Bioethics, Euthanasia, and Physician-Assisted Suicide

We all labor against our own cure, for death is the cure of all diseases.
—Sir Thomas Browne, 1605–1682, Urn Burial

Objectives

After reading this chapter, you will be able to answer the following questions:

• How do ethics and morality differ?
• What is bioethics, and what is the role of a bioethicist?
• How do active and passive euthanasia differ?
• What are the religious, legal, and social views toward euthanasia?
• What is physician-assisted suicide?
• What is the current legal environment regarding physician-assisted suicide?
• How do issues of gender bias, pain relief, and the voluntary nature of physician-assisted suicide factor into arguments for and against the practice?

Controversy continues to swirl around the issues of legalized euthanasia and physician-assisted suicide (PAS). The controversy rests on differing views of the ethics and practical morality of such legislation, what effect it would have on the practice of euthanasia and PAS, who typically asks for it, and on whether improving pain management and palliative care would be a better first step.

What Is Medically Ethical Behavior?

Ethical behavior is defined by moral principles or values based on concepts of whether something is good or bad. Moral behavior is based on socially accepted codes or notions of right and wrong. Thus, ethics and morality are similar but not identical.

Ethical decision making must balance the rights of an individual to decide for him/herself, the views of society as a whole, and the desires and wishes of a family and others close to the individual. Justice involves making decisions to balance competing interests so that everyone is treated fairly.

These definitions are, perhaps unfortunately, hypothetical. They address the question, “What should be done?” In reality, and in the bureaucratic setting of a hospital or other healthcare institution, the question more often is “What can be done?” and
the answer is “Do everything possible, even if it is not always appropriate.” In times past, when not much could be done to prolong death, sympathy and efforts to manage pain were the norm. Now, with the enormous advances in techniques, equipment, and drugs, the imperative to treat and cure at all costs sometimes overwhelms compassion.

**Bioethics**

The growing difficulty and complexity (as well as the dangers) of medical decision making have created the role of the *bioethicist*. A bioethicist is a hospital staff person who is educated in philosophy, psychology, religion, law, humanities, and the social sciences (Guyer, 1998). This person’s role is to help the medical professionals, the family, and the patient make difficult medical decisions, especially for those patients at the end of their life. The bioethicist meets with the patient, his or her family, and medical staff, collecting the facts and surveying the various views involved before offering a recommendation regarding next steps for the patient. If one or more parties balk at the bioethicist’s decision, meetings are held so that all parties can talk over things. If these meetings fail to produce an agreed upon path of action, the hospital’s ethics committee reviews the case and makes a ruling.

In principle, the bioethicist represents the interests of the patient above all others. But the inevitable influence of the institutional setting and interaction with hospital medical professionals can erode the best of good intentions, and the bioethicist often comes to ally with the professionals and their views on patient care (DeVries & Subedi, 1998)—or even subvert his or her role by selling cover-ups for cost-cutting measures to managed-care insurance companies (Shalit, 1997).

**The Doctor’s Oath of Practice**

All cultures have had guidelines in the form of codes, prayers, creeds, or oaths to guide their healers. One of the earliest oaths comes from the Chareka Samhita of ancient India. This oath calls for the medical student to “follow a path of personal sacrifice and commitment to duty.” In China, ethical codes of conduct for physicians appear from the Taoist writer, Sun Szu-Miao. His writings stress the importance of “preserving life and serving the interest of the patient.” A widely known Judaic text is the Daily Prayer of a Physician, attributed to Moses Maimonides, a twelfth-century Jewish physician in Egypt, but probably written by Marcus Herz, a German physician. This text first appeared in print in 1793 (see box).

Codes from other cultures are similar to the Hippocratic oath. Hippocrates, a Greek physician who lived from 466 B.C. to 377 B.C., is known as the father of medicine. Even though not specifi-

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**Daily Prayer of a Physician**

Almighty God, grant that my patients have confidence in me and my art and follow my directions and my counsel. Remove from their midst all charlatans and the whole host of officious relatives and know-all nurses, cruel people who arrogantly frustrate the wisest purposes of our art and often lead Thy creatures to their death. Should those who are wiser than I wish to improve and instruct me, let my soul gratefully follow their guidance. Should conceited fools, however, censure me, then let love for my profession steel me against them. Imbue my soul with gentleness and calmness when older colleagues, proud of their age, wish to displace me or to scorn me or disdainfully to teach me. Let me be contented in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained to sufficient knowledge, but vouchsafe to me the strength, the leisure and the ambition ever to extend my knowledge.

(Excerpts, translated by H. Friedenwald, 1917.)
What Is Medically Ethical Behavior?

Hippocratic Oath (modern version)

I will apply, for the benefit of the sick, all measures required.

I will remember that there is art in medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know.

Most especially must I tread with care in matters of life and death.

I will remember that I treat a sick human being, whose illness may affect the person’s family and economic stability.

I will prevent disease whenever I can, for prevention is preferable to cure.

cally spelled out in the oath, the implied message for doctors is “Above all, do no harm.” Members of the American Medical Association (AMA) are bound by the Hippocratic oath in its modern version (Lasagna, 1964)[J1], in which the ideal ethical behaviors for medical doctors are explained (see box).

Many physicians today believe that the Hippocratic oath is outdated, because some of today’s issues were unheard of at the time the oath was created. For example, years ago, no one had heard of legalized abortion or test-tube babies.

Physicians’ Perspectives on Life and Death

Caring for dying patients is part of every doctor’s training and experience. Yet physicians’ perspectives regarding death differ. For example, most doctors admit that patient deaths disturb them very little. Others, although not as many, say that their patients’ deaths, even those they knew only for a short time, are very disturbing. The most commonly reported grief symptom is “feeling upset when thinking about the patient” (Redinbaugh et al., 2003).

Medical Ethics and Capital Punishment

In 1976, the U.S. Supreme Court legalized capital punishment. Because the Eighth Amendment to the Constitution forbids cruel and unusual punishment, the method of using lethal injections was introduced. To make sure the lethal injections were administered properly, courts required medical personnel to attend executions (Gawande, 2007). The American Medical Association balked

A Physician’s First Encounter with Death

As a new doctor assigned to the first of his clinical rotations on the Internal Medicine service, Dr. Sherwin Nuland helped an intern by agreeing to complete the admission workup on a new coronary patient who had just arrived. Before Nuland got far into the routine admissions work, the patient died of a massive, and inevitable, heart attack. Alone in that room with the corpse, Nuland tried everything to save the dead man. Then, the door to the room swung open and Nuland’s friend rushed in to see Nuland crying, out of control and begging the patient to live. His friend said, “It’s okay, buddy—it’s okay. You did everything you could . . . Shep, now you know what it’s like to be a doctor.” (Nuland, 1995, p. 8.)
at this practice, resolving that "A physician . . .
should not be a participant in a legally authorized
execution" (Article 2.06 of the AMA Code of
Medical Ethics).

One doctor, a prison physician, has a different
view about attending executions. He feels obliged
to attend inmates when they are about to die. He
views executions as an end-of-life issue, a time
when a doctor should make sure the person about
to die is comfortable and does not have pain or suf-
fering. Anti-capital-punishment activists have
challenged his medical license and AMA member-
ship, but he believes that it is wrong to stop
attending executions. He and his medical team are
paid quite well for their services; he donates his
share of it to a children’s shelter (Gawande, 2007).

Euthanasia

The ability to keep a dying person alive has raised
difficult questions for the terminal patient, his or
her physician, as well as policymakers and the
general public. Should a patient be allowed to
die? Should the medical profession help a patient
to die? (Weir, 1998).

In euthanasia, the physician takes some sort of
action to end a patient’s life. When the physician
takes direct action to do so, it is sometimes called
active euthanasia, to distinguish it from passive
euthanasia, which is simply withholding or
withdrawing the treatment needed to sustain life
and allowing the patient to die. Physician-assisted
suicide involves the physician supplying the means,
usually medication, to a patient who then decides and takes the necessary action to end his or her life.

When it comes to distinguishing between
active and passive euthanasia, proponents of
active euthanasia argue that there are no impor-
tant moral distinctions between the two practices,
so both should be allowed. Opponents of active
euthanasia, but who support the passive form,
argue that, when life support is withdrawn, the
cause of death is the underlying disease—not
action by the physician.

If it were legal, more than one-third of U.S.
physicians would be willing to offer active euthana-
sia with medication, and one-fourth would be will-
ing to give a lethal injection (Meier, et al., 1998).
An increasing number of people in the United
States support the painless euthanasia of incurably
ill patients—if they and their families request it
(Blendon, Szalay, & Knox, 1992; Caddell &
Newton, 1995; Rogers, 1996). This increased
acceptance is paralleled in other countries (Genuis,
Genuis, & Chang, 1994; Singer, Choudhry,
Armstrong, Meslin, & Lowy, 1995; Steinberg,
Najman, Cartwright, MacDonald, & Williams,
1997; Suarez-Almazor, Belzile, & Bruera, 1997;
Van der Maas, Pijnenborg, & van Delden, 1995).

But what, specifically, might make euthanasia acceptable? Acceptability, according to Frileux et
al. (2003), depends mainly upon:

- the level of patient suffering in spite of
treatment;
- the extent to which the patient requested
the life-ending procedure;
- the age of the patient; and
- curability of the illness.

Karen Ann Quinlan and
Terri Schiavo

Ethical questions about the “right to die” have
become prominent since the landmark case involv-
ing Karen Ann Quinlan in 1975. Because Quinlan
was in a persistent vegetative state (PVS), a coma
state of wakefulness without detectable awareness,
her parents asked for her respirator to be removed.
After much controversy, the New Jersey Supreme
Court ruled that her respirator could be dis contin-

A more recent case is the one involving Terri
Schiavo. In 1990, Schiavo, then age 26, collapsed
at her home in St. Petersburg, Florida, and never recovered. She entered a coma and was kept alive by the tools of modern medicine. She had experienced respiratory and cardiac arrest and remained in a coma for 10 weeks. She did not have a living will. After 3 years, she was diagnosed as being in a PVS. This condition of wakefulness persuaded her parents, Robert and Mary Schindler, that she could recover.

In 1998, her husband, who was also her legal guardian, petitioned the state courts to remove her feeding tube, but her parents objected. The case generated intense media attention, involvement by politicians and interest groups, a series of state and federal court actions, and eventually attempted intervention by the U.S. Congress.

Despite these efforts, the state courts steadfastly held that she was in a PVS and ordered that she should cease to receive life support. Her gastric feeding tube was removed (for the third time), and she died 13 days later of dehydration, on March 31, 2005, at the age of 41 in a Pinellas Park hospice facility.

The Schiavo case resulted in 14 appeals and numerous motions, petitions, and hearings in the Florida courts, all of which were denied, and five suits in Federal District Court, all of which also were denied. Also noteworthy is that a subpoena by a congressional committee was filed in an attempt to qualify Schiavo for witness protection as was federal legislation (the Palm Sunday Compromise) and four denials of the Supreme Court of the United States to review the appeals courts decisions.

The Palm Sunday Compromise, formally known as the Act for the Relief of the Parents of Theresa Marie Schiavo, was an act of Congress to allow the case to be moved to a federal court. The name “Palm Sunday Compromise” was invented by House Majority Leader Tom DeLay, highlighting the mixture of religion and politics that overshadowed the Schiavo case.

**Religious Perspectives on Euthanasia**

In this age of life-prolonging medicine, the deliberate decision to end a life generates a significant amount of religious discussion (O’Connell, 1995). Ethical concerns from a religious perspective likely will become even more central when and if euthanasia enters the mainstream of medical practice and society struggles to achieve consensus on this issue.

The futility of medical treatment to sustain life has collided with religious ethics. In the case of Baby K, an anencephalic infant, physicians concluded that Baby K's life could not be sustained and that continued treatment would be futile. The infant’s mother insisted that Baby K should be kept alive because God might choose to perform a miracle (Post, 1995).

In the mother's defense, Post (1995) insisted that religious beliefs should be taken seriously by medical personnel and included in medical or social policies concerning futile treatment. Others argued, however, that physicians should not be compelled to violate their own moral convictions and professional standards to accommodate the religious beliefs of others (Paris & Reardon, 1992). Refusal to continue futile treatment “is not abandonment of the patient; it is an assertion of professional responsibility” (Paris & Reardon, 1992, p. 133). Before refusing to provide treatment, the physician should explain why the proposed treatment is futile, and, if possible, arrange a conference with the hospital ethics committee or the pastoral care department. Often a consensus does emerge, thereby averting a break in the physician–patient relationship.

**Is Legal Availability of Euthanasia Justified?**

People, in general, are becoming more receptive to euthanasia. Advances in medical technology often cause people to worry about lingering, nasty deaths hooked to machines, unable to communicate, the modern equivalent of the seventeenth- and eighteenth-century fear of being buried alive (Daniel, 1997). But what are the arguments and justifications, pro and con, for euthanasia?

Proponents of legalized euthanasia argue that the right to self-determination encompasses the right to choose how and when to die. The believe
that keeping a person alive who wishes to die is not only an infringement of that person’s rights, but an irresponsible use of resources (McLean & Britton, 1996). Treatment costs are high, for example, for AIDS and cancer, but very low for lethal injection. These proponents also argue that because euthanasia is already taking place, it should be made legal so that it can be regulated. For instance, a doctor can administer drugs to relieve pain knowing that he or she might kill the patient. As long as the doctor’s intention is to relieve pain, this practice should be acceptable, and the death that ensues should be ruled accidental.

Many opponents to legalize euthanasia, however, worry about an inevitable “slippery slope,” such as demonstrated by the case of a healthy 50-year-old woman who, distressed after her two sons died, was helped to die by her doctor. The doctor was censured but not convicted of wrongdoing, thus establishing mental suffering as a valid reason for euthanasia (Keown, 1995). The decision to help a person end his or her life might be at first, but the more it is done the easier it might become. In other words, the line between what is and is not acceptable might become blurred (Daniel, 1997).

Many argue that palliative care—pain management, symptom control, and psychological and spiritual support—is the acceptable alternative to euthanasia (George, 1997). Most doctors, however, are in need of training in both palliative care and medical ethics (Keown, 1995). Also, a shortage of available beds and funds makes extensive use of palliative care difficult. Perhaps, rather than campaigning for legal euthanasia, doctors and families of the terminally ill should be demanding adequate palliative care (Nathanson, as cited in Daniel, 1997).

How Patients View Euthanasia

What might lie behind a patient’s requests for euthanasia? Mak, Elwyn, and Finlay (2003) revealed that concerns are not always confined to physical and functional decline. They also stated that many patients experience hidden psychosocial and existential issues embedded in life experience, fears about the future, and yearnings for care and social connection. Many patients express fears of pain or a painful death, lack of quality of life, and lack of hope (Johansen, Hølen, Kaasa, Loge, & Materstvedt, 2007). Furthermore, they might fear physical disintegration and loss of function and loss of personal relationships, which leads to a perceived loss of self and wholeness (Lavery, Boyle, Dickens, Maclean, & Singer, 2001) that gradually diminishes until they oftentimes

**MY STORY: “STOP! LET HER DIE”**

I always have believed that doctors should do everything in their power to keep everybody alive. That was especially true for my grandmother. That was very clear for me.

Suddenly, my grandmother had a stroke. We were told that her stroke was too severe and that she probably would soon die. While she was in the hospital, only one family member at a time could visit her—and then for only 5 minutes. I thought my turn would never arrive to get one last visit. But it did.

I walked back to the intensive care ward to find two nurses working to get my grandmother to breathe. Apparently, she had just quit breathing. When I saw them working so hard, I thought, “How cruel!” Just as I thought it, I also was shocked at my reaction. What had changed the way I previously had believed?

Then, I knew. I changed my beliefs when reality for me changed. I think I understood that a dignified death isn’t about force; it’s about letting death take its course. I feel like I grew up a lot that day.
see a future worse than death itself (Mak, Elwyn, & Finlay).

The prospect of good quality end-of-life care and social connectedness might help patients see their reality differently and lead them to reevaluate the desire for death (Mak, Elwyn, & Finlay, 2003). This reevaluation suggests that improvements in palliative care should precede consideration of legalized euthanasia.

Beyond assessing mental competence or determining legal guidelines, physicians and other healthcare professionals must acquire the skills for providing good end-of-life care, which includes the ability to connect with patients, to diagnose suffering, and to understand patients’ hidden agendas through in-depth exploration. These skills are especially important for encouraging patients’ feelings of hope and personal worth. Thus, to give physicians better communication skills and attitudes, medical education should include medical humanities, experiential learning, and reflective practice (Bolton, 2001; Vass, 2002).

**Physician-Assisted Suicide**

Most people judge euthanasia to be less acceptable than physician-assisted suicide (PAS), the process in which the physician simply gives the patient the means to end his or her life. With PAS, the patient takes the action and can until the last minute decide not to go ahead with the act (Rogers, 1996).

In the past, most people died relatively quickly as a result of accident or illness. Today, despite advances in palliative care, death is too often protracted, painful, and undignified. In the United States, 80% to 85% of people die in institutions, 70% of those after a decision to withdraw or withhold treatment, and the great majority are elderly (Fraser & Walters, 2000).

Results from public opinion polls consistently supported PAS. In one poll, even 50% of Catholic voters answered “yes” to the question, “Shall the law allow terminally ill adult patients obtain a physician’s prescription for drugs to end life?” (Dietz, 1997). Some recent report results suggest that attitudes to PAS become more positive with age (Littlejohn & Burrows-Johnson, 1996; Sedlitz, Duberstein, Cox, & Conwell, 1995).

In 2005, a majority (70%) of 1,010 Americans polled favored allowing some form of PAS. This percentage is up from previous years, but less than the peak of 73% percent approving in 1993 (Taylor, 2005).

PAS is controversial. This controversy, however, is not new. Beginning in 1870 and continuing until the 1930s, there was widespread public debate in the United States over legalization of PAS. World War II and the reactions to the Nazi death camps suspended further discussion until 1971, when, in the Netherlands, a doctor who admitted administering a lethal dose of morphine was given a 1-year suspended sentence. The leniency of the sentence prompted a public debate, and, in 1984, the Royal Dutch Medical
Association offered guidelines to help the courts decide at what point euthanasia was a crime. In 1990, the Ministry of Justice accepted these criteria, and, in 1993, the Dutch parliament voted in favor of this reporting system (Daniel, 1997). PAS has strong public support in the Netherlands, where it is monitored by the government. In 2001, about 0.2% of all deaths in the Netherlands were the result of PAS (van der Heide, et al., 2007). Because people are living longer, the practice of PAS is likely to increase.

Oregon, which passed the Death with Dignity Act, is the only U.S. state that allows PAS. In Oregon, a physician must sign an Attending Physician’s Compliance Form, which is sent to the Oregon Public Health Department to ensure that the physician has complied with the law. On this form, the physician must attest to the following:

- The patient has requested the physician’s assistance in suicide three times, the last in writing, with the statement is dated and signed by the patient in the presence of two witnesses.
- The physician must wait at least 15 days after the initial oral request to the second oral request and at least 2 days after the final written request before writing the prescription for the lethal drug. The patient’s written request for medication to end his or her life is attached to the compliance form.
- Two physicians have determined that the patient has a life expectancy of 6 months or less.
- The patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- At least one of the two witnesses to the patient’s written request for the lethal prescription is a person who is not a relative of the patient, does not stand to benefit from the estate of the patient, and is not an employee of the institution where the patient is being treated.

The physician also must indicate on the form that the patient was fully informed about:

- his or her medical diagnosis;
- his or her prognosis;
- the potential risks associated with taking the medication;
- probable result of taking the medication; and
- the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.

The patient has the right to rescind the request for medication to end his or her life at any time.

In 2003, 38 people (one-tenth of 1% of all Oregon deaths) committed PAS. Twenty-one PAS deaths occurred in 2001, and less than half that in 1998 (Lee, 2003). Most of those selecting PAS people had cancer and were well-educated white males. The top three reasons they cited for wanting to end their lives were:

- loss of the ability to make their own decisions (84%);
- decreasing ability to participate in activities they enjoyed (84%); and
- loss of control of their bodily functions (47%) (Lee, 2003).

**Physician-assisted Suicide and the Law**

In the United States, the “liberty interest”—an individual’s right of choice—is guaranteed by the Fourteenth Amendment. Thus, the issue of PAS is

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**Questions & Answers**

**Question:** Are any other states besides Oregon trying to legalize PAS?

**Answer:** In 2004, Arizona, Hawaii, and Vermont introduced state bills to allow PAS. At the same time, John Ashcroft, then United States Attorney General, issued a directive making it illegal for doctors to prescribe controlled narcotics to help terminally ill patients die. In 2006, the Supreme Court ruled (6–3 in Gonzales vs. Oregon) that Ashcroft had overstepped his authority.
as much about control as about dying, and patients, and possibly family, should have the right to participate in all end-of-life decisions. However, 34 states have statutes explicitly making it illegal for anyone to assist in a suicide.

One state, Oregon, as the result of a citizen initiative ballot (Measure 16), passed the Death With Dignity Act, permitting PAS death under very restricted conditions. Shortly thereafter, opponents of the law persuaded the lower house of the Oregon legislature to return Measure 16 to the voters for repeal.

Some months earlier, the ninth circuit federal appeals court upheld Measure 16 but allowed a stay until the Supreme Court ruled that Americans did not have a constitutional “right to die.” The Supreme Court, however, did not preclude states from passing laws establishing such a right (Savage, 1997).

In their decision to uphold Measure 16, the ninth circuit judges said that the “liberty interest” should allow competent, terminally ill patients the right to choose the time and manner of their death. They considered that adequately rigorous safeguards could be implemented in the decision process to prevent abuse. “We believe that the possibility of abuse . . . does not outweigh the liberty interest at issue” (Compassion in Dying v State of Wash, 79 F 3d 790, p. 837).

Addressing the issue of physician-assisted suicide, the judges stated:

“We see no ethical or constitutionally recognizable difference between a doctor’s pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life . . . . To the extent that a difference exists, we conclude that it is one of degree and not one of kind (Compassion in Dying v State of Wash, 79 F 3d 790, p. 824).

The judges also observed that “today, doctors are generally permitted to administer death-inducing medication, as long as they can point to a concomitant pain-relieving purpose” (p. 822). Physicians are aware of this double effect, a term that “originates in Roman Catholic moral theology, which holds that it is sometimes morally jus-

pecifically, in medical usage, double effect can be described as follows: The intent of palliative treatment of the terminally ill is to relieve pain and suffering, but the patient’s death is a possible side effect of the treatment. It is, therefore, ethically acceptable for a physician to increase pain-relieving medication gradually, being aware that the medication may depress respiration and cause death.

In November 1997, 60% of Oregon voters rejected the repeal of Measure 16. The appeals court then lifted the stay. Both proponents and opponents of Measure 16 predict the adoption of similar measures in other states (Murphy, 1997).

In Australia, The Rights of the Terminally Ill Act went into effect July 1, 1996, in the Northern Territory, but the legislation was short-lived. In March 1997, the federal parliament effectively repealed it by passing the Euthanasia Laws Bill (Gordon, 1997). Draft legislation in the state of South Australia, however, if passed, will challenge it. Both the Oregon and Northern Territory laws had exhaustive provisions designed to safeguard the integrity of the legislation and to prevent abuse (Oregon Revised Statute 127; Cordner, 1995).

Has all the legal maneuvering about PAS resulted in justice? To most people, medical justice means the fair and equal treatment of patients. But the current situation seems unjust. For instance, terminally ill patients often are too debilitated to take active steps to end their suffering should they choose to do so.

Because it is illegal in most states for a person to assist a suicide, many terminal patients are denied choices available to the more privileged in society, because they are much more likely to have a relationship of trust with a medical practitioner who will discreetly help to alleviate their suffering. When commenting on the demise of his legislation, the former Northern Territory chief minister observed that the senators who voted for repeal belong to a privileged, wealthy group who, themselves, have access to voluntary euthanasia (Ceresa, 1997).
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Religion is another factor inhibiting beliefs about the suitability of PAS. In Michigan, approximately 30% of physicians who opposed assisted suicide did so primarily because of religious conviction (Bachman, 1996). The principal opponents of both the Oregon and Northern Territory legislations held strong religious views. Results from a number of other studies suggest that among the general population fervent religious belief is an important predictor of opposition to PAS (Bachman, 1996; Suarez-Almazor, Belzile, & Bruera, 1997; Ward, 1980). As the ninth circuit judges stated:

Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all other members of a democratic society, and to compel those whose values differ from theirs to die painful, protracted, and agonizing deaths. (Compassion in Dying v. State of Wash., 79 F 3d 790, p. 839)

If both patients and physicians were free to choose, patients could select a physician holding views on PAS or euthanasia similar to their own.

Another important matter is the impact of terminal illness on patients’ families. Currently, it is illegal to assist a person in committing suicide in two-thirds of the United States. Consequently, people who are in unbearable pain often die alone (if they commit suicide), because they do not want to put loved ones at legal risk. When considering the possibility of this kind of risk, the ninth circuit judges observed that almost all who agreed to assist the dying avoided prosecution, but would “likely suffer pain and guilt for the rest of their lives. This burden would be substantially alleviated if doctors were authorized to assist terminally ill persons to end their lives and to supervise and direct others in the implementation of that process” (p. 836). According to Fraser and Walters (2000), it seems that a democratic society that observes justice and liberty should permit differing opinions and allow terminally ill people some freedom to decide for themselves when and how they die.

**Gender Bias and Physician-assisted Suicide**

Proponents of PAS often offer a story or case study to convince the reader or listener (Keenan, 1998). One such story (Vorenberg and Wanzer, 1997) is the case of “Uncle Louis,” who is in constant pain because there is supposedly no good pain management for his type of cancer. After many therapies and surgery, he is definitely terminal. He has discussed PAS with his physician, and he now wants it. Proponents then ask if Uncle Louis should be left to suffer.

The implication is that Uncle Louis has a right to die. But how common is the case of Uncle Louis? Is he really representative of the people asking for PAS? In most cases, the person asking for PAS is usually a woman, not a man (Vorenberg & Wanzer, 1997). Why might the reason be? Many more elderly poor are women, and women are twice as likely to suffer from depression as men. Age, poverty, and depression are among the leading reasons why people ask for PAS. The female patient also is more likely to be worried about her condition’s impact on others. And a certain type of woman—depressive, self-effacing, and near the end of a life largely spent serving others—might be particularly vulnerable to the offer of PAS.

The case of Uncle Louis is about one man who has tried every possible option, consulted physician and family, and apparently faces unmanageable pain. He has considered his decision, but he is unable to carry it out because laws prohibit it. The more likely case, however, is that of a woman who, if she fears pain, fears it because her healthcare providers do not properly manage it. She chooses PAS because she does not want to burden her family.

Gender inequality involving the wishes of the dying is found in the courts as well. After hearing families testify about an incompetent patient’s wishes to be removed from life support, judges rule in favor of a male patient in 75% of cases, but only 15% for females. In their opinions, it appears that most judges treat men’s decisions as rational but women’s as emotional and immature (Miles & August, 1990).
The irony of a case like Uncle Louis’ is that it is an attempt to persuade people to change the law for a rather small number of empowered persons. The cost of this persuasion is doing away with those persons who already find themselves isolated from society, family, and the healthcare industry.

**Pain and PAS**

A second questionable aspect of the Uncle Louis case is the absence of pain relief medication (Keenan, 1998). In 1994, the New York State Task Force on Life and the Law reported, “Taken together, modern pain relief techniques can alleviate pain in all but extremely rare cases. Effective techniques have been developed to treat pain for patients in diverse conditions” (Martyn & Bourguignon, 1997). Yet, all too often, pain relief is not provided.

Actually, pain relief is a minor factor in the motivation of people who seek PAS, according to the medical ethicist Ezekiel Emanuel (1997). According to Emanuel, “No study has ever shown that pain plays a major role in motivating patient requests for physician-assisted suicide or euthanasia” (p. 75). Distress and dependency are the primary concerns of PAS candidates.

**How Voluntary Is PAS?**

How likely is it that most PAS candidates would enjoy the choice that Uncle Louis has? Of 3600 Dutch deaths reported as PAS in 1994, about 1000 were cases wherein the physician took the patient’s life without an explicit request from the family or the patient (Keenan, 1998). Dutch statistics on PAS, however, leveled off and then declined in the period 1995–2001 (Onwuteaka-Philipsen, et al., 2007).

Even more unsettling about the possibility of involuntary PAS is that The Royal Dutch Medical Society and the Dutch courts have extended mercy killing to infants and to psychiatric patients. Regarding these developments, two Dutch lawyers commented that the increase in involuntary euthanasia and mercy killing in the Netherlands has gone unchecked, despite legal conditions that were designed to guarantee voluntarism (Keown, 1995). In response to these concerns, in the Netherlends euthanasia requests are assessed by the public prosecutor only after being advised by a multidisciplinary committee of medical, ethics, and legal specialists (Onwuteaka-Philipsen, et al., 2007). The rate of PAS (1995 to 2001) has been level and accompanied by an increase in effective pain management.

Could a similar creep toward involuntary PAS happen in the United States? The Dutch are a more homogenous society, with universal health care. U.S. society is fragmented and economically stratified, with a patchwork healthcare system. The likelihood of creep toward involuntary PAS, therefore, might be greater in the United States (Kaveny, 1997).

**Hard Cases and Representative Cases**

Real cases like Uncle Louis’ exist (Keenan, 1998). Ethicists call them “hard cases,” meaning they raise the question of whether a particular law should be absolute. For instance, an abused wife who kills her husband might be morally excused or even morally right, and, therefore, a judge and jury might be persuaded to “let her off.” Legalizing her action, though, might make it an acceptable alternative and jeopardize other, more civil, methods for resolving domestic conflict. A hard case like the abused wife as an exception to the law does not justify creating a new law—not should it be used to nullify an existing law.

Thus, in debating PAS legislation, it seems more important to ask whether cases cited in defense or rebuke are representative cases or hard cases. Does Uncle Louis represent a large group for whom the law should be changed? If he is not representative, then it is exactly like the case of the abused wife. Hard cases depend not on legislators making new laws, but on judges and juries interpreting existing laws and precedents for a particular case.

If the one case of Uncle Louis is not representative, what might be a representative case? More likely, it might be an isolated and depressed woman who does not want to be a burden, who has, at best, uncertain access to adequate health care, and whose own wishes are rarely solicited or
heeded. When this case is taken into account, it seems that the critical issue facing Americans in caring for the dying is not lack of autonomy, but the inability to care properly for the dying. In short, the typical case is a reminder of a society’s failure to the aging, to women, and to the poor.

What, then, would be the social effect of a law that permits PAS? Proponents for the case of Uncle Louis are only interested in the autonomous person. But opponents of legalization try to persuade others that the law that the friends of “Uncle Louis” want invalidated is the same law that keeps the person of more common instance from being marginalized to death.

SUMMARY

- Ethical behavior is defined by moral principles or values based on concepts of good or bad.
- The growing difficulty and complexity (as well as the dangers) of medical decision-making have created the role of the bioethicist, whose job it is to help medical professionals and families make difficult medical decisions, especially for people at the end of life.
- All cultures have guidelines—codes, prayers, creeds or oaths—to guide their healers. Members of the AMA are bound by the Hippocratic Oath. Even though not specifically spelled out in the oath, the implied message for doctors is “to do no harm.”
- In euthanasia, the physician takes an action to end the patient’s life. When the physician takes direct action to do so, it is called active euthanasia, distinguishing it from passive euthanasia, which is simply withholding or withdrawing the treatment needed to sustain life and allowing the patient to die. Physician-assisted suicide involves the physician supplying the means, usually medication, to a patient who then decides and takes the necessary action.
- If it were legal, more than one-third of U.S. physicians would be willing to offer active euthanasia with medication. One-quarter would be willing to give a lethal injection. An increasing number of people in the United States support painless euthanasia of incurably ill patients—if they and their families request it.
- Proponents of legalized euthanasia argue that rights to self-determination include the right to choose how and when to die.
- Opponents of legalized euthanasia worry about a “slippery slope” wherein ending a life might be a difficult decision at first, but then become easier the more it is done.
- Most people are more supportive of physician-assisted suicide (PAS). In 2005, a majority (70%) of 1,010 Americans polled favored allowing some form of PAS.
- In the United States, 34 states have statutes explicitly making it illegal for anyone to assist in a suicide.
- Currently, Oregon is the only state that allows PAS. In 2003, 38 people (one-tenth of 1% of all Oregon deaths) were attributed to PAS.
- In Australia, The Rights of the Terminally Ill Act went into effect July 1, 1996, in the Northern Territory, but in March 1997 the federal parliament effectively repealed it by passing the Euthanasia Laws Bill.
- Women ask for PAS more often than men.
- When debating PAS legislation, it is important to ask whether cases cited in defense or rebuke are representative cases or hard cases.

ADDITIONAL RESOURCES

Books


Movie


Critical Thinking

1. Was the removal of Terri Schiavo’s feeding tube active or passive euthanasia? Explain.
2. If you have a terminal illness, with a paralyzed body but active mind, describe three good reasons for continuing to live.

Class Activities

1. Interview a person who deals with terminal illness on a daily basis (e.g., a physician or nurse) and report findings to the class.
2. As a class, debate whether or not PAS should be legalized.

References


Sometimes a small victory.
Chapter 5: Bioethics, Euthanasia, and Physician-Assisted Suicide


