A NEW JUSTIFICATION FOR PHYSICIAN-ASSISTED SUICIDE

By

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**Introduction**

The topics of physician-assisted suicide (PAS) and euthanasia have become incredibly heated issues in moral philosophy over the past two decades. The debate really became a topic of public interest in the early 1990s when Oregon was considering whether to legalize PAS. After the bill to legalize PAS was finally passed in 1997, the debate regarding the morality of PAS was no longer in the public eye quite as much, but it has still been an important topic of contention. In this paper, I will present a new case for in favor of legalizing assisted suicide. First, I will argue against a consequentialist anti-PAS position by drawing on a decade of data from Oregon that shows that none of the fears of legalization have actually been realized. I will then proceed to discuss the intrinsic morality of PAS and present a new justification for PAS designed to soundly refute one of the most important voices on the opposing side of the debate. Finally, I will discuss the topic of doctors and their role in PAS; I will show that they are not necessary in the final killing steps, which should allay many worries of the opposition, who often argue not that assisted suicide is necessarily immoral, but that doctors just should not be involved.

**The Consequentialist Argument**

When considering a case for physician-assisted suicide, one must first consider some of the past arguments against it. In the nineteen-nineties, numerous people argued against the idea of PAS and in many instances they presented explicitly consequentialist arguments regarding what would happen if PAS were ever legalized. Some of these arguments were theoretical at the time; however, since the Oregon Death with Dignity Act has now been in place for over ten years, there is over a decade of data which we can draw upon in order to analyze some of the claims made against the legalization of PAS.
The primary consequentialist argument made by opponents to PAS such as Leon Kass is that doctors will inevitably start killing the wrong people. Kass grants that euthanasia or PAS might seem like a good idea in principle in that it helps preserve people’s autonomy and prevent suffering. But he maintains that it will inevitably be abused if it is legalized. He argues that although the group of people who are typically supposed to participate in PAS are terminally ill patients who volitionally ask for it, it will certainly be used on people who do not actually want to end their lives, but will be influenced by their doctors or families into doing so. He argues that abuse is an unavoidable result and will occur whether or not it is intentional (Kass, 24).

Other opponents, such as Felicia Cohn and Joanne Lynn, make a similar, but more focused argument. They maintain that specific “vulnerable groups” will be especially susceptible to abuse. They argue that “poor people” and “the elderly” would feel great pressure to participate in PAS for a variety of reasons. Specifically, end-of-life care is incredibly expensive and people from both of these groups would feel that their illness is imposing an undue burden on their family members. As a result, they would choose PAS not out of any desire of their own to end their lives, but out of an effort to assist their family. No one should feel the pressure to kill himself solely to aid his family’s financial burden and therefore this objection presents a clear reason why one would reject PAS.

One issue that none of the consequentialist opponents adequately take account of is that someone could raise the same objections to the withdrawal of life-support as they could to physician-assisted suicide. Kass and other objectors find withdrawing life-support to be a perfectly acceptable form of treatment, but they do not even consider the fact that the same negative outcomes they felt were inevitable with physician-assisted suicide would then also be inevitable in withdrawing life-support. A patient could just as easily be persuaded to withdraw life-support as they could to participate in physician-assisted suicide, so it seems as if the
consequentialist argument against the legalization of PAS commits one to being opposed to the withdrawal of life-support as well. These arguments were once used to oppose the withdrawal of life-support, but after many years the practice is now considered a legitimate medical option and these considerations are no longer salient. It should be noted here that many opponents differentiate between these two cases based on the principle of double-effect. Such a line of thought, however, is based on a view of intrinsic moral principle and not on consequences, so I will not be discussing it here. I will discuss the argument from the principle of double-effect in a later section of the paper.

The above consequentialist arguments regarding the possibilities of killing the wrong people and vulnerable groups are seemingly legitimate objections to physician-assisted suicide. Yet did either consequence actually occur when PAS was legalized in Oregon? The evidence suggests that abuses in the form of those cited by Kass, Cohn and Lynn did not actually occur when PAS was legalized and practiced.

First, the requirements of the Oregon law itself seemingly prevent the types of abuses that Kass discussed. There are significant measures taken in the bill in order to help prevent abuses and make it relatively difficult to actually obtain the medication. For example, one of the requirements states that there must be two witnesses present when a patient makes the written request for the medication. Furthermore, one of the witnesses must not be a relative of the patient, a person who is denoted in the patient’s will, nor a person who works at the hospital. This stipulation is obviously in place to prevent against the very types of abuse that Kass was discussing. It is trying to assure that someone will be present who would have no reason to influence the patient’s decision towards death and can verify that no coercion was occurring. Strict regulations such as these are a significant measure in preventing the very abuse that concerned Kass. Opponents of PAS might suggest that the coercion will be much more subtle in
that patients will feel pressure to undergo PAS even without outside pressure. Yet this should also be a concern for anybody in support of allowing people to withdraw life-support because patients could feel equally as pressured in those situations. Therefore, for opponents like Kass, this subtle coercion should not pose an issue because they are also in support of allowing the withdrawal of life-support.

In spite of the facts regarding the bill, Kass would still probably claim that abuse was inevitable in spite of the well-intentioned restrictions of the bill. Upon reviewing the statistics of who actually used PAS in accordance with the Oregon law, we can see that we do not have any evidence that these abuses occurred. First, it should be noted that very few people have actually used the Oregon bill since it passed in 1998. In the ten years between 1998 and 2007, only 546 prescriptions were written and of those prescriptions, only 341 people actually took the drug. When we compare this to the 296,558 total deaths from all causes in that same ten year span we can see how small of a percentage used physician-assisted suicide. These data alone provides a significant counter-argument to Kass because he seemed to think that a significant percentage of the population would be committing suicide every year, but in fact it has proven to be a very small percentage of the population.

The case in favor of physician-assisted suicide is further bolstered when considering the argument regarding negative treatment of “vulnerable” groups. There are actually a variety of studies which seem to prove that these groups have not been pressured into using this type of medication. First, let me define what I mean by “vulnerable” groups. These would be any groups that would have some reason to participate in physician-assisted suicide for reasons other than just a lack of desire to continue living. For example, the poor are often considered vulnerable in this situation because they might want physician-assisted suicide to reduce the financial burden on their family. The elderly are also often considered vulnerable for similar reasons as the poor,
but also because people judge them to be easily influenced. Other groups such as women and racial minorities are also considered vulnerable due to the prejudice against them in the past. Finally, illnesses that historically hold certain stigmas, such as AIDS, should also probably be considered for completeness’ sake, even though most of these groups really would no longer be considered “vulnerable.”

One study that analyzed all of these groups and more showed that the practice of physician-assisted suicide did not seem to be disproportionately used by “vulnerable” groups whatsoever. As a whole, “vulnerable” groups did not display disproportionate use of physician-assisted suicide and the only group who showed any sort of disproportionate use was AIDS patients (Battin, et. al 594). Considering the facts that AIDS patients are only labeled as “vulnerable” due to an out-of-date stigma, it is easily arguable that no actual vulnerable groups seems to be abused by the legalization of PAS. The vast majority of people who did use PAS were white, college-educated, city residents. Furthermore, the most Death with Dignity Act deaths occurred in the 55-84 age-range; but the highest ratio when comparing DWDA deaths to total deaths in Oregon is found in the 18-34 age range (Hedberg, et. al 125). This demographic is almost certainly not a “vulnerable” group and the fact that almost all of the participants fall into this category further bolsters the argument that concerns about abuse have not been vindicated.

The only worrisome statistic found in all of the data regarding PAS in Oregon is the lack of psychiatric evaluations performed on patients who asked for the treatment (Hedberg, et. al 130-1). Opponents to physician-assisted suicide would argue that a lack of psychiatric evaluation would lead to a higher likelihood of abuse of psychologically unstable patients. According to the Oregon law, doctors are not actually required to ask for a psychiatric evaluation unless they feel that the patient is in need of counseling. One could argue that doctors should be required to
request such evaluations in order to prevent abuse. Yet if one were to argue for this requirement in the case of PAS, they would also be committed to argue for this requirement in the case of withdrawal of life-support. One could just as easily be swayed by psychiatric illness when requesting to withdraw their life-support as they could when requesting physician-assisted suicide. Considering that both treatments result in the death of the patient, the requirements should be similar for both. Since we do not seem to find psychiatric illness a sufficient concern to outlaw the withdrawal of life-support, it does not seem as if there is sufficient consequentialist justification to call for higher psychiatric standards in PAS.

Another concern is that a patient could easily be deemed competent and still have motives that many would consider unacceptable. A person would not have to be incompetent to be influenced by family members or to be concerned about their family’s financial status. This could be viewed as yet another reason why physician-assisted suicide should not be legalized. But this argument could easily be made in the case of withdrawal of life-support as well. We do not know the real motive behind a patient’s decision to withdraw life-support and it could easily be something like pressure from a family member. Yet we do not see this as a sufficient reason to remove this as a valid end-of-life option, so we cannot see this as a sufficient reason to remove physician-assisted suicide as a valid treatment option.

The real consideration in this situation is what should really fall under the legal spectrum. Should the law be able to dictate what medical treatment a person is allowed to receive solely based on their motives? Consenting to this would be equivalent to the law saying that people are not allowed to lie in their everyday lives. Although some may consider it to be a good idea in theory, it just does not fall under the duty of the law. It seems reasonable to say that a person’s motives are her own and the law really should not hold much power of them.
Even though the statistical evidence greatly favors the legalization of PAS, some might say that all of this is insufficient. One could easily say that although the evidence argues against rampant abuse, it would be very easy for a single patient to be abused once in a while and we would not necessarily have evidence of it. One could further argue that due to this possibility, PAS should be illegal because the death of one unduly pressured patient is a great enough evil that it is not worth allowing others to have it as a legal option. This person would be correct in arguing that rare instances of abuse could possibly occur; but I would argue that this is not a sufficient reason to disallow the rest of the people, those who are not being abused, from having some sort of comfort in their final days.

This could easily be compared to the idea of guilt and innocence in court cases. There is always the potential that an innocent person could be convicted, so the only way to absolutely ensure than no innocent people are punished would be to convict nobody. This, however, would be absurd. An opponent of PAS might argue that this is not a perfectly analogous case due to the issue of reversibility. The decisions of court cases can typically be reversed, whereas the decision of physician-assisted suicide cannot be reversed. So, the only court case decision that would actually be completely analogous would be death penalty cases because those remove the rest of your life.

If one is against the idea of the death penalty, a better example would be to compare the issue of PAS to the issue of road speeds. If all roads, including highways, had a strictly enforced speed limit of thirty miles per hour, there would be fewer road fatalities. Yet due to society holding other values than just safety, we are willing to risk a few more deaths in favor of speed, timeliness, and other factors. So, it would seem reasonable that if we are willing to risk higher death rates in favor of timeliness, we should also be willing to risk a rare case of abuse in order to bring comfort to hundreds of people at the ends of their life.
It is here that I would like to discuss the principle of double-effect. This principle states something relatively simple: one can commit an action that has both a positive and a negative outcome as long as the good outcome is intended. Objectors to PAS argue that there is a significant difference between withdrawal of life support and PAS in that the actual goal of withdrawal is not to kill the patient although it is a foreseeable negative outcome, whereas the primary goal of PAS is actually to kill the patient. There are a couple problems with this argument. First, if we are to accept the objection from the doctrine of double-effect as legitimate, it seems that the primary goal of both withdrawal and PAS is to help a patient who feels their quality of life has become so low that it is no longer worth living. This shows that in both instances, the physician is actually aiming for a positive outcome and the death of the patient is just a foreseeable, but acceptable negative outcome.

The other problem with the objection from the doctrine of double effect is that it solely views morality from a non-consequentialist moral perspective and does not take the consequences into account. We cannot only view PAS from a deontological perspective, but practical consequences must be taken into consideration as well. The practical consequences of withdrawal and of PAS are the same because in both instances, be it through inaction or through prescription, a doctor willingly and knowingly helps bring a patient to death. It cannot only be about intentions because one can have great intentions and still commit actions many would consider morally reprehensible. Therefore, the doctrine of double effect, with appeals to intention and not to consequences, is ineffective in providing any real, practical distinction between withdrawal and PAS.

What would make someone argue against PAS from a consequentialist perspective considering that the Oregon experience seems to be decisive evidence that the negative consequences feared have not come to pass? Specifically, what would make someone oppose
PAS while still considering withdrawal of life-support to be a legitimate option? The basic
difference between the two treatment options is that PAS kills someone as a result of third-party
action whereas withdrawal of life-support kills someone as a result of inaction. Yet this really
does not seem to be a significant difference with regard to the worry about death as a result of
undue influence. Both result in the expected death of the patient as the result of an agreement
between the doctor and the patient. Therefore, due to all the evidence displaying lack of abuse
and the lack of relevant consequentialist differences between PAS and withdrawal of life-
support, it is only logical that consequentialist issues should not prevent PAS from being
considered a valid treatment option.

The Moral Argument

Having shown that the consequentialist arguments should not prohibit the legalization of
PAS, we must now consider the innate morality of the issue. It is not enough to say that nothing
bad happened; we must make sure that this is not a deplorable practice from a non-
consequentialist moral position as well. One of the best arguments presented against physician-
assisted suicide was given by Daniel Callahan in the early nineties in which he attacks the basic
arguments used to justify PAS.

Callahan presents an attack on physician-assisted suicide by arguing that the supporting
case is based on a faulty reasoning. He starts by saying that there are two basic arguments used
to support PAS: the argument based on autonomy and the argument based on mercy. He then
states that there are problems with each argument when viewed individually. If one was solely to
present a case for PAS based on autonomy it seems that patients would then be allowed to
receive PAS solely out of a desire to commit suicide. If one were to argue for PAS solely based
on mercy, it seems that doctors would then be allowed, if not required, to kill suffering patients
even if they were incompetent or did not want PAS. In a typical supporting case for PAS, such as
the one exemplified in the Oregon law, these two aspects are presented together in that the
patient must both be terminally ill and competent. The reason to join the arguments is obvious:
when used in conjunction they prevent abuses such as the ones stated above. Callahan claims,
however, that there is really no reason for the arguments to be considered together and that as a
result their conjunction is completely arbitrary.

Callahan states that each could be used to justify PAS, but each also has its own negative,
unavoidable and morally repugnant consequences. He says that “each has its own logic, and each
could be used to justify euthanasia and physician-assisted suicide. But that logic, it seems
evident, offers little resistance to denying any competent person the right to be killed, sick or not,
and little resistance to killing those who are not competent, so long as there is good reason to
believe they are suffering” (Callahan 63). Callahan is presenting a reductio ad absurdum by
saying that if you find any justificatory force in either of the arguments, you are then committed
to finding it acceptable to kill these other groups of people. Yet since we obviously cannot find it
acceptable to enact PAS on the incompetent or the perfectly healthy, we cannot find it acceptable
to allow its use in any case. He says that although joining the two reasons does solve this
problem of abuse, there is no logical reason whatsoever to connect them other than to help justify
PAS.

One could pose the counterargument that this is just a situation of two necessary but
individually insufficient conditions. A similar argument could be made in the case of a teacher
grading papers. If a teacher is to give a student a perfect score on a test, it seems that there are
two primary considerations: first, the test must have no mistakes; second, the student must not
have cheated. Neither of these conditions is sufficient on its own to merit a perfect score, but
together they will get the student the desired grade. This is similar to the case of PAS because
neither condition is sufficient on its own, but together they give the patient both relief and autonomy without having horrible consequences.

Unfortunately, something seems to be amiss with the above counterargument because these situations really do not feel analogous. Callahan actually does seem to be correct in his statement that justifications from autonomy and mercy are not naturally linked. Yet in the case of the teacher, there does seem to be some organic connection between a test with no mistakes and a test that the student did not cheat on. The reason for this connection can be easily explained by considering the epistemological difference between evidence and defeaters. The easiest way to explain this distinction is through example. If a close friend were to tell you a piece of information, you would consider a few things as evidence as to whether or not what he is telling you is the truth. You would consider whether he seems sincere, whether he is known to lie, and other such factors and upon determining that he is a trustworthy friend who seems sincere, you would believe what he is telling you to be a truthful statement. These reasons are considered evidence. If you then learned that this friend was under pressure from the mob to tell you a lie, however, you would then no longer believe him. This would be considered a defeater.

Furthermore, despite the fact that there was an extenuating circumstance in this instance, it is unlikely that you would begin to think of “he’s not under pressure from the mob” as a normal consideration when evaluating the veracity of a person’s statement. There is an endless supply of defeaters for any one situation, so we do not consider them all; we only consider what we deem to be positive evidence. In the case of the teacher, the fact that the student made no mistakes could be viewed as evidence for giving him a perfect score, whereas a later realization that he is cheating would only be viewed as a defeater, or a reason to remove that grade. So, it would appear that the instance of the teacher is not a good counterexample to Callahan. Callahan would argue that the sole reason for linking the two arguments for PAS seems to be to make the
argument as a whole work. The two individual arguments are not actually connected, but the
supporter of PAS forces a link in order to make the overall case for PAS work. Callahan feels
that there is something wrong with this sort of jury rigging and whether is the final result of his
objection is correct or not, he seems to have a point in saying that the two arguments are not
actually connected.

Another way one could argue against Callahan is to separate the arguments and say that
PAS is founded either on mercy or autonomy alone. If we consider the argument for PAS solely
from the perspective of mercy, this would lead to killing patients who do not wish to be killed.
This is clearly unacceptable and therefore an argument solely from mercy will not work as a
justification for physician-assisted suicide.

So, since an argument solely from mercy does not work, let us consider an argument
solely from autonomy. We previously considered a problem that results from this argument in
that it would allow doctors to kill people who were not terminally ill. Upon further consideration,
however, it would appear that this would not really be a consequence for this argument.
Maintaining one’s autonomy is supposed to help maintain one’s freedom and not just their ability
to make decisions. This is why we are not allowed to make contracts that allow you to consign
yourself to slavery. So, this would not allow doctors to kill just anyone because it would take
away their liberty.

The problem with this argument is that there is no clear way to draw the line between
who is acceptable to kill and who is not. One could argue that since these patients are dying
anyway, it is no longer a question of whether the person will die, but how and when. Yet this is
really the consideration for all of us because dying is one of the few guarantees in life. The only
thing that really seems to separate those who are acceptable candidates for PAS and those who
are not acceptable candidates is whether they will be destined to spend their last few months in
pointless suffering. This would return us to the argument of mercy. So, although it would seem that PAS can solely be justified through autonomy, the argument of mercy would still have to be used to determine who is an acceptable candidate.

Since neither of these ideas work, we must recognize the possibility that PAS could be justified under slightly different terms than those suggested by Callahan. If we consider the general, underlying purpose for PAS, it seems that it is to prevent someone from living a life that they do not wish to live. This would imply that PAS is actually rooted in a quality of life issue and that a person’s quality of life should be the underlying justification. This would most closely be related to Callahan’s idea of mercy, but the primary difference is that mercy is a judgment made from an outside perspective whereas quality of life can only be determined by the person living the life in question. This is also where Callahan’s concept of autonomy is relevant. Since a person can only make an accurate quality of life judgment from a first-person perspective, the best way the rest of us can determine another’s quality of life is by trusting their judgment on their own quality of life. So, if a person rationally comes to the conclusion that her life is not worth living, it seems that we must accept this decision and allow her to end her life. This might seem to root the argument in a concern for autonomy; but it in fact states that the real evidence for the argument lies in a quality of life concern and uses the autonomy concern more as a defeater. It is the person’s quality of life that really gives us reason to allow physician assisted suicide, but the only way we can determine a quality of life is through a personal account. So, we must use autonomy as a determiner, or defeater, in order to decide who is an acceptable candidate.

So, the justification for PAS is based on a determination regarding one’s quality of life, but the only way we can determine a person’s quality of life is through their autonomous opinion. This argument is still subject to the same pitfalls as the one presented by Callahan and
we must consider these issues. First, how can we avoid saying that we must kill people who do not want to be killed. This is easily solved by the second half of the argument that involves determination through autonomy. Although two cases of the same horrible disease may look the same from a third-party perspective, they can produce completely different reactions in two different people. One might think that the quality of life during the last few, paralytic months of a disease like ALS are not worth living while another might find great worth in those months and deem them as valuable. As stated above, a person’s quality of life can solely be determined from a first-person perspective and therefore the general populace cannot make these judgments for others.

The other consideration that one must make is whether or not we should allow people to kill themselves who are not terminally ill. Well, it is possible that this perspective would lead to this conclusion, but does this really seem like that negative of a conclusion? If someone has lived their entire life with severe depression, has tried various medications and other treatments but none of them have been effective, who are we to say that their life is necessarily worth living. According to the PAS and euthanasia laws in the Netherlands, one is allowed to kill oneself solely based on depression. This has only been approved in very few instances, but maybe this is not a morally reprehensible policy. It might seem odd because we have this notion that all life is sacred, but it is possible that some people’s lives are so miserable that we should allow them to end. There are other situations which could pose a problem that should also be discussed. Since we have determined that one’s quality of life can only be determined through the patient’s own autonomous decisions, one might worry that we are committed to helping someone commit suicide even if there is nothing wrong with them. For example, if someone has recently suffered a bad breakup or is experiencing existential angst and does not wish to live, what is to say that we should not also consider these as acceptable reasons to allow a patient to end her life? These
are obviously not acceptable reasons to medically assist someone with suicide, so we must add one final defeater in order to prevent these individuals from being considered acceptable candidates for PAS. We must also say that the poor quality of life must be irreparable. This omits individuals with broken hearts and existential angst and solely allows individuals with terminal diseases and irreparable depression to be viewed as acceptable candidates for PAS. Whether this is a good idea to make this a legal option in a litigious country such as ours is a different matter, but from a purely moral perspective, it would not be so damning to argue that someone could be justified in requesting PAS for reasons other than terminal illness.

So, using this new perspective based on quality of life, it seems that this is not only a better argument for PAS in that it addresses the root purpose for the treatment, but it also solves the problems raised by Callahan. By basing the justification on one root cause we avoid Callahan’s argument that autonomy and mercy are not connected. Furthermore, we can solve the two objections that arise due to justifications based on mercy and autonomy.

**The Role of the Doctor**

Finally, since we have determined that PAS seems to be a legitimate end-of-life decision from both a consequentialist and deontological perspective, we must consider what role the doctor should actually play in the process. Some, such as Fiona Randall and Robin Downie, do not argue against assisted suicide per se; but they do argue against physicians being the ones to provide the lethal medication. They argue that the British Medical Association (BMA) requires doctors to act in the best interests of the patient, which is defined as including “clinical improvement” as a key component” (Randall 2010, 324). They also state that the General Medical Council (GMC) “notes explicitly that death is a ‘serious adverse outcome’ of treatment,” and that it is illogical for doctors to aim at adverse outcomes (Randall 2010, 324). So,
based on the definition of the kind of treatment doctors should be providing in contrast with the definition of death as a result of that treatment, it seems that doctors are unable to provide medicine that would be lethal to a patient.

There are a couple responses to this objection. First, it would seem that we can answer this in conjunction with the response previously given to Callahan. Despite the definitions given by the BMA and the GMC, it seems that what a doctor should really be aiming to do is to help provide the best quality of life for the patient. Franklin Miller and Howard Brody wrote “An absolute prohibition of physician-assisted death based on respect for the human body represents a mistaken view of medical priorities. Respect for the human body must be accompanied by respect for the person whose body it is…. in unfortunate circumstances the most appropriate service for the patient requires ending bodily life” (Miller 13). The real point that Miller and Brody make here is that there are other priorities for a doctor than preventing death at all costs. This is an outdated notion and sometimes other priorities outrank the idea of saving a life if the patient has determined that his life is no longer worth living. As stated earlier, quality of life is something that can only be determined by the patient, so whether or not a treatment is beneficial to one’s quality of life can only accurately be decided by the patient. Therefore, if a patient legitimately feels that a treatment will improve their quality of life, it is in the doctor’s job description to be able to help them. It is probably a large request to change these definitions because in some respect it changes what it means to be a doctor. We are not making these changes, however, solely to make PAS work; instead, we are making these changes because they seem more appropriate to the concept of a doctor. As a side effect of the changes, they happen to justify PAS as a legitimate end-of-life option.

Opponents to PAS could very reasonably respond that in order for quality of life to be a consideration, there must be a life; if someone commits suicide, there is no longer life and
therefore quality is no longer a consideration. This could be accurate, so we should consider new terminology. When a doctor decides to help a patient end her life, what they are really trying to do is reduce suffering caused by a medical condition. Importantly, it does not matter which kind of suffering, be it physical pain or mental anguish, but the overall reduction of suffering is the goal (where suffering is determined by the patient him/herself). This applies not only to PAS, but also to withdrawal of life support. In both cases, they are following a patient’s autonomous decision regarding her treatment. In both cases, they are following a course of treatment that the patient and the doctor both agree will almost certainly end in the patient’s death. And finally, in both cases they are doing these things because it is what the patient thinks will lead him to an overall reduction in suffering. This should not be taken in opposition to earlier arguments made about improving one’s quality of life, however, because one would be hard-pressed to find someone whose ideal quality of life was wrought with suffering of any variety. Instead, PAS should be considered not necessarily improving one’s quality of life, but instead ending a life in which the quality has become so irreparably low that the life is no longer worth living.

This still does not provide an answer as to whether this is the responsibility of the doctor, but if we continue with our analogy to withdrawal of life support, it seems a reasonable assumption. Some would argue that even though death might actually greatly reduce a patient’s overall suffering, it is not the doctor’s job to provide this treatment any more than it would be his job to provide unnecessary cosmetic surgery or anabolic steroids to other patients. Some patients feel that their life would be greatly improved by unnecessary and excessive cosmetic surgery because they want to “look the way they feel.” Some athletes could argue that a short time of taking anabolic steroids will make them better at their sport and provide them with a lot of money so they can retire early. In both of these situations it is possible that the patients’ qualities of life would be improved and any suffering they might be experiencing would lessen, but many
feel that it is not really the job of a doctor. Although an important consideration, I would argue that the issue of PAS is different because medicine is already so implicated in their condition. In most instances of physician-assisted suicide, it is due to medicine that the patient is alive at all and without its intervention, most would have died long ago. So, unlike someone desiring unnecessary cosmetic surgery or steroids, medicine is already deeply implicated in the states of these patients and it would seem that this would imply that the doctor is at least partially responsible for helping to allow the patient to end her life in the way she sees fit. Unlike the seekers of cosmetics and steroids, they are not essentially healthy people; they are sick individuals who are trying to find relief from medically-influenced suffering.

Despite all of the above evidence, some might still feel uncomfortable allowing doctors to provide lethal medications. There are very few clear decisions in any situation involving death and killing and although it seems logical and evidentially acceptable for it to be legalized, it might be best to not have doctors as the ones who finally provide the drug. They should still be involved insofar as they need to help determine who is an acceptable candidate for assisted suicide, but it might be better to have a third party actually provide the medicine. Once all the conversations and analyses have taken place, it seems to be much more of a legal matter than a medical matter anyway. As long as the medicine is enough to kill any human, there is no need for the prescriber to have a great knowledge of medicine or pharmacology, they just need to be authorized to write the prescription.

It seems as if a reasonable solution to the doctor problem would be to authorize a lawyer, or some other technician, to be the actual prescriber of the medicine and have the doctor’s role end at the analysis of the patient’s condition. Although she takes a different perspective on the overall issue of PAS, Fiona Randall argued for this approach in her article on euthanasia, *Two Lawyers and a Technician*. She feels that if assisted suicide or euthanasia is to be legalized,
doctors really should not participate in the process. Although I disagree, I do not think it is a completely unreasonable claim. She feels instead that two lawyers should work with doctors and make the final decision as to whether or not a patient is a candidate and then a technician could actually provide the prescription, or in the case of her article which discusses active euthanasia, the lethal injection (Randall 1993, 198). Robert M. Sade presented a similar idea many years ago when he proposed the idea of “legistrothanatry” as a new profession where a type of lawyer would actually give the final prescription. I feel that doctors should be involved in the process, but ultimately, I feel that this could be a good solution to many objections raised against PAS. No longer would we have to consider whether the general perception of doctors would change and it would still allow those who want assisted suicide to be able to access it.

Overall, there seems to be really no sufficient evidence which should prevent assisted suicide from being legalized or considered a valid end-of-life option. Consequentialist arguments have been generally proven wrong as a result of the evidence from Oregon and the Netherlands, where these practices have been legal for years. Furthermore, it seems that PAS, when seen in the light of quality-of-life or reduction-of-suffering, is perfectly deontologically and morally acceptable. Finally, even if people are still made uncomfortable by the notion of doctors being so connected with killing, there is no reason for doctors to actually be involved in the final process. Once they help determine whether the patient would actually be a candidate, there is really no need for them to participate in the actual prescription process. So, it appears that assisted suicide should be considered a valid end-of-life decision from every relevant perspective.
Works Cited


