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# Physicians-Assisted Suicide and Euthanasia: Reevaluating the Moral Permissibility of 'Killing'

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An abstract of
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of Emory University in partial fulfillment
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# Abstract

## Physicians-Assisted Suicide and Euthanasia: Reevaluating the Moral Permissibility of 'Killing'

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This thesis seeks to provide and alternative perspective of how physicians-assisted suicide (PAS) and euthanasia can be considered morally permissible as medical practices in the United States. The first two chapters lay the groundwork for the main arguments used against and for PAS and euthanasia. The third and final chapter argues that the morality of PAS and euthanasia must be determined based on three principles: 1) respect of autonomy, 2) physician duty of beneficence, and 3) placing moral weight on the reasons and intended results of an action. According to these principles, PAS and euthanasia are not only morally equivalent but they are just as morally permissible as 'letting die'. I conclude that with my proposed guidelines for safeguards to prevent abuse of PAS and euthanasia, the two medical practices should be legalized in the United States.

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## Introduction

Doctor Jack Kevorkian was one of the first physicians to make euthanasia and physicians-assisted suicide (PAS) a public debate amongst Americans. In the 1990's, he assisted people like Alzheimer's patient Janet Adkins, to commit suicide in order to avoid the inevitably intolerable pain and suffering of her terminal illness. Dr. Kevorkian underwent a detailed process of getting to know Janet Adkins and her family in order to determine whether she was in a rational state of mind about her suicide. Janet and her family all decided Dr. Kevorkian's help was necessary for Janet's happiness in the end stages of her life. He set up three intravenous bottles containing sedative thiopental and potassium chloride, which put her under and then ultimately killed her while she was unconscious. Dr. Kevorkian was not the one to "flip the switch" that began this lethal process, which took only six minutes; instead it was Janet Adkins—aware of the timer that would release potassium chloride after she was unconscious—who initiated the drip.

Another case of physicians-assisted suicide is Dr. Timothy Quill who had a long-time patient named Diane who suffered from terminal, acute myelomonocytic leukemia. After months of suffering and a personal understanding of the effect of her illness, Dr. Quill prescribed Diane a lethal dosage of drugs to kill herself. This personal relationship is similar to the way Dutch medicine is practiced with long-term doctor/patient relationships. Diane eventually took the medication, though not immediately because she wanted to wait until she felt ready. No one found out what happened between Diane and Dr. Quill, until he published an article in a medicine journal. This article sparked much debate about the role of physicians as care-providers.

These two examples touch on several issues regarding the morality of PAS and euthanasia. There is a distinction between the two terms yet many regard them as similar in moral discussions. Euthanasia is the term used for mercy killing and is not the same as suicide. There are different forms of euthanasia, which are passive or active and voluntary, involuntary or non-voluntary. The difference between voluntary, involuntary and non-voluntary euthanasia is exactly what is sounds like, voluntary patients grant permission to perform euthanasia, involuntary patients refuse permission to perform euthanasia, and non-voluntary patients are unknown because they are not in a conscious state to grant or deny permission. An example of non-voluntary euthanasia is the case of coma patient Suzie who left no advance directive and the doctor determined that she will never recover from her coma. Suzie is in a persistent vegetative state (PVS) where she is entirely dependent on machines to eat and breath and has no brain activity. Suzie's parents decide it is in her best interest to pull the plugs, which will lead to her death. However, there is no will or consent by Suzie to do such things. This is an act of non-voluntary euthanasia. Voluntary euthanasia on the other hand is with the consent of the patient to end his or her own life.

The difference between active and passive euthanasia has to do with how the patient dies. Active implies that a specific action from the hands of the physician kills the patient, such as a medication or some 'unnatural' cause. Passive euthanasia or withholding treatment, also considered 'allowing' the patient to die, is when the patient knowingly dies from natural causes because he or she has denied medical treatment that could have kept him or her alive longer. Pulling the plug is one of the most common examples for a patient who needs a machine to live. He may not die immediately, but the indirect effect of the action is his death. Many see passive euthanasia as morally permissible because no person or medical treatment in particular can be held accountable for the death of a patient, only natural death is responsible.

There is debate about which of these labels PAS falls under. Some argue it is a form of passive voluntary-euthanasia because the physician is not physically assisting the patient with her death. However, a prescribed lethal dosage of medication is not a natural death for anyone, therefore others view PAS as active-voluntary euthanasia. A third group sees physicians-assisted suicide in a category of its own because the patient, like Janet Atkins, takes it upon herself to commit the actual act instead of relying on the hands of someone else. To better understand the difference between PAS and euthanasia, we shall look at the two medical treatments through an ethical lens. This discussion will focus on voluntary-active euthanasia but I will refer to it only as euthanasia.

In ethical discussion, three actors or participants must be identified: the agent, the *Patient* and the judge. For the sake of this discussion where there are two meanings for the word patient, one will be the patient in the hospital and the *Patient* will be the actor for sake of ethical dialogue. The agent is the one who performs the action. However, in order for the individual to be an agent she must follow four criteria; she must have knowledge of the situation; she must be minimally rational in that she understands the consequences of her actions; she must be free to act under non-coerced circumstances; and finally she must possess the abilities to perform the action. In general, the average adult falls under these criterion. Those who do not qualify are babies and infants because they do not rationally understand the consequences of their actions and are therefore not fully rational. Others such as the senile and mentally impaired also do not qualify as agents for the same reasons; they lack the mental capacity to understand the consequences of their actions.

To be a *Patient* in the ethical sense means that an individual must possess some minimal sense of awareness of the action being done to her. This immediately disqualifies inanimate objects such as rocks, sticks or properties. This leaves much room for debate when it comes to qualifying animals and fetuses, however it is not part of this discussion and will not be further looked into. The important distinction in this life and death debate is that the *Patient* receives the action done by the agent.

The third and last character is the judge. The judge does not have to be involved in the action yet she can be. The judge must qualify two criteria, she must be informed and she must be rational. This means she must understand the circumstance in which the action is done and also comprehend the consequences of that action. Her judgment does not necessarily affect the other actors or the action because the judge may be a completely separate party. An example of a separate party judge is an individual who reads about a physician pulling the plug on a patient in a newspaper article. The judge is the reader who does not know either the physician or the patient yet is fully informed of the circumstance and can rationalize the consequences. He may place a judgment when saying, “That doctor was wrong for pulling the plug on the patient, no one should be allowed that power.” This judgment is in response to the agent and the *Patient* yet the judge has no power over the action or the two other characters.

With these definitions, it is clear that when one is an agent one is also a judge. However, this does not mean that a *Patient* is necessarily a judge or that an agent is necessarily a *Patient*. In the unique case of suicide, the individual is the agent, the *Patient* and the judge all at one time. What about the cases of physicians-assisted suicide, or euthanasia? Is there a difference and if so, is it important in the moral distinction between the PAS and euthanasia?

The difference between PAS and euthanasia does depend on who is the agent and who is the *Patient*. For PAS there are two agents and one *Patient*; the physician is an agent because she acts by prescribing the lethal dosage of medication for the patient and is fully aware of the situation and its consequences. The medical patient is an agent, a judge and a *Patient* because he takes the lethal dosage of medication to commit suicide, judges that it is the best option to end his life and dies from the action. Because there are two agents, we can determine the direct and indirectness of the two agents based on how closely their actions are tied to the suicide; the physician is an indirect agent and the patient is a direct agent.

In the case of euthanasia, there is one agent—the physician—and one *Patient*—the medical patient who will die; but the patient is also a judge with the most influential decision. However, the act of killing is now in the physical hands of the physician and no longer in the physical control of the patient. This may be for various reason such as the patient not having the physical ability to perform the act himself and simply needs the hands of another; or there is the possibility that the patient is in a coma or unwilling to make the final act. For whatever reason, the physician is understood to be the only agent for euthanasia.

Now that the physical distinction is made between PAS and euthanasia, the issue becomes whether this difference is morally significant enough to treat PAS and euthanasia as separate moral discussions or to refer to them together. Is there a moral difference between the two or is it just semantics?

Another question and the main aim that will be addressed is whether PAS and euthanasia are morally permissible. The purpose of this analysis is strictly concerned with the ethical/moral discussion and not with the legal restrictions. Therefore, I will first present the opposing popular arguments for and against these two end-of-life treatments. After presenting a thorough description of the moral dialogue, I will present my own account of the morality of physicians-assisted suicide and euthanasia and to what extent I find them morally permissible. Other questions that will be discussed are whether there are limitations when an individual can decide his or her own death; under what circumstances is it appropriate for a physician to provide his patient with the option to end her life? It is morally acceptable for a physician to help her patient end his life or must physicians only help keep people alive? I will present opinions from philosophers and physicians to provide different accounts of moral permissibility in hopes of igniting the dilemma once more.

# Chapter 1: Arguments Against PAS and Euthanasia

There are many arguments today that oppose physicians-assisted suicide and euthanasia. Some of the arguments are specific to the United States because they depend on the structural limitations of our health care system, while arguments of religious perspective apply universally. In this first chapter I will examine the four most prominent stances that argue against PAS and euthanasia. First I focus on the culture-specific arguments such as the social construction and understanding of the role of medical care. Second I focus on the 'slippery-slope' argument that says that legalization of PAS and voluntary euthanasia will lead to more horrific means later on. Third, on how our society can provide better alternatives for end-of-life treatment. Fourth and finally I focus on the fundamental Christian-religious perspective regarding the sin of suicide in any form, a common foundation for the beliefs of many US citizens.

## *I. 'Killing' v. 'Letting Die'*

For many people in the United States there is an important moral distinction between the two terms 'killing' and 'letting die'. The term 'killing' has a negative societal connotation. According to philosophers Gert, Culver and Clouser, killing means, 'causing death'[1] and is not morally permissible, with the exception of self-defense and in United States capital punishment.

Gert, Culver and Clouser argue that the doctor-patient relationship is based on the historic and social assumption that the role of doctors is to keep their patients alive and healthy. There is no wiggle room or exceptional cases to this ethical rule. Doctors cannot 'kill' their patients because this would be in direct opposition to their jobs as physicians. This vision of a physician's professional duty dates back to the Hippocratic Oath in ancient Greece that forbade its members—a portion of the physicians at the time—to kill any of their patients. It states:

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[1] Gert, Culver and Clouser, "An Alternative to Physician Assisted Suicide" in *Contemporary Issues in Bioethics* Edited by Beauchamp, Walters, Kahn, and Mastroianni, pp. 457.

> "I will neither give a deadly drug to anybody if asked for it, not will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art. I will not use the knife, not even on suffers of stone, but I will withdraw in favor of such men as are engaged in this work."[2]

The Hippocratic oath established the beginning of medical ethical standards that does not allow physicians to kill their patients. This excerpt is the focal point that many doctors and medical ethicists refer to as the foundation for their work. Although PAS today requires drugs that were not available at the time the Hippocratic oath was written, the passage nevertheless undermines the basic concept of assisted suicide. Since the Hippocratic oath restricts physicians from 'killing' their patients, it is necessary to create a distinction between 'killing' and 'letting die' because circumstances where patients are allowed to die do not qualify under the oath.

Now we must ask, what constitutes killing? There are many interpretations of what it means to 'cause death'. Some understand it only as a direct action i.e. lethal injection. Yet others extend the definition to include indirect actions such as when a physician prescribes medication to a patient who he knows intends to commit suicide. Opponents of PAS consider 'killing' as the indirect act of doctors prescribing medication to patients so they can kill themselves. Even though physicians are not directly injecting their patients with a lethal dosage the way they would in the case of voluntary-active-euthanasia, they argue that the indirect act is enough to be considered contrary to the responsibility of physicians. Physicians-assisted suicide is classified as 'killing' because doctors' actions intentionally provide the tools to directly initiate death in a manner that normally would not have occurred from any other circumstance and by no natural cause. Needless to say that since the indirectness of PAS is 'killing' voluntary-active-euthanasia too is 'killing' and should not be a permitted act for physicians. This argument of a physician's

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[2] G.E.R. Lloyd, *Hippocratic Writings,* trans. Chadwick and W.N. Mann, Penguin, New York, 1950, p. 13.

responsibility dates back to the 1800's when the debate about PAS began in the United States. The American Medical Association (AMA) adopted the same general principles from the Hippocratic Oath and established an ethical code that morally forbade doctors from taking any part in a patient's death.

Opponents of PAS and euthanasia argue that the difference between 'killing' and 'letting die' is that the latter allows nature to take its course. 'Letting die' is considered voluntary passive euthanasia. The moral permissibility of 'letting die' according to the AMA requires three conditions: 1) the patient's wish to withhold treatment to keep themselves alive (e.g. by not using a feeding tube or any sort of machine); 2) patients are a competent and rational individuals; and 3) patients are terminally ill or will soon die naturally if taken off the life-sustaining treatment.

According to the American Medical Association in 1973, there are four requirements for physicians to withhold treatment for patients: 1) the patient's death must not be part of the doctor's or medical staff's *intention;* 2) the cessation of treatment is permissible only if 'biological death is imminent'; 3) 'extraordinary' means must be needed to keep the patient alive; 4) the right to make this decision is reserved to the patient and/or the immediate family.[3] These standards are required of all doctors and nurses in the United States.

The first requirement is part of what is referred to as the *principle of double-effect*. This principle distinguishes between the direct killing of a patient and the unintended side effect of death. An example to clarify the *principle of double-effect* is common among patients who seek pain treatment for end-of life care. Our hypothetical patient Joshua has late stage terminal throat cancer in his larynx or voice box and he is waiting for death to take him. Joshua's pain is so

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[3] James Rachels, *The End of Life, Euthanasia and Morality,* Debunking Irrelevant Distinctions, p. 89

prominent that he needs around the clock care by nurses to monitor a morphine drip whenever the pain becomes unmanageable. At times the pain is so outstanding that enough morphine is used to knock Joshua unconscious. His last and final painful attack required so much morphine by the nurse that it caused him to lapse into a coma and ultimately die.

The intention of the medical staff was to manage Joshua's pain even though they were aware of the possible and likely chance of his death. However, the *principle of double-effect* allows for a nurse, doctor or medical staff personnel to perform a certain action, giving morphine in Joshua's case, as long as it is intended to do good. It is also important to the double-effect principle that there cannot be any better options for the *Patient* and that the good intention outweighs the potential bad possible outcome. In Joshua's case the nurse had no better option but to give him a dangerous dose of morphine to treat his intolerable volume of pain. In the eyes of the medical staff, it was in the best medical interest of their patient Joshua to provide morphine. This distinction of good versus bad intention is morally significant.

One way to understand the role of medical staff and the conditions that hold them responsible to the survival of their patients is to compare their similarities to that of a parent. Parents are responsible for keeping their children alive and healthy because the children not only require it of their parents but also request it. If parents should act negligently towards their children, then they are harming them. If children should die due to negligence, then the parents are said to have killed their child. Although this form of action indirectly kills the children, it is considered killing because the children request and require their parents to care for them.[4]

In the comparable case provided by Gert, Culver and Clouser of doctors and patients, if a doctor neglects to treat his patient who is in need of treatment to survive and, most importantly,

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[4] Gert, Culver and Clouser, "An Alternative to Physician Assisted Suicide" from *Contemporary Issues in Bioethics* Edited by Beauchamp, Walters, Kahn and Mastroianni, pp. 459.

requests life-sustaining treatment, then he is considered to have killed his patient. Doctors have moral and legal responsibilities to treat their patients under this circumstance. However, when patients do not request treatment, in fact they refuse treatment, Gert, Culver and Clouser argue that doctors no longer have the same responsibility towards them. In this case, when a doctor does not provide life-sustaining treatment at the request of her patient, it is not considered killing, but instead is considered 'allowing them to die' from natural causes. "When an informed competent patient makes a rational decision to stop life-prolonging treatment, a physician cannot have a duty to overrule his refusal of treatment, even though normally a physician has a duty to prevent death"[5]. This exception, opponents argue, is what makes 'letting die' morally permissible and distinguishes it from killing.

The second condition that justifies 'letting die' is that a patient is competent and rational when requesting to refuse life-sustaining treatment. This means that patients cannot chose to end life-sustaining treatment due to depression or for any other reason than because their life will be over soon due to natural causes and they would prefer to live the rest of their days out of the hospital. Physicians must make sure that patients do not refuse life-sustaining treatment for treatable illnesses or depression.

This reasoning ties into the third condition of 'letting die'. Patients must be terminally ill and far along in the process of dying from their illness in order for withholding or withdrawing of life-sustaining treatment to be considered morally permissible and thus allowing the natural causes of death to take their toll. Legally, hospice-palliative care requires that a patient must be diagnosed in her last six months of life to withhold or withdraw treatment.

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[5] Gert, Culver and Clouser, "An Alternative to Physician Assisted Suicide" from *Contemporary Issues in Bioethics* Edited by Beauchamp, Walters, Kahn and Mastroianni, pp. 459.

Another distinction, opponents argue, between ‘killing’ and ‘letting die’ has to do with the intentions involved no matter if the actions are active or passive. When people kill, their intentions are to end the life of the individual, but the intentions when allowing someone to die vary depending on the situation. In the case of PAS, the intention of physician is to kill the patient. However, when a physician allows his patient die by withdrawing or withholding life-sustaining treatment—passive euthanasia, his intentions are to respect the wishes of his patient and “to relieve pain”[6]. This focus on intention is similar to the *principle of double-effect* because the physician or medical staff is still occupied with doing what is in the best interest of the patient.

Although philosophers like Gert, Culver and Clouser believe that it is morally permissible to allow a patient to die if they are considered rational and competent in their decision, there is another more conservative opinion that does not even tolerate this condition. It is somewhat of a catch-22 that does not permit the patient to rationally and competently decide to withhold treatment. The argument begs the question of rational suicide because it is based on the assumption that as humans we have so powerful survival instincts that any decision to die is irrational[7]. If there is a requirement to be rational and competent to choose death, but no one can rationally choose death over life, then it is impossible to allow someone to choose death because they must be irrational.

### *II. Slippery-Slope Argument*

Proponents of the second group of arguments are less concerned with intentions involved in the difference between ‘killing’ and ‘letting die’. Instead, the argument steers away from the legalization of PAS and the consequences of eventual legalization of more extreme cases. This

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[6] James Rachels, *The End of Life, Euthanasia and Morality,* Debunking Irrelevant Distinctions, pp. 104.

[7] Gregory Pence, Medical Ethics, Accounts of the Cases That Shaped and Define Medical Ethics, pp. 15.

section is focused on the 'slippery-slope' argument and arguments similar to it. There are several versions of the argument that depend on the variables that cause the slippery-slope. In addition, there are two types of slopes, an *empirical* and a *conceptual slope*[8]. The empirical slope argues that after a first step in one direction, in this case legalizing PAS, something bad in human nature is opened and will cause further problems that will soon be our of our control. The conceptual slope argues that after that first step, no matter how small or big, we will be led to treat similar cases similarly and eventually this will lead to extreme cases. "Once physicians are permitted to kill one kind of patient because 'quality of life' is so low as to make ' life not worthy to be lived', then not only can, but the same reasoning *will* be used in similar cases.[9]".

The variables involved in both empirical and conceptual slippery-slope arguments are 1) financial burdens on the families of the patient; 2) financial greed and incentives involved for doctors; 3) medical laziness where physicians no longer want to deal with a sickly patient; 4) and insensitive moral acceptance of killing that will broaden to a wider range of people – to those not terminally ill. In the most extreme cases of this argument, PAS will lead to voluntary active euthanasia, and finally to doctors killing their patients without consent, otherwise known as involuntary active euthanasia. Generally speaking, opponents of PAS and euthanasia believe the first step towards a change in what we consider morally and socially acceptable can quickly be abused and be morphed into something negative.

In our capitalist country where health care is a business and a very expensive one at that, the financial burden on families of patients is a very real problem. In addition to health care expenses, the technology today adds to the problem because there are so many tools to keep patients alive longer compared to fifty or one hundred years ago. This leaves families liable to

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[8] Gregory Pence, Medical Ethics, Accounts of the Cases That Shaped and Define Medical Ethics, pp. 68.

[9] Gregory Pence, Medical Ethics, Accounts of the Cases that Shaped and Define Medical Ethics, pp. 68.

pay for end of life treatment such as machines, nursing homes and treatments that can last years for a terminally ill patient.

However, if physicians-assisted suicide is legalized, it opens up another option for the terminally ill. Of course PAS will help those patients who prefer death as opposed to end of life treatment in the finals stages of their terminal illness. But what of those who still desire to live yet feel that they are a financial burden on their families? Proponents of PAS argue that families are made of people who love and care for one another, so naturally their concern for the patient overrides the issue of money. However true this may be, it does not deal with the indirect pressure the patient feels no matter what her family members tell her.

For example, Karen has a terminal illness that requires she have 24 hour care to handle her feeding tube. Her daughter Joyce, a single mother with son Steven in his senior year of high school, has to help pay for her mother's care. Karen understands that she may have several years left, which of course Joyce will have to pay for. But she also knows that Steven has aspirations to go to college. Joyce cannot afford to pay for both her mother's medical treatment and her son's 4-year college degree. Steven has no other option but to go a local community college. Although Joyce and Steven tell Karen that her life is more important than anything, including Steven's immediate education, Karen feels awful and burdensome. If the option of PAS is available to Karen, she very well might feel inclined to end her life earlier than she wants because she cannot deal with the guilt of denying Steven his college education. By making PAS available to patients like Karen, an opportunity presents itself to end life early even when it is undesired. Many cannot deal with the pressure of knowing that others they love are suffering due to their own misfortune of illness.

A second financial variable is the greed of doctors and the hospitals where they work. Just as it is expensive for families to pay for their relatives, it is also costly for institutions to keep patients. Terminally ill and elderly patients who must remain in the hospital until their death are expensive for the hospital. Patients are not unaware of their situation, especially if society begins to complain politically about their cost on. With the legalization of PAS, patients will feel the social pressures from the institutions and from public debate about where our health care money is spent.

As for the doctors, they make their money on surgery, not the elderly and terminally ill who just require upkeep and maintenance procedures. So when a cancer patient takes up a hospital bed instead of a patient who needs an organ transplant, the doctors see this as an opportunity lost to make money. There is a societal assumption that physicians are morally driven and that money is not a factor. However, the very industry they work in is one of the biggest businesses in the country. With PAS available to doctors, the greedy ones or those suffering financial setbacks are likely to influence their patients in the direction of PAS as a reasonable option.

Along similar lines, doctors are susceptible to laziness in their work. After treating a sickly patient who he knows is going to die soon, the doctor could get tired of treating his patient. Again, doctors are human and not morally immune to such things as laziness. Physicians-assisted suicide is the perfect outlet for these kinds of doctors who want an easy way out. Of course we cannot assume physicians ordinarily take this approach to their work; but once a trend starts with a few lazy doctors, it becomes less of a shock to colleagues and more of a norm.

This leads us to one version of the empirical slope arguments that the legalization of PAS will open the door to the moral acceptability of killing. This argument assumes the worst in human nature and that abuse is inevitable. The role of a physician is to treat his patient and to make sure she is in the best health. Society values a physician's role as one who does the opposite of killing patients—as stated earlier in the section regarding the Hippocratic Oath. If one of our only professions that protects against death is allowed to kill, then the sanctity of the position is gone along with the security of civilians when they visit the doctor. The health of the country cannot afford to be skeptical of our doctors and their decisions because there will be no one left to care for our well being.

Opponents to the slippery-slope argument point out that the foundations for the arguments are not based on much factual evidence but on assumptions. However much this may be the case, Holland is a very real example of how the slippery-slope works. Not only is PAS legal and socially acceptable, euthanasia is also accepted although not entirely legal. One of the more startling realities in Holland is not only the moral flexibility in their laws, but the frequency that physicians and their patients maneuver their way around such laws to perform outlawed procedures. Too much discretion is left to the physician to analyze the individual cases instead of following government regulation.

In the documentary and discussion *Choosing Death* featured by Frontline News, the focus is on Holland and displays how their medical practice really works. The first few cases presented are not as controversial because they follow laws and deal with only terminally ill cancer patients in their last few years and maybe months to live. The patients must request euthanasia from the physician in order for the act to be socially acceptable and for the physicians to avoid prosecution. The second round of patients become younger and lack any physical illness; instead two of the patients face mental instability. Neither of these patients will die from their illness but instead believe their lives are not worth living because they have lost their ‘humanness’ quality that is so important to them. Similar to the previous group, these two patients request euthanasia. However, one of them is a 24-year old girl who claims to suffer from a mental inability to allow herself to eat. Is this reason enough to perform euthanasia? According to the slipper-slope argument, this can lead to euthanasia of those who are not terminally ill, and even to the very young.

Many Americans fear that once we legalize PAS, our country will fall into the same downward spiral as Holland. Physicians in Holland have euthanized not only their patients who are in the final few weeks or days of their lives, but they have also moved to euthanize AIDS patients who are not in late stages of the disease but instead, those who want to avoid any amount of suffering. Doctors have also agreed to euthanize younger patients with mental illnesses who have expressed their desire to end life. Patients suffering from mental illness are not mentally competent and therefore cannot decide whether to end their life or not. The most extreme case in the film demonstrates euthanasia performed on a physically deformed infant whose parents decided they did not want their child to suffer. The most frightening aspect of this last case is that physicians act on decisions from third parties. It is an understanding in the US and in Holland that a parent or guardian does have the legal right to be a guardian over their children until a certain age. In many cases this is not problematic because the adult is more knowledgeable than the child in what is the best life decision. In the case of life and death however, it is not that simple. No individual has the legal or moral right to decide the death of another. Euthanasia in Holland is a clear example of the slippery-slope theory. Once one form of euthanasia is morally acceptable, justification for more extreme measures is bound to follow.

Physicians and philosophers argue that if Holland has reached these extremes, the United States will not be far behind after the legalization of PAS.

### *III. Better Alternatives*

According to the arguments of philosophers Felicia Cohn and Joanne Lynn, there are better alternatives to PAS and euthanasia that do not involve sacrificing the patient's life. However, in order to reach these alternatives, we need to redirect the focus of medical care in our country to concern ourselves more with the terminally ill instead of discarding. Due to the extent in quality of medical care that our country has at its disposal with options such as hospice care and palliative care, there should be no reason for doctors and patients to resort to killing.

Palliative care is medical treatment that reduces the pain and suffering of a disease, no matter if the disease is fatal or not. Treatment deals with the reduction of the symptoms of a disease and not with the disease itself. It is about making the patient as pain-free and suffering-free with her disease as possible.

Hospice care is a more specific type of palliative care because it too does not treat or cure illnesses but its focal treatment is comfortable end of life treatment. Most patients who receive hospice care are usually dying from terminal illness such as HIV/AIDS and cancer or even simply old age. This is the point in a patient's illness that he decides to no longer receive treatment to cure an illness. Instead he accepts his death is near and hospice care is available to make it as comfortable as possible, both physically and psychologically. Hospice care can be done at home, in the hospital, or in hospice facilities that are specifically for dying patients. Around the clock care is available depending on the severity of the patient's illness. It is focused on what the patient needs and wants according to his personal standard of quality-of-life. This standard can range from physical, emotional, spiritual and psychological quality. Cohn and

Lynn argue that our health care system needs to rearrange its priorities to take better care for those with terminal illness. They say that currently there is insufficient care and attention paid to terminally ill patients. Once that is fixed, there will be no excuse or reason for PAS.

One of the main reasons patients seek PAS is to avoid the pains and physical suffering caused by terminal illness or to stop their current suffering. However, with medical technology today the standard of care has increased to encompass many means of dealing with suffering from physical pain. Physical pain is much more commonly treated today than it use to be with medicines such as morphine and services like around the clock nurse care. Therefore pain is not sufficient ground for PAS.

Hospice-palliative care began in the United States in the 1970's and in 1982 it was implemented into the government funded Medicare plan. Medicare currently pays for 80% of all hospice care, which means it is readily available to those who need it. According to the Medicare packages A and B, which are considered the most standard option, hospice care is completely covered with no additional fees such as a co-payment. The patient only has a co-payment for additional outpatient medications. In addition, Medicare costs are based on an individual's tax returns in order to be affordable for all. Included in the hospice coverage is around the clock nursing, although not coverage for new locations because the treatment can be had in the home or a hospital. Additionally, hospice care can only be covered in the last six months of life and a physician must diagnose it.

Another aspect of hospice care is the psychological treatment of the patient's family members. The decision to withhold treatment is a difficult one to deal with as a family because the death of a loved one is a near and inevitable fate. Hospice-palliative care encompasses all aspects of comfort, physical and psychological for every member affected.

Philosophers Cohn and Lynn, along with other 'better alternatives' advocates, believe our basic medical standard of care has increased so much in the last century to a point where suffering patients can always find other means for end of life treatment besides PAS or euthanasia. The only issue is figuring out how to redirect our social consciousness to focus on making these options more available and popular so that they become the first resorts for dying patients.

## *IV. Religious Morals*

One of the founding assumptions for the 'better alternatives' argument is that life is always better than death because life innately sacred. This belief comes from the religious argument that is deeply imbedded in our culture. For many, the argument against PAS is simple and matter of fact. For the religiously inclined, there is a strong foundation in the moral code that does not allow room for killing of any kind. Our society is built on religious groundwork that dates back to the colonizing era. As argued by Kenneth Vaux, the United States has a 'holiness' ethics[10] that believes all life to be sacred until the last breath of air. To end a life short of its natural death not only defies the plan of God, but it kills a part of God's sacred creation, man.

This concept dates back further than the founding of the United States to the time of Plato/Socrates and the Pythagorean philosophers. They believed that an individual is responsible to die a natural death. Additionally, all humans are given the opportunity by the Gods to live and we should view our lives as 'posts' assigned by the Gods that they alone can dismiss us from[11].

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[10] Kenneth L. Vaux, Death Ethics; Religious and Cultural Values in Prolonging and Ending Life, pp. 22.

[11] Kenneth L. Vaux, Death Ethics; Religious and Cultural Values in Prolonging and Ending Life, pp. 3.

One of the religiously fundamental perspectives came from the philosopher and theologian Thomas Aquinas in the 13th century when he wrote on suicide in his book *Summa Theologica*. Aquinas argued that suicide is wrong for three reasons:

> "First, because everything naturally loves itself, the result being that everything naturally keeps itself in being, and resists corruption so far as it can. Wherefore suicide is contrary to the inclination of nature, and to charity where by every man should love himself. Hence, suicide is always a moral sin, as being contrary to the natural law and to charity. Secondly, because every part, as such, belongs to the whole. Now every man is part of the community, and so, as such, he is part of the community. Hence, by killing himself he injures the community, as the Philosophy declares. Thirdly, because life is God's gift to man, and is subject to His power, who kills and makes to live. Hence, whoever takes his own life, sins against God, even as he who kills another's slave, sins against that slave's master, and he who usurps to himself judgment of a matter not entrusted to him. For it belongs to God alone to pronounce sentence of death and life, according to Deuteronomy 32:39 'I will kill and I will make to live.'"[12]

These arguments lay the groundwork for Christian thought on suicide and its different forms. One of the strongest arguments is his third because life is still seen as a sacred gift from God that we humans must value until our final moment. Aquinas develops the argument by involving the faculty of man's freewill. He says that God granted man freewill to rule his own life. Man has the natural capacity and the ability to determine how he will live his life on a daily basis, however, freewill does not carry any weight when it comes to ending one's life—one's mortal life—in order to live the after life, that power is granted by God alone. Therefore, it is only God who can lawfully grant life and death to man, and not man's freewill.

Additionally, life's death is the worst evil to encounter, so for those seeking escape from an unhappy or painful life by death will only encounter a greater evil in return for their lesser evil. Aquinas says, "Suicide is the most fatal of sins because it cannot be repented of"[13]. Repenting of sins is one of the most important aspects of Christian belief so that one is prepared

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[12] Thomas Aquinas, The Summa Theologica of St. Thomas Aquinas: Second part of the Second Part., Online Edition by Kevin Knight, http://www.newadvent.org/summa/3064.htm.

[13] William E. Phipps, "Christian Perspectives on Suicide" *The Christian Century*, ed. Ted and Winnie Brock, pp.972.

to enter the gates of heaven and join God in the after life. Yet if suicide is the final sin man commits, he does not have the opportunity to cleans his conscience of sin before meeting God.

Aquinas also argues that we should not seek an escape from our current condition of life through death because God has a plan for us all, whether it is to suffer or to live a prosperous life. Our momentary suffering is not a sufficient reason to commit suicide because we cannot see the end plan that God has in mind, only He can. Therefore, suicide shortens God's plan based on an impermanent state of suffering or pain. Our impatience and ignorance of God's plan is not a naturally lawful reason for inflicting our own death.

These four general arguments represent opposition to physicians-assisted suicide and euthanasia. There are variations of more specific arguments from different philosophers, but they all maintain the general principles of religion, slippery-slope or potential risk of future misfortunes, better alternatives that eliminate the need for PAS or euthanasia, and the moral responsibility of physicians to keep their patients alive. The arguments in this chapter are concerned with the actions and responsibilities of different agents, and assumes that the *Patient*—who is also an agent—unreasonably desires death because he does not see a better option, or because he is a victim of circumstance. Although this may be true of a patient who is only a *Patient*, it is more complicated for patients of PAS and euthanasia who are *Patients,* judges and possibly agents as well. This is where the shift in perspective takes place for arguments in favor of PAS and euthanasia. Chapter two will present arguments that treat patients as two or all three of the ethical characters instead of just the *Patient*.

# Chapter 2: Arguments For PAS and Euthanasia

Just as there are arguments against PAS and the different forms of euthanasia, there are several groups of arguments about the moral acceptability of the practice and favor for their legalization in the United States. This position has three groups of arguments: 1) the importance of patient autonomy, a concept that developed after the establishment of religious belief; 2) a different perspective of physician and medical care's beneficent responsibility; and 3) the importance of the difference between pain and suffering.

## *I. Patient Autonomy*

The principle of autonomy originated in political philosophy to describe the individual rights and individual freedoms of citizens. The founding fathers embedded the principle of autonomy into our culture so that today it is believed to be an innate human right. It is now applied in medical ethics to mean the "freedom from external constraint and the presence of critical mental capacities such as understanding, intending, and voluntary decision-making capacities."[14] There currently exist two main factors of patient autonomy in the field of biomedical ethics: 1) respecting patient's quality of life standard; and 2) maintaining patient dignity. Because these two factors have many similarities and even depend on each other, I will treat them as two pieces of one argument. The first deals with situations where patients no longer experience the quality-of-life they consider worth living; the second focuses primarily on patients who want to prevent a minimal quality-of-life state.

### *I.a.) Quality of Life Argument*

In Chapter one, the religious perspective states that life is a gift from God with intrinsic value and that to be alive is reason enough to never end one's own life. Contemporary

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[14] Beauchamp, Walters, Kahn, and Mastroianni, "Ethical Theories and Bioethics", *Contemporary issues in Bioethics*, pp. 22.

philosopher Don Marquis takes a similar perspective when he argues against abortion. "The loss of one's life is one of the greatest losses one can suffer. The loss of one's life deprives one of all the experiences, activities, projects, and enjoyments that would otherwise have constituted one's future. Therefore, killing someone is wrong, primarily because the killing inflicts (one of) the greatest possible losses on the victim."[15] Although his argument is not religiously based, Marquis draws on the same assumption that life is inherently good. The religious argument assumes that any life is better than no life at all, suffering or no suffering. Marquis assumes that there are inevitably good, pleasant and worthwhile experiences in one's life. Although he may be right in the case of abortion because the fetus has the potential of an entire lifetime, this is not the case with terminally ill patients who are in their final stages of life.

Marques' account of autonomy is based on two qualities that are innately human, that of the *discontinuation* account and the *desire* account. Marquis argues that people value the experience of living and want that experience to continue. Killing or murder would be the discontinuation of all experience, something no grown person wants. The desire account states that we have a strong desire to continue living, not for life in itself, but for our value of the "goodness" that comes from the experiences while living.

The *desire* and *discontinuation* accounts fall under human autonomy because they are reasons we use to exercise our autonomy. According to Marquis' argument, it is natural for humans to have a desire to live in order to gain good experiences. Therefore, when an individual loses that desire to continue living, he must no longer be experiencing "good" things. This loss of desire is clearly an extremely powerful change if it reverses what is part of human nature. This change should be taken very seriously because it means that the lack in quality-of-life is

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[15] Don Marquis, "The Problem of Justifying Abortion" in *Contemporary Issues in Bioethics* Edited by Beauchamp, Walters, Kahn and Mastroianna, pp. 346.

powerful enough to cause our autonomous decision to end life to override our natural desire to continue living.

Marquis also claims that the concept of ‘value’ is key to determining what is ‘good’. He claims that others, aside from the individual, can define value. However, this is not an autonomous decision and therefore false. Value for quality-of-life is subjective and therefore must be evaluated by the individual who is living those specific experiences.

The main trouble that proponents of PAS and euthanasia see with these two arguments is their inability to take into account the importance of the quality-of-life according to the individual. In the field of ethics there is an ongoing discussion about the various ways to talk about quality-of-life. There are general divisions that separate the different variations of quality-of-life. The first level is a state of ‘well-being’ where an individual is healthy, both mentally and physically, because she is active; she does not rely on any consistent medication to keep her healthy and is most likely in her youth. The second division is later on in life when her body is no longer in tip-top shape because age physically takes a toll on her but she still has all of her mental capacities and health. The third general division is what we might consider a state of ‘minimal quality-of-life’ because she is either physically incapable of taking care of herself and/or is mentally unstable. Specific examples may include constant physical pain, insanity, severe-depression, loss of mental and/or physical abilities, suffering from a non-terminal illness, suffering from a terminal illness or semi to totally vegetative states. These are all reasons given either by individuals who no longer believe they live a high quality-of-life or ethicists and law-makers when it comes to comatose patients.

It is clear from both the anti-PAS/euthanasia arguments that human life is valued more than other life forms. Why is this? It is based on the rational mind of self-awareness and self-determination. It is also important to note that the quality-of-life standards above also place a high amount of weight on the human mind because a rational mind is not only valuable, but it is a defining human attribute. Autonomy encompasses the two qualities of self-awareness and self-determination. Therefore, as humans we have the ability to determine the way in which we live our lives as long as it does not cause harm to others, the natural capacity to place a subjective value on our own lives, and the right to plan our own end when we no longer experience a quality-of-life worth living.

The quality-of-life determined by the individual patient is based on the mental and physical capabilities that he may not longer manage or posses. It is the responsibility of the physician and society to accept individual evaluation of life's worth because it is the individual and no one else who can determine when the goodness of life is outweighed by the badness.

A more specific example of the application of autonomy with respect to quality-of-life is when a patient is dying a painful death caused by liver cancer. We will call our patient Jacob. His life's work focuses on geological exploration around the world that requires him to be very physical on a daily basis. He has found joy in his work and being outdoors for thirty plus years. Jacob is now hooked up to machines that function in place of his liver, he has a constant morphine drip monitored by around the clock nurses to handle his constant pain. The only chance Jacob has to survive this cancer is by some miracle recovery. Instead of choosing palliative-hospice care, Jacob wishes to end his pain and suffering because his quality-of-life denies him the joy and purposed it served before. Jacob decides that a life restricted to a hospital bed while dependent on machines is not one worthwhile enough to continue living. This personal assessment may not make sense to all people, but Jacob's autonomous evaluation of his quality-of-life is no less valid.

Philosophers such as Dan Brock argue in favor patient autonomy with several restrictions that do not permit just anyone to kill himself or herself. These restrictions are noteworthy because they keep the argument restricted to euthanasia and PAS without allowing any form of suicide or killing. In his article *Voluntary Active Euthanasia*, Dan Brock considers quality-of-life as one's "Own conception of a good life, at least within the bounds of justice and consistent with other doing so as well."[16] He also says that self-determination can be carried out when the person is assumed to be reasonable and has the decision-making capacity.

### *I.b.) Maintaining 'Dignity'*

When patients claim they want to maintain their dignity, they are also exercising their autonomy. The main difference with maintaining dignity and quality-of-life evaluations is that maintaining dignity is the foresight that life *will* lose its quality and the individual wants to avoid that point entirely. Our current system has some legal version of this belief with advanced directives, living wills, and durable power of attorney. An advance directive is a legal document that states what the patient wants for end-of-life care in the case that he will no longer be able to convey that himself i.e. if he is in a coma. A living will directs which forms of life-sustaining treatment the patient either accepts or refuses; examples include tube feeding, dialysis machines, and resuscitation. A durable power of attorney legally defines the patient's surrogate to make decisions when the patient no longer can. This is usually family members such as parents, children or siblings.

All of these legal documents are examples of how our society already places some importance on a patient's foresight in end-of-life care. They legally allow patients to withdraw or refuse life-sustaining treatment, which are forms of voluntary-passive euthanasia. The

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[16] Dan Brock, "Voluntary Active Euthanasia" in *Contemporary Issues in Bioethics* Edited by Beauchamp, Walters, Kahn and Mastroianni, pp. 438.

difference with patients wanting to maintain their quality-of-life is simply avoiding situations where they know life will not be worth living.

In the Frontline documentary about the debate on euthanasia, a Dutch man named Frank deals with this situation. Frank is diagnosed with cancer and his long-time physician tells him he has a year to live. Frank is also a hunter so his concept of a humane death reflects the way he hunts. He believes that no life, including his, should suffer in the end. He also argues that he decides how he is to live his life; therefore he has every right to decide when it is no longer worth living. He sets up an agreement with his physician that gives Frank the power to end his life when he feels it should end instead of suffering in the end. Frank believes he will lose his dignity of being human when he can no longer function normally and he does not want his loved ones to see him end his life this way.

This is a very common concern for many terminally ill patients who have family members and friends around. They do not want to be remembered as feeble, connected to life-support machines, or lack their rational sense. Many people hold high value to their personality and character, so when the risk of losing that from illnesses like Alzheimer or Parkinson disease is likely, they choose to prevent reaching this point.

This desire is the same as those who have advanced directives or living wills, the difference is at what point the patient wants to end her life. Advanced directives and living wills end a quality-of-life that is no longer seen as worthwhile while the maintaining dignity argument prevents that stage from taking place at all. The difference requires a move from voluntary-passive euthanasia to voluntary-active euthanasia or PAS and here in lies the moral dilemma for some. However, in the next argument of a physician’s beneficent responsibility to patients, it will be argued that respect and assistance of patient autonomy is just as important as medical responsibility to keep patients alive.

*II.) Physician Beneficent Responsibility to Patients*

One of the main arguments against PAS and euthanasia in the previous chapter is based on the societal standard of a physician's responsibility to her patient. The Hippocratic Oath denies that a physician can cause the death of her patient. However, Gregory Pence points out in his book *Medical Ethics* that at the time of its creation, the Hippocratic Oath only applied to a small number of physicians who belonged to an exclusive society. During this time there were many other doctors that morally permitted assisted suicide in their practice. In fact, it was common for a physician to assist in the death of a patient to ease their suffering and pain. In the same way that there were different standards of moral practice in ancient Greece, there are different standards of a physician's duty amongst American citizens today. There are citizens who believe is it equally as important for a doctor or medical staff to act on behalf of his patient's desires, whether that be to continue treatment or assist in end-of-life treatment.

In the article *Physicians, Assisted Suicide, and the Right to Live or Die* by Rosamond Rhodes, physician responsibility is not understood to strictly prevent death, but to act for the good of the patient[17]. Rhodes considers the duty of beneficence to be the most important and morally binding aspect of a physician duty. He defines beneficence as the moral obligation to act for the good of someone else. When it comes to the specific case of doctor-patient relationships, the duty of beneficence can mean several different things: 1) doctors have an absolute duty to prevent pain and death to their patients (as argued in chapter 1; 2) doctors should do what is in the best interest for their patient while respecting their wishes. This second

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[17] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die" in *Physicians Assisted Suicide* Edited by Battin, Rhodes and Silvers, pp. 170.

component is not considered in the arguments of chapter 1. Arguments similar to Rhodes' introduce this second duty, which also considers respect for the patient as another important aspect of the doctor-patient relationship. Rhodes cites the American Medical Association's Principles of Ethics regarding these two duties, "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."[18]

In most medical cases patients and doctors do not have conflicting interests or desires. The standard situation or assumption is that an individual enters/stays in a hospital for medical treatment to get healthy. However, in the case of PAS and voluntary-passive or active euthanasia, a patient no longer desires life-sustaining treatment and care. This complicates matters in two ways: 1) it calls into question what is considered when we talk about the patient's 'dignity'; and 2) it raises questions about the amount of weight we should place on the duty of physicians to consider the 'dignity' of their patients when it opposes physician duty to medically treat a patient's illness.

Rhodes argues that if we assume that a physician's primary responsibility is beneficence and in that she must take into account the dignity of her patient, then a physician does not necessarily have two conflicting duties as it might first appear. Rhodes says that our medical care currently runs on a 'needs-based' system in that, "The more assistance a needy person requires, the greater the amount of assistance that must be given."[19] His examples include the degree of assistance a sick person is given based on her need. When a patient needs medication yet has the abilities to take the medicine on her own, a doctor prescribes her a dosage and it is up to the individual to purchase and take the prescribed medication. When a patient is so sick she

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[18] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die", pp. 170.

[19] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die", pp. 171.

no longer has the abilities to take the medication or capacity to administer proper treatment such as surgery or hospitalization, the physician must meet the increased demand of treatment.

Similar to when physicians have the moral and professional responsibility of beneficence to meet patients' needs for more extensive treatment due to pain and suffering, they are equally responsible under this duty to meet the needs of preserving patient dignity and/or respecting patient autonomy.[20] Rhodes argues that physicians should fulfill these three needs based on the moral and professional obligation of beneficence. Therefore, both PAS and euthanasia are morally justifiable acts when there are no better options available to fulfill the need of dignity and autonomy.

For example, when a patient requires relief from suffering of a terminal illness such as late stage AIDS virus in order to maintain his autonomy and dignity in life but he requires the assistance from another because he alone is not capable of ending it himself, a physician is morally obligated to take on this assisting role. This responsibility falls more heavily on a physician because he has the ability i.e. medical equipment, the knowledge of how to use the equipment, and the relationship of a care-taker for the patient. Rhodes not only argues the moral justification of a physician to perform PAS or voluntary active and passive euthanasia, he says that if a doctor is aware of her patient's incurable suffering and her patient's desire to end life yet allows the suffering to continue, then she is in moral violation of her duty of beneficence.

Although Rhodes is an advocate for PAS and euthanasia, he also believes alternatives must be exhausted before the final decision can be made. Such alternatives are psychological treatment to make sure patients are not depressed with a skewed desire, or pain management options if that is the desired goal. With this said, it only furthers his reason why physicians are

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[20] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die", pp. 171.

best fit to perform PAS and euthanasia; they are the most knowledgeable of medical history and alternatives for their patients.

Lastly, Rhodes argues that we must treat similar cases similarly when evaluating the moral acceptability of physician duty to their patient. Because physicians are allowed to cut into people to remove limbs and organs (surgery) out of their duty of beneficence or psychiatrists are allowed to physically confine people (psychiatric wards) out of their duty of beneficence and even provide potentially lethal dosages of drugs (medication) out of their duty of beneficence, physicians should be allowed to assist in end-of-life treatment (PAS and euthanasia) out of their duty of beneficence.[21] Rhodes applies the rule of universalizability to the case of PAS and voluntary passive and active euthanasia and does not accept the universal rule that all killing is wrong.

### *III.) Ordinary v. Extraordinary Means of Treatment*

In the last several decades two very important arguments and distinctions have developed based on the longevity of human life and the medical resources available: ordinary versus extraordinary medical treatments and physical pain versus psychological suffering. It is important to note the history of hospitals and medicine until the 1900's to see how these issues have developed. Hospitals used to be considered poor houses run by the church where people went to die and doctors were hardly ever seen there. Instead, physicians traveled around and treated patients in their homes. Surgeons did not find much work in the hospitals until the development of sanitation and antiseptic chemicals in the 1800's.

Needless to say our standards of medical treatment and use of hospitals has drastically changed since then. Expectations play a large role in medical treatment today because hospitals

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[21] Rosamond Rhodes, "Physicians, Assisted Suicide, and the Right to Live or Die", pp. 172-173.

and medical care are now capable of so much. The discussion on passive euthanasia has been limited so far because it is not the main focus for this paper. However, I would like to address one argument in favor passive euthanasia. The standard of medical care is a sliding scale. Today, standard care includes treatments such as IVs, prescription medicine to cure illnesses such as the common flu, shots, check-ups, x-rays, MRIs, palliative-hospice care, and in-patient treatments. However, there is debate about whether certain types of available care are standard or extraordinary. In the debate of PAS and euthanasia, the main concern lies with passive euthanasia, which includes withholding and withdrawing life-sustaining treatment.

Proponents of passive euthanasia claim that life support by feeding tubes and breathing machines are extraordinary means of treatment that are not required of the physician to offer or for the patient to accept. This issue pertains mostly to those patients who would not survive unless supported by machines. Until recently there were laws that prohibited patients from withdrawing extraordinary means of treatment in order to end their lives.

When a patient's life is dependent on a machine to breath or to obtain nutrients, the quality-of-life can be diminished to the point where he no longer sees the point in living. Because such treatment artificially keeps a patient alive, it is considered extraordinary and not ordinary. Those who desire this extraordinary treatment have the right to it, but those who do not want it have an equal right to deny the treatment or withdraw it once they no longer find meaning for it. Therefore, there is a moral obligation for a physician to respond to the wants of her patient by either providing or withholding/withdrawing artificial life-sustaining treatment.

## *IV.) Physical Pain v. Psychological Suffering*

Many opponents to PAS and euthanasia make the claim that we have sufficient pain treatments with palliative-hospice care and other forms of medical care. Morphine is a commonly used drug to treat severe physical pain, however, opponents fail to recognize the difference between physical pain and psychological suffering. In chapter 3 of *Physician Assisted Dying* by Pence, he establishes two arguments regarding pain and suffering as sufficient reason for PAS and euthanasia. The first is that suffering can be both a physical and mental experience for a patient. It is also far more difficult to treat mental suffering compared to physical due to the limits of medication. Forms of mental suffering can include but are not limited to helplessness, stress, exhaustion, terror, and loss. These forms of mental suffering do not always mean that a patient is facing depression. This distinction is important to make because depression is not argued by any to be a reason for PAS or euthanasia. Since mental suffering is much more difficult to treat with medication than physical pain, it is should be reason enough for a patient to no longer wish to carry on.

The second argument by Pence for pain treatment, if it is physical, is when pain management goes too far. The known risk of morphine with patients facing excruciating amounts of pain is that it can induce a coma. Some patients would rather face death if their pain were so strong that it runs a high risk of putting them in a coma. There is no point to surviving in a vegetative state because the person has no brain function and cannot experience life like a human. Patients see PAS and euthanasia as a positive experience in this respect.

John Stuart Mill supports these two arguments presented by Pence with his discussion on autonomy. Mill says,

> That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant….The only part of the conduct of any one, for which he is amenable to society, is that which concern others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[22]

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[22] John Stuart Mill, *On Liberty* (1859), Apeton-Century-Crofts, New York, 1974.

Mill's perspective of autonomy allows for an individual to be her own sovereign, and thus places the greatest value on autonomy. As long as our actions do not infringe on the physical or psychological safety and comfort of others, we should be allowed to determine our own actions. Mill's concept of autonomy is the basis for many who argue in favor of PAS and/or active euthanasia.

One such group that embodies Mill's autonomy argument is the Hemlock Society. It is a nationally recognized euthanasia advocacy group led by a man named Derek Humphry. The Hemlock Society advocates both patient autonomy and the importance of pain and suffering when making a decision for end of life treatment. Just like the majority of Americans, the Hemlock Society does not believe in an emotional decision by a mentally unstable person to end her life; instead they believe in the "justifiable suicide'—that is, rational and planned self-deliverance."[23] The Hemlock Society believes that suicide, what they refer to as 'autoeuthanasia' and euthanasia, can be justified for two reasons: 1) Advanced terminal illness that is causing unbearable suffering to the individual; and 2) grave physical handicap so restricting that the individual cannot, even after due consideration and training, tolerate such a limited existence.[24]

The Hemlock Society does not believe just anyone can commit authoeuthanasia or euthanasia. They have a specific set of ethical guidelines that qualify a suicide to be rational: 1) the person is a mature adult; 2) the person has clearly made a considered decision; 3) the decision has not be made at the first knowledge of the life-threatening illness, and reasonable medical help has been sought; 4) the treating physician has be informed, and his or her response

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[23] Derek Humphry "The Case for Rational Suicide" in *Last Rights? Assisted Suicide and Euthanasia* Edited by Michael M Uhlmann, pp. 307.

[24] Derek Humphry, "The Case for Rational Suicide", pp. 308.

has been taken into account; 5) the person has made a will disposing of his or her worldly effects; 6) the person has made plans to exit this life that do not involve others in criminal liability; 7) the person leaves a note saying exactly why he or she is committing suicide.[25] These guidelines differentiate suicide from ‘autoeuthanasia’ because suicide is an emotional endeavor where ‘autoeuthanasia’ is a rational decision.

The Society believes that these guidelines prevent any emotionally and mentally unstable individuals from making irrational decisions to end their lives. Additionally, Humphry provides a counter argument to those who believe in the legalizing euthanasia will lead to a slippery-slope. He states that the autonomous power given to the patient to end his life when he sees fit will make him live even longer if he did not have that option. Humphry reasons that many terminal patients feel stress because they do not know when their life will end and are anxious about the inevitable pain they will soon suffer. Instead, when they have the means of killing themselves, they not only can reevaluate where they stand in life, but they no longer have the stress that causes them more sickness; Humphry says this is not an idea but a fact. He encountered many elderly and sickly individuals who expressed reasonable desires to end their lives before provided with medication or a means to end their lives. Yet once they obtained a means for ending their lives, they decided they could hold on longer. Humphry essentially argues that the right to end one’s own life has the opposite affect that the slippery-slope assumes because the comfort and power of the choice will limit the amount of suicides.

Another famous example of patient autonomy is the case of Diane and her physician Timothy Quill. After Dr. Quill assisted in the death of Diane, he went on to write about the criteria necessary to regulate a health care system that performs PAS. Quill acknowledges that

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[25] Derek Humphry, The seven ethical parameters stated by the Hemlock Society, pp. 308-309.

there are terminally ill patients who suffer regardless of palliative-hospice care treatments available to them; Quill also asserts the importance of patient dignity at the end of life. Quill says “Yet it is neither idiosyncratic, selfish, nor emblematic of a psychiatric disorder for a person with an incurable illness to want to have some control over how he leaves this world.”[26] This statement makes it clear that Quill believes that terminally ill patients can reasonably decide how they wish to end their lives.

However, Quill is cautious about allowing patients to choose PAS as a final option. Patients must attempt other forms of comfort care and the approval must come from their primary-care physician who is most aware of the patients’ medical history. Quill’s criteria is as follows: 1) the patient must, of his own free will and at his own initiative, clearly and repeatedly request to die rather than continue suffering; 2) the patient’s judgment must not be distorted; 3) the patient must have a condition that is incurable, and associated with severe unrelenting, intolerable suffering; 4) the physician must ensure that the patient’s suffering and the request are not the result of inadequate comfort care; 5) physician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship; 6) consultation with another experienced physicians is required; and 7) clear documentation to support each condition above is required.[27] Requirement one does not allow for any room of uncertainty because death is *the* irreversible request. Requirement two means that a patient cannot be depressed and they must be fully aware of the consequences of PAS; review from a psychiatrist should be used to make certain that the patient is entirely rational when making the decision. Requirement four states that comfort care must be sought first and definitely strongly considered before any discussion of

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[26] Timothy Quill, “Death and Dignity: B) Potential Clinical Criteria for Physician-Assisted Suicide” in *Last Rights? Assisted Suicide and Euthanasia Debate* Edited by Michael M Uhlmann, pp. 327.

[27] Timothy Quill, The seven ‘Proposed Criteria’ to monitor the ethical conduct of PAS if it was legalized. pp. 330-32.

PAS. Although Quill believes PAS should be legally available to patients, it should be used with caution and as a last resort option to the terminally ill who demonstrate a reasonable request to end their lives.

The guidelines established above are very similar to what is set in place in Holland for the standard to carry out euthanasia. They are as follows: 1) only a medical practitioner should carry out euthanasia; 2) there should be an explicit request from the patient that leaves no room for doubt about the patient's desire to die; 3) patients' decisions should be well-informed, free and persistent; 4) patient must be in a situation of unbearable pain and suffering without hope of improvement; 5) there must be no other measures available to make the patient's suffering bearable (according to patient standards); and 6) the doctor must be very careful in reaching the decision and should seek a second opinion from another independent doctor.[28] What goes unstated in this set of guidelines for the Netherlands is the importance of the doctor-patient relationship because the medical system there is set up so a physician and her patient have a long-term relationship. This characteristic is very unlike the US system where primary-care physicians change with insurance coverage, and insurance can change depending on jobs. Relationships like that of Quill and his patient Diane are considered standard in Holland where in the US it is scarcely found. With Quill's hypothetical guidelines in place and the assumed personal doctor-patient relationship, the slippery-slope argument carries no weight. Physicians-assisted suicide and active euthanasia can be closely monitored to make sure it does not overstep moral boundaries that violate patient autonomy.

In summary, the arguments in favor of PAS and euthanasia are strongly based on the assumed importance of patient autonomy and the patient's evaluation for quality-of-life and

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[28] Frances M. Kamm, "Physician-Assisted Suicide, Euthanasia, and Intending Death" in *Physicians Assisted Suicide* Edited by Battin, Rhodes, and Silvers, pp. 47.

dignity. Variables for this evaluation include physical pain, psychological suffering and expectations for medical treatment. The patient is regarded as the most important judge in end-of-life care while the physician is morally and professionally responsible—according to the beneficent role discussed by Rhodes—for assisting when needed. The role of religious doctrine has no place here because the patient is held responsible for an end-of-life decision instead of God or any other moral judge.

# Chapter Three: Killing Can be Morally Permissible

This third and final chapter is dedicated to deconstructing the arguments of chapter one and presenting my argument in favor of the moral permissibility of both PAS and euthanasia. My argument is based on a collection of different meta-ethical principles rather than just one. These principles are: 1) the importance of respecting human autonomy to determine quality-of-life standards; 2) the *prima facie* principle of beneficence in the context of the professional medical setting; 3) and placing the moral value of an action in the *reason* for the action and the *intended result* of the action. These three principles come from various philosophers and time periods to best accommodate the issue at hand. I look to 19th century philosopher John Stuart Mill, contemporaries such as James Rachels and Rosamond Rhodes, the social political philosopher Thomas Hobbes, and finally 20th century ethicist W. D. Ross.

The first principle of human autonomy originated from social political philosophy and philosopher Thomas Hobbes who said that humans, as rational beings, have the natural inalienable right and sovereign power to think freely. This is the root of human autonomy to think and act freely without coercion from the law, which transformed from a social political philosophical principle to an ethical principle. John Stuart Mill is one who applies the principle directly to the freedom of individuals to determine their own standard for quality-of-life and to eventually make the decision to end their own lives. Just as we expect our own autonomous decisions to be respected by others, we must respect the right for others to express their autonomous wishes. The only restriction is that one's autonomous decision cannot impede the safety and autonomy of another. Autonomy is an inalienable right that cannot be denied by any societal law because as rational beings we have the ability and therefore the right to be our own sovereign. Autonomy is key in the debate of life and death ethical issues because it places the moral decision in the hands of the informed patient versus allowing it to be a debate among physicians or family members.

The second guiding principle is that of beneficence understood as a combination of two philosophers: intuitionist W.D. Ross was the first to classify beneficence as a *prima facia* duty or guideline that all humans have towards each other. These *prima facia* duties come from the evolution of principles that have proven to be most useful for a functional society. Rosamond Rhodes, mentioned in chapter two, closely defines how the principle applies to the particular case of PAS and euthanasia. Beneficence is the act of doing well towards others versus the principle of non-maleficence, which is the act of not harming others. Ross describes a number of *prima facia* principles that have the potential to come into conflict based on the circumstance of a situation. Instead of relying on our moral intuition to solve the conflict the way Ross proposes, Rosamond Rhodes provides a more logical explanation of why a physician must follow the principle of beneficence. Although generally speaking it is socially acceptable to over-ride the duty of beneficence by other *prima facia* principles such as the duty of non-maleficence, it is the guiding principle for the professional duty of a physician. Therefore, when dealing with medical ethics, and specifically with the treatment of PAS or euthanasia, beneficence is the primary guiding principle physicians must follow.

The third and last principle originates from philosopher James Rachels and his Equivalence thesis; the moral value of an action is determined by the *reason* and *intended outcome* of an action and not based solely on the action itself. This principle will be discussed in full in part B of this chapter.

## A.) Argument Rebuttal

### *Killing Versus Letting Die*

The definitions of ‘killing’ and ‘letting die’ used in chapter one make an inadequate moral distinction between the two terms. It is not enough to argue that ‘letting die’ is any more permissible than ‘killing’ by a physician because he allows nature to take its course. A physician is still one hundred percent aware of the consequences of her actions by withdrawing or withholding treatment. If we accept the Hippocratic Oath standard for physicians, then active-euthanasia acts against physician responsibility while withholding/or withdrawing treatment neglects the standard. Neither can be considered better than the other because both refuse to act in accordance with the moral professional standard.

For those opponents who rely on the use of intention as a way to justify passive-euthanasia (‘letting die’) over PAS and euthanasia (‘killing’), their argument is also invalid. Opponents claim that the intention of ‘letting die’ is to allow nature to take its course while the intention of ‘killing’ is to kill the patient. If we take a closer look at the intentions of passive-euthanasia, PAS and active-euthanasia, it is easy to see that all three cases share the same intention; respecting the wish of the patient to end his or her life as a preferable alternative to continue living a sufferable and painful life. Euthanasia is considered a different act than murder for a reason; it is the act of mercy killing and not an act of vengeance or of bad intention. The intention of the physician is to do what is in the best interest of his patients, even if that means to assist them in ending their lives. Physicians-assisted suicide and voluntary active-euthanasia are moral exceptions to intentional death because the aim is not the death, but using death as a means of relieving suffering or pain or unhappiness and of respecting the autonomy wish of the patient.

### *Slippery-Slope Argument*

The weakness of the slippery-slope argument is that it is entirely speculative. There is no data to base the theory or to support it; instead it lies on a foundation of assumptions. First I will address the flaw in the empirical slippery-slope assumption. To begin, it assumes that PAS and euthanasia are wrong actions in the way that murder is morally wrong. If we do not assume that PAS and euthanasia are morally wrong, then it is not possible that their moral permissibility will open the door to further bad consequences in human behavior. The flaw with the conceptual slippery-slope assumption is that treating similar cases similarly will inevitably stretch all the way to societal values that allow murder. Both slopes assume the worst in human nature and in doctors. It is as if the societal norms and legal laws are the only forms of regulation that can prevent medical murder from taking the place of PAS and euthanasia.

The variables of family financial burdens, financial greed for doctors, medical laziness, and moral leniency do not hold enough weight to be legitimate reasons why PAS and euthanasia should not be morally accepted as a form of medical practice. Any sick patient can be costly, especially when dealing with extraordinary forms of medical care. However, the role assumed by a family is a caring one; one that puts the importance of a family member before any bill. Although opponents believe in indirect pressure on a patient, it is not a sufficient reason to move a patient to kill herself. As humans we have a natural capacity to survive if we still want to live. It is only when we no longer desire to live a low quality-of-life that we are able to accept the possibility of death as a better alternative.

The variables of financial greed for doctors and medical laziness are rare cases of physicians who already carry those traits and would practice greed and laziness in their work no matter if PAS or euthanasia were available. However, those physicians who are not greed or lazy will not magically become that way just because euthanasia is an option. Additionally, PAS and euthanasia, like any other medical service, will be monitored closely and will not be available without due reason. I will speak more about establishing standards and regulations for the moral permissibility of PAS or euthanasia later in the chapter.

*Better Alternatives*

Philosophers and physicians who believe in better alternatives as a means to eliminate the need for PAS and euthanasia neglect the possibility that patients might want to still choose to end their lives no matter the quality of treatment available to them. Currently, hospice-palliative care provides sufficient medical care to patients with both physical and psychological treatments. Even with these options, there are still patients who prefer to end their lives. It is interesting to note that in the official table put out by the state of Oregon Health Authority of characteristics and end-of-life care for the total 460 patients who have died between the years 1998 and 2009, 88.2 percent[29] of patients were already enrolled in hospice-palliative care when they requested PAS treatment. This fact is interesting because it demonstrates that providing hospice-palliative care is not a more appealing alternative in practice to those who are concerned with not just pain, but loss in dignity and quality-of-life. Although Oregon is only a sample and cannot accurately represent the entire population of the United States, it is the only practicing example of how PAS works in the United States health care system. Therefore, results such as these should be taken into serious consideration when predicting the lack of effect of hospice-palliative treatment for patients who have the option of PAS.

The argument of pain versus suffering also presents a problem for the ‘better alternatives’ argument. As stated in chapter two, there is a qualitative difference between pain and suffering, where pain is more easily treated than suffering. Hospice-palliative care is better for pain treatment, but deals only slightly with suffering. The argument presented by Cohn and Lynn

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[29] Characteristics and end-of-life care of 525 DWDA patients who died after ingesting a lethal dose of medication as of January 7, 2011, by year, Oregon 1998-2010, page 2.

makes the mistake of assuming that all patients would prefer to live if their pain was controlled. This assumption neglects the importance of the patient's dissatisfaction with the quality of life as a reason for PAS or euthanasia. There are cases of suffering patients who seek death as a relief from their minimal quality-of-life and not escape from pain. The same table from the of Oregon Health Authority shows that the top three End-of-Life Concerns from patients are losing autonomy (90.8%), less able to engage in activities that make life enjoyable (87.3%), and loss of dignity (85.2%).[30] These statistics should not be overlooked because it demonstrates that the majority of patients who have sought PAS are more concerned with quality and dignity of life rather than pain management.

I believe cases of pain and suffering should be held to an equal standard. That said, 'better alternatives' is not a strong enough reason to prevent PAS and euthanasia as forms of end-of-life treatment because they are still acceptable forms of treatment for patients suffering from minimal quality-of-life.

### *Religious Moral Perspective*

The problem with the religious moral perspective on PAS or euthanasia is its founding principle. In order to begin to believe Augustine or Aquinas' arguments, one must agree with their notion of God and his power. Therefore, religious followers believe in God's power to take and grant life while non-religious people do not see God as the ultimate power to dictate life and death. It is difficult to argue between the two doctrines because the argument cannot be about suicide but must begin with whether God exists or not and whether he is the only one with the moral power to take life.

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[30] Characteristics and end-of-life care of 525 DWDA patients who died after ingesting a lethal dose of medication as of January 7, 2011, by year, Oregon 1998-2010, page 2.

One of the problems with applying the arguments of Augustine and Aquinas to today's PAS and euthanasia discussion is the difference made by advanced medical care and in the way people normally die. At the time of these two philosophers, or any time before the 1900's and the creation of penicillin, the majority of people died relatively quickly from infectious disease and at a younger age. Today, the biggest causes of death in the United States are heart disease, diabetes, HIV/AIDS and other long-term terminal illnesses. People die more frequently from terminal illness because life expectancy has increased dramatically. This is due in large part to the medical care available. Circumstances of how people die play a big role in how PAS and euthanasia are viewed. The religious moral perspective deals only with suicide the way it was used at the time it was written. There was no opinion specifically dealing with end-of-life care for patients who have lived long, fulfilling lives and simply would rather avoid the pain and suffering of a drawn out death; or a patient suffering from a terminal illness that has brought them to a state of minimal quality-of-life they can no longer reasonably tolerate. Augustine and Aquinas address suicide, not PAS or euthanasia. The mistake made today by religious doctrine is either assuming PAS and euthanasia are the same as suicide or imposing the moral rules of suicide on these medical practices.

A second argument against the religious doctrine is that one could assume the religious approach and argue that God intended for us to use our reason so as to make our own decisions; one of these reasonable decisions can include PAS or euthanasia. These two medical practices are based on reasoning and not on emotions as the way the biblical text refers to suicide.

### B.) How PAS and Euthanasia are Morally Permissible:

This section is focused on answering the questions presented in the introduction as a way to describe and define how PAS and euthanasia are morally equivalent and both morally permissible actions in medical practice.

### *Is there a moral difference between PAS and euthanasia?*

The introduction to my thesis describes the physical difference between PAS and voluntary-active euthanasia. The primary difference is concerned with the actions of the various ethical characters, namely the *Patient* and the agent. Physicians-assisted suicide is similar to suicide because the patient acts as the *Patient*, agent and judge, and the physician is the secondary agent that facilitates the suicide by prescribing the lethal dosage of medication. The only reason a patient of euthanasia cannot be all three characters—agent, judge and *Patient*—is because he either cannot physically conduct the act or he decides the physician is better equipped.

Many patients who wish to end their lives because their suffering has reached an unbearable limit or they feel they have lost their standard for quality-of -life, still care to die in a humane form. This makes suicide tricky because of course it would be physically less difficult to take a bullet to the head or jump off a building but it is physically deforming and psychologically difficult to achieve. Another option that avoids physical trauma is an overdose on prescription drugs or painkillers. This strategy may avoid physical deformation but runs the risk of an attempt going wrong, which is often the case. Failed suicide attempts have left people in worse shape than they started; such outcomes can be a persistent-vegetative state (PVS), becoming paralyzed and/or other physical deformities.

The average person does not have the medical familiarity to formulate a proper lethal dosage and a physician does. The advantage of PAS and/or euthanasia is the physical aid of the physician and the application of his medical knowledge, whether he is a direct or indirect agent. This difference of direct action and indirect action is the only change between the role of a physician in PAS and euthanasia. This difference, however, is not a moral one. The actions in themselves carry no intrinsic moral value; instead we must look to other variables involved to determine whether the actions are moral.

Contemporary philosopher James Rachels uses the same argument to disqualify the moral weight placed on the difference between the actions of 'letting die' and 'killing'. He calls this argument the 'Equivalence Thesis'.[31] This argument applies similarly to the lack of intrinsic moral difference between the acts of PAS and euthanasia because both practices have the same result and are done for the same reason. Therefore, we cannot consider PAS as right and euthanasia wrong, and vice a versa; the two cases must either both be morally wrong or both be morally right. I argue that they are not morally different based entirely on the directness or indirectness of the physician's action.

An example Rachels uses to better illustrate the Equivalence Thesis is of two women who act to kill their spouse. The first woman, Jill, knows that cutting off her husband's head will kill him, so she does it. The second woman, Jane, knows that punching her husband in the nose will kill him, so she does it. In this case, both actions are equally wrong. At first it may seem absurd that punching someone in the nose and cutting off someone's head are equally wrong actions. However, if we analyze why we normally consider cutting a head off as more wrong than punching someone in the nose, it has to do with the result and purpose. Normally cutting a head off kills, while punching someone in the nose is only meant to harm them but does not kill them.

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[31] James Rachels, *The End of Life, Euthanasia and Morality*, Active and Passive Euthanasia, p. 228.

This difference in *result* and *reason* are where the morality of these two actions lies and not within the actions themselves.

The noteworthy similarities between the roles of physicians in PAS and euthanasia are more important to consider if we are to truly evaluate their moral qualities. First, in both cases the physician's intention is to help her patient achieve the best possible outcome for his illness, just as any other physician intends when treating a patient. The *reason* for assisting in patient suicide or euthanasia is for the best interest of the patient's needs and wants. The *reason* is based on the two other principles, beneficence and respecting patient autonomy. Secondly, the *result* for both cases is that the patient dies. I am not yet evaluating whether death is morally right or wrong, only that it is the end result that it is dependent on the physician's actions, either directly or indirectly.

The only exception to making a moral distinction between PAS and euthanasia is when one of the two acts violates the principle of autonomy or beneficence by neglecting the patient's wish or deliberately not acting in the best interest of the patient. For example, if patient Linda wants to be prescribed a medication that she can take at her own discretion when she feels the time to die is most appropriate, it would be morally wrong and unacceptable for her physician to perform euthanasia during one of her visits to the hospital. In the same respect, it would be morally wrong for Linda's physician—who has no moral objection to euthanasia—to only prescribe her medication when she prefers euthanasia through lethal injection because she psychologically cannot bring herself to commit the act by herself.

This brings up the issue of physician autonomy. Just as a patient has the autonomous right to decide how to end his life, a physician has an equal autonomous right to not perform PAS or euthanasia if she morally objects to the action. However, if a physician has no moral qualm with performing either of the two medical practices, but rather denies the treatment out of selfish or malicious reasons to harm her patient, then it becomes morally wrong to deny treatment. It is the same with abortion or any other medical practice that morally challenges the beliefs of a physician. A medical treatment is not morally required of a physician if it violates his or her beliefs. It is the case that not all physicians believe the same things, and where one physician does not morally approve of a practice, there are ten more who do and are willing to act.

It is then clearly presented that there are no moral qualitative differences specifically attached to PAS or euthanasia because they are performed for the same *reason* and because they both produce the same desired *results* based on the patient's autonomous decision. Their moral equivalence only disappears once the *reasons* for acting, or not acting for that matter, are attached to the autonomous want of the patient.

### *Are they morally permissible?*

Now that I have established the moral equivalency of PAS and euthanasia, the question is whether the two are morally permissible or not. In his book *End of Life, Euthanasia and Morality*, Rachels points out one of the reasons why our culture is so resistant to the idea of active euthanasia versus passive euthanasia, otherwise known as the difference between 'killing' and 'letting die'. He says that one of the hardest things for our culture to grasp is how PAS and euthanasia—which are both considered forms of 'killing' and not 'letting die'—can be morally good actions. Killing can be good? Yes, as socially counter-intuitive as it sounds, in certain circumstances killing, not murder, can be morally acceptable and potentially preferable. One of the reasons why we have problems with the word 'killing' is because it is nearly always associated with negative actions like murder with malicious intent, or even unintentional action.

In the same light, ‘letting die’ is only associated with a controlled medical setting with actions based on the principle of beneficence. This provides a positive setting in the only way we understand ‘letting die’ or passive euthanasia, and it is one of the reasons why it is substantially more morally acceptable than ‘killing’.

An additional reason to separate active versus passive forms of euthanasia relies on the physical component mentioned in the introduction and its relationship to the feeling of responsibility. This association between physical participation and responsibility is a faulty tool when it comes to measuring the morality of passive versus active forms of euthanasia. Our society maintains this view because social emphasis lies on the principle of non-maleficence over the principle of beneficence; this is seen in our laws and even in the basis of our religious doctrine. The Ten Commandments focuses on moral rules of non-maleficence such as ‘Do not Kill’ and not on a moral obligation of beneficence. There are no laws in our country that require citizens to help those they see in need. For example, in the series finale of the comedy show *Seinfeld*, the main characters are waiting for a plane repair in Latham, Massachusetts when they witness a carjack and make a few jokes while catching the event on tape. Unknown to them, they broke the local law of ‘duty to rescue’ and are sent to court. The characters are outraged that they are held responsible for what they feel was a crime where they did not act or directly cause harm to the victim whose car was stolen. The scenario seems absurd to viewers because there is no such obligation in place currently nor does it seem appropriate to punish people who do not act to harm others. Although this example is not completely parallel to the circumstance passive euthanasia, it does highlight our social interpretation of non-action as morally permissible or less responsible than taking action.

Rachels draws attention to the same flaw in social assumption that inactivity is not morally bad with an example of a life and death situation. Two older cousins, who both are in a position of inheritance should their 6-year-old cousin die, intend to drown him while he takes a bath. The only difference in this case is that cousin James does drown his younger cousin in the bath and cousin Bob does not because just as he enters the bathroom, his baby cousin slips, hits his head and falls into the water. Bob is happy about the incident and is ready to keep the child down if he does eventually come up, but it so happens that the child dies on his own.[32] It is important here to note that the two scenarios are exactly the same when it comes to the intentions of the two men and the *results*. The only noted difference is in the 'killing' or 'letting die' of the child. Rachels applies his Equivalence Thesis this time to passive and active forms of euthanasia to demonstrate how the actions are morally equal, and in this case, morally wrong.

There seems to be a conflict between when it is morally wrong not to act and the social norm that does not morally obligate us to act out of beneficence. However, if life and death cases such as euthanasia and PAS are analyzed in more detail, it becomes clear that they are exceptions to the social norm. The medical setting of PAS and euthanasia is based on a personal relationship between the physician and the patient unlike the relationship of two strangers in the street. This relationship rests on the assumption that the role of a physician in the medical setting, as argued in chapter two by Rhodes, is different from an ordinary citizen because it is the duty of her professional position to work on behalf of the principle of beneficence over non-maleficence.

Through the use of the 'Equivalence Thesis', we can see that the acts 'letting die' and 'killing' are morally equal and that their moral weight comes from the *reasons* and the *intended*

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[32] James Rachels, *The End of Life, Euthanasia and Morality*, Active and Passive Euthanasia, p. 112.

*result* of the two acts. Just like the example presented by Rachels, it is equally morally unacceptable to 'let die' as it is to 'kill' and vice a versa where it is equally morally acceptable to 'kill' as it is to 'let die'.

Rachels demonstrates a scenario where killing and letting die are equally morally wrong, so how are PAS and euthanasia instances of moral permissibility? In addition to a physician's duty, there is also a difference in *intended reason* for why the act is performed. Physicians-assisted suicide and euthanasia may be considered acts of 'killing', but we must be able to distinguish this type of killing from the murder in Rachels' example of the cousins based on the *reason* for the action. Patients must reasonably request either forms of medical killing before physicians can consider the option as a possibility. It is the reasonable wish of the patient and not the physician to end life; the physician simply acts out of her responsibility of beneficence and not out of maleficence.

It is also not practical for various reasons for physicians to always do everything in their power to prevent death because there is the possibility that the patient does not want to be resuscitated; the pros of keeping a patient alive for a little while longer does not outweigh the cons of cost and time of medical personnel and/or when more pain and suffering are caused by keeping the patient alive. In circumstances such as these, it is permissible for physicians and medical staff to allow room for other possibilities in end-of-life treatment. Physicians who deal with terminally ill and dying patients understand this concept in practice. Hospice-palliative care is a clear example of socially acceptable death and not acting in ways to prevent it. So why should other forms of treatment such as PAS and euthanasia—active forms—be morally excluded when they share the same *reasons* and *intended results*? The answer is that the active forms of end-of-life treatment with intentions of beneficence should not be morally excluded from medical practice because we accept the passive form of 'letting die'.

*Are there limitations when an individual can decide his or her own death?*

Accepting the moral permissibility of PAS and euthanasia is just the first step. Next, boundaries must be established to prevent an abuse of the medical treatments. Just as in any case of life and death medical treatments, serious precautions must be set in place to secure that they are not used frivolously or unnecessarily.

The Oregon Death with Dignity act currently is a practicing form of legalized physicians-assisted suicide in the United States. The act was put in place in 1997 to deal strictly with terminally ill patients who are diagnosed with 6 months or less to live. The precautions aim towards securing that the patient is an Oregon resident and not someone who comes to Oregon to die; he must be an informed patient, which means he is aware of his A) diagnosis, B) prognosis, C) potential risk associated with taking the medication prescribed, D) the probable result of taking the medicine, E) and the alternatives such as hospice-palliative care[33]; the patient must wait a minimum of 15 days before taking the prescribed medication; and the autonomous request of the patient through various written forms for both patients and attending physicians.

These rules are set in place to make sure that patients are rational competent beings who do not choose death based on impulsive, emotionally charged decisions; patients must be informed of their decision and it's consequences. Finally, patients must voluntarily ask for treatment without coercion from physicians or family members. These requirements, or 'safeguards' of the Oregon Death with Dignity Act parallel the qualifications of agency discussed in the introduction. It is suiting that any moral regulative system of PAS and/or

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[33] The Oregon Death with Dignity Act, Oregon Revised Statutes; Section 3 Safeguards, 127.815§3.01 Attending physician responsibilities, p. 3.

euthanasia guarantees that the patient fulfills the requirements of agency with a slight adjustment of what it means to have ‘the ability to perform the act’. There are some cases where a patient’s act of requesting may be considered his ‘ability to act’ because it is the extent he is physically able to perform even though the patient does not take the final physical stop to end his life the way he would in the case of PAS. An example of this is an amyotrophic lateral sclerosis also known as Lou Gehrig’s disease or ALS patient who physically cannot voluntary move because her neurons died and can no longer control her muscles. There is no effect on the senses or her ability to reason, but as an ALS patient, she slowly lose control of swallowing and breathing yet is completely aware physically and psychologically of her suffering.

Physicians-assisted suicide and euthanasia should not be used liberally for just any patient who claims that he or she no longer want to live. Evolutionarily speaking, humans have a natural tendency to promote life, both as a physical reflex, subconscious and conscious desire. In cases where patients choose to die rather than to continue living, there must be a significant reason to counteract evolution. It is the responsibility of the physician to determine what that reason is and how it can be dealt with. Physicians-assisted suicide or euthanasia should only be considered after alternatives such as psychological treatment and pain treatment are either attempted or discussed and not as a first option.

In order to secure that patients fulfill agency qualities—rational in that they understand the consequences, knowledge of the situation, acting freely, and ability to perform the action—certain precautions are required. The average adult has the ability to reason, where a child is still mentally maturing. For this reason, PAS and euthanasia candidates must be adults over the age of 18 with the exception of extreme cases of terminal illness that leaves a child with less than 6 months to live because no one, no matter age, should have to suffer at the end of life if they choose death as a more reasonable option. If a child under the age of 18 is placed in this situation, psychologist, physicians and family members must use extreme caution not to influence the patient yet determine if the request is reasonable. Psychological analysis is necessary in general to ensure that patients are not using PAS or euthanasia to escape depression or a momentary hardship. A rational decision to end life consists of terminally ill patients with a limited time frame left in life or patients in such a restricted physical and/or psychological state that their quality of life is diminished to a point where death is more desirable than to continue living.

Secondly, the patient must be fully informed by her physician of the condition of her illness, future conditions, and the likelihood or timeframe of survival. It is the physician's responsibility to also inform his patient of potential treatments and the different options they provide. The physician may present his professional medical opinion of what he thinks is the best potential decision based on the safety and autonomy of the patient.

After the patient is fully aware of her options and the medical opinion of the physician, she must have the room to come to an option she personally feels most comfortable with. As for the last requirement, I argued earlier that the ability to act includes the action of asking the physician to perform euthanasia. These safeguards are still very general because I am not dealing with the legal regulations put in place by the law; instead, I present moral guidelines for law makers to follow when specifying legislation the way Oregon has established.

### *When is it appropriate for a physician to provide patients with the option to end life?*

It is morally acceptable for patients to have the option to end life when they have a limited time left due to terminal illness or are in such a state of suffering that death is the optimal option. When is a physician allowed to provide the option to end his life? I argue that in order to make end-of -life treatment as rational and thought out as possible, patients should not have a limited time frame before considering PAS or euthanasia; this statement should not be confused with acting on PAS or euthanasia. The more a patient has time to discuss the possibility of PAS and euthanasia with her physician, the more time she has to evaluate the option in a slightly less emotionally driven mentality. She can decide at what point in her illness that she no longer considers quality-of-life worthwhile. This is the same concept as advanced directives with the only difference being that advanced directives are passive ‘letting die’ and early standards for PAS and euthanasia are active ‘killing’. And it follows that if we morally accept advanced directives, we must also accept early standards for PAS and euthanasia.

Since time is an important aspect in the end-of-life decision, it is safer to place a minimum amount of time a patient must wait before he or she can take a prescribed medication or a minimum number of times he or she can ask a physician to perform euthanasia. For example, to secure that patients are rational and certain with their choice of euthanasia or PAS, they must either ask at least three different times or allow two weeks time to elapse after they receive the prescribed medicine.

With such safeguards to guarantee that patients fulfill all four requirements of agency for the medical treatment of PAS and/or euthanasia, there is no moral reason to deny these two types of end-of-life treatments.

# Conclusion

Physicians-assisted suicide and euthanasia are clearly commonly discussed topics in the medical ethics field. Technological advances in medical care and major causes of death in the United States are big factors in why patients live longer and suffer more in the end stages of life than they did in the past. With these developing ethical problems, our medical ethics need to be reevaluated to better deal with these recent changes. The state of Oregon has made important moral reconsiderations by legalizing PAS with strict legal safeguards, but that is only the first step. More states need to allow their residents the autonomous decision of how to end their lives and Oregon legislature should be aware of the moral equality of PAS and euthanasia.

I propose that the moral values we place on the physical actions of PAS and euthanasia are misdirected and that focus should instead be targeted at the *reason* for the action and the *intended result* of the action. All the while, physicians are morally responsible to respect patient autonomy through their guiding professional principle of beneficence. Physicians also need to ensure that patients are capable, aware agents of their own decision to end life and act freely and rationally. With the proper legal and moral safeguards for PAS and euthanasia, there is no need to be concerned that society is going to fall down the slippery slope that will force the elderly, disabled or anyone unable to meet the standards of an agent to kill themselves. Physicians-assisted suicide and voluntary-active euthanasia are practiced out of a physician's professional concern for the well being of his patient, and there are circumstances where ending life can be in the patient's best interest. My argument is not that patients should kill themselves, but that it is morally right they have the option to end their lives or seek the best alternative to end-of-life care; this makes PAS and euthanasia morally permissible in medical practice.

# Bibliography

Ackerman, Felicia, “Assisted Suicide, Terminal Illness, Sever Disability, and the Double Standard”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 149-62.

Aquinas, Thomas, The Summa Theologica of St. Thomas Aquinas: Second part of the Second Part. Translated by Fathers of the English Dominican Province, Online Edition by Kevin Knight, 2008.

Battin, Margaret Pasbst, “Ethical Issues in Physician-Assisted Suicide” *Last Rights: Assisted Suicide and Euthanasia,* ed. Michael Uhlmann (Michigan: William B. Eerdmans Publishing, 1998), pp. 111-46.

Battin, Margaret P., “Physician-Assisted Suicide: Safe, Legal, Rare?”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 63-72.

Baumrin, Bernard, “Physician, Stay Thy Hand!”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 177-81.

Brock, Dan, “Physician-Assisted Suicide as a Last-Resort Option as the End of Life” *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA, Thompson Wadsworth, 2008), pp. 465-72.

Brock, Dan, “Voluntary Active Euthanasia” *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA, Thompson Wadsworth, 2008), pp. 437-45.

Cohn, Felicia and Lynn, Joanne, “Vulnerable People: Practice; Rejoiners to Claims in Favor or Assisted Suicide” *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA, Thompson Wadsworth, 2008), pp. 446-53.

Dworkin, Ronald, “Do We Have a Right to Die?” *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael Uhlmann (Michigan: William B. Eerdmans Publishing, 1998), pp. 75-94.

Englehardt, H. Tristram, “Physician-Assisted Suicide and Euthanasia: Another Battle in the Culture Wars” *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA, Thompson Wadsworth, 2008), pp. 454-56.

Francis, Leslie Pickering, “Assisted Suicide: Are the Elderly a Special Case?”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 75-90.

Gert, Bernard, Culver, Charles M., and Clouser, K. Danner, "An Alternative to Physician-Assisted Suicide" *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA, Thompson Wadsworth, 2008), pp. 457-64.

Hedin, Herbert, "Assisted Suicide and Euthanasia: The Dutch Experience", *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael Uhlmann (Michigan: William B. Eerdmans Publishing, 1998), pp. 367-86.

Humphry, Derek, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. The Hemlock Society; Eugene, Oregon 1991.

Humphry, Derek, "The Case for Rational Suicide" *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael Uhlmann (Michigan: William B. Eerdmans Publishing, 1998), pp. 307-16.

Kamm, Frances M., "Physician-Assisted Suicide, Euthanasia, and Intended Death", *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 28-62.

Larue, Gerald A., Playing God: 50 Religions' Views on Your Right to Die. Moyer Bell; Wakefield, Rhode Island 1996.

Marquis, Don, "The Weakness of the Case of Legalizing Physician-Assisted Suicide", *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 267-78.

Marquis, Don, "Why Abortion is Immoral" *Contemporary Issues in Bioethics,* ed. Tin Beauchano, LeRoy Walters, Jeffrey Kahn, and Anna Mastoianni (Belmont CA,Thompson Wadsworth, 2008), pp. 345-52.

McLean, Sheila & Britton, Alison, The Case For Physician Assisted Suicide. HarperCollins Publishers Pandora; Hammersmith, London 1997.

Moore, G.E., "Principa Ethica", *Moral Discourse & Practice*, ed. Stephen Darwall, Allan Gibbard, and Peter Railton (New York: Oxford University Press, 1997), pp. 51-64.

Oddie, Graham, "Killing and Letting-Die: Bare Differences and Clear Differences," Philosophical Studies 88 (1997), pp. 267-287.

Pence, Gregory, Medical Ethics: Accounts of the Cases That Shaped and Deine Medical Ethics. The McGraw-Hill Companies; New York, NY, 2008.

Phipps, William E., "Christian Perspectives on Suicide" *The Christian Century*, ed. Ted and Winnie Brock (1985), pp.970-72.

Quill, Timothy E., “Death and Dignity: B. Criteria for Physician-Assisted Suicide” *Last Rights: Assisted Suicide and Euthanasia Debated*, ed. Michael Uhlmann (Michigan: William B. Eerdmans Publishing, 1998), pp. 326-35.

Rachels, James, “Killing and Letting Die,” *Encyclopedia of Ethics*, 2nd edition, ed. Lawrence Becker and Charlotte Becker (New York: Routledge, 2001), vol. 2, pp. 947-50.

Rachels, James, The End of Life: Euthanasia and Morality. Oxford University Press; 1986.

Rhodes, Rosamond, “Physicians, Assisted Suicide and the Right to Live or Die”, *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers (New York, Routledge, 1998), pp. 165-76.

Smith, Wesley J., Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder. Random House; New York 1997.

Vanderpool, Harold Y. “Doctors and the Dying of Patients in American History” *Physicians-Assisted Suicide*, ed. Robert Wei.r. (Indianapolis: Indiana University Press, 1997), pp. 33-69.

Vaux, Kenneth L., Death Ethics; Religious and Cultural Values in Prolonging and Ending Life. Trinity Press International, Philadelphia, PA 1992.

http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx (Oregon Revised Statute, ORS) For Oregon’s Death with Dignity Act.