Aporia vol. 27 no. 1–2017

The Legalization of Physician-Assisted Suicide

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In recent years, legislators and ethicists have vigorously debated over the legalization of physician-assisted suicide. In the United States, five states have legalized physician-assisted suicide, and the legislators of 20 other states are currently considering some kind of physician-assisted suicide legislation (Death With Dignity National Center). Proponents of legalized physician-assisted suicide generally appeal to two principal claims: (1) Physician-assisted suicide should be legalized in order to respect individuals' self-determination (or autonomy), and (2) physician-assisted suicide should be legalized to allow patients to obtain relief from suffering (Vaughn 598–99). On the other hand, opponents of legalized physician-assisted suicide have appealed to a variety of arguments concerning its inherent immorality, concerning the proper role of physicians, and concerning various societal consequences. I will argue that none of these arguments made by opponents are strong enough to justify a blanket prohibition of physician-assisted suicide. Thus, physician-assisted suicide may be legalized, as long as it is regulated in a way that exemplifies the two principal claims made by its proponents.

The organization of this paper will be as follows: In Section I, I will outline various definitions and key terms relevant to this discussion. In Section II, I will outline the opponents' main arguments against the legalization of physician-assisted suicide, and I will argue why each of these arguments is not strong enough to warrant a blanket prohibition of

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the legalization of physician-assisted suicide. In Section III, I will outline various forms of regulation which should ensure that the negative societal consequences pointed out by opponents do not occur. In Section IV, I offer a conclusion to my arguments and briefly explain some of the implications of the kind of legalization of physician-assisted suicide which I advocate.

I. Definitions and Key Terms

Physician-assisted suicide can be defined as the practice of prescribing self-administrable lethal medications to patients who desire to end their lives. In the bioethics literature, physician-assisted suicide is sometimes discussed alongside euthanasia. These two terms should not be confused. *Euthanasia* can be defined as "bringing about the death of another person for that person's sake" (Vaughn 595). The important distinction here is that with physician-assisted suicide, the patient takes his or her own life (with the help of a physician), while euthanasia involves a physician taking the life of a patient.

Another important distinction is between euthanasia which is *voluntary* and euthanasia which is *involuntary*. Voluntary euthanasia means that the patient to be killed has given his or her consent to the act, while involuntary euthanasia means that the patient to be killed has not given his or her consent to the act (Vaughn 596).

Finally, as has been noted by bioethicist Angela Faulconer, physician-assisted suicide and euthanasia are often rebranded using other terms which have either more positive or more negative connotations, often revealing the stance of him or her who uses these terms ("Rebranding Death"). For example, physician-assisted suicide is often termed "death with dignity" or "aid in dying" by those who support its legalization.

II. Main Arguments against the Legalization of Physician-Assisted Suicide

Let us first consider opponents' arguments against the legalization of physician-assisted suicide. Some opponents argue that the practice of physician-assisted suicide is inherently immoral. It is inherently immoral according to these opponents because we have a negative duty to not kill (some may add a condition, asserting that we have a negative duty to not kill the innocent). This negative duty might be based on the belief that life has inherent value or on the belief that only God should have power over the giving and taking of life (Brock 11, Arras 361).

Neither of these beliefs offers sufficient justification for a legal prohibition. First of all, I contend that the duty to not kill is not an absolute duty and thus that killing is not absolutely immoral in all circumstances. As with many moral duties, I think that there are clear exceptions—cases in which physician-assisted suicide is in no way immoral. It is not difficult to imagine someone who has lived a full life but is now diagnosed with a terminal illness. Imagine that this person's abilities to function normally are going downhill quickly, and that this process is irreversible—there is no chance that the person will ever regain normal health and functionality. For the sake of argument, imagine that all of the family and friends of this person are at peace with knowing that their loved one will soon depart from them, and that it pains them to see their loved one suffer from pain that cannot be managed. Suppose that this person with a terminal illness is competent and psychologically healthy, but has no desire to face a future of increasing pain and decreasing autonomy. It is perhaps easier to imagine these conditions if one has some personal experience resembling them, but even if one has not witnessed such conditions, I think that it is not unreasonable to view physician-assisted suicide as a morally respectable, merciful option for those who are in these conditions and who desire it. I will explore the conditions that are characteristic of these exceptional cases in further detail in Section III.

But even if the moral convictions of opponents are correct—even if practicing physician-assisted suicide is inherently immoral—immorality does not necessarily indicate that something should be made illegal. Arguing that some act should be illegal solely because of the immorality of the act is unjustifiably paternalistic. As John Stuart Mill famously argued in *On Liberty*, "Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each other to live as seems good to the rest" (23). To be clear, Mill does not condemn interferences of one's autonomy when these interferences prevent persons from harming others; he condemns only those interferences which are aimed at preventing persons from harming themselves (whether physically or morally). In a secular society, we are generally not justified in subjecting others to our own moral and religious convictions even if we are convinced that such subjection would be for the good of others. Thus, arguing that physician-assisted suicide should be illegal just because of a moral or religious conviction is not justifiable.

Some opponents argue that the legalization of physician-assisted suicide would represent an inappropriate expansion of the role of physicians. Bioethicist Daniel Callahan argues that the role of physicians should be limited to "the promotion and preservation of health" and that physicians should not enter "the boundless realm of general human happiness and

well-being" (53). The practice of physician-assisted suicide, it is argued, would undermine the proper role of physicians as healers, since assisting with death is effectively the opposite of promoting and preserving health. Callahan explains that patients who request lethal medications do so because they feel that their life no longer has value (53). Since claims about the value of life cannot be clinically evaluated by physicians, physicians should not be expected to prescribe medication based on such claims (53).

Callahan's claim that the role of physicians is merely to promote and preserve health is overly restrictive. Plastic surgeons and physicians who perform vasectomies (while they may be acting to promote health in some cases) are not necessarily limited to Callahan's description of the role of physicians. More importantly, the treatment of pain should unquestionably be included within the role of physicians, even though the treatment of pain is not necessarily associated with the promotion and preservation of health. Physicians who treat the pain of patients with incurable diseases are in no way undermining the proper role of physicians. Furthermore, there is no inherent reason why physicians should refrain from promoting "general human happiness and well-being" if they have the resources and skills to do so.

Even if it were determined that the practice of physician-assisted suicide is not compatible with the role of most physicians as healers, this would not justify a prohibition of the practice. The practice of physician-assisted suicide could be limited to institutions where palliative and hospice care are provided exclusively to patients with incurable diseases. Physicians and care providers who work at such institutions could be designated as "end-of-life care givers" to make clear their distinct roles. This institutional separation would resolve concerns that the practice of physician-assisted suicide would undermine the role of physicians whose primary aims are to promote and preserve health.

Some (perhaps most) opponents argue against physician-assisted suicide by appealing to negative social consequences that are considered likely to occur if the practice is legalized. They argue that the legalization of physician-assisted suicide is the first step onto a slippery slope toward voluntary euthanasia and perhaps even involuntary euthanasia. If physician-assisted suicide is legalized, this seems to confer a "right to die" upon certain patients. But not all patients who desire physician-assisted suicide are capable of self-administering a medication, even though they might otherwise qualify for its use. Thus, voluntary euthanasia—in which a lethal injection is administered by a physician—may be seen as a fair exercise of these patients' "right to die." Because of this line of thinking, some opponents think that the legalization of voluntary euthanasia would be an inevitable consequence of the legalization of physician-assisted suicide.

According to Callahan, euthanasia (even if voluntary) is even worse than physician-assisted suicide "because it is a fundamental moral wrong for one person to give over his life and fate to another, and no less a wrong for another person to have that kind of total, final power" (53). Callahan goes on to condemn euthanasia by comparing it to slavery and dueling (53).

But the legalization of voluntary euthanasia, according to opponents, would not necessarily be the bottom of this slippery slope; the practice of *voluntary* euthanasia could easily lead to the practice of *involuntary* euthanasia (Arras 361). Since we already grant persons with legal guardianship or a power of attorney to make various healthcare decisions on behalf of patients who are incapable of expressing their own interests, it seems likely that euthanasia could be administered to these vulnerable patients, even though they themselves did not request it. Although we cannot be certain whether or not some patients of this condition would request euthanasia if they were able to do so, it is certainly possible that euthanasia could be administered to some who would not want it—that is, the door would be opened for involuntary euthanasia, which would certainly be a negative consequence.

But, some opponents argue, patients who are incapable of expressing their own interests are not the only persons susceptible to involuntary euthanasia. Physicians—and society at large—could become accustomed to the idea that euthanasia is a cheap and convenient solution to suffering. This convenient solution might be seen as a preferable alternative to treatments which require greater resources or are more expensive (Faulconer). Physicians who adopt this view might pressure fully competent patients into requesting euthanasia, or they might even administer euthanasia despite the absence of any request at all. Because of the privacy laws surrounding the physician-patient relationship, such abuses could go unnoticed (Arras 361). Surely such a dreadful possibility—even if it is not a *guaranteed* consequence of the legalization of physician-assisted suicide—warrants serious consideration.

In response to these slippery slope arguments, I argue that these concerns represent a rather cynical view of humanity. These arguments assume that citizens and legislators will be blind to the consequences of the laws they support. These arguments also assume that our ability to make ethical decisions is determined by the laws that bind us. This "legal determinism" misrepresents the goodness and rationality of mankind. A change of legislation will not make legal guardians irresponsible in deciding what is best for those who they represent, nor will it turn physicians into malicious killers. In order to make each contingency of the slippery slope seem plausible, opponents must adopt an unrealistically pessimistic view of society.

However, even though such slippery slope arguments represent a cynical view of humanity, they still warrant serious consideration. The possibility of physician-assisted suicide leading to involuntary euthanasia, even if not very likely, would be a tragedy. But our consideration of these possible negative consequences does not lead us to the conclusion that physician-assisted suicide should be absolutely prohibited. Rather, we need to consider how the practice of physician-assisted suicide can be regulated so that these negative consequences will be prevented. Thus, I turn now to a discussion of how physician-assisted suicide should be regulated.

III. Regulation

Physician-assisted suicide should be regulated in a way that exemplifies the two principle claims that are appealed to by its proponents. Recall that the first claim is this: Physician-assisted suicide should be legalized in order to respect individuals' self-determination (or autonomy). In order to ensure that physician-assisted suicide is practiced in a way that respects individuals' self-determination, it must be limited to cases that are indisputably voluntary.

For the practice to be indisputably voluntary, several regulatory conditions must be met. First, since euthanasia could be administered involuntarily, the legalization of physician-assisted suicide must allow only the prescription of *self-administrable* medications. Second, since patients suffering from terminal illnesses may also suffer from a psychological disorder like depression, patients who request physician-assisted suicide must meet with a qualified psychiatrist. If the psychiatrist determines that the patient is suffering from a psychological disorder, the patient must receive treatment for that disorder before qualifying for physician-assisted suicide.

Besides ensuring that the patient is not suffering from a psychological disorder, the involvement of the psychiatrist is important for other reasons as well. The psychiatrist would function as a third party advocate for the patient. The psychiatrist would be able to ensure that the patient is not requesting physician-assisted suicide because of social pressure from physicians or family members. Since a psychiatrist would be necessarily involved in every case of requested physician-assisted suicide, abuse by a physician would not remain undetected within the privacy of the physician-patient relationship.

A third regulatory condition was suggested by bioethicist Dan W. Brock: "The patient should be provided with all relevant information about his or her medical condition, current prognosis, available alternative

treatments, and the prognosis of each" (18). This information is essential because a lack of accurate understanding regarding one's medical condition would inhibit the individual's ability to make a rational, voluntary decision.

But even if the patient has been provided with accurate information, the patient still may not fully appreciate that information, especially the information regarding alternative treatments. Thus, a fourth regulatory condition should require patients to actually *receive* the best available treatment alternative before resorting to physician-assisted suicide. After informing the patient as to what available treatment alternative is the most effective, the physician should assist the patient in arranging for that treatment. This treatment could cause patients to change their minds regarding their desire for physician-assisted suicide. As was noted by bioethicist John D. Arras, "the New York State Task Force on Life and Law found that the vast majority of patients who request [physician-assisted suicide] . . . can be treated successfully for . . . their pain, and that when they receive adequate . . . palliative care, their requests to die usually are withdrawn" (361). This fact demonstrates that some requests for physician-assisted suicide are made by patients who have not fully appreciated the options that are available to them. Such premature requests cannot be considered truly voluntary, and thus patients should be required to receive the most effective treatment alternative before resorting to physician-assisted suicide.

Some might object that the most effective treatment alternatives are not always available to some patients because of geographic distance or financial limitations. It is unfortunate that some may not have access to adequate care because of where they live or because of what they can afford, but I think that these factors should be considered when determining what treatment alternatives are truly "available." If the most effective treatment alternatives are not available to a patient due to distance or due to financial limitations, then physician-assisted suicide should not be denied to that patient (assuming that the other regulatory conditions have been met). This unfortunate circumstance should motivate us as a society to be invested in healthcare reform that makes adequate end-of-life treatments available to as many people as possible. As soon as these treatment alternatives are available, then patients have no excuse to not try them before resorting to physician-assisted suicide.

If those four regulatory conditions are met, then patients' requests for physician-assisted suicide can be considered truly voluntary and in alignment with the proponents' claim that physician-assisted suicide should respect patients' self-determination. These four regulatory conditions should also resolve opponents' concerns regarding the negative consequences of legalizing physician-assisted suicide. As long as these regulations are

applied in good faith, euthanasia will never be permitted, and physicians will not be able to abuse the law by coercing their patients into requesting physician-assisted suicide.

But the first claim made by proponents—that physician-assisted suicide should respect individuals' self-determination—is not the only guide for the regulation of physician-assisted suicide. If we only considered self-determination when deciding how physician-assisted suicide should be practiced, then we might allow patients to request it regardless of their physical condition (Arras 361). Some patients might desire to die even if their pain has been or can be successfully treated. Even though these patients may be fully capable of making voluntary requests, it would be wrong to respect their self-determination without any consideration of their physical condition. Thus, we must consider the second claim made by proponents—that physician-assisted suicide should be legalized to allow patients to obtain relief from suffering. This claim should also guide the way we regulate the practice of physician-assisted suicide. Based on this claim, physician-assisted suicide should be limited to those patients whose pain cannot be successfully treated. Even John D. Arras, who opposes the legalization of physician-assisted suicide, admits that "a small percentage of patients suffer from conditions . . . that currently lie beyond the reach of the best medical and humane care" (361).

IV. Conclusion

In this paper, I have shown how arguments offered by opponents are not strong enough to warrant a blanket prohibition of physician-assisted suicide. Opponents who argue that physician-assisted suicide is inherently immoral cannot use their moral and religious convictions to limit the freedom of others. Opponents who argue that the practice of physician-assisted suicide would undermine the proper role of physicians misunderstand what that proper role is. Concerns about the consequences of legalizing physician-assisted suicide do warrant consideration, but these concerns can be resolved by regulating the practice. The two principal claims made by proponents of legalized physician-assisted suicide—namely, (1) that physician-assisted suicide should be legalized in order to respect individuals' self-determination (or autonomy), and (2) that physician-assisted suicide should be legalized to allow patients to obtain relief from suffering—offer a basis for several regulatory conditions that should be met before physician-assisted suicide can be practiced. If these regulatory conditions are met, negative social consequences can be prevented.

The kind of legalization of physician-assisted suicide which I have advocated in this paper is quite conservative. The regulations which I have suggested would ensure that the practice would be limited to those exceptional cases in which patients desire the practice and are capable of exercising self-determination, and in which patients are truly in need of relief from suffering. It is possible that the regulations which I have suggested are so conservative that physician-assisted suicide would be out of reach to some individuals who could have otherwise benefited from it. However, I believe that these regulations are necessary to prevent the greater evil of abuses such as involuntary euthanasia. As physician-assisted suicide becomes legally available in more jurisdictions, surely further research will be done which will allow for the refinement of these regulations, ensuring that the practice is made available for those who need it while the vulnerable are protected from its abuse. I am optimistic that this is an ideal which can be achieved.

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