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ROBERT HALL ON PHYSICIAN-ASSISTED SUICIDE AND ITS IMPLICATION FOR MEDICAL ETHICS

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Abstract: The practice of physician-assisted suicide has been a complex and controversial issue in bio-medical ethics. Bioethicists, philosophers, theologians and scholars from different fields continue to make contributions to this age long practice. Contributing to this controversial issue Robert Hall a professor of philosophy in his paper *Physician-Assisted Suicide Should be Legalized,* argues that such assistance is ethical, humane and should be legalized. This is problematic and worrisome. However, from the Deontologic perspective, this paper argues that such assistance is unethical and not in tandem to medical ethics. Contributing to this discussion this paper further argues that Hall's view is problematic and if accepted it will definitely turn the physician from a health care giver to a death inducer. This paper adopted the method of textual analysis and it is purely argumentative.

Keywords: Suicide, Ethical, Physician, Medical, Health

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INTRODUCTION

Before now, voluntary death has been condemned but in recent times public and legal opinions are shifting from this condemnation to its permissibility. The central argument is that people have the right to end their lives when terminal diseases make life miserable. The right to die has been one of the most hotly debated topics in health and public discussions. This controversy is evident when cases of euthanasia and physician assisted suicide (PAS) are being discussed. Euthanasia and physician assisted suicide are not one and the same thing though they overlap. Both aim at ending the life of the patient out of so called compassion. Some of the arguments used for physician assisted suicide are the same for euthanasia. Physician assisted suicide and euthanasia are allowed in places like Oregon, Netherlands, Washington DC, Belgium and Luxembourg. In some other countries it is still under deliberation. In others countries it is done secretly. In physician assisted suicide an adult suffering from incurable or terminal disease that cause him/her physical pain seek the assistance of the physician to end his/her life. Although in some countries physician assisted suicide is limited to competent adults with incurable but not terminal disease that gives them physical or psychological pain. Physician assisted suicide is usually carried out among people with cancer, the disabled or the elderly and in such conditions the person out of pain, frustration and depression may express the desire to end his/her life. However, some physicians dismiss such request from those patients while others proceed to assist the patient to die.

Scholars both in medicine and other sectors keep reacting and making contributions to this controversial issue. For instance, in 2005 Lord Joffe moved a bill in UK for euthanasia and physician assisted suicide to be legalized. Though many voted against the bill but Lord Joffe declared that he will continue to reintroduce the bill at all levels of the parliament. The Bill would "enable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request" (Joffe 2005, p.4). This is the bone of contention because it touches the core of human existence which is life, human life not animal or plant life. Based on this people have expressed divergent views and positions on this issue. Some argue that physician assisted suicide is ethically right and a humane act, because it is a rational choice for a person with incurable disease or terminal illness to seek assistance to end his /her life. They based their argument on individual right and autonomy. For others Physician assisted suicide is murder and against the physician's duty to preserve human life. His duty is to care and not to kill. Proponents of PAS present that the individual have the right to free him/herself from pain and suffering and have control over the circumstances of dying. While the opponents have it that PAS can lead to a slippery slope and it questions the integrity of the physician. This issue is addressed strictly from the point of view of medical ethics. The issue of whether mentally competent terminally ill patient has right to seek for assistance to die, is morally one of the most difficult, divisive and heart wrenching issue in medical ethics today. Some disturbing questions emanate from physician assisted suicide which include thus: is it a moral action for a terminally ill or aged person to seek to terminate his/her life? Can an incurable disease justify physician assisted suicide? Is assisting a terminally ill patient to end his life within the physician's duty?

This paper will addresses these disturbing questions and make contribution to this ongoing debate.

Euthanasia and Physician Assisted Suicide (Pas): Conceptual Clarification

Often people confuse euthanasia and physician-assisted suicide. They see the two as one and the same thing and use them interchangeably. Both practices are similar but there is a subtle difference between them. In PAS the terminally ill patient ask the physician to assist him/her in dying. The physician may provide a lethal medication, drug or some other means but the patient does the final act. While in euthanasia another person other than the patient directly causes the death of the patient.

Euthanasia etymologically is a combination of two Greek words "eu" meaning "good" or "well" and "thanantos" meaning "death". So literally it means a good death. It is often referred to as mercy killing. For Ekennia "it could be called painless death provoked by medical intervention" (2003:161). It is the practice of killing someone painlessly to relieve suffering from an incurable disease. In Euthanasia two issues are involved: "it involves deliberate taking of human life either one's own life or another person's life. Thus, it is a form of deliberate killing (b) the destruction of the life of the other is for the sake of the victim, that is, the person whose life is terminated" (Ekennia 2003, p.161). The person is either suffering from an incurable or terminal illness. Euthanasia can be active or passive. In active euthanasia the action ab initio is intended to kill the patient and it does kill the patient. Here the physician or another person directly causes the death of the patient for instance, by giving the patient a lethal injection. The death of the patient is now as a result of the injection and not from the sickness. It is passive when medical intervention is withdrawn and the patient is allowed to die from the effect of the illness. In passive euthanasia medication, life sustaining machine, respirator and so on will be withdrawn or disconnected and the patient dies from the natural effect of the terminal illness. Euthanasia "has become one of the debatable topics in biomedical ethics"(Ikegbu et al 2019, p.217).

Physician-assisted suicide (PAS) is also called physician-aid-in-dying (PAD) or voluntary death. Brandi et al prefers to use physician-assisted dying in place of physician-assisted suicide because "it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation physician-assisted suicide" (2019, p.36). According to (Madelyn 2006) physician-assisted suicide "is when a doctor provides a patient with a lethal overdose of medication for self-administration with the explicit goal of enabling the patient to commit suicide". This is different from the principle of double effect where a drug could be prescribed with the goal of relieving pain while it is also known that death could arise as a secondary effect. For (Anfang 2021, p.10) in Oregon it is also called physician-assisted-death(PAD) which does not include "activities typically considered as current medical practice within standard palliative or hospice care, such as terminal sedation do-not-resuscitate orders or withdrawal of life support". In PAS the doctor prescribes like 100capsules of a drug, the patient takes it without medical prescription or supervision (overdose) and death becomes the outcome. In PAS "a doctor prescribes the deadly drug but the patient must take the drug himself" (www.ncbi.nlm.nih). It is a practice where a competent, terminally ill patient request for a lethal dose of drugs from a physician and which the patient intends to use to end his/her life. According to Brody PAS is a "situation in

which a patient kills him or herself, using means which have been supplied by the physician, with the physician being aware that the patient intended to use those means for the purpose of suicide" (1995, p.20). It is the physician's role to the act initiated and ended by the patient. Here the patient carries out the action but he/she is helped by the physician. The patient directly carries out the act; the physician is indirectly involved by prescribing the drug. In PAS the patient express intention to end his/her life, the physician provides the means and the patient carries the final act that leads to his/her death. In summary euthanasia and PAS are slightly different. In PAS the physician provides the means while in euthanasia the physician is the direct agent of death. It is called physician assisted because the physician provides the medication while the patient decides to take it or not. In euthanasia the physician or another person directly ends the patient's life. Both are similar because they aim at ending the life of an incurable or terminally ill person but their difference lies on who directly carries out the action.

Robert Hall's View on Physician-Assisted Suicide (PAS)

Robert Hall is a professor of Sociology and Philosophy at West Virginia State College. In his article titled: *"Physician-Assisted Suicide should be legalized" he* argues that physician-assisted suicide is an ethical and humane act that should be legalized. He defined physician-assisted suicide as a condition in which "a conscious and competent patient asks the physician to take some action that will bring about his or her death or to provide the means for the patient or the patient's family to take the action" (1998, p.90). He mentioned "gradual integration of the powers and capacities which make us human, severe instances of amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, lupus, end-stage lung disease, advanced brain cancer or gastric cancer" (p.90) as some of the cases that often prompt physician-assisted suicide. In his view some of these conditions are so intolerable that the patient desires death as the only relief.

This practice is an age long one in the medical practice and which has attracted a lot of attention. For Hall his question is, should PAS be carried with the assistance and regulation of the medical profession or should remain hidden? He noted that recently the standard practice is "to sedate these patients into complete unconsciousness and to withhold nutrition and hydration until they die" (p.91). This act relieves the patient of the pain and conscious experience of his/her situation. For him this is what we call passive euthanasia. But in his opinion it is active. However he noted that patients in extreme health conditions would prefer to end their lives instantly than putting themselves and their families in agony for long. Again some of the patients in such extreme conditions are not on life sustaining machine so death is their only refuge and they need assistance. We already know that a patient only has a legal right to refuse treatment and not to request for death. But Hall on this holds that the practice of medicine and law should be changed to allow the physician assist either directly or indirectly. He posited that "the law should ensure through a second medical opinion if necessary that assistance will only be available if and when a competent physician judges that there is no other way left to relieve the patient of his or her misery"(1998, p.91). Hall in his paper criticized some of the arguments used against PAS. Critics of PAS argues that if it is legalized mentally deranged and depressed persons would quickly choose it. Hall responded to this criticism that already laws have been placed to make sure that any medical procedure is for the

best interest of the patient and in physician-assisted suicide, "the physician would have to be convinced that nothing else could be done to the patient that an easier death was in his or her best interest"(p.91). Another argument has it that if PAS is legalized it will lead to the slippery slope of killing people with every type of disability. Hall addressed this criticism and argued that informed consent is paramount in any medical treatment. He stated that: "physician-assisted suicide would have to remain strictly at the patients informed request. People should, of course, be allowed to express their wishes through living wills and surrogate decision-makers as long as these means are used to enact the patient's wishes"(p.92).

Hall also rejected the sanctity of life argument. It has always been said that life is sacred and therefore should not be destroyed. For Hall (1998) the value of life rest on its ability to respond lovingly to God and to others. Quoting John Shelby writes that:

> …the sacredness of my life is not ultimately found in my biological extension. It is found rather in the touch, the smile and the love of those to whom I can knowingly respond .When that ability to respond disappears permanently, so I believe, does the meaning and the value of my biological life. Even my hope of life beyond biological death is vested in a living relationship with the God, who, my faith tradition teaches me, calls me by name. I believe that the image of God is formed in me by my ability to respond to that calling Deity. If that is so, then the image of God has moved beyond my mortal body when my ability to respond consciously to that Divine Presence disappears. So nothing sacred is compromised by assisting my death in those circumstances (1998, p.92).

Critics of PAS further have argued that if physicians alone decide when to end life it will lead to voluntary euthanasia and if patients alone decide, suicide will even be permitted on emotional and psychological grounds. But Hall replied that the decision cannot lie on the physician nor the patient alone but both must agree and this is in line with medical ethics for him. He asserts that: "the principle of beneficence requires that physicians do only what is in the patient's interest and the principle of autonomy requires that treatment be administered only at the patient's request. Taken together, as they must be, a morally justifiable decision could only be made when the physician and patient come to an agreement" (p.93). In his view both the physician and the patient must agree. The patient must be fully informed and his/her consent given. This informed consent requires full knowledge of the procedures, alternatives and possible consequences.

Another concern that Hall responded to was the case that PAS will diminish the trust and respect patients have for their physicians. Trust simply means that the physician should not harm. Hall on this posits that: "the fact is that many patients now want to trust that their physicians will stay with them and will not abandon them when the only way out of their suffering is to help them to die as they choose. The medical profession as a whole will gain public respect if it agrees to medicalize the dying process rather than leaving the final act to be performed with handguns, plastic bags, and illegally acquired drugs"(p.94). Hall's conclusion is that PAS will enable the physician help those who have no other way out than death. For him all we can do is to regulate it than to allow people to self-help method.

THEORETICAL FRAMEWORK

The theoretical framework on which this paper is based is deontologism, specifically Kant's formalistic deontologism which focuses on the action itself as an end. Kant's deontologism centers on answering the question, what is the nature of morality? His intention was to distinguish a moral act from non-moral act. Put in another way what distinguishes a person who acts morally from one who does not. Kant argued that this can be answered by distinguishing between actions done from good will and sense of duty and that done from inclination, self-interest, emotions and feelings. Kant's deontologism is against the view that one should act according to one's inclination or how it pleases him/her. In his view one is acting morally only when he suppresses his/her feelings, emotions, self-interest and inclinations and does that which he/she has an obligation to do. His theory is closely bound with one's duties and obligation.

Kant argued that since we are rational beings we ought to behave rationally and act as if our actions were to be made a universal law, thus his principle of universalization. This principle is the first principle of the categorical imperative which says that one should act on that maxim which he/she wills to be a universal law. This means that if one wants to perform a particular act let him/her first ask whether he/she will wish everyone to perform such action. If the answer is "Yes" then the act is moral but if "No" it is morally wrong. Kant's second formulation reminds us that we should treat humanity either yourself or another person always as an end and never as a means to an end. Kant emphasizes the dignity of humanity. This is like the biblical injunction which says do to others what you will wish done to you. To treat another as a means to an end is to disregard the person's dignity, humanity and just see him/her as a thing that deserves no respect.

In summary, Kant's deontologism revolves on what ought to be done. What ought to be done is an obligation and obligation is entirely different from inclination. This obligation is what ought to be done against what one wishes to do out of self-interest, sentiment or any inclination. In the context of this paper the physician has to realize that he has an obligation to preserve and do all within his knowledge to care and save life and not to assist death. According to Popkin and Avrum an "obligation is that which one ought to do despite one's inclination to do otherwise" (1993, p.42). Once it is an obligation one ought to fulfill it.

THE IMPLICATIONS OF ROBERT HALLS VIEWS FOR MEDICAL ETHICS

For Hall PAS is ethical, humane and for the best interest of the patient. According to him no physician will accept to offer any medical assistance if it is not in the best interest of the patient. That means that the physician is convinced that PAS is in the patient's best interest. But the concern of this paper is that Hall did not give details of what the patient's best interest entails. One may want to be clarified on what it means for PAS to be in the best interest of the patient? Questions as these can arise, can forced death, assisted suicide, or terminating life at the slightest frustration ever be in the best interest of the patient? This is a question that cannot be answered in a hurry because its implications are legion. However Hall is trying to interpret PAS being in the patient best interest as compassion for the sick and the only way of showing that compassion is to assist him/her to die. In this connection since the patient is suffering from a terminal disease therefore death will surely be in his/her best interest. This is an error in reasoning. Death cannot be the only way of showing compassion for the sick. Rather, acting in

the best interest of patient means the physician has the obligation to stand by the patient throughout the struggle. The physician is like the God the patient is seeing at that critical moment of his life and he hopes to be saved and not to be killed. The patient needs hope and assurance. It is a fact that medical science has advanced to the point of predicting how long one may live in serious illnesses but there are testimonies of people who lived longer than predicted. There are cases of patients who have been pronounced to have less than 2weeks to live but who survived and still living till today. PAS does not give this opportunity or chance. Some recover from such serious illness and become better and continued to manage their health till its natural end. Also a patient might be on the hand of a bad physician and his prediction of hopeless condition wrong. He/she might not be aware of other means of relieving the patient from pain. In such situation the physician sees the patient's cry for death as a relief. The physician in this case is acting in his own best interest and not in the best interest of the patient. In our view the patient's cry for death is a cry for assistance to live and not assistance to die even when he seems to ask for death. In such circumstances, subtle pressure would bring people to ask for immediate, fast and painless death, when what they want is affection, powerful support and love. Best interest is doing all within the capacity of the physician to alleviate pain and suffering of the patient and not to assist him or her to die. Vergallo et al (2022) maintains that the availability and widespread use of ever more sophisticated medical devices and treatment have made it possible to prolong the lives of chronic or even terminally ill, patients. The physician should stop at nothing but preserving the life of his/her patient. Although there are certain situations that seem hopeless but that, does not justify a physician assisting a patient to die. In the words of (Jones 2010, p.2) "if society agrees that it is in some people's interest for them to end their own lives, it is difficult to resist the logical conclusion that others should be helped to die even if they have not made such a request". We cannot deny the fact that pain and suffering are inevitable part of human life. It comes in diverse ways and we are not trying to glorify pain and suffering. What we interpret as the patient's best interest is palliative care which means physical, emotional and spiritual loving care even when cure is seen as no longer possible. Palliative care does not quicken death but provides relief from pain and suffering and we argue that it will surely diminish the desire for death.

If PAS is legalized there is the possibility that it will lead to a slippery slope where mentally deranged, disabled, elderly and depressed persons will quickly opt for it. Although Hall denied this argument, for him informed consent is what PAS requires. Slippery slope in this context means that "once we allow doctors to shorten the life of patients who request it, doctors could and would wantonly kill burdensome patients who do not want to die" (Hagg cited in Hall 1998, p.23). The implication of this is that if certain practices like PAS is accepted it will invariably lead to acceptance of many unacceptable practices. The issue is that if something is seen as not so harmful and is allowed it will transcend to or definitely lead to something that might be unthinkable or morally questionable in the future. On slippery slope Pellegrino writes that "in a society as obsessed with the cost of health care and the principle of utility, the dangers of the slippery slope are far from fantasy… Assisted suicide is a half-way house, a stop on the way to other forms of direct euthanasia, for example, for incompetent patients by advance directive or suicide in the elderly" (1998, p.20).

Again the physician who prescribes drug for a patient to use for suicide can also go further to administer the drug himself. If he is free to prescribe he can as well move further to give the drug himself. If PAS is allowed definitely it will extend to people who suffer from various forms of disability, who see their lives as worthless and does no longer desire to live. The elderly will definitely opt for it when they feel rejected and abandoned by family and friends or when faced with serious health challenges. People will go as far as encouraging their aged family members to opt for PAS instead of taking the responsibility to care for them. That joy that the parents derive by being cared for by their families will be seen as herculean task that should be avoided. Parents in old age needs care and assistance until their natural death but if PAS is allowed such care and assistance will become a thing of the past.

There is also this danger that if it is allowed it will move from terminally ill patients to chronically ill patients. Both are not the same. Terminally ill is when a disease is progressive, irreversible and seems incurable. In terminal illness death is anticipated. On the other hand, chronically ill means an illness one may live with the rest of his/her life but it can be treated or managed. It is chronic because one gets sick over and over again for a particular sickness but which can be cured or treated with time. Children who are chronically ill will be in danger of being sent to early death through PAS. People who are chronically ill will be seen as burden and PAS seen as a way of lifting the burden and doing away with them. It will definitely move from PAS to voluntary euthanasia and further to non-voluntary euthanasia. It has the potentiality of stepping out of boundaries and becoming legalized murder.

PAS compromises the physician-patient relationship and destroys the trust and respect patients have for their physicians. Physicians are trained as health care givers and not death assistance or inducers. Physicians by extension include doctors, nurses, pharmacists, laboratory technologists etc. Their duty is to save life and make it worth living .A patient would always wish his doctors possesses required knowledge and sufficient professional skills to handle his/her health. The patient puts a whole lot of trust and confidence on the physician to cure his/her sickness and he/she does it with respect. The physician has full control over the health of the patient but that does not warrant a neglect of the aim of his profession. Ekennia writing on respect and individuality of every patient asserts that "medical authority and dominance over patients should never degenerate into neglecting the uniqueness of each individual patient and human respect that should reign throughout the period of health care. An ideal physician should be primarily concerned by ensuring the best treatment for his/her patient" (2003, p.59). When a physician subscribes to PAS that trust that exist between the physician and the patient is put in jeopardy. The patient expects the doctor to do everything to restore his/her life and not to assist him/her to die. If he/she wanted death he/she will not come to the hospital because there are several ways he/she can end his/her life either by poison or other means. No matter how one wants death he desires to live. Furthermore Ekennia commenting on the duty of physicians writes that: "the sole goal of a physician is to cure patients and help them maintain good health and to preserve life. It would be inimical and contradictory to the medical profession when a physician is actively and deliberately involved in taking away the life that he/she should have saved…performing euthanasia is totally

unethical" (2003, p.59). When PAS is seen as an ethical, humane act the patient can no longer trust the physician. He/she will analyze whatever the physician prescribes with high level of criticality. Doubt will set in. We are aware that trust is an essential part of medical care and if it is lost a great asset is lost. Assisting death is not part of the medical practice. Medical practice is an ethical and trustworthy profession. Imagine a doctor suggesting to his patient to take lethal drug to end his/her life. It sounds like an abomination. In a discussion with a certain woman whose husband had been terminally ill narrated his ordeal in the hand of a certain doctor. She expressed disappointment on how this doctor suggested suicide to her husband. In fact she took her husband away from that hospital to another place but even there she could not allow her husband alone with the doctor because of her previous experience. She was monitoring every medication the doctor administers and according to her, her husband lived for another seven years. Further PAS will strain doctor-doctor relationship, and the medical profession as a whole. The truth of the matter is that physicians have opportunities to kill which patients do not know so if PAS is allowed it will be catastrophic. On the mystery of life and death (Somerville 2010, p.2) writes that: "it is a very important part of the art of medicine to sense and respect the mystery of life and death, to hold this mystery in trust and to hand it on to future generation-including future generations of physicians". Legalizing PAS threatens this trust.

Autonomy means that decisions about time and circumstances of death are personal issues. People can choose how and when to die. It speaks of dying with dignity. Autonomy argument is normally used by proponents of euthanasia and PAS to justify it. It bases its argument on self-determination and freedom of choice. Our view is that the autonomy argument when applied to PAS cannot sail smoothly. To start with, it is clear that no one gave him or herself life. Our lives have an origin. Someone is responsible for our coming into existence. For Christians it is God who is the source of human life. This is the position of the medieval philosophers like Thomas Aquinas, St. Augustine, St. Anslem. For Muslims Allah is the source of life while traditional religion says that life came from the gods and protected by our ancestors. This implies that none of us created his or her life and if that is so we cannot terminate what we did not create just like that. No one can create life out of nothing and so our right towards our life is not absolute. We are therefore accountable to that being that is the source of life. If we are accountable then we do not have absolute right to terminate life no matter the condition. We cannot have absolute right over life because it is just a gift given to us. Christianity, Islam and traditional religion view suicide as an unacceptable, abominable act. Yes we can claim to have right over our life but that right is not absolute; it has limitations because we are not the source of our life. Life itself is a mystery. Secondly autonomy does not necessarily mean that a person should do whatever he or she pleases with his or her life. Our autonomy to life has limitations. Autonomy can also be seen as value. It properly means value, worth, and human life is of imponderable value and this make PAS unethical since it destroys the autonomy of the patient.

There is the possibility of abuse. Another danger is that once it is legalized it will be difficult to control. PAS can be recommended at the slightest serious health challenge. People and children who are disabled or deformed will be sent to early death. It will become a death sentence to be given at will. The mystery of

death and dying will be lost. In cases of suffering patient it will lead to cases where the suffering is just predicated for the future and not the present. Some have argued that taking care of the terminally ill is capital intensive. The view of this work is that the government should provide medical care for such people. They should allocate resources to health sector for people who are terminally ill and the elderly. Further it can be abused such that children will no longer want to take the burden of looking after their sick or aged parents. At such situation they will seek for PAS. According to (Beauchamp 1999, p.34) "a system that does not have clear cut boundaries may be open to abuse. Additionally legalizing 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."

Hall argues that whenever the physician and the patient agree, PAS is justified in such situation. In other words informed consent justifies PAS. Proponents of euthanasia and PAS argue that informed consent justifies it. Consent is informed when a fully competent adult having knowledge of his health condition wishes to end his/her life. When a patient that is terminally ill gives his consent to be assisted to die, it is taken that the decision was his. It is good to understand that most of those who consent to suicide do not do so freely; their consent is not a free one but one given out of fear of isolation, pain, frustration, burden to others. These factors influenced the patient's decision and consent. It is worthy of note that even when the patient gives consent to be assisted to die within his/her mind he/she is still looking out for one to tell him/her that all hope is not lost. He/she wants to be assured that there is an alternative medication to aid his/her condition; secondly sometimes the family members make such decisions on behalf of the patient. One cannot rule out the possibility of greed, or the urge to inherit or take away the persons possession. There have been cases of children wishing their father death so that they can share his possession. Such might be the intention behind such decisions though they often conceal it. We can see that such consent from family member has an underlying or ulterior motive. That shows that many request PAS as a result of pressure from family members and even the physician. The physician should rather reassure the patient of continued care and commitment. They need to be reassured that the physician will not abandon them but will care and attend to their health needs. The physician's obligation is to care and not to harm.

PAS is antithetical to medical practice. It violates the Hippocratic Oath. The dictum of medicine is "never kill always care" death is not a medical care. In PAS death becomes a substitute for treatment and care. The American Medical Association (AMA) (1995-2021) rejects PAS for those at the end of their life. They argue that: "allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physicians role as healer, would be difficult or impossible to control and would pose serious societal risk". The AMA further advocates that multidisciplinary interventions be sought, including specialty consultation, hospice care, pastoral support, family counseling, emotional support, comfort care and pain control".

The Judeo-Christian position holds that human life is sacred and people do not have right to end both their lives and that of others. This is in line with Kant's view that every human is an end in itself and he

upheld the respect for persons. PAS diminishes the idea of sanctity of life. It can lead to reduction in the abhorrence of homicide and thereby devaluing human life. The sanctity of human life is however about proper and full respect for human life. All human beings whether disadvantaged, disabled, sick or healthy are all valuable and their lives must be respected, valued and cherished. From the spiritual perspective life is seen as a gift from God which should not be destroyed. The dignity of human life lies in its sanctity. Life should be protected so the physician should not intend to end any life ab initio. For (Ariche et al 2016, p.139) "the patient is a person who is in need of medical help and care" and not in need of death. PAS kills the desire for further medical research. The physician should be preoccupied with the zeal to research into ways of curing or assisting patients suffering from serious ailments. The primary duty of the physician is to care for the sick not to assist to die.

CONCLUSION

Terminally ill patients can be in dilemma and in a frustrating situation that the only thing in their mind is death as a solution. They demand the physician assist them die as a way out of all pain and suffering. This is could be understood but being ill is not a death sentence. PAS is a morally problematic and complex issue. Helping a patient to die is against the principle of beneficence and non-maleficence in medicine which emphasizes no harm and a positive action of treating and caring for the patient. If PAS is legalized the physician invariably becomes a destroyer of life and no longer protector of life. What we need is good terminal care, pain management for those in pains and palliative care service delivery. The sick and the terminally ill need the care of the physician. The doctors, nurses and all health workers should work together to provide adequate care towards assisting the sick to live or to manage their lives till nature calls and not to assist them to die. The physician must do no harm but must exhaust all possible ways of helping the patient to manage his failing health. The government on their part should make available resources to assist those who are in this stage of their lives. Just as relief packages are sent to internally displaced persons, medical resources, drugs and other relief packages should be sent to various hospitals for the upkeep of the terminally ill. Physicians who are experts in various fields of medicine should be sent to such patients and hospitals.

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