians.⁷ Yet, the likelihood of projected moral erosion is not something we can assess by good evidence. Beauchamp elucidates: “Judging from the past track record of our society, we should seriously take into account that the slope of the trail toward the unjustified taking of life will be so slippery and precipitous that we ought to never embark on it”.⁷

Those in favour of PAS dismiss the slippery slope argument because of lack of evidence and because of its so-called “heavily metaphoric character”.⁷ Instead, supporters of PAS use empirical evidence from Belgium, Luxemburg, the Netherlands, Switzerland and certain states in the United States (Montana, Oregon and Washington), where PAS is legalised. Timothy Quill’s ‘Latest Report Card of Legal Regulation of PAS’ provides evidence that none of the abuses predicted have materialised in Oregon. Quill also concedes that the restrictions set out in the state of Oregon’s Death With Dignity Act have been neither loosened nor broadened.⁹

The competent adult’s case for physician-assisted suicide

A core argument for PAS draws on the fact that the right to die should be a fundamental freedom of each person.³ This liberty derives from a series of landmark cases from *In re Quinlan* (1976), whereby the New Jersey Supreme Court stated that a patient’s rights and autonomy should prevail over the physician’s judgment regarding end-of-life decisions.³ The UK group Dignity in Dying argue that “mentally competent, terminally ill adults should have the choice of an assisted death, within strict legal safeguards, if they feel their suffering has become unbearable”.¹⁰ Supporters of assisted suicide believe that one should die with dignity and not have to endure a drawn out, painful death. Derek Humphrey of the Hemlock Society USA, a national right-to-die organisation, writes:

“It isn’t just a question of pain. It is a question of dignity, self-control and distress. If you can’t eat, sleep or read, and there is certainty that you are dying, it is a matter of dignity to be able to end your life”.⁵ An argument for the legalisation of PAS also draws on the principle of the patient’s autonomy. Autonomy can be defined as a “self rule or freedom of the will that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice”.⁷ The WMA ethics manual states that physicians are obligated to respect the decision-making capacities of autonomous persons.⁴ Decisions about death are personal, and because of this, advocates of PAS believe that any competent person has the right to make decisions about when to end his or her own life.⁷ It has been argued that complete prohibition on assisted death infringes upon the patient’s personal liberty. This argument centres on the belief that the State should not impose a view of when or how its citizens should die.

Physician-assisted suicide and the autonomous disabled

Respecting the autonomy of patients is a professional obligation that extends to those who are disabled but competent. Such is the case of Paul Longmore, a ventilator-dependant quadriplegic.⁴ Longmore argues that our society is hostile and prejudiced against those who look differently and function differently because they require and increasingly demand alternative physical and social arrangements to live ‘normally’.¹¹ In our society, disability incurs a loss of self-control and self-determination, loss of one’s humanity and separation from the human community or, in other words, social death. This impression stigmatises and segregates those who are disabled, leaving them in a position where their so-called autonomous decisions to die are actually bogus.¹² By creating intolerable conditions for disabled people, society paints them into a corner whereby the right to die inevitably becomes a duty to die. Such patients are so socially oppressed that they feel pressured into ‘choosing’ to end their lives. The message to disabled people is that rather than upholding your right to live productively and meaningfully, this society chooses to engineer your death.^{5,12} Essentially, the argument is made that advocates of assisted suicide assume a non-existent autonomy and therefore offer an illusory self-determination.¹¹ It must be kept in mind that life can continue to be fulfilling even with severe disability. Pence states that: “[a]lthough wanting to die after being horribly burned or after being diagnosed

with a terminal disease is understandable, people who are in the throes of depression frequently don't understand how they can come to feel much better".⁵ By this logic, their request to die is irrational since it can be argued that such patients are not competent and therefore are not autonomous.

Distributive justice

Distributive justice refers to the fair, equitable and appropriate distribution of all rights, responsibilities and goods in society.⁷ At a time when medical funding is restricted and progressively decreasing, is it ethical to engage in expensive treatment of terminally ill people in order to extend their lives by a few weeks? This argument is called 'the rule of rescue' and is continually put forth by PAS advocates. For example, Elizabeth Bouvia, a woman almost paralysed by cerebral palsy, fought to refuse sustenance in order to end her life. The courts denied her request in 1986 and, as of 2008, she is still alive and receiving 24-hour care.⁵ As a result, the money used for her care was not available for other medical services. Distributive justice warrants us to consider if it is ethical to spend money on those who wish to die when there are others who want to live but do not have the resources.

From 1933 to 1945, during the Third Reich in Germany, Nazi doctors justified medical killing with the crude concept of *Lebensunwertes Leben*, which translates to "life unworthy of life".⁵ This idea, purporting that those who are weak and dying are not worthy of life, completely diminishes the sanctity and value of human life. This argument is easy to refute on the basis that treating those who are dying as a numerical value or a burden on society contradicts the duty of the physician to preserve every life, especially those who are weak and suffering. Moreover, prognosis is an imperfect science, and it is not uncommon for terminal cases to survive for years despite having been given a prognosis on the order of months.

Concluding remarks

I believe that conditional or unconditional legislation permitting PAS would drastically lower the respect for and value of human life. PAS may seem like a quick fix for the pain and suffering that our society is so eager to resolve; however, I believe we must be cautious of the consequences of 'the slippery slope'. Although it has been argued that PAS allows for the dignified death of a patient, I would not consider suicide to be a dignified death. By condoning the death of those who are terminally ill, PAS may in turn lead to discrimination against those who are mentally and physically weakest in society. Furthermore, this promotes the idea that life is only worth living if you have a certain level of health. In my opinion, it would be better to promote ideals that are centred on the value of life and to inform patients and their families of alternatives to PAS. If these patients were made to feel that they were not a burden to society and were provided with better care and resources, I believe they would learn to value their life, regardless of age, disease or disability. The Hippocratic Oath, which we as physicians take, promotes the preservation and sanctity of life, and thus cannot condone PAS.

*"Our present social context is marked by a dramatic struggle between the culture of life and the culture of death; therefore, we must develop a deep critical sense capable of discerning true values and authentic needs."*¹³
Pope John Paul II

Acknowledgements

I would like to sincerely thank Dr David Smith and Dr Noreen Carroll for inspiring my interest in bioethics, for their help with editing and their continuous support. I would like to acknowledge the help of my sister, Maryssa Gabriel LLB, for her technical support in examining the legal arguments surrounding PAS.

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