# **Dignified Death as Assisted by Physician**

## Introduction

Physician-assisted death is not a new invention. In ancient Rome and Greece, Strouse (2017) writes, physician-assisted suicide and voluntary euthanasia were a common practice that were used to spare people of high ranks in the society from prolonged suffering. Today, the topic of physician-assisted death has gained prominence in the world of medicine. Steinberg (2017) observed that the publicized deaths assisted by physicians have raised concerns surrounding the ethicality of this practice with reference to the role of medical care to uphold wellness and promote life. With the prevalence of terminal illness, many people are aware of their inevitable deaths, a factor that brings in the debate on the dignity in death.

The purpose of this paper is to analyze the opposing viewpoints that form the basis of the debate on physician aid in dying. Drawing arguments from a consortium of peer-reviewed articles, the discussion reviews the literature, before using this information to analyze the arguments for and against the physician-assisted deaths. Of more significance, the paper presents a logical standpoint that sets to defend my stance on this debate, that the patient has the right to die with dignity and have the assistance of his or her physician and nurses.

## Discussion

In a bid to widen the understanding on the ethical and social issues surrounding physician aid-in-dying, Ward (2017) defined it as a practice in which a physician gives a terminally ill but competent patient a prescription for a lethal medication. This is often done upon a request by the patient, as the patient intends to use the medication to end his or her own life. In many states where the practice is legal, Strouse (2017) noted that the request for physician aid-in-dying is restricted to terminally ill people who have less than six months to live. The prescription by the physician enables the patient to purchase the drug from a pharmacy and take it at their point of comfort.

Prescriptions are not the only method that the practice of physician aid-in-dying is facilitated. According to Carp (2015), euthanasia is the most common method that is used in conducting the practice of physician aid-in-dying. Euthanasia, as defined by Van Norman (2014), refers to the administration of lethal injection or intravenous (IV) drug by the physician, hence the death of a patient after the administration of the drug or injection. On the other hand, life-support termination can be another way through which a patient dies. In this system, a person withdraws the life-sustaining devices with the aim of ending the life of a patient. Life support devices may include the respiratory assistance, or nutrition and water assistance. In the US, physician aid-in-dying is legal in four states, while euthanasia is illegal. However, life support termination is a legal practice in the US, and is a common in the US hospitals.

Physician aid-in-dying is classified as voluntary, involuntary or non-voluntary. Physician aid-in-dying is voluntary when death is hastened or care withdrawn with the consent and request of a competent patient. On the other hand, involuntary physician aid-in-dying occurs when a patient’s death is orchestrated without the expressed wishes of the patient, despite the patient being competent. The involuntary physician aid-in-dying was likened by Orentlicher, Pope and Rich (2014) to murder. In some instances, physician aid-in-dying may be conducted on patients who are incompetent and unable to make any formal request for such action. This is referred to as non-voluntary physician aid-in-dying, where the decision to hasten the death of a patient is reached due to the patient’s inability to participate in the decision.

However, as Muller (2011) explains, differences in terminology have clouded the understanding of people on what is entailed in physician aid-in-dying. Different groups and people use diverse terms to refer to the situation whereby a physician prescribes legal drug to a requesting patient. Whereas some refer to it as physician-assisted suicide (PAS), others use the term physician aid-in-dying (PAD). As Ward (2017) writes, the purpose of requesting the lethal drugs by the patient is the main factor that distinguishes these terms.

For a long while, physician-assisted suicide was a term used to refer to the process of prescribing lethal drugs to a patient with terminal illness. However, with time, a phenomenon arose where patients with mental illness and depression would request for lethal drugs. Such practices called for a distinction in physician aid-in-dying and physician-assisted suicide. Today, physician aid-in-dying refers to the act of helping people with terminal illness to die out of their own consent, while physician-assisted suicide envisages giving help to someone to commit suicide when they are in facing other forms of suffering other than terminal illness.

As Muller (2011) explains, it is important for nurses to understand the role that language plays in determining their position in this debate. As evidenced, the use of either physician aid-in-dying or physician-assisted suicide is a reflection of the ideological support or objection that a person has towards the practice. However, the study by Binder (2016) reiterated the need for honest and open discussions surrounding the issues of ending life with the assistance of a medical practitioner.

From the ethical viewpoint, the topic of physician aid-in-dying continues to be debated. Those in favor of the practice have drafted arguments that portray physician aid-in-dying as ethically permissible, while those on the opposing side of the debate have argued that physician aid-in-dying is unethical as it contradicts the traditional duty of the physicians to preserve life and do no harm. Ethics and social issues are the main constructs upon which the debate on physician aid-in-dying is founded.

The issue of morality in the justification of suicide draws significant relevance to the opposing side of the debate on physician aid-in-dying. According to Varelius (2015), physician aid-in-dying is defined by the end-product of the process, which is death of a patient. While quoting the Kantian view of ethics, the author stated that suicide is viewed as a violation of the moral duty to value and honor rational creatures, including human lives. Therefore, it is the duty of humans to respect life, as the destruction of human life is considered wrong even if it leads to more happiness or improvement in the life of another.

Those who argue against physician aid-in-dying have stated that the practice is ethically impermissible as it violates the religious and secular traditions that define the sanctity of human life. Besides, these arguments have been expounded by the distinction between active and passive death. Physician aid-in-dying has been equated to active killing, which is unjustifiable. This is unlike withholding treatment or the refusal to treatment by the patient, which is passive killing.

The justification of physician aid-in-dying gives rooms for manipulation of the vulnerable populations that lack access to quality healthcare and life support. As O’Rourke, O’Rourke and Hudson (2017) explain, this provision opens doors for the prevalence of abuse as such populations may be pushed into accepting assisted death. Besides, physician aid-in-dying heightens the balance between human life and financial burdens that accrue from the treatment process. Many burdened families may opt to exploit or coerce loved ones into accepting physician aid-in-dying as a strategy to contain the costs of medical treatment.

Physician aid-in-dying brings into contention the professional integrity of physicians (Van Norman, 2014). The public image of the profession is tainted due to the violation of the practice in medicine that binds physicians to a code of conduct that guarantees no harm to the patient. The concern about those opposed to this practice is that professional physicians may use physician aid-in-dying as a way of sidestepping their responsibility to protect lives, hence covering up their negligence and mistakes through the provision of legal termination of a patient’s life.

However, I believe that the moral and social issues arising from the debate do not consider the reality of the issues surrounding the plight of terminally ill patients who have to make the decision to implement physician aid-in-dying. As Clodfelter and Adashi (2016) elucidate, the right of the patient stretches to include decisions about the circumstances and time of death. By being competent, patients should be allowed to exercise their rights to determine the timing and manner of their deaths.

While the opponents of physician aid-in-dying argue that it is ethically impermissible due to its disrespect for the sanctity of life, Steinberg (2017) contradicts their view by claiming that they are blind to the factors that make life valuable. As such, life is valuable in the presence of family, love and good health. Therefore, the practice of physician aid-in-dying does not necessarily demean the sanctity of human life, but considers the pain that a person undergoes in the process of lacking the goods that make life valuable, in this case, health.

Terminal illnesses limit the ability of a person to enjoy life. Competent, terminally ill patients have the legal right to decline treatment that will prolong their death (Orentlicher, Pope and Rich, 2016). The suffering that such illnesses cause to the patient, friends and family supersedes the pain. Therefore, I am in support of the argument that physician aid-in-dying should be upheld, as it draws a clear line between the interest of the state and that of the individual. The dignity of an individual is jeopardized by terminal illnesses that present psychological, social and financial burden to the patient and the family. Physician aid-in-dying is a way of relieving suffering, hence being a compassionate response to the unremitting suffering endured by the patient. Legalization of physician aid-in-dying would enhance open discussions about better care mechanisms in ending the life of competent, terminally ill patients.

## Conclusion

The ability of a person to know that they are going to die within a specified time due to terminal illness often subjects the person to slow, painful and mentally torturous process. While people are entitled to choose the manner in which they die, Orentlicher, Pope and Rich (2016) explains that physician-assisted deaths minimize the painful experiences that such people endure prior to their ultimate death. In conclusion, the debate about physician-aided death presents the ethical standpoint of the role of physicians in promoting life against the right of a patient to choose the manner in which he/she is going to die.

## **References**

Binder, R. (2016). Physician Aid-in-Dying: Role of Psychiatrists. Psychiatric News, 51(1), 1-1. http://dx.doi.org/10.1176/appi.pn.2016.1a1

Carp, F. (2015). Ethical issues in death and dying. Psychology Critiques, 67(8). http://dx.doi.org/10.1037/129836811

Clodfelter, R., & Adashi, E. (2016). The Liberty to Die. JAMA, 315(3), 251. http://dx.doi.org/10.1001/jama.2015.16242

Muller, D. (2011). Attention to Language in a Request for Physician Aid in Dying. American Journal Of Hospice And Palliative Medicine, 28(1), 63-64. http://dx.doi.org/10.1177/1049909110381080

O’Rourke, M., O’Rourke, M., & Hudson, M. (2017). Reasons to Reject Physician Assisted Suicide/Physician Aid in Dying. Journal Of Oncology Practice, 13(10), 683-686. http://dx.doi.org/10.1200/jop.2017.021840

Orentlicher, D., Pope, T., & Rich, B. (2014). The Changing Legal Climate for Physician Aid in Dying.JAMA, 311(19), 1961. http://dx.doi.org/10.1001/jama.2014.4117

Orentlicher, D., Pope, T., & Rich, B. (2016). Clinical Criteria for Physician Aid in Dying. Journal Of Palliative Medicine, 19(3), 259-262. http://dx.doi.org/10.1089/jpm.2015.0092

Steinberg, K. (2017). Is Physician Aid-in-Dying the Way to Go?. Caring For The Ages, 18(8), 2-3. http://dx.doi.org/10.1016/j.carage.2017.07.003

Strouse, T. (2017). End-of-life options and the legal pathways to physician aid in dying. The Journal Of Community And Supportive Oncology, 15(1), 1-3. http://dx.doi.org/10.12788/jcso.0327

Van Norman, G. (2014). Physician aid-in-dying. Current Opinion In Anaesthesiology, 27(2), 177-182. http://dx.doi.org/10.1097/aco.0000000000000046

Varelius, J. (2015). On the Moral Acceptability of Physician-Assisted Dying for Non-Autonomous Psychiatric Patients. Bioethics, 30(4), 227-233. http://dx.doi.org/10.1111/bioe.12182

Ward, J. (2017). Physician Aid in Dying: Caught Between the Extremes. Journal Of Oncology Practice,13(10), 667-669. http://dx.doi.org/10.1200/jop.2017.026377