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Ethics and Euthanasia

Most doctors take the Hippocratic Oath at some time in their careers. Through this oath, they swear that they will use their knowledge to benefit the sick and work for their fellow human beings (Tyson). This can be looked at several ways but the general meaning behind this oath is that they will try and reduce illness and suffering whenever possible. This combined with ideas that Lauris Kaldjian approached in his book *Practicing Medicine and Ethics: Integrating Wisdom, Conscience, and Goals of Care* can bring up interesting points in regard to physician-assisted suicide. Kaldjian encouraged the idea of a “good life” and doing good for the patient as a basis for how to judge ethical actions and ideas. With these ideas in place, it can be seen that physician-assisted suicide/euthanasia is a morally sound idea in harsh, end-of-life cases when suffering outweighs the possibility of a good life.

Kaldjian stressed human flourishing and the good life when talking about the ethics behind medicine. These ideas are built around the idea of striving for happiness and how it is linked to care and medicine. He mentions the Hastings Center’s four goals of medicine: the prevention of illness and promotion of health, the relief of pain and suffering, providing care, a cure, and/or comfort for those who are ill, and to avoid premature death while pursuing a peaceful death (22).

These four goals are strong goals and can lead to quality care of patients, but they also depict the steps that Kaldjian most likely believes should be taken when providing care to patients. The first step in medicine is always the prevention of illness and promotion of health. In the best cases, people can live long, healthy, happy lives and die at a ripe old age but in other cases even the best care cannot prevent illness. That is when the next step comes up which

involves the relief of pain and suffering and to cure those who can be cured. Finding a treatment and cure that is within reach is always the best option but that, again, is not always there and so maintaining the patient's comfort becomes the best possible solution. That then leads to the final point, prevention of a premature death and promotion of a peaceful death. Doctors generally want their patients to live as long and as happy of lives as possible and do not want patients dying for minimally significant causes. As technology and medicine continues to advance, more people are able to continue living good lives even after diagnosed with terminal illnesses or disabilities that would have previously been a death sentence. There can also come a time, though, when trying to avoid a premature death is not possible while maintaining the comfort of the patient and so it comes down to focusing on promoting a good death with minimal suffering.

This final step is where the possibility of physician-assisted suicide could be of aid. At this point, all the possible steps have been taken to try to cure and then simply comfort the patient and to allow them to lead a life worth living. It is possible that suffering could be minimized by drugs, but it is also possible that the patient can continue to be in great amounts of pain despite the use of medications due to built up tolerances to or how their body metabolizes different compounds. That is when it is a good idea to look at Kaldjian's seven goals of care: to cure, to live longer, to maintain quality of life/independence, to maintain comfort, to achieve life goals, give support to patient's family and caregivers, and to clarify diagnosis/treatment/prognosis of the patient (23).

When it comes to end of life cases, these goals have to be taken into account. These goals of care can serve as a bridge between the patient and practitioner so that practitioners may understand why a patient may choose one treatment over another. These goals could also serve as a guide to what the patient may want from life and to see if it is at all possible in their given

condition. In many cases, these values can be accounted for in some way, being around family or participating in hobbies, all of which could maintain comfort, quality of life, or even allow them to achieve life goals. In other cases, however, it is harder for those goals to be met. If a patient has to be near comatose in order to get relief from their suffering, they may have comfort of some sort, but they have minimal quality of life or independence. This can work for some patients who fear death or value quantity over quality but for patients who want to be able to achieve life goals such as seeing their children get married or traveling, this lack of independence and quality of life could possibly be considered a fate worse than death. There could also be cases of people who are suffering and only have the possibility of living a few more months. They may argue that they do not have much to live for anymore and thus cannot find a logical reason to have to live with their continued suffering. In these cases, along with cases such as those of elderly who have outlived friends, whose family has become distant, or are too disabled to take part in things that make them happy, the question has to be asked; are they flourishing and living a good life or should they be able to end their suffering if that is an option they would wish to have?

The Hippocratic Oath says that physicians will always consider that, at times, “warmth, sympathy, and understanding” can aid more than standard medical practice may be able to achieve. It also says that, faced with the power to take a life, they should remain humble (Tyson). This tells physicians to only reach for extreme treatment when more reasonable ones have failed but to do what is best for the patient, whether that is use medicine, sympathy, or a combination thereof, so that they can live their best possible life. In general, it is the goal of the doctor to reduce the suffering of the patients in their care so that they have the chance to be happy and live a fulfilling life. It is true that medicine has come a far way in being able to do this but there are

still times that medicine is unable to accomplish this goal and so those extreme options shouldn't be completely eliminated.

It can be acknowledged that physicians cannot always eliminate suffering and pain, but they can at least reduce it. This can then allow the patients to continue living a full life. But in some cases, medicine cannot eliminate enough pain or medicine stops working after continued use. In these cases, Kaldjian would say that the physician has to acknowledge the patients' willingness to withstand suffering. Treatments and illnesses can become overly burdensome for patients. This burden could take a physical form, an example being them having to tote around an excess of equipment anytime they want to go somewhere in order to survive. The burden can also take an emotional form, an example being an athletic person suddenly becoming permanently bedridden and unable to follow life goals. When illnesses become overly severe and the likely outcomes of treatments are dim at best, it should be understood that patients may want to let go and stop their suffering if they do not have anything worthwhile to continue their suffering for (26). Given their individual life circumstances with friends and family, it is possible that there is not much keeping them going. Under conditions such as these, a logical case could be made for physician-assisted suicide.

This option is already available to our animal companions in the form of euthanasia. Euthanasia is defined as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (such as persons or domestic animals) in a relatively painless way for reasons of mercy" (Dictionary by Merriam-Webster). By definition euthanasia can be a mercy for these animals who are unable to live a fulfilling life with their families. Animals often will acknowledge when they are done fighting and will stop eating. At times, they can be coaxed back into eating but other times it is simply not possible as their pain had already become too

great. Euthanasia can then offer a more painless option for them to go rather than having them suffer through the pains of starvation. Some people in the veterinary field will often wonder why this same option is not given to the human population.

The option given for humans has been acknowledged as physician-assisted suicide and is often rejected due to the sanctity of life and human dignity. Physician-assisted suicide can be defined as “suicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient's intent” (Dictionary by Merriam-Webster). That is to say that, the painless mercy that has been offered to our suffering animal companions is not available to similarly suffering humans. Some states, however, have legalized physician-assisted suicide under a given set of conditions in part due to its relation to the euthanization of animals and the mercy it can offer for those suffering chronic pain or exceedingly poor foreseen outcomes.

California, Colorado, Montana, Oregon, Vermont, and Washington are all states that have legalized physician-assisted suicide (Assisted Suicide Laws in the United States). Through the legalization of physician-assisted suicide, it became regulated so that there was a direct line of instructions that had to be followed and requirements that would have to be met for the procedure to take part. This effectively limits what a physician can do within the law while maintaining that the patient has the option available to them if they meet the requirements.

As an example, Oregon’s Death with Dignity Act says that only patients above the age of 18 are competent enough to make decisions. They also have to have a terminal illness which limits life expectancy to within 6 months to be able to request physician-assisted suicide (Norman-Eady). This assures that the patient is stable enough to consider all given options and have a

realistic view on what each option offers. It also assures that people will be unable to simply end their life at any time and without a logical, medically relevant reason as to why death was desired and that the act would be intended to reduce suffering that would have had to have been endured had physician-assisted suicide not been an option.

Some people who argue against physician-assisted suicide are opposed due to the idea that it would be outside the rights of what a physician is meant to do. Physicians are meant to help, heal, and do no harm to their patients. Many consider physician-assisted suicide just a fancy term for murder. Murder, however, can be defined as “the crime of unlawfully killing a person especially with malice aforethought” (Dictionary by Merriam-Webster). What should be understood is that the intents behind murder and physician-assisted suicide are very different. The intent behind murder is generally to be malicious, harmful, and/or to increase suffering. On the other hand, physician-assisted suicide is intended as a mercy killing opted for by the patient so as to alleviate their own suffering. It is unlikely that a physician would take joy from aiding in the patient’s suicide and it may even cause them a bit of grief but, overall, it is understood that the patient would stop suffering and friends and family present can have a chance to process their grief and move on. On top of that, it is also impossible for physician-assisted suicide to take place without it being requested by the patient multiple times and having multiple witnesses present so as to maintain that all options are explored, and a single doctor cannot become an “Angle of Death” to patients that they perceive as suffering too much to live.

Another argument put up is that it could take away the chance for the patient to be well again. Technology and medicine have been speeding ahead in the last few decades. It would make sense to believe that a cure for whatever illness is present could potentially be right around the corner. The problem with this line of thinking is that, it isn’t a guarantee. The odds are that it

is more likely the patient will suffer longer with nothing to gain for having waited for this miracle cure. This also involves cases with patients in a coma. Families will hope and pray that the patient will wake up. It is true that some patients will wake up after being in a coma for years, but this is highly unlikely. It is more likely they will remain comatose which could bring excess suffering for their family as they wait and hope their loved one might wake up but never see that come to realization.

A third argument questions why a patient who is tired of suffering could not simply take their own life instead of involving a doctor and getting into the moral/ethical arguments involving them. In some cases, people will do exactly that but there are also numerous reasons why they would prefer to go through a doctor rather than on their own. Three of the biggest reasons involve capability, legality, and suffering. The first involves capability or rather the lack there of. It is possible for a patient to maintain mental sharpness while their body degenerates, an example being Steven Hawking. These people could go through the logical steps and decisions as to whether or not death is the best option but without help, they would be unable to go through with it. The second involves legality. If the patient is financially responsible for another or a loved one would benefit from a life insurance policy, many of these policies will not take effect if the involved party commits suicide. They may be able to end their own suffering, but their family would not gain any aid for the funeral or their own continuation of life. For people who want their families and friends to be able to move on from them, they may find it difficult leaving them with such a burden that would have possibly been prevented. The third reason involves suffering. These people seeking physician-assisted suicide tend to do so out of fear or the desire to end their own suffering. Many options available could potentially increase their suffering before decreasing it. If they decide to stop eating as our animal companions do, they

would end up suffering weeks before they pass as their body metabolizes itself. If they decide to use a firearm, looking down the barrel of a gun alone can be terrifying. On top of that, it is possible to survive such a wound in some cases and that could be even more intimidating for some because then they would have to suffer the consequences of those injuries as well. The same can go for overdosing on medications. It is possible to survive and end up suffering consequences of the attempt. It is also possible that they would not be fully incapacitated as they die and would have to suffer any pain or fear related to such effects.

Legalizing physician-assisted suicide also leads many to worry that it would promote standard suicide or decrease the level of care physician will give to severely ill patients. To date, in states that have legalized physician-assisted suicide, there has not been a relative impact in the number of general suicides (Jones). That is to say that there is neither a positive or negative impact on suicide rates with the legalization of physician-assisted suicide so the fact that it remains illegal in so many states is only harming those who live with extended amounts of suffering. As to the idea that legalizing physician-assisted suicide would decrease the level of care received by patients is unsound due to several points made earlier in this paper. These points would be that physicians generally do not want to lose patients and may grieve with the families and there are regulations put in place to maintain that it is the patient's choice and that options have either not worked or are too burdensome to the patient.

Over all, patients would be able to benefit from the legalization of physician-assisted suicide when it comes down to difficult end of life cases. Physicians devote their lives to promoting health through medicine, technology, and support for their patients and thus do not wish to see their patients suffering. If they have already provided all other options available to them that could allow their patients to continue living a good life and it was not enough, their

care shouldn't have to stop there. We have been willing to give our animal companions a merciful death for some time now, but most states are still unwilling to allow humans the same benefit. People argue that the dignity of life deserves more than just putting someone to sleep but there seems to be very little dignity in someone who slowly loses control of their body, limbs, bowels, and all, or who are suffering such tremendous pain that life feels like a lost cause. That does not seem like a valid dignity that should be held higher than the comfort of those very patients. Some states having legalized physician-assisted suicide shows that it can provide a release for suffering patients without causing increases in general suicides. This also allows for it to be regulated so that only cases that logically lead to physician-assisted suicide as a benefit would partake in it. Most doctors take an oath to care for their patients and promote health and well-being amongst many more things. End of life cases are never easy but physician-assisted suicide can be seen to be morally sound when used to promote the decrease of suffering and an increase in control for the patients in those difficult times.

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