A Synopsis of Ethics in Physician-assisted Suicide

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ABSTRACT

The purpose of this paper is to infmm, educate, and possibly dissuade those with a negative disposition towards physician-assisted suicide, also commonly referred to as physician assisted death. This paper analyzes information from six different published scholarly articles in reference to physician-assisted suicide. The articles range from clinical studies, to different points of view, to the doctoral process on physician-assisted suicide. Despite the vast amount of information available on this topic, much of the world still has a negative point of view when it comes to physician-assisted suicide. The following will review a brief history of physician-assisted suicide, the legal aspects involved in such a journey, the clinical process of euthanasia, and the mental state of those left behind from someone who is involved in physician-assisted suicide. These articles are meant to show that patients do in fact deserve to choose whether or not they live.

Suicide is a painful and traumatic event that can affect the lives of many people surrounding the individual who chose to commit suicide. As such, the topic of any type of suicide, even legally physician-assisted suicide, has been stigmatized for centuries. To date there are only four states in the United States where this procedure has been legalized. Since physician-assisted suicide is in fact a form of suicide, albeit a noble one, it is oftentimes referred to as selfish and undignified. The mentality of this process being a shameful act, is formed by minds who are uneducated, and closed-minded. This essay serves to enlighten its readers by presenting the history, legalities, clinical process, family perspective, and the only medically documented alternative of physician-assisted suicide. Patients deserve the right to decide whether or not their life continues when faced with a terminal illness.

Throughout history suicide has been buried in the shadows as a shameful or regretful act regardless of circumstance. While there are rare individual cases that forego the preset consequences, as a whole suicide or assisted death is all treated under the same umbrella: it is wrong. Remarkably wrong in fact, since it is against the law in the vast majority of the world. By today's standards, those who are on death's door are still considered narcissistic or cowardly if they don't continue to fight until the bitter end. Those who are closest to the individual who took their own life, are often in agreement with this concmrence. After the initial shock and grief, or sometimes even during, the deceased is called selfish for leaving their family or loved ones behind. What the prevailing populace fails to understand, is that physician-assisted suicide is not simply an easy way out, or an escape from responsibility. Physician-assisted suicide is designed to help and heal all of those involved; it is not meant to degrade the participant, or to tear families apart. The general consensus on suicide is clear, as it is illegal to take one's own life in nearly any circumstance.

In modern society, physician-assisted suicide has only been legalized in four U.S. states, and 8 foreign countries. That is four states out of the fifty that comprise our nation where an adult is given the choice to do what they wish with the end of their life. It is ludicrous that what one does with their individual life is governed on a federal and state basis. One could go as far as to say it is borderline proof that citizens are merely government property. "In 1977 the U.S. Supreme Court rules that state laws banning physician-assisted suicide do not violate the Constitution" (Physician-Assisted Suicide Fast Facts, 2016, para. 12). As a result, the majority of U.S. states plainly see little reason to change their laws pertaining to physician-assisted suicide. Since the federal Supreme Court doesn't see it as a constitutional violation to deprive individuals of their end of life rights, why would the government on the individual state level take the time and resources to see it any differently?

The governmental view on suicide can be traced back as early as Ancient Athens. At that time, anyone who was found to have committed suicide was denied a proper burial. This means they were buried without a headstone, alone, and away from upstanding citizens. It was frowned upon for their families to visit the grave site. The severity and brutality of the punishment was much worse in England, under Louis the XIV. Louis the XIV would have the corpse of the deceased dragged through streets, so that the remaining family had to share in their shame. While in modern days it is not near as severe, "the Church of England may still deny ordinary burial rites to certain suicide victims" (Neeleman, J., 2007, p. 252). It was also illegal to assist anyone in suicide, or to encourage it any fashion. Clearly these ideals followed the settlers and were implemented, in their own fashion, in America. It wasn't until centuries later that this ideal was brought to light and it is still in the process of potentially being changed or overturned all together.

On October 27, 1997 the Death with Dignity Act was implemented in Oregon; Washington followed suit nearly a decade later in 2008. Prior to Washington implementing the Death with Dignity Act, Kevorkian was convicted of murder for assisting in suicides of multiple patients in 1999. The laws pertaining to assisted suicide state that the patient must be the one to administer the euthanasia medicine; Kevorkian made the mistake of administering it himself. In May of 2013, Vermont signed the Patient Choice and Control at End of Life into law; California followed suit in October of 2015. These two acts both state that it is legal to euthanize an individual who meets certain parameters, should they request physician-assisted suicide.

The Death with Dignity Act is what legally enables physicians to assist qualified individuals with death in Washington and Oregon. In Vermont and California there is a different, though similar, law called the Patient Choice and Control at End of Life. Both sets of laws "allow a competent adult resident of the state to obtain a prescription from a physician for a lethal dose of medication for the purposes of causing death through self-administration" (Ganzini, L., 2016, p.77). The law does not permit administration of the prescription by anyone other than the patient. If a physician were to assist in giving the patient the euthanasia medicine, they could be tried for murder. Physicians participating in prescribing lethal medication for euthanasia purposes are by law required to report information pertaining to the case. This protocol is to ensure that it is not a subjective procedure based solely on the decision of the practicing physician. When this information is reported, it is reviewed by multiple people and boards to verify there are no laws in conflict with the physician's actions.

Beyond the reporting required of the physician, there are multiple fmms and avenues of paper work that an individual must complete before being considered, and ultimately approved for physician-assisted suicide. First, an individual who is terminally illmust fill out an

application to be submitted for approval. It has been shown that few people understand all of their End of Life options. Due to this, one of the earliest forms involved in the physician assisted death is the Informed Consent form. This form outlines all other possible options with the patient to ensure that they are absolutely certain about ending their life. All of this is in addition to the forms that must be filled out regarding the current health of the applicant. "Although distress and ambivalence at the end of life are not uncommon, it can be problematic to discern whether patients are clinically depressed when they express futility regarding treatment options" (Lehto, R. H., Olsen, D. P., & Chan, R. R, 2015, p.184). It must be proven, and then signed, that the applicant is not acting under duress of depression. Furthermore, a patient must review and consent to a form that explains the self-administration option. After all of the above foims have been completed and submitted; if the individual is approved, then and only then will they receive a prescription for the method of euthanasia.

Safety measures are written into the laws surround physician-assisted suicide to establish that patients are of sound mental state, and are not requesting death for a treatable illness. These laws govern the clinical process of physician-assisted suicide. "Oregon, Washington, and Vermont require a 15-day waiting period between the first request for Aid in Dying and the writing of a prescription" (Orentlicher, D., Pope, T. M., Rich, B. A., 2015, p. 261). This waiting period allows the pending deceased time to have a change of heart. Also, it has been written that only a certified Dr. can prescribe the drugs for use in this assistance. Nurses are only allowed to be present to help the comfort level of the patient as they pass, not to assist in the euthanasia process. The safety measures are seemingly endless, strict, and unforgiving when it comes to physician-assisted suicide.

The first step in the clinical process for physician-assisted suicide is eligibility. There are key markers a patient must meet in order for their request of physician-assisted suicide to be granted. The physician will first go through alternative methods to death such as hospice care or management/treatment of symptoms. Ifthe patient decides to follow through with their application then they must have an incurable disease that will result in their demise within six months, and must have the mental cognizance to make major medical decisions. They must also be physically capable of taking the lethal medication prescribed to them. These criteria as listed above are meant to guide and provide knowledge for this procedure.

Once eligibility has been confirmed, and a patient has been approved for physician-assisted suicide, a prescription is written. The prescription can only be written by a Dr. that has been previously approved to aid in suicide. Once the prescription has been written, the physician must then notify the patient's pharmacist. In doing this, the physician is giving the pharmacist the time to decide whether or not to patiicipate in the decision the patient has made. The prescription is usually written for lethal drugs that are in a pill form. Since the euthanasia drugs are in a pill form it makes the ingestion process smoother for the patient. The medicine will then induce a short heavy sleep coma, and finally death.

Once the patient has been prescribed the appropriate dosage of euthanasia medicine, the next step is the final step. It is recommended that family be present for consoling purposes; however, it is not necessary that a physician is present. It is not uncommon for the patient to request the physician be present. In some ways it is easier if a physician is present to identify the time of death, and to mentally prepare the family or patient for what to expect. "When a physician is not present, family or friends can notify the patient's physician, hospice, or funeral home of the time of death" (Orentlicher, D. et al, 2015, p. 261). In the event a physician is not

present, it is not necessary to contact 911 when the patient begins dying, and ultimately stops breathing. Once the patient has passed on, the family can then contact the funeral home to pick up the physical remains and continue on with the mourning process. It is important to inform the physician who aided in this suicide about the time of death, and answer any potential questions they may have. Without this information the physician cannot properly complete the reports required of them for assisting in the requested suicide.

Last, and certainly not least, are the mental effects on those left behind. Study information shows that family members close to the potential deceased are not as negatively impacted as one might be led to think. Since physician-assisted suicide has so many steps and safeguards in place, it allows family members to come to terms with the decision and be prepared for their loved one to pass. "Over 90% felt at peace with and included in the decedents' end-of-life choices, accepted the death, and were satisfied with the opportunities to say goodbye" (Ganzini, L., Goy, E. R., Dobscha, S. K., Prigerson, H., 2009, p.814). Involving the immediate family in this process allows them to feel as if they have some control over the inevitable. It also gives them an opportunity to be financially, emotionally, and physically prepared for the funeral. In giving the choice to the patient, not only is the patient at peace, but so is the family.

The only medical alternative to physician-assisted suicide is caring for a terminal patient as best as possible. Caring for a terminal patient as best as possible breaks down to keeping them comfortable while, in essence, they wait to expire. Exercising this practice can become extremely costly. A patient could remain in the hospital for days or even weeks before they finally pass. In order to keep the terminal patient comfortable, they will most likely need to be on some sort of pain preventative medicine throughout their stay; this is not even including the cost of the room itself, or the food and care provided during the patient's wait to passing. Not

only is this a costly venture, but also not one that can always be can-ied out to the fullest. "Pain experts around the world agree that pain is undertreated in a variety of practice settings" (Sachs, G. A., Ahronheim, *I.* C, Rhymes, J. A., Volicer, L., Lynn, J., 1995, p. 556). In using this method of aiding in death, it may not be possible to keep the patient comfortable; since, pain is undertreated. There is also the psychological aspect to this option to consider. It is better to choose the time of your own passing through physician-assisted death, rather than waiting day after day not knowing what is going to happen. Fear emanates from the unknown. Legalizing physician-assisted suicide allows the terminally ill to take their life into their own hands.

The primary dispute against this argument, is whether or not a mercy killing is "right". Historically speaking, suicide is considered immoral and a criminal offense against the government, but also against God. In today's society, God has all but been removed from government proceedings and law, why choose to only leave him in medicine? Ethically and medically speaking, the reasons previously discussed prove that physician-assisted suicide is a just calling. It is unfair that an individual who is terminally ill does not even have the right to decide on their own terms when they pass. As for a moral standpoint on whether or not murder can be condoned, that is a bit more complex matter. There is no dispute in this essay as to whether or not physician-assisted suicide is murder; however, it is not a morally wrong procedure. It can be argued that murder of any flavor is morally wrong; however, if this was the case then why is murder in self-defense not considered to be wrong? If men and women can be sent to their deaths to fight for this country, why can't a terminally ill individual decide whether or not they want to continue living?

Another point on the opposing side is that legalizing physician-assisted suicide could lead to over abuse of power. "A problem exists with the notion of evidencing objectively the need for

assisted suicide and the terms that would mark its misuse" (Coggon, J., 2006, p.340). The idea here being that there would suddenly be a mass amount of the population at risk to be abused by physicians. It is agreeable that there will be a risk for abuse, as there is with every other aspect of practicing medicine. Does this mean that medicine as a general whole should be abolished? No, of course not. This simply conveys the necessity to apply multiple safeguards, laws, policies, and procedures in place for this topic of medicine. As previously stated, there are a variety of all of these practices that are implemented in the four states whom have already legalized physician-assisted suicide.

Possibly the most concerning point on the opposing side of this argument is the potential undermining of the medical profession. Modern practicing medicine is still based around the premise of the Hippocratic Oath. While there are many versions of the Hippocratic Oath in today's society, the overall purpose still rings clear: do no harm to your patients. Does assisting in a patient's death count as harm? No, with the amount of rules and regulations held in place to monitor this procedure, it is clear that physician-assisted suicide is a benefit to the patient. By the time a patient is approved for this procedure, it is proven that physician-assisted suicide is absolutely necessary; however, it has been shown that certain doctors do still carry regret after performing this service. "Physicians reported significant emotional burden from having performed euthanasia and PAS that, in some cases, even led to changes in practice patterns" (Emmanuel, E. J., 1999, p. 636). While it is obvious this practice weighs heavy on some professionals, it should not completely outweigh the benefits and necessities of physician-assisted suicide.

Despite all objection or adverse opinions; when carried out properly, physician-assisted suicide is a helpful procedure on multiple levels. It helps financially, mentally, and emotionally

to not only the terminal patient but also the surrounding family members. There are many safeguards are procedures in place to ensure this practice does not become an act akin to flat out selfish murder. Not only are there safeguards to prevent murder for selfish gain, but there are also safeguards to ensure the mental capacity of all involved. As a result, patients should have the legal right to decide whether or not they wish to die; they deserve to make an informed decision and request physician-assisted suicide.

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