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Writing 2

19 May 2016

Euthanasia: An Exploration of Attitudes Surrounding Physician-Assisted Suicide in the United States

In 1990, Terri Schiavo suffered a heart attack that deprived oxygen to her brain. This oxygen deprivation caused brain damage that left her in a "persistent vegetative state", and in 1998 her husband Michael Schiavo requested that her feeding tube be removed. When Schiavo's parents refused to allow her daughter to be killed, a legal argument ensued, with the issue revolving around Schiavo's right to die and her husband's right to remove her feeding tube. The issue grew into a large national debate, with federal legislation being passed in favor of Schiavo's life. Schiavo's parents fought strongly in order to keep their daughter alive, however the state court decided that the feeding tube will be removed by request of Schiavo's husband, and she died in March of 2005 (Marcovitz). This case brought to light the importance of end-of-life care, bringing attention to physician-assisted suicide and euthanasia. The etymology of euthanasia can be traced to its Greek roots, *Eu* and *Thanatosis* meaning "good death". In today's society, euthanasia is related to the assisted suicide of someone, which can be done directly or indirectly. Euthanasia has existed in the United States since the start of the 20th Century, with many publications and efforts to regulate it. It is defined as the act when a physician intentionally kills a person at the voluntary request of the patient (Radbruch). However, other definitions exist that broaden the scope of euthanasia to active, passive, voluntary and involuntary euthanasia, all being different types of euthanasia. Since euthanasia is such an important topic in the healthcare

environment, many views and opinions exist on the matter. Although there is legitimate opposition towards euthanasia because it violates the traditional role of a physician, the moral and logical arguments for its support demonstrates that euthanasia should be legal, but with heavy regulations in place.

The Hippocratic Oath plays a major role in the arguments against euthanasia, for it sets a definition for the responsibilities of the modern doctor. The Hippocratic Oath is the oath taken by physician's and holds the American Medical Association's Code of Ethics. The ethical guidelines set by the Hippocratic Oath is the basis of the physician's moral decisions and sets a clear definition for the role of a physician. The classical version of the Hippocratic Oath, in one line, states, "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect" ("Bioethics"). To uphold the Hippocratic Oath, physician's must be able to protect patient's life by not allowing them to take deadly drugs nor having it as an option to patient's. However, in the modern Hippocratic Oath, this statement has been removed. In its place, it states, "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick" ("Bioethics"). In modern times, the Hippocratic Oath has been adapted and asks doctors to consider the family of patients and remember that they are treating human beings and not an illness. This introduction of morality into doctor's behavior is an argument to show that although not explicitly mentioned in the modern Hippocratic oath, doctors should still not suggest death to a patient or bring it about them. However, it provides leeway for those instances where a patient's death is the best possible outcome for the patient and their family, and by being able to

provide that, doctors are still preserving the promise they have taken. The concepts within the Hippocratic Oath are pivotal points for the opposition of euthanasia.

Those opposed to euthanasia have a simple belief that humans don't have the right to kill others, no matter the reason, an idea originating from the Hippocratic Oath for physicians. In arguments against euthanasia, the clause mentioned previously in the classical Hippocratic Oath is addressed. Leon Kass published an essay examining the ethics of active euthanasia, touching on topics such as "mercy"-killing and being humane. While discussing the Hippocratic Oath, he writes:

> In forswearing the giving of poison, the physician recognizes and restrains the godlike power he wields over patients, mindful that his drugs can both cure and kill. But in forswearing the giving of poison when asked for it, the Hippocratic physician rejects the view that the patient's choice for death can make killing him right. For the physician, at least, human life in living bodies commands respect and reverence--by its very nature. As its respectability does not depend upon human agreement or patient consent, revocation of one's consent to live does not deprive one's living body of respectability. The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and, therefore, also what the Oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he cannot choose what physicianship means (Kass 38).

In Kass's essay, he begins by separating human life from human autonomy, stating how the physician's role is focused on respecting human life rather than freedom of choice of the patient. He states that the ethics doctors hold do not deal with autonomy of the patient or from

compassion and morals, but from the mystery of life. The concept that life is a mystery which we lack a proper understanding of exemplifies the practice of medicine as an art that physicians are committed to. The distinction made between human life and human autonomy is the major difference in the debate on euthanasia. Those who support euthanasia believe in the right to die and give precedence to human autonomy while the opposition choose human life élite. Due to this belief, the ethical importance of the mystery of life in relation to the Hippocratic Oath shows that people don't have any justifiable right to take away human life. The great respect physicians hold towards human life helps to understand the relationship between physicians and patients better.

Ethical arguments for the support of euthanasia deal with identifying the role of a physician, as well as the importance of a physician-patient relationship. Dr. Prediman K. Shah, the Director of Clinical Cardiology at Cedars-Sinai Medical Center in Beverly Hills, provided a firsthand perspective on euthanasia during an interview. When asked about his stance on the topic of euthanasia he stated:

> I am not a fan of [euthanasia]. Because physicians are supposed to preserve life and prevent suffering, but not terminate life. Fundamentally in principle, I am opposed to physicians participating in the demise of a patient. Obviously, there is a lot of controversy about this, because one additional attribute of a physician is to prevent suffering. And if you have somebody who is suffering from a terminal illness, could you ethically justify the hastening of their demise? I personally would not participate in that, but I could certainly sympathize and understand how others might feel differently (Shah).

In his response, Shah showed his opposition to euthanasia based on the ideas expressed in the Hippocratic Oath. The belief that physicians are held responsible for the life of humans places

immense value on the patient and physician relationship. This relationship is very important, as people look to doctors for answers to all of their health-related problems and concerns. In addition, ethics play a major role in the physician-patient relationship and Shah makes a point to ask if there is ethical justification for accelerating someone's death. Moreover, Shah helps provide a simple definition for the role of the physician, modeled from the Hippocratic Oath. Theoretically, the two important onuses of a physician are to preserve life and alleviate suffering. If a physician does not uphold these two obligations, then he has gone against the Hippocratic Oath, his role as a physician, and has breached the trust in the physician-patient relationship. Therefore, arguments against euthanasia bring focus on the physician-patient relationship for if doctors are able to kill, how can they be trusted to keep someone alive? In addition, if death is hastened often, it could cause doctors to lose their sense of compassion towards their patient, which in turn can bring about more death. While the physician-patient relationship is of importance in the argument for euthanasia, the mystery of life is another topic derived from the Hippocratic Oath.

In modern society, the scientific advances in medicine and anatomy has boomed, yet despite this, human life remains a mystery. When asked about his experiences with euthanasia, Dr. Shah shared an anecdote from his early career:

> I had a very interesting experience of a Hispanic women in her fifties with heart failure in terminal condition in our ICU. And I was sitting by her bedside with her family, and she was in a terminal state and she stopped breathing, and her heart slowed down, heart stopped and there wasn't much we could do standing there. And literally ten minutes later, while we were explaining to the family what had happened, she suddenly woke up again, started breathing again, and came back with a pulse. She lived for at least another

> hour or so, before finally, passed away. It was a very striking experience because I witnessed death, or what I thought was death, but in a few minutes the patient was alive again. It was a very unusual occurrence. And that reinforced in me the feeling that you cannot actively participate in hastening the demise, because you'll never know what's going to happen […] The whole family was there and they were ready to pull the cover over her. It was unbelievable. We don't understand life as much as we think we do (Shah).

In medicine, the Lazarus phenomenon is a reality that is seen rarely but has been confirmed (Adhiyaman). Shah's experience with the Lazarus phenomenon sheds light on the mystery of life. Witnessing the death of someone, yet have them come back to life illustrates that life and death are fluid, uncontrollable and mysterious. By ending life early, humans take control over the natural process of death, despite the lack of understanding of it. It reinforces the idea that no has the right to kill someone, because life is not truly understood. The accepted view of life and death is very polar, yet it is experiences such as Shah's and the Lazarus phenomenon that emphasize the enigmatic nature of life. Consequently, while debating against euthanasia, the mystery of life is a pathos appeal and helps doctors make an ethical decision against euthanasia. By interfering with natural processes and taking control over the death of someone, doctors have made decisions that cannot be ethically justified nor can be upheld by the original Hippocratic Oath. For this reason, arguments against euthanasia are founded upon the respect towards human life and by holding doctor's accountable in their practice. Although the arguments against euthanasia are clear, the support for euthanasia argue very strong points.

The arguments for the support of euthanasia stem from a basic idea that everyone has the right to die. In an Amicus Brief for *Vicco v. Quill* in 1996, the right to die is addressed by the

American Civil Liberties Union (ACLU) who say, “The exercise of this right is as central to personal autonomy and bodily integrity as rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment” (ACLU Brief). In this brief, the ACLU compare the right to death to every other right that Americans have, including refusal of medical assistance, a right that has been in place since the early 2000s (Standler). It logically claims that if people have the right to refuse medical treatment, then they should also have the right to die. Personal autonomy is a right that is protected by the 14th amendment, and the right to die is a form of personal autonomy that should also be protected. In addition to the logical arguments for the right to die, there are moral aspects surrounding the right to death. The national outrage over the case that took the life of Terri Schiavo presented multiple perspectives on end-of-life cases, euthanasia, and the right to die. The arguments for the support of euthanasia and the right to die deal directly with those whose quality of life have been crippled. The controversy surrounding Miss Schiavo’s death originated from the claim that she did not want to be kept alive artificially prior to her heart attack. What protected her right to die was the parent’s inability to provide evidence to counter the claim, and despite the legislation passed in Schiavo’s favor and the public’s heavy support for her life, she was given the right to die. Although a legal debate by nature, the lessons to be taken from the Schiavo case are moral and ethical. It brought to light the importance of end-of-life care, and in a New York Times article, the author states, “the name Schiavo is virtually a synonym for epic questions about when life ends and who gets to make that determination” (Haberman). In essence, the Schiavo case begged questions to the public about when is it morally acceptable to allow someone to die, and how quality of life plays a

factor into that answer. Even though there is support for the right to die, there is also heavy opposition.

The idea that individuals have the right to die is an argument that helps justify the act of euthanasia. In response to legal debate about euthanasia and the right to die, the New York State Task Force on Life and Law was formed, and published the report *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context.* Within the report, it was stated: "The fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns. The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity […] which [is] flatly inconsistent with society's basic conception of personal dignity[...]. Restrictions on suicide[...]simply prevent individuals from intervening in the natural process of dying" (When Death). The argument against the right to die makes a clear distinction between refusal of treatment and assistance in suicide. Moreover, granting people the right to die allows for artificial processes of dying, and takes away from the natural occurrence of death, and the allowing of phenomena and "miracles" such as the Lazarus effect. Under the concept that life is not fully understood, the prevention of assisted suicide allows the natural process of death to happen, without human interference. During the consideration for the *Pain Relief Promotion Act of 1999*, which did not pass the Senate, Dr. Tom Coburn MD, asks if, "we want doctors deciding who lives and who dies? No, we do not want that. This is a slope, a real slope where we are going to become God. We do not have that power" (Providing). In a religious argument, Coburn shows that the power to take life is godly, and is not a power possessed by humans. Additionally, the concept that human life naturally gains respectability exhorts a sense of humility while dealing with life and death. Due to the sanctity of life, it is inequitable to allow the freedom to

terminate life. Coburn makes the argument by bringing in a religious belief, claiming that doctors will become Gods. The belief that doctors will become gods among men if given the power to kill creates a distortion in the physician-patient relationship, tying together the basic arguments against euthanasia. Although the two sides have clear positions, the practice of euthanasia is wide spread in medicine today.

In many places around the world, euthanasia is already legalized and practiced in hospitals. The statistical data about deaths from euthanasia is available, and can provide a basis for how it should be dealt with in the United States. In a white paper from the European Association for Palliative Care, a comprehensive data table (**Table I**) provides a glance at the popularity of euthanasia as a treatment option. In the United States, only two states have legalized euthanasia as a treatment option for patients.

Table 1. Prevalence of euthanasia and physician-assisted suicide in countries with legislation allowing these practices.

Country	Year	Deaths	Percentage of all deaths
United States			
Oregon[7]	1998	16 (24 people with prescriptions)	
	2014	105 (155 people with prescriptions)	0.31
Washington[8]	2009	36 (63 people with prescriptions)	
	2013	119 (173 people with prescriptions)	0.23
Vermont		n.a.	
Montana		n.a.	
California		n.a.	
New Mexico		n.a.	
New Jersey		n.a.	
Switzerland	2009[9]	Approx. 300	0.48
	2010[10]	353 (slow increase in the last decade)[9]	0.56
The Netherlands	2001[11]	All	2.6
		Without explicit request of the patient	0.7
	2005[11]	All	1.7
		Without explicit request from the patient	0.4
	2010[11]	All	2.8
		Without explicit request from the patient	0.2
	2014[12]	4188	
	2015[12]	4829	3.4
		4501 euthanasia	3.2
		286 physician-assisted suicide	0.2
		42 both	<0.1
Belgium	2003[13]	235	
	2011[13]	1133	
	2012[14]	1432	
	2013[14]	1807	1.7
		1454 in Flanders	
		353 in Wallonia	
	2013[15]	Physician survey in Flanders	4.6
Luxemburg	2011–2012[16]	14	0.18

n. a.: not available.

Table I from Radbruch, Lukas, et. al. "Euthanasia and Physician-assisted Suicide: A white paper from the European Association for Palliative Care" 2016

In the Netherlands, a policy was passed that allowed physicians to perform euthanasia on patients, thus all deaths from euthanasia between 2001 and 2010 were covered under the new policy (Radbruch). An obvious trend in countries such as Belgium and the Netherlands is the increase in number of deaths. This suggests that euthanasia, if offered as a treatment, will become a more popular option for patients. However, patient acceptance of euthanasia differs from physicians' willingness to accept, offer or perform euthanasia as a treatment option. A study focused on the attitudes towards euthanasia in a medical context which provided seven vignettes to physicians and psychiatrists to gauge the acceptance of euthanasia. The seven vignettes outlined a situation where a patient was offered euthanasia or was requested by the patient. While physicians were generally against, psychiatrist's views were slightly lenient (Levy). It was stated in the journal, "The very concepts of autonomy and voluntariness in the context of psychiatric illness engender difficult ethical and philosophical questions. It could also be possible that preoccupation by psychiatrists regarding failed treatment for depression (leading to suicide) may also have resulted in such a conservative approach to physician assisted-suicide" (Levy). The attitude towards euthanasia by psychiatrist was very conservative while physicians were obviously on the opposite spectrum. In the overall debate for euthanasia, the numbers provided by the studies help to better understand how euthanasia is perceived worldwide in order to better deal with euthanasia in the United States. In addition to euthanasia being practiced worldwide, passive euthanasia and alternatives are commonly seen today.

Passive euthanasia and euthanasia alternatives are frequently seen in practice today, which include palliative sedation as well as Do-Not-Resuscitate Orders. In hospitals nationally, Do-Not-Resuscitate (DNR) Orders are a common practice and are by definition a form of passive

euthanasia. A DNR order is defined as, “written instructions from a physician telling health care providers not to perform Cardiopulmonary Resuscitation (CPR)” (Understanding). In an emergency situation where CPR is needed, health professionals will automatically begin resuscitation. However, patients with DNR Orders in place will not receive resuscitation due to the costly effects of it on the patient. The consequences outweigh the benefits, and the patient is allowed to die. This falls under passive euthanasia for health professionals withhold life-saving treatment and allow the patient to die. Another example of passive euthanasia is palliative sedation. Palliative sedation is defined as, “the use of medications to induce decreased or absent awareness in order to relieve otherwise intractable suffering at the end of life” (Olsen). Palliative sedation falls under the form of palliative care, an alternative to euthanasia offered to patients. Palliative care tends to target the symptoms of diseases rather than the underlying cause. In the debate on euthanasia, palliative sedation is a controversy due to the belief that it tends to hasten death in some cases. In an article exploring the ethics of palliative sedation, it was stated that, “Distinguishing PS from physician-assisted suicide and euthanasia calls on the ethical principles of beneficence (duty to alleviate suffering) and non-maleficence (duty to prevent or avoid harm). Palliative sedation differs from physician-assisted suicide and euthanasia by intent and outcome” (Olsen). In this article, the Hippocratic Oath of physician’s is referred to once more as an ethical guideline. In this case, the division of palliative sedation and physician-assisted suicide deals with the intention of the doctor. A physician who intends to sedate the patient for relief of suffering has made a different ethical decision then the physician who chooses to inject a patient with the intention of killing them. It is through this distinction that palliative sedation has become a more accepted form of treatment. However, despite the existence of euthanasia alternatives, some states have legalized physician assisted suicide.

In Oregon and Washington, physician-assisted suicide has been legalized and practiced as a form of treatment for patients. In 1994, the Death with Dignity Act was passed in Oregon, which made it the first state to legalize physician-assisted suicide in the U.S. The Death with Dignity Act is defined as, "an end-of-life option that allows certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified manner" (FAQ). This end-of-life option provides euthanasia to patients as form of treatment, however the act only allows physician-assisted suicide. Although the Death with Dignity Act provides new treatment options for patients, it also lacks the ability to cover all suffering patients. Patients such as Terri Schiavo would not have benefitted from the act, and would still have had to suffer. In an effort to provide legislation on the matter of euthanasia, progress has been made. Oregon and Washington have passed the Death with Dignity Act, with 80% acceptance as opposed to 51% when it first passed (FAQ). Yet, the debate continues for despite the benefits of the act, it lacks a comprehensive solution that meets the middle ground.

Euthanasia in practice violates the role of a physician, hence the opposition towards euthanasia, however the arguments for its support suggest that euthanasia should be legal, but with heavy regulation in place. With Death with Dignity Acts legalized in two states, progressed has been made towards the legalization of euthanasia, however it is still important to focus on the regulation. Euthanasia violates the fundamental purpose of doctors, and until legislation is able to preserve the role while allowing euthanasia to take place, the debate will continue. Alternatives to euthanasia are always proposed and practiced, however with many patients requesting to be killed, it is important to be able to have legal room to support moral and ethical judgements. While the demand for doctors exists, the role of the physician and the physician-

patient relationship must be protected. However, as long as people have the right to live, they also have the right to die, and with that legislation should strive to protect both. Euthanasia should be legalized, but with clear regulations to allow the best possible outcome for every patient, without anyone being wronged and without anyone possessing too much power.

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