The Ethical Dilemma of Physician-Assisted Suicide and Euthanasia

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While healthcare reform is often a heavily debated topic by politicians, healthcare providers, and the general public, there is perhaps no greater debate in healthcare than physician-assisted suicide or euthanasia. Modern advancements in medicine and technology, as well as policy changes in several states, have progressed treatment options available to patients considering euthanasia. Pappas (1996), commented that, "Breakthroughs of the past century have empowered doctors to battle acute infection successfully, thus transforming the hospital, from functioning essentially as a hospice, to an institution which provides medical, surgical and curative treatment for the sick and injured," (p. 387).

One may think that the advances of modern medicine have extended to include ethical issues regarding a patient's right-to-die. Yet, while euthanasia is overwhelmingly considered humane in case of animals, the same cannot be said regarding human patients. In fact, even though humans possess the capacity to reason, thereby making hard choices and decisions regarding end-of-life care, it is still more acceptable to allow animals to die with dignity over people. Death is certain for everyone. That is why ethical issues surrounding a patient's right-to-die affects everyone from currently healthy individuals to those who are braving terminal illness.

Ethical arguments in favor of euthanasia began appearing in medical journals in the United Kingdom and the United States as early as the 1870s. The legal history of euthanasia dates back at least a century in the United States, with Ohio proposing the first bill to legalize euthanasia in 1906. That measure was not adopted but the movement to allow dignity in death has raged on. In some cases, dignity in death victories have been won. For example, the establishment of a living will and legal protections for doctors who discontinue treatment are two advancements that were implemented as a result of the right-to-die movement in the United States.

Most recently, the American public was introduced to two infamous right-to-die cases: Terri Schiavo and Dr. Kevorkian. Montero (2011) referenced how the American public became familiar with Kevorkian and highlighted other high-profile right-to-die cases as well. He stated, "Public attention to end-of life issues occurred throughout the 1990s with the controversy surrounding Jack Kevorkian, the Michigan doctor who assisted terminally ill patients in taking their lives (Kirk & Sullivan, 1996), and earlier still with the Karen Ann Quinlan and Nancy Cruzan cases, which both involved women in vegetative states like Schiavo (Pence, 2004)" (Montero, 2011, p. 165). Indeed, Dr. Kevorkian was a medical pathologist who rose to infamy during the mid-to-late 1990s after he was tried numerous times for murder as a result of helping patients die through physician-assisted suicide. He was tried a total of five times; the first three trials ended in not guilty verdicts, with the fourth ending in a mistrial. His last trial for the murder of Thomas Youk resulted in a guilty conviction for the charge of second-degree murder.

The Terri Schiavo case was the antithesis of the Dr. Kevorkian case in many ways. First, Dr. Kevorkian, also known as "Dr. Death", helped terminally ill patients end their lives through physician-assisted suicide because he believed in a patient's right to die with dignity. In 1998, Schiavo's husband wanted to end Terri's life by taking her off respirators and having doctors remove her feeding tubes. Her parents vehemently opposed him, citing that she was still conscious, even though numerous doctors had already declared Schiavo brain-dead as early as 1990. In her case, the parents were fighting for the right to keep her alive despite medical evidence that concluded Schiavo was not conscious and did not have the brain capacity to regain consciousness in the foreseeable future.

Euthanasia and end-of-life care are topics that have been controversial for quite some time. Recent legal changes have continued to push this issue to the forefront for the medical

community as well. In the early 1990s, a small group of Oregon citizens formed the Oregon Right to Die committee. The efforts of this group would later give way to the Oregon Death with Dignity Act. Other states had campaigned, unsuccessfully, to implement right-to-die laws. In 1991, a small group of right-to-die supporters in Washington worked to adopt pro end-of-life legislation for their state. In 1992, a group of California citizens did the same. In both cases, the measures were not passed because the general public voted against them. The Oregon Death with Dignity Act was different as its language lacked any calls to legalize euthanasia in the state. Stutsman, an Oregon lawyer and pioneer of the state's Death with Dignity Act, wrote, "We had studied the losses in Washington and California. We learned from those who had gone before us," (Stutsman, 2013, par. 5). Also, Stutsman (2013) discussed how different the parameters for physician-assisted were in his proposed measure, stating:

> "Unlike the recently failed efforts, our proposed measure would not seek to "legalize euthanasia," in loosely defined circumstances. We sought to outlaw Kevorkian's conduct and render Humphry's book unnecessary in Oregon by allowing only a competent, terminally ill adult patient, with a prognosis of six months or less to live, to obtain prescription medications to hasten his or her death, within narrow, tightly defined circumstances," (par. 5).

It is understandable that a terminally ill person would want to forgo a potentially painful and agonizing death by choosing the immediacy of euthanasia over a slow, prolonged death. When prefaced in that manner, most would agree that putting an end to one's suffering is not an outwardly harmful thing to do. However, euthanasia opponents have numerous reasons for their staunch opposition to legalizing the practice. One reason is the "slippery slope" effect that many fear would develop in doctor-patient relationships. Magnuson (2004) described how right-to-die opponents view physician-assisted suicide and the potential ethical complications that can develop. He stated, "To legalise euthanasia is to set in motion a "subtle transformation of ethical sensibility. Over time we become blind to how we once thought". In Manne's view, the criminal

law functions as a kind of "moral dyke": to breach that dyke, even for the sake of competent, suffering patients is ultimately to put other vulnerable classes of patient at risk," (p. 441).

Also, Keown (2002) expanded on the slippery slope notion being a key barrier to legalizing euthanasia. He commented that opposition to euthanasia is rooted in the concern that, "...if VAE/PAS2 were permitted they would not remain voluntary for long, and that patients who did not really want to die, or who were not suffering severely, or whose suffering could be alleviated by palliative medicine, would nevertheless have their lives terminated. Indeed, fear of this 'slippery slope' is proving to be *the* major obstacle to reform," (p. xi).

The aforementioned concept is interesting because it demonstrates that even under the best of patient circumstances, there are potential risks associated with physician-assisted suicide for patients who fall outside of the standard for which the law was written. For example, the Oregon Death with Dignity Act was passed specifically because it addressed the ideal conditions for a terminally ill patient to make the determination to move forward with euthanasia. However, opponents fear that without the presence of a law criminalizing the act of physician-assisted suicide, patients who are least equipped to make a decision regarding their own care would be the most vulnerable.

Religion is another reason why many do not support legalizing right-to-die measures. Traina (1998) discussed specific afterlife beliefs that may cause those affiliated with varying religions to oppose right-to-die initiatives. She wrote, "Buddhists and Hindus believe in reincarnation-a person's earthly life and earthly suffering do not end with the death of her current body...Thus artificially shortening life in order to relieve physical suffering in the short term may actually increase existential suffering in the long term," (Traina, 1998, p. 1148). Even among religions that do not stress the afterlife, like those in the Jewish faith,

there is still an opposition to euthanasia or physician-assisted suicide. In those instances, opposition prevails because of the belief in "God's divine will" for one's life. Choosing to end one's life directly interferes with that will, which is frowned upon on the Jewish (and Christian) community.

While there are many other reasons opponents do not support euthanasia or physician-assisted suicide, the two outlined above are the most commonly stated. As evidenced above, proponents of euthanasia believe in a person's right to die with dignity. In a compilation piece that originally in January 1950, The Nation published experts who argued for and against the legalization of physician-assisted suicide. Proponent Harry Benjamin made the connection between the disparity of animals rights in death when compared to human rights in death. Benjamin (1950) wrote, "It seems inconceivable that in a happier world of the future no provision should be made for putting out of their misery persons suffering from an excessively painful and incurable disease. We shall have to find some legal way to accord to human beings the relief we accord to animals," (par. 1).

Others have argued that euthanasia, like abortion, is a choice issue. They assert that people should have the ability to make a choice about dying in a humane, safe way. Those proponents believe that choice should be made legal by the state. Another way the issue of abortion and euthanasia are likened to each other by proponents is through their belief that deregulation on each issue gives rise to unsafe medical practices. In the 1950s when abortions were illegal in the United States, many unlicensed doctors and "specialists" were performing unsanitary, unsafe and dangerous abortion procedures for anyone who had the cash. In the same way, euthanasia proponents believe there is a growing underground euthanasia community that is bringing unnecessary and dangerous controversy to the subject.

There is indeed an entire underworld of unregulated euthanasia. In 1990, Canadian citizen David Lewis was a man living with HIV who claimed he facilitated assisted suicides for at least eight of his friends, all of whom were living with full-blown AIDS. During that era, AIDS was considered a death sentence due to slow technological advances, minimal treatment options and the fact that very little was known about the pathology of the disease. The story prompted researcher Russel Odgen to find and study the underground euthanasia community in Canada. Proponents of legalized and regulated physician-assisted suicide have valid points about the unsafe nature of underground euthanasia practices. Martindale (2005) interviewed Odgen about his experiences researching the underground right-to-die community and found some disturbing trends. He studied 34 underground euthanasia cases and found that "half were botched and ultimately resulted in increased suffering. In five situations, suffocation was unsuccessful. In one instance, the individual who assisted in the suicide had to resort to shooting the patient--in another, to slitting his wrists with a razor blade. These failed attempts often led to the acts of euthanasia taking several hours or longer to complete…" (Martindale, 2005, par. 4).

Physician-assisted suicide and euthanasia sounds great in theory but presents many issues in practice. Because the process is still largely outlawed in the United States, save for a few states like Oregon with their Dignity in Death Act, it is still a practice that is relegated to the fringes of society. As a result, terminally ill patients and their families are put into difficult situations. If a person helped their family member die on their own terms, they could legally be tried for murder. If they do nothing, they have to witness their loved one deteriorate in hospice, waiting for the inevitable.

This is an issue where animal rights and human rights could overlap. Veterinarians routinely have to safely and humanely "put down" animals and guide the family through the

process. Perhaps as our healthcare system advances, a collaboration between medical doctors who specialize in human patients and those who specialize in treating animals could come together to design a way for euthanasia to work for people. While the concern from opponents is justified, I believe the terminally ill should be able to die on their own terms. No terminally ill person should be forced to live until a natural death claims them. No terminally ill person should have to spend their last days fighting a disease while incurring medical debts that may be passed on to their families. Activists in Oregon are on the right track with the adoption of the Dignity in Death Act.

As the population continues to age, hopefully more doctors and influencers in the medical community can collaborate to design a safe, ethical compromise that will allow patients to die with dignity and give the public enough valid reasons to live with the changes to medical law.

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