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Zoe I. Marinacci
Gettysburg College

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Physician Assisted Dying as an Extension of Healing

Abstract

The role of a physician is to provide care for those who seek their assistance. Lisa Yount attributes the most ancient statement about this activity to the Hippocratic Oath. Many doctors, in fact, still take this oath, part of which reads, "I will [not] give a deadly drug to anybody if asked for it, nor will I make a suggestion to that effect," (8). This vow is still widely considered to be the ultimate statement of the physician's moral creed (Yount 8). Debate over whether active physician assisted dying is an extension of healing ability or a violation of their moral code is a longstanding argument. As medicine has developed, legal systems around the world have attempted to meet the needs of the patients in end of life care, but the practice of active physician assisted dying remains illegal in most parts of the world. Passive physician assisted dying is a generally accepted legal option for patients in extreme suffering, or terminal cases based on the intent to relieve pain. Due to its legal status and its shared intent with active physician assisted dying, it presents a strong pretense for the legalization of active physician assisted dying. Arguments posed against the legalization of active physician assisted dying are founded on hasty assumptions of extremity that can be disproven. Critics are worried that patients will be forced to make hasty decisions to end their lives, will be vulnerable to a pressured request for death even if they are unwilling to die, that physicians will end lives of patients who could have been adequately alleviated otherwise, and that regrettable societal consequences will result from people losing the ability to distinguish between permissible and impermissible forms of death. Active physician assisted dying should be legalized for all suffering persons because it is an extension of the physicians healing abilities in correspondence with a person's right to die.

Keywords

Euthanization, Physician, Death, End of Life Care

Disciplines

Applied Ethics | Ethics and Political Philosophy | Philosophy

Comments

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Zoe Marinacci

Buz Myers

Research Paper

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Physician Assisted Dying as an Extension of Healing

The role of a physician is to provide care for those who seek their assistance. Lisa Yount attributes the most ancient statement about this activity to the Hippocratic Oath. Many doctors, in fact, still take this oath, part of which reads, “I will [not] give a deadly drug to anybody if asked for it, nor will I make a suggestion to that effect,” (8). This vow is still widely considered to be the ultimate statement of the physician’s moral creed (Yount 8). Debate over whether active physician assisted dying is an extension of healing ability or a violation of their moral code is a longstanding argument. As medicine has developed, legal systems around the world have attempted to meet the needs of the patients in end of life care, but the practice of active physician assisted dying remains illegal in most parts of the world. Passive physician assisted dying is a generally accepted legal option for patients in extreme suffering, or terminal cases based on the intent to relieve pain. Due to its legal status and its shared intent with active physician assisted dying, it presents a strong pretense for the legalization of active physician assisted dying. Arguments posed against the legalization of active physician assisted dying are founded on hasty assumptions of extremity that can be disproven. Critics are worried that patients will be forced to make hasty decisions to end their lives, will be vulnerable to a pressured request for death even if they are unwilling to die, that physicians will end lives of patients who could have been adequately alleviated otherwise, and that regrettable societal consequences will result from people losing the ability to distinguish between permissible and impermissible forms of death.

Active physician assisted dying should be legalized for all suffering persons because it is an extension of the physicians healing abilities in correspondence with a person's right to die.

The legalization of physician assisted dying is a long-standing debate of ethics in the medical field. Attempts to legalize it in the United States began in 1906 in Ohio but were not largely supported until the increased presence of chronic illnesses resulted from longer life expectancies and improved medical technology in the late 1990s (Yount 11). The definition of active physician assisted dying is that the physician takes a physical role in the administration of a medicine intended to end the life of a patient (Verelius 665). The first right-to-die case came before the United States Supreme Court in 1990 when the family of a young woman, Nancy Cruzan, who had been involved in a car crash and was kept alive in a vegetative state for 7 years in the state of Missouri requested that the feeding tube keeping her alive be removed. Initially, the US Supreme Court ruled that "a competent person had a constitutionally protected right to insist on clear and convincing evidence of wishes of patients who did not have decision making capacity before such treatments was discontinued" but upheld Missouri's right to insist on clear and convincing evidence of the patient's wishes who did not have decision-making abilities before treatment is discontinued (Dowbiggin 164). The family's lawyers garnered more evidence and came back to a trial which Missouri withdrew from, allowing the feeding tube to be removed. This case was viewed as the US Supreme Court's recognition of a person's right to die, and therefore a huge step towards the right to active physician assisted suicide.

Despite the US Supreme Court ruling, and the initial refusal of the Missouri Supreme Court to allow Cruzan the right to die, the Missouri Department of Health remained committed to honoring her right. In a brief presented to the court, the Missouri Department of Health, "would not stand in Cruzan's parents' way to remove her life support" (Dowbiggin 165). Although staff

members of the Missouri Department of Health are not practicing physicians, they work more closely with medical professionals than the politicians employed by the state's Supreme Court. Their commitment to legal access to physician assisted dying, especially this early in the crusade for its acceptance, shows the medical field's commitment to the idea that physician assisted dying is an extension of their healing abilities.

Patients in America, since the Supreme Court Ruling in 1996 and 1997 can refuse or elect the withdrawal of their treatment to go through what is called passive assisted dying. Despite this, according to the Federal Supreme Court, they still do not have Constitutional right to end their life with the active assistance of a physician (Spence et al 695). Today, active physician assisted suicide is legal in some other countries, as well as some states within the United States that have passed legislature making it legal in Oregon, Washington, Vermont, Montana, California, Colorado, and Washington, D.C. (Myers 400). Studies of public opinion also show that the international trends have moved in favor of assisted suicide which indicates its relevancy in household and legal conversations around the world (Myers 400). Continuing forward in a world where chronic diseases are so prevalent and life expectancies are increasing tremendously, it is only humane that the legal system address the validity of active physician assisted dying.

Passive physician assisted dying and active physician assisted dying have similar intentions: to relieve a suffering person. The nature of suffering, however, is different in both methods which warrants the legalization and access to both. It is a patient's right to choose which will be more effective for their personalized end-of-life-plan. In passive physician assisted dying, it is likely that the patient is already close to death in the terminal stages of their illness and will only require care to manage their physical pain after all treatments for the disease are withheld. This is an intentional act to avoid the prolongation of life (Ho 26). The option of passive assisted death

is a given right according to US law and is further supported by the presence of hospice care (Spence et al 696). In many cases, patients who elect for this form of dying are already in immense amounts of physical pain as a result of the attempted treatment of their disease. If the treatment becomes “burdensome,” or they have no curative options available, they may elect for passive physician assisted dying (Spence et al 696). The patient will have the pain treated until their death while the medicines maintaining their life are withdrawn (Ho 27). It is important to realize that the primary reason for the election of passive physician assisted dying is the physician’s healing of physical pain.

In the case of active physician assisted dying, the complexities of suffering are often much more. In fact, studies found a surprising factor in patients who underwent physician assisted death under the Death with Dignity Act in Oregon, most of whom were already receiving hospice care and all of which lived in the state with, arguably, the best end-of-life care in the country. Patients who completed their deaths under the Death with Dignity Act did not cite pain or other physical conditions as the primary determinants of their decisions (Wineberg and Werth 514). This finding is significant in the separation of active and passive physician assisted dying and indicates a need for each individual method.

Motivations specifically associated with active physician assisted dying are mainly connected to the loss of control at the end-of-life. Howard Wineberg and James L. Werth Jr. concluded, after consultation with the physicians of patients who underwent active assisted dying, that the key factors involved with physician assisted suicide are loss of independence, loss of autonomy, lack of control over body functions, and the loss of ability to participate in enjoyable activities (505). This phenomenon is amplified in a study assessing the lack of dignity associated with end of life care in cases of non-cancer. Results of patients with Amyotrophic Lateral Sclerosis (ALS)

show that the largest concern associated with the development of their disease is “not being able to continue my usual routines” (Chochinov et al 7). Only passive assisted dying is legal and generally accepted at this point because society assumes that physical pain is the main factor involved in the desire to end one’s life. Disproportionately though, patients who are in extreme suffering identify factors other than their physical pain as their motivations to end their lives which should be a sign that active physician assisted dying aligns more complementary to their wishes to eliminate this loss of control because of its definite timeline. With access to active physician assisted dying, patients have significantly more control over exactly when they die, eliminating the increase of their loss of control and autonomy which would instead be amplified in the case of passive assisted dying.

The illegal status of active physician assisted suicide undermines the severity of suffering of many patients who cite reasons other than physical pain in their choice. In fact, some participants explained this phenomenon in a study analyzing the feelings and observations of family members involved in the decision making process of patients who underwent active physician assisted death. The study points out that, “Some participants recalled that they only understood the depth of the patient’s suffering after the assisted suicide” and proceeded to explain that, “The actual assisted suicide allowed them to acknowledge the intensity of the patient’s suffering” (Gamondi et al 1090). Harvey Max Chochinov explains in his study on the dignity and distress towards end of life across non-cancer populations when he states, “Despite their... psychological and existential suffering, patients with non-malignant conditions such as ALS, End Stage Renal Disease (ESRD), and Chronic Obstructive Pulmonary Disease (COPD) tend to be underserved by palliative care” (2). The idea that psychological and existential suffering requires less care

than physical pain in end-of-life- procedures totally undermines a huge percentage of suffering patients who deserve healing.

Additionally, the issue of adequate end of life care as provided by family members is an increasing issue which warrants the necessity to shorten the process of death. This factor is illustrated most vividly in the case study by Wineberg and Werth on physician assisted dying in Oregon, where it is legal. The data show disproportionate numbers of divorced persons electing to undergo physician assisted dying (513). This concept amplifies the effect of loss of independence.

Not every divorced person is lacking a spouse-like partner, or children to support them, but a disproportionate number of them are, resulting in the necessity for a certain level of independence to sustain normal life. Spouses and children are usually the primary caregivers for terminally ill persons, meaning that a divorced person has significantly less family resources in end of life care. Studies found that patients who were not married were less likely than married persons to receive assistance from family and friends (Wineberg and Werth 506). The resulting “desire for death” stems from that loss of ability and the hopelessness associated with considering end-of-life options following their inability to care for themselves. Their only perceived option may be to hire others to assist them with their everyday tasks, but this demographic of people is less likely to be able to pay for care than if they were married (Wineberg and Werth 506). The practical implications of loss of independence and autonomy are growing and warrant the need for end-of-life decision-making ability to be accessible in the form of physician assisted dying.

An assumption made by critics of legalized active physician assisted death is that patients will be forced to make hasty decisions to end their lives. In a Swiss case study, families were

asked to speak on experiences following the completion of their family member's active physician assisted death. The selected family members were involved in their relative's decision-making process, and every family member spoke on a range of a five-step decision making process beginning with contemplation, moving to gaining acceptance, then gaining permission, explaining organization, and evaluating the aftermath. In the discussion of the study it is stated that, "Consistent with earlier research, assisted suicide appeared to be predominately the result of a thoughtful, complex, and negotiated decision" (Gamondi et al 1090). All contributors to the study had pertinent information to contribute to all five steps, indicating that the patients thoroughly analyzed the decision before following through.

Corresponding with pressured death, the worry that undereducated individuals will be unfairly targeted to elect for physician assisted dying is one shared by many critics. However, in the case study analyzed by Wineberg and Werth, a disproportionate number of people who elected for assisted death were educated above the high school level. Studies of public opinion show that those with higher education are more supportive of assisted suicide (Wineberg and Werth 508). The study also speculated that poorly educated persons may be more distrustful of the medical profession which may be the cause of their disproportionate election to continue with their "natural" process of dying (Wineberg and Werth 509). The supportive data shows that individuals educated at the high school level or less are less likely to elect for physician assisted dying in their end-of-life care plans, indicating that they are realistically not a target for exploitation.

Due to the extreme moral significance associated with the decision to assist in a person's death, it is unlikely that logically, the medical team involved will hastily recommend the death of a patient. In an argument written by Jukka Varelius, it is established that generally, active

physician assisted dying has a heightened moral significance than passive assisted dying, and that when a decision is more significant morally that people tend to pay more attention and treat the decision with more care (667). For example, a surgeon would take more care and precision when performing a complicated procedure on another person than they would in taking a few aspirin for their own headache. Therefore, when the medical team is confronted with the possibility of assisted dying as an option, the decision-making process will logically take more time (Varelius 668). So, if the passive dying, or withdrawal of treatment is legal and accepted to not be a hasty end-of-life option, then active assisted dying should be considered even more of a thoughtful, relevant option.

Another argument against the legalization of active physician assisted dying is that vulnerable patients who are unwilling to die will be pressured to request for death. Varelius addresses this in his argument by explaining that by nature, people are less likely to partake in something considered to be more morally questionable (668). For example, a person is less likely to cheat in a high stakes poker game than they are when playing casually with a group of friends. The temptation is minimized in the case of lessened moral questionability because of the increased chances of acceptance (Varelius 669). If that person got caught cheating in the high stakes match, they could lose everything they owned and never be allowed to participate again, whereas getting caught with your buddies might just mean that they scold you and keep a closer eye on you for the succeeding matches. In the case of physician assisted dying, the moral questionability is perceived as being much larger, so physicians will be less tempted to partake in the malpractice of the procedure as it can quickly result in the suspension of their medical license and therefore limit their ability to work which would affect them significantly both economically and socially.

Many patients' requests for assisted death are not accepted. In the Netherlands, physician assisted death is legal in cases of "unbearable suffering" with no hope of relief, but their condition does not have to be fatal. Statistics are showing that requests for assisted dying in the Netherlands have increased by about 3% since the legalization, but that only about half of all requests are approved ("Euthanasia deaths becoming common in Netherlands"). This fraction of acceptance illustrates physicians' unwillingness to pressure for assisted death. Based on a study in the Netherlands, patients who had their requests for death denied suffered a higher occurrence of mental health problems than patients whose requests had been granted (Dees et al 346). This statistic indicates that despite a patient's dedication or expectation for acceptance, physicians are more likely to advise against assisted death than they are to pressure for it.

Next, the worry that physicians will end the lives of patients who could have been adequately alleviated otherwise is one shared by many who do not support the legalization of active physician assisted dying. However, as previously discussed, the chances of a physician making a hasty decision when considering assisted death as an option are very low. There are many criteria that the patient must meet to be considered a candidate for the procedure. In most places where active physician assisted dying is legal, it is under the premise that a person is suffering inexorably. In some fewer progressive cases, the disease of the patient electing for assistance in their death must be terminal, meaning that it would cause death in 6 months or less on its own (Wineberg and Werth 502). This asserts already that a person will not be allowed the option unless it is certain that their disease will cause their death within a specified amount of time.

Additionally, to prevent misuse of the practice it will be important to monitor and record the purposes for which it is used. Gerald Dworkin suggests in his book, *Euthanasia and Physician-Assisted Suicide: For and Against*, that a monitoring system be implemented to track patients'

requests for death. This system would detect unreasonable factors such as family abuse, financial coercion, or requests motivated by undiagnosed or untreated pain (51). This “double-check” system would minimize the number of deaths attributed to causes that could have been treated. This system can also serve as a database to recommend help to people who are suffering from abuse, untreated or undiagnosed diseases, thus increasing the scope of general treatment and fulfilling the physicians ultimate healing goal while avoiding the over-prescription of death to those who can otherwise be helped. Along with physicians’ intrinsic desire not to complete unnecessary assisted deaths, a method of accountability will aid in the elimination of prescription of death to those who could otherwise be alleviated.

Furthermore, critics question whether consequences regrettable to society will result from people losing the ability to distinguish between permissible and impermissible forms of death if active physician assisted dying becomes a generally accepted and legal option. This is also known as the “slippery slope” argument. The concern is founded on the idea that if active physician assisted dying is accepted, then people will be led to endorse active non-voluntary euthanasia. However, this is quickly disproven in study which measured people’s acceptance of different forms of euthanasia. The conclusion in this case is undeniably that, “People who accept some forms of euthanasia simply are not led to accept other, more morally objectionable forms of euthanasia” (Verelius 669). In the practical case of the legalization of active physician assisted death in the Netherlands, the data shows no signs of the slippery-slope model. The author of the study collecting the referenced data writes, “The frequency of ending of life without explicit patient request did not increase over the studied years” (Verelius 670). People simply will not develop evil tendencies because of the legalization of the physician’s participation in the voluntary death of suffering patients.

Active physician assisted dying should be legalized for all suffering persons because it is an extension of the physicians healing abilities in correspondence with a person's right to die. Relatively recent legal victories have paved the way for a clearer right to die for the people of the United States. Passive physician assisted dying is already a generally accepted method of healing pain but does not account for the multifaceted suffering that those who elect for active physician assisted dying have which require an expedited method of death. Arguments against the legalization of active physician assisted dying are ill-advised and unfounded as they argue that patients will make hasty decisions, physicians will pressure unwilling patients to elect for death, that physicians will end the lives of patients who could've been adequately alleviated otherwise, or that society will embark on a "slippery-slope" of morals. What is truly immoral is that suffering patients do not universally have legal access to their right to die and that physicians cannot legally fulfill their healing obligations to their patients.

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