

# Good assisted suicide research paper example

[Health & Medicine](#), [Euthanasia](#)



Suicide and suicide attempts in the western world have long been considered criminal and punishable. Ancient Romans and Greeks prohibited most suicide, or suicide among the healthy, and punished those who committed suicide by denying them proper burial rituals (Rosenfeld 24). In England and the American colonies, laws continued to punish individuals who committed suicide by denying them a proper burial and both English and American laws found anyone assisting in suicide potentially guilty of murder. In the last several decades, questions about euthanasia and, specifically, the legality of physician-assisted suicide have repeatedly found their way into the legal system and public discourse in various European countries and the United States. Debates on this topic often become heated, as debates that focus largely on controversial ethical topics often do. At the core of the physician-assisted suicide debate is on one hand, the importance of individual liberty, autonomy and the right of an individual to make important, personal medical decisions, while on the other hand, opponents stress the importance of life and find that all killing, including physician-assisted suicide, is immoral. While opponents of assisted suicide do tend to present some logical arguments, these arguments should only be taken into consideration when regulating physician-assisted suicide and not be allowed to impede on the personal liberties of individuals. Although strict regulation of the process is important, individuals should be allowed to decide when to end their lives.

Understanding the terminology used to discuss assisted suicide and related end-of-life terminology is important, as misunderstandings and misuse of terms can cause confusion. In general, the institution of assisted suicide is

very closely related to the loaded, powerful word “ euthanasia,” which comes from Greek and means “ good death.” In the literature euthanasia traditionally is divided into three different types: voluntary euthanasia, non-voluntary euthanasia and involuntary euthanasia. The Cambridge Dictionary of Philosophy gives us the following descriptions of these types: “ Voluntary euthanasia is euthanasia with the patient’s consent, or at his request. Involuntary euthanasia is euthanasia over the patient’s objections. Non-voluntary euthanasia is the killing of a person deemed incompetent with the consent of someone—say a parent—authorized to speak on his behalf” (Euthanasia). One additional method, terminal sedation, involves a physician administering pain medication that permits the individual to sleep through the remainder of their life (Rosenfeld 7).

Also, each of the types mentioned above can be classified as either passive or active euthanasia. Passive euthanasia means to withhold of life-supporting medical care like mechanical ventilation, artificial nutrition and hydration or dialysis, or to allow a person to die. Active euthanasia is the intentional execution of certain actions to terminate the life of person who is suffering from an incurable disease.

Additionally, the term “ physician-assisted suicide” is used to describe the situation when physician prescribes a lethal dose of a medication to a terminally ill patient, providing the patient with the means to end their own life. All of these terms are very helpful to understand that many people misunderstand what exactly the right to die is. Only the last one, the physician-assisted suicide, is mentioned by four states as a legal possibility to end the life of an individual.

Opponents of physician-assisted suicide make several arguments against the practice. One argument at the heart of the debate revolves around the ethical point of view that all killing is morally unacceptable. Many medical schools require that graduating medical students swear to some form of the Hippocratic Oath that addresses treating the sick to the best of one's abilities, patient privacy and other important principles. Some non-physicians and physicians alike find the practice of physician-assisted suicide morally unacceptable and a violation of the Hippocratic Oath. In a 2001 position paper, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) published their stance:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) does not support the legalization of physician-assisted suicide.

The routine practice of physician-assisted suicide raises serious ethical and other concerns. Legalization would undermine the patient-physician relationship and

the trust necessary to sustain it; alter the medical profession's role in society; and endanger the value our society places on life, especially on the lives of disabled, incompetent, and vulnerable individuals. The ACP-ASIM remains thoroughly committed to improving care for patients at the end of life.

Advocates for physician-assisted suicide are quick to point out that it may sometimes be less morally acceptable to allow a terminally-ill, competent fellow human to suffer. Another glaringly immoral concept here is that when one says that a terminally ill person should not be allowed to responsibly decide when and how to end their life they are seriously infringing on the ill

individual's personal liberty and wishing upon them a potentially-undignified and emotionally and physical painful death.

Another argument that opponents of physician-assisted suicide make is that improving palliative care can eliminate nearly all requests for physician-assisted suicide. In the same position paper published by the ACP-ASIM that lays out the organization's position, this is addressed. They posit that society's fear of death and an emphasis on curing illness have negatively impacted the quality of end of life care. Additionally, they call for increased embracing of hospice and state-of-the-art palliative care that includes better and more widely-available pain control techniques. They also recommend measures like reimbursement and incentives for comfort care that alleviate looming concerns about the costs of long-term care and burdens on relatives. It is farfetched to believe that improving palliative care will completely eliminate the desire of some patients to pursue physician-assisted suicide and difficult to believe that there will be, in the near future, widespread improvements in end-of-life care, especially for people in poverty or with no surviving relatives, and it is immoral to force them to end their days in substandard, depressing conditions.

In the same vein as the belief that improving palliative care will virtually eliminate requests for physician-assisted suicide is the concern that legalizing the procedure will negatively impact progress being made in improving palliative care. There is also concern about the role depression, rather than rational, planned thinking plays in individuals requesting physician-assisted suicide, as depression may be alleviated with improved care. The screening processes in place where physician-assisted suicide is

allowed help to ensure that the decision the patient is making is not driven by a condition like depression and instead by logical, rational thought.

A New York Times opinion piece written by Dr. Ezekiel J. Emanuel and published in 2012 when voters in Massachusetts were considering allowing physician-assisted suicide pointed out that the process of physician-assisted suicide was not always flawless, graceful and peaceful and could cause suffering:

many things can go wrong during an assisted suicide. Patients vomit up the pills they take. They don't take enough pills. They wake up instead of dying. Patients in the Dutch study vomited up their medications in 7 percent of cases; in 15 percent of cases, patients either did not die or took a very long time to die — hours, even days; in 18 percent, doctors had to intervene to administer a lethal medication themselves, converting a physician-assisted suicide into euthanasia.

While there are bound to be botched assisted suicides, as with any medical procedure, patients are educated about the possibility of this. Dr. Emanuel unethically plays on fear when he attempts to sway voters to decide against a procedure only a very small minority will ever take advantage of.

An additional argument that opponents of physician-assisted suicide make is that following the legalization of physician-assisted suicide, the requirements for eligibility will gradually be loosened and the number of patients requesting physician-assisted suicide will thus grow, constituting a “slippery slope.” When making this argument, the case of the Netherlands is frequently brought up, as the practices of euthanasia and physician-assisted suicide have expanded in the last few decades since they were

decriminalized and then legalized. While this may be true, to some extent, it is unlikely that physician-assisted suicide will be expanded to allow anyone who is not terminally ill to take advantage of the process, thus fixing the percent of deaths by physician-assisted suicide.

Of course, many people are worried about the overuse or improper use of physician-assisted suicide, such as when elders might be coerced by their family members or other outside forces. However, as we learn from reading Oregon's Dignity Act, there are some very straightforward requirements that protect incurably suffering people from injustice. First, not everybody is allowed to pursue physician-assisted suicide in Oregon. A person must be an Oregon resident, 18 years of age or older, must have decisionmaking capacity, and must be suffering from a terminal disease that will lead to death within six months. The procedure takes time and requires some necessary steps. The diagnosis must be confirmed by the two different doctors. The patient must fill a special form which must be signed, dated and witnessed by two persons to verify that the patient is "capable, acting voluntarily, and not being coerced to sign the request". Then there is a time to notice the patient's family and authorities. The request can be canceled at the any time (Oregon Legislature). All of these steps ensure that the patient's rights are sufficiently protected and accidents or pressure from outside sources are very unlikely. Moreover, since abuse might occur in the all aspects of life, including in substandard palliative care, this is definitely not a strong reason to neglect willing of some people to avoid the pain or mindlessness of suffering near the end of life.

Proponents of physician-assisted suicide present many compelling

arguments in favor of limited, careful and controlled use of the practice, often challenging the concerns voiced by the opponents of physician-assisted suicide. Of the utmost importance to this stance is the right of the individual to end life on their own terms, or personal liberty.

Supporters of physician-assisted suicide also contend that the decision to procure life-ending medication is a logical action driven by rational thought rather than the result of depression. Even where physician-assisted suicide is permitted, a thorough assessment by one or two physicians ensures that a patient's diagnosis and prognosis is certain and that any other conditions that could influence a patient's decision-making including, but certainly not limited to, depression, are not present or interfering with the patient's rational thinking. It is difficult to imagine that a patient dealing with their own imminent death would not exhibit some symptoms of depression, but it is the responsibility of one or multiple physicians that are conducting thorough assessments to determine whether or not the symptoms of depression, if present, render a patient incompetent or if depression is playing a greater role than rational decision-making for a patient (Faber-Langendoen and Karlawish 47).

In his New York Times piece, Dr. Emanuel points out that on occasion, problems arise during the physician-assisted suicide process. However, looking at the Dutch statistics from a different angle highlight the relative effectiveness of oral drugs used for assisted suicide while still highlighting the need for improvements in the process and the importance of educated physician presence for when assisted suicide, as a medical procedure, is met with any sort of complication. According to Faber-Langendoen and Karlawish



(49), who suggest the importance of physician presence in suicide attempts to address attempts that may fail:

If sufficient quantities of barbiturates are ingested without vomiting, most patients die within one hour; approximately 25 percent survive up to five hours, with occasional survivors up to twenty-four hours. Of seventy-five reported cases using oral medications, 77 percent of patients died without further intervention. However, 20 percent died only after additional administration of intravenous paralytics, suggesting that oral medication alone may be either insufficient or unacceptably slow for a substantial minority of patients wishing to end their lives.

Offering patients facing death the option of legal physician-assisted suicide may help to prevent botched suicide attempts and misuse of drugs.

Additionally, even knowing that they have the option of playing a role in the planning and ending of their own life can have an empowering and reassuring impact on terminally ill patients.

Studying states and countries where physician-assisted suicide has been legalized offers insight into different ways the process is addressed and regulated to effectively preserve the value of life and individual liberty. In the state of Vermont, where there is broad public support for physician-assisted suicide, legislation allowing the practice was passed earlier this year, making it the first state to approve the practice through legislation rather than public referendum. For the first three years of the law's existence, it will closely resemble the law and regulations in Oregon that involve significant statutory procedures and safeguards including a second physician's evaluation and a 15-day waiting period between the patient's requests for life-ending

medication (Span). However, after three years many of these procedural requirements will drop away and the physician- assisted suicide decision largely becomes a private decision between a mentally competent patient and a doctor. Additionally, physicians are protected from civil and criminal liability as well s professional misconduct charges. Still remaining after this period, however, is the requirement that the patient is expected to die within six months and the mandate that the physician inform patients of all possible end-of-life services and possible risks of the medications. Additionally, because it is legislation rather than a set-in-stone referendum, the law is open to amendments ranging from minor changes in terminology to more significant adjustments like those to the requirements for physician-assisted suicides.

Opponents of physician-assisted suicide may offer a valid point when they suggest the possibility that legalizing physician-assisted suicide is a “slippery slope.” A review of euthanasia and assisted suicide in European countries and U. S. states conducted by Nicole Steck et al published in Medical Care found that in the Netherlands, the percentage of physician-assisted deaths among all deaths was as high as 2. 9 percent in some regions, as opposed to 0. 1 to 0. 2 percent in U. S. states.

However, careful regulation and monitoring of trends in and potential problems with physician-assisted suicide and, where applicable, changes to existing legislation will help to keep physician-assisted suicide numbers low or serve as a guide to stimulate improvements in palliative care.

Additionally, continuing to limit physician-assisted suicide only to individuals with a prognosis of less than six months remaining of life will by default limit

occurrences of physician-assisted suicide. This concern highlights the need for broad improvements for end-of-life practices and palliative care.

Reasonable thinking suggests that legalizing physician-assisted suicide will not impede efforts to improve palliative care, as statistics show that even where the practice is legal, only a percentage of patients that are potentially eligible for assisted suicide and discuss it with their physician ultimately decide to pursue physician-assisted suicide and a large percentage opt to die naturally. Instead, it is other external forces like limited resources, insufficient government funding or broader societal values that continue to neglect the importance of hospice and other care factors that limit advancements aimed at improving palliative care.

Scientific studies can address some aspects of the debate surrounding physician-assisted suicide like determining the role depression does or does not play in the decision to request assistance with dying. Other arguments surrounding this debate are difficult or impossible to study with data and cold scientific fact. The importance of autonomy or personal liberty is weighed against the belief that all life is sacred and physicians have a moral obligation to provide care only as it allows a patient to live. No one on either side of the debate is arguing that life is not sacred. At the core of the debate, however, is that proponents of physician-assisted suicide place greater importance on quality of life and an individual's right to die on their own terms while opponents choose their own beliefs over those of the individual who is suffering. No physician ought to be obligated to take part in physician-assisted suicide and no individual is required to utilize it, as the personal liberty of these individuals is as important as the freedom of their

compassionate or terminally-ill counterparts to play a role in a peaceful, empowering end-of-life process.

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