**Titel**

PROFESSIONAL INTEGRITY AND THE DILEMMA IN PHYSICIAN-ASSISTED SUICIDE (PAS)

**Författare**

CHRISTIAN CHIDI ECHEWODO

**Abstract**

There is no stronger or more enduring prohibition in medicine than the rule against the killing of patients by doctors. This prohibition is rooted in some medical codes and principles. Outstanding among the principles surrounding these prohibitions are the principles of beneficence and non-maleficence. The contents of these principles in a way mark the professional integrity of the physician. But the modern approach to health care services pulls a demand for the respect of the individual right of self-determination. This demand is now glaring in almost all the practices pertaining to health care services. In end of life decisions, this modern demand is found much in practices like physician-assisted suicide and euthanasia. It demands that the physician ought to respect the wish and choice of the patient, and so, must assist the patient in bringing about his or
her death when requested. In such manner, this views the principle of autonomy
as absolute and should not be overridden in any circumstance. However, the
physician on his part is part of the medical profession that has integrity to protect.
This integrity in medical profession which demands that the physician works only
towards the health care of the patient and to what reduces diseases and deaths
often go contrary to this respect for individual autonomy. Thus faced with such
requests by patients, the physician always sees his integrity in conflict with his
demand to respect the autonomous choice of the patient and so has a dilemma in
responding to such requests. This is the focus of this work, “Professional Integrity
and the Dilemma in Physician-Assisted Suicide” However, the centre of my
argument in this work is not merely though necessary to develop general
arguments for or against the general justification of PAS, but to critically view the
role played by the physicians in assisting the death of their patients as it comes in
conflict with the medical obligation and integrity. Is it morally right, out rightly
wrong or in certain situation permissible that physicians respond positively to the
request of the patients for PAS? This is the overarching moral problem in the
morality of physician-assisted suicide, and this work will consider this in line
with the main problem in the work “the dilemma of professional physicians in the
assistance of suicide.

Nyckelord
Keyword
Professional Integrity, Physician-Assisted Suicide, Euthanasia, Morality, Principle
of Autonomy, Principle of Beneficence
PROFESSIONAL INTEGRITY AND THE DILEMMA IN PHYSICIAN-ASSISTED SUICIDE (PAS)

BY
CHRISTIAN CHIDI ECHEWODO
Master's Thesis in Applied Ethics
Centre for Applied Ethics
Linköping University Sweden
May 27, 2004

SUPERVISOR
Bo Petersson (Prof.) Linköping University, Sweden
DEDICATION

This work is dedicated to my beloved sister Edith O. Echewodo for her care and love to me.
ACKNOWLEDGEMENT

The success of this work owes a lot to the various contributions and criticisms by people outside the writer. Though the writer contributed much in the work, yet the contributions of other people helped to reshape, reconstruct and readjust certain controversial issues encountered in the cause of writing this work. I acknowledge in a special way the handwork of God in this project.

The various contributions, directions, corrections and criticisms of the Supervisor of the work Prof. Bo Petersson helped in the actual realization of this work. The lectures of my two Professors, Prof. Bo Petersson and Prof. Göran Collste, the various contributions and arguments of my colleagues in class, and the suggestions received from friends helped in making this work a success.

The knowledge and experience gotten from the contributions of my co-participants and the Guest Speakers at the Towards a Free and Virtuous Society Conference in Texas widened my knowledge about freedom for which the issue of choice making rests on.

I really thank everybody who falls in these above mentioned categories and all other people who in one way or the other contributed immensely to the success of this work. I thank you all.

Christian Chidi Echewodo
CTE Linköping University,
Sweden.
ABSTRACT

There is no stronger or more enduring prohibition in medicine than the rule against the killing of patients by doctors. This prohibition is rooted in some medical codes and principles. Outstanding among the principles surrounding these prohibitions are the principles of beneficence and non-maleficience. The contents of these principles in a way mark the professional integrity of the physician. But the modern approach to health care services pulls a demand for the respect of the individual right of self-determination. This demand is now glaring in almost all the practices pertaining to health care services. In end of life decisions, this modern demand is found much in practices like physician-assisted suicide and euthanasia. It demands that the physician ought to respect the wish and choice of the patient, and so, must assist the patient in bringing about his or her death when requested. In such manner, this views the principle of autonomy as absolute and should not be overridden in any circumstance.

However, the physician on his part is part of the medical profession that has integrity to protect. This integrity in medical profession which demands that the physician works only towards the health care of the patient and to what reduces diseases and deaths often go contrary to this respect for individual autonomy. Thus faced with such requests by patients, the physician always sees his integrity in conflict with his demand to respect the autonomous choice of the patient and so has a dilemma in responding to such requests. This is the focus of this work, “Professional Integrity and the Dilemma in Physician-Assisted Suicide”

However, the centre of my argument in this work is not merely though necessary to develop general arguments for or against the general justification of PAS, but to critically view the role played by the physicians in assisting the death of their patients as it comes in conflict with the medical obligation and integrity. Is it morally right, out rightly wrong or in certain situation permissible that physicians respond positively to the request of the patients for PAS? This is the overarching moral problem in the morality of physician-assisted suicide, and this work will consider this in line with the main problem in the work “the dilemma of professional physicians in the assistance of suicide.”
# TABLE OF CONTENTS

## CHAPTER ONE:

1.0 General Introduction.................................................................1
1.1 Explication of terms.................................................................6
    Physician-assisted suicide.......................................................6
    General conception of euthanasia..............................................7
1.1.1 Active and Passive Killing (Euthanasia and PAS).......................9
1.2 The General Notion of Morality................................................13
1.3 The General Conception Professional Integrity of the physician......14

## CHAPTER TWO:

2.0 The Morality of Physician-Assisted Suicide...............................16
2.1 Historical overview of the issue of PAS....................................16
2.2 Physician-Assisted Suicide, Arguments For and Against................19
2.3 The Christian View of PAS......................................................24

## CHAPTER THREE:

3.0 Professional Integrity and the Dilemma in PAS............................28
3.1 Background Cases in PAS......................................................28
    3.1.1 Dr. Kevorkian and the Suicide Machine...............................29
    3.1.2 Dr. Timothy Quill and Assisted-Suicide..............................31
3.2 The Person of the Patient.....................................................32
    3.2.1 The patient and the principles of autonomy and beneficence.....34
    3.2.2 The rationale behind choice making of the patient...............40
    3.2.3 Competence of the patient............................................41
    3.2.4 Circumstances surrounding choice making in Pas...................41
    3.2.5 The possibility of irrational choice..................................44
        Rational decision making.................................................45
        Irrational decision making.............................................45
3.3 Table for Issues and Realities in decision making in PAS...........47
CHAPTER FOUR:

4.0 PAS versus professional integrity of the physician..........................49
4.0.1 The dilemmas of physicians in PAS........................................50
4.0.2 When do dilemmas occur?......................................................50
4.0.3 Physicians dilemma in assisting death.................................52

CHAPTER FIVE:

5.0 Evaluation and Conclusion.......................................................56
5.1 Evaluations..............................................................................56
5.2 Conclusion..............................................................................62

BIBLIOGRAPHY

Books............................................................................................65
Encyclopaedia and Dictionaries.....................................................67
Journals, Encyclical and News Papers.........................................67
Reports and unpublished articles...............................................68
Internet Sources...........................................................................69
CHAPTER ONE

1.0 GENERAL INTRODUCTION

…There is severe dehydration, uncontrolled itching and fatigue. These patients are completely exhausted. Some of them can’t turn around in their beds. They become incontinent. All these factors make a kind of suffering from which they only want to escape…

And of course you are suffering because you have a mind. You are thinking about what is happening to you. You have fears and anxiety and sorrow. In the end, it gives a complete loss of human dignity. You cannot stop that feeling with medical treatment.¹

The contents and implications of the words in the above quotation appear as a form of argument in various debates on the morality of physician-assisted suicide. Physician-assisted suicide (PAS) is one among the various perennial problems in medicine, ethics, and even in law. With media attention being focused on medical, moral and legal cases connected with Dr. Jack KeVorkian, a retired pathologist in Michigan and Dr. Timothy Quill, an internist in New York, one can observe that this issue has become a substantial public interest.² The American medical association developing a policy opposing PAS, and the fact that on October 27, 1997 physician-assisted suicide became a legal medical option for terminally ill Oregonians are facts pointing to the controversial nature of PAS. This Oregon Death with Dignity Act requires that the Oregon Health Services (OHS) monitor compliance with the law, collect information about the patients and physicians who participate in legal PAS, and publish an annual statistical report. Furthermore the interdisciplinary society for health and human values publishing a thoughtful, well balanced document that addresses many of the factors that make it a complex issue that divides physicians, other health care professionals and the general public,³ and the Netherland’s, Reviewing Termination of Life on Request and Assisted Suicide Act which took effect from April 1, 2002 point to the same problems in PAS.

Two striking principles play vital roles in decisions on PAS, the principle of autonomy and the principle of beneficence. They ensure respecting the autonomous choice

of the patient and keeping to the integrity of the medical profession respectively. It is worth noting as I indicated in my abstract that there is no stronger or more enduring prohibition in medicine than the rule against the killing of patients by doctors. The content of the Hippocratic Oath, though not accepted by some physicians is a proofs that the fundamental obligations of physicians are neither to cause nor to help in bringing about the harm that may result in the death of their patients, but to promote their health by cure, prevent diseases and in all, work towards their welfare, which is the goal of health.2

However, many arguments in the current literatures of medical ethics suggest a need to reform both the laws and the codes guiding medical practices. One modern trend here is in the need to recognise the autonomy right of the individual person, hence, the right of the person to make decisions about what should happen to or what concerns his or her live. When this right is applied to medicine and health care, certain phrases come into vogue: Death with dignity, euthanasia, allowing to die, assisted suicide, mercy killing, privacy, confidentiality. The issue of assisted suicide is becoming outstanding and more controversial among these terms, because certain medical principles and issues come in conflict in such choices, requests and actions. The physician is always exposed to dilemmas such that his professional integrity that obliges him to promote health and prevent diseases conflicts with the need for him to respect the autonomous choice of the patient in health care services.

As a matter of fact, this issue of PAS has less to do with how and when a patient decides to die than it does with how and when people are allowed to kill others. People

2 The Oath of Hippocrates. I SWEAR by Apollo the physician and Æsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this Art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen, which, according to my ability and judgment, I consider for the benefit of my patients, and abstain, from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot. Confer, Hippocrates. “The Oath and Law of Hippocrates.” Vol. XXXVIII, Part 1, in The Harvard Classics, edited by Charles W. Eliot, New York: P. F. Collier & Son, 1909–14, from http://www.bartleby.com/38/1/1.html
who make up their mind to die “tend to claim the right to do so,” but the real difficulty begins when they request that some one kills them and in this case a professional physician. When confronted with such request as PAS the physicians tend to face dilemmas in making decisions on such choices of their patients. These dilemmas physicians encounter have called for debates to critically look into the nature, condition, manner and morality of the helping hand of the physician in assisted suicide. The debates have been focused on finding a substantial ground where by PAS can either be permitted on the one hand or not be allowed on the other. In the course of these debates, three different and often opposing positions tend to emerge. There are the opinions of those that accept PAS and argue for its justification based on certain reasons for which the need for the respect of the individual right to autonomy is glaring. Another group’s opinion out rightly rejects any act of justifying PAS; on the ground that it diminishes to the zero point the fundamental value, dignity and integrity of Human Life. The other group holds the opinion that in certain cases and manners PAS can be allowed but under certain conditions.

However, the focus of my argument in this work is not merely though necessary to develop general arguments for or against the general justification of PAS, but to critically view the role played by the physicians in assisting the death of their patients as it comes in conflict with their medical obligation and integrity. This is the overarching moral problem of assisted suicide. By considering this role the physician plays in assisting the death of the patient, it is a clear fact that this choice made by the patient often comes in conflict with the obligation of the physician. The physician in this situation has the dilemma of choosing whether to assist the patient to take his or her life (respecting the autonomous choice of the patient), hence going contrary to the fundamental obligation of his profession, or refusing to help out, hence not respecting the autonomous choice of the patient. This is the main issue to be tackled in this work. In a bid to achieve my aim in this work, efforts will be made to critically address certain questions inherent in such discussions and which would help get certain controversial points clear. Such questions include:

- How is assisted suicide a dilemma to the professional integrity of the physician? This will involve finding out the things that constitute dilemma for the physician when the choice or request of PAS is made. This means knowing how, when, why and where the request for PAS can come in conflict with the obligations of the physician.

- If competent patients have legal and moral rights to refuse treatments that would prolong their lives (deaths) in cases of deteriorating illnesses, or request for a
treatment that would cause their deaths, should there be a similar right/duty to enlist the assistance of the physician to help patients cause their deaths? This will in a way entail considering the right and duty relationship. It is often said that possessing a right entails that another person has a duty to respect your right. This person who has a duty to respect your right has his or her own right, which you have a duty to respect too. But if these rights and duties from both sides come in conflict, can any one of the rights be overridden?

- Does the patient’s right of self-determination call for the physician’s total adherence? If yes what happens in matters of irrational choices/decisions of the patients? This in a way relates to the problem of right and duty but mainly concerns whether there can be absolute rights or not. It will be worth noting to find out whether the individual right to autonomy is an absolute right that must be respected in all circumstances or whether it is as Beauchamp and Childress would say, prima facie right that can be overridden in cases of conflicts with other right that are of higher value.

- Are there any conditions that should warrant the ethical permissibility of PAS? This focuses mainly on the debates about the morality of PAS. Some opinions see PAS as an act that should not in a any way be encouraged while some other opinions hold that it is morally right for a patient to request that a physician helps him or her to take his or her life and that the physician owes it as a duty to help the patient achieve this aim. But do these opinions follow? This question entails that there is the need for a critical look into these different views.

The main objective of this work lingers on providing sound information that will help in making right decisions about some medical practices, with more emphasis on the various things that surround the act of PAS. Here I aim at bringing into focus all the things that make the choice of PAS a dilemma for the physician and sought for ways of coming out of such dilemmas. This will provide the ground for the right action and decisions in medical ethics.

The Theoretical Framework of this work is mainly based on the various principles of medical ethics that seem active in the discussions on PAS. PAS involves the right of the patient to make autonomous choice or decision about doing something that will bring about his death, hence the principle of autonomy. It involves the physician’s assistance in the death of the patient and his professional obligations, hence, the principle of beneficence and nonmaleficence. Most of the arguments in the debates about PAS point to these
principles for justifying the act in one way and not justifying it in another way. The main concern of this work entails that when a patient makes the request for PAS to the physician, responding to this request is always a double-edged sword for the medical professional. This double-edged sword issue is mainly based on the fact that the principle of autonomy and the principle of beneficence and nonmaleficence come in conflict. Hence one can envisage that the physician encounters a dilemma in making decisions on such request.

However, I have structures this work to follow certain stages and patterns of analysis. The first part of this work would deal with the explication of terms. The debates on PAS are often clouded with misplacement and misconceptions of important concepts that are mainly found in end-of-life discussions. It becomes necessary that proper understanding of these concepts and what they really mean would help in making sound arguments. Hence, in order to alleviate confusion it is nice to make distinctions between such concepts as, assisted suicide, euthanasia, voluntary, non-voluntary and involuntary euthanasia as well as passive and active euthanasia and PAS. The clear explanation of what morality and physician professional integrity mean would in a way help in understanding well the concept and practice of PAS.

In the second part of this work efforts would be made to discuss in details the morality of PAS. This means discussing the debates and opinions on the morality of PAS in history. Since there have been series of debates on this issue of PAS, it becomes a task here to critically discuss the various arguments in the issue of PAS. The Christian position on this issue would be considered in this part.

The third part centres on the main point of discussion in this work. It will look deep into the physician’s professional integrity as it comes in conflict with the request for PAS. The background cases here would mainly focus on Dr Kevorkian and his suicide machine as well as considering his assistance in the death of Janet Adkins. The second case would be on Dr Quill’s assistance in the death of his patient Diane. Since the act of PAS involves in a special way the actions of both the patient and the physician, this part would consider in a stage form the person of the patient. Here what constitutes the patient’s autonomy that makes him to have the right to autonomous choice of treatment would be critically viewed. The various conditions that always push the patient to make such choice of death would be dealt with. These conditions or circumstances will make room for the understanding of the possibility of irrational choices in PAS.

Part four of this work will deal with the dilemmas themselves. The question, “how is PAS a dilemma to the professional physician?” would be considered. A clear
understanding of this would entail knowing when dilemmas properly occur and the things that are always responsible for these dilemmas. These are the main concerns of this fourth part of the work.

The fifth part deals with the evaluation and conclusion of the work. In the evaluation I will try to bring in a nutshell all the points and arguments made in the work. This would give a good ground to make proper conclusion of this work. I foresee the conclusion to gear towards ascertaining that physicians encounter dilemmas when they are requested to help in suicide. These dilemmas are not impossibilities rather they prompt the medical profession to action of finding a way to tackle them. Hence efforts must be made in the medical profession to find lasting solutions to these dilemmas physicians encounter in most cases of health care.

1.1 **EXPLICATION OF TERMS.**

Physician-Assisted Suicide is one of the perennial ethical problems in medicine as well as an issue that involves law and public policy. It is an issue that has become the subject of significant professional interest on the part of physicians, biomedical ethicists and health-law attorneys. In all discussions over PAS there are always some conceptual confusions clouding both the debate over PAS and other discussions around it. These confusions stem from what I refer to as misplacement of ideas and priorities. Often arguments over PAS do not recognize the distinctions between some other medical and ethical issues that have certain things in common with PAS. Such issues include; euthanasia, voluntary, non voluntary and involuntary euthanasia, active and passive euthanasia and assisted suicide.

Some conceptual clarity can be gained by pointing out that an assisted suicide involves someone (a patient or another person outside the clinical setting or in a clinical setting as the case may be) who has the motive of committing suicide, intends to die, wants to do something that will bring about his or her death, and is non-coerced in decision about his or her death.\(^3\) In contrast to ordinary suicide, an assisted suicide requires aid from a relative or friend, physician, or some other person who carries out the role of the “enabler”. This enable plays the role of assisting the suicidal person by providing the weapon of self-destruction, supplying information on the most effective ways of committing suicide, providing a prescription for a lethal drug or helping the person in the actual act of killing.

However, when a physician is in the role of the enabler, he receives a request by a patient for assistance in committing suicide. The physician assesses the patient’s medical

\(^3\) Robert F. Weir, (Ed) *Ibid*, p.viii
condition, makes the difficult decision to help the suicidal individual, and then responds to the request for assistance by providing a potentially lethal prescription as well as information on how to use the prescription to achieve the patient’s desired goal of death. This is what is referred to as physician-assisted suicide (PAS). At the heart and basis of PAS lies the concept of death, the cause of it and the attitudes toward it. It can be expressed as the intentional assistance given to a person precisely a patient by a physician to enable that patient terminate his or her life upon the patient’s request. Here the physician provides the means but the patient performs the actual action. Dan W. Brock asserts that a paradigm case of physician-assisted suicide is the patient ending his or her life with a lethal injection. Margaret P. Battin in her article “Physician-Assisted Suicide: Safe, Legal, Rare?” explains, “In this changed view, dying is no longer something that happens to you but something you do.” She compares PAS to our current view of reproduction as a process of control. She envisions death and the circumstances surrounding it, as events pre-planned and controlled nowadays just like reproduction. PAS would transform the attitude people have on death and the manner and circumstances in which people die. PAS involves such features as:

1. The agent and the subject: This means the physician and the patient.
2. The intention of the act: This concerns the intention of both the patient and the physician in such action and this stems at doing some action that would result in the death of the subject.
3. The motive of the action: Here involves the reason for the action and in most cases concerns what is of benefit to the patient.
4. The cause factor: This deals with who does the action and what is actually done, that results in the death of the patient.
5. The Outcome: This is the end result of the action.

On the other hand, when the physician administers the lethal dose or directly withdraws life-sustaining instruments often because the patient is unable to do so, it is referred to as euthanasia or in a more precise term voluntary active euthanasia. Euthanasia is often defined as the act of bringing about the death of a hopeless ill and suffering person in a relatively quick and painless way for reasons of mercy. Various features characterise the concept of

---

euthanasia. These features in a way are found too in PAS, but in the cause of the work we will understand how they differ from each other. As a matter of fact euthanasia involves,

1. The agent and the subject: This concerns the physician and the patient.
2. Intention of the agent. This intention often stems at doing some actions that would result in the death of the subject.
3. The motive of the agent. Here it is taken to be for the best interest of the subject
4. Cause factor: This concerns what the agent does or chooses not to do that ends in the death of the patient
5. The outcome. This is always the death of the patient.

The implication of these features inherent in euthanasia is that the physician plays both the active role as well as the passive role in the death of the patient. Here the doctor suggests, brings the means and does the action. Hence euthanasia can be seen or defined as death that results from the intention of one person to kill another person, using the most gentle and easy means possible, that is motivated solely for the best interest of the person who dies.\(^7\) According to Austin Fagothey, euthanasia is the giving of an easy, painless death to one suffering from an incurable or agonizing ailment.\(^8\) This too implies that the whole act of killing rests on the physician in matters of euthanasia.

There are various forms of euthanasia. It can be voluntary, non-voluntary or involuntary. It can also be active or passive. For the purpose of this work I will not dwell so much on these forms of euthanasia but will try and explain what they are and consider how relevant their distinctions are morally.

When someone (in most cases physician) out of passion, does an action with the intention of ending the life of another (a suffering patient) at his or her request it is voluntary Euthanasia. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request. Hence when the patient whose life is to be ended is unable to choose between life and death, probably as a result of illness or accident which has rendered a formerly competent person permanently incompetent, and the physician goes ahead to end the patient’s life it is non- voluntary euthanasia.

In the case of involuntary euthanasia there is a compassionate act to end the life of a patient who is perceived to be suffering, could make a voluntary request but has not made so. Here the patient has not given consent but the physician may be, from the request of the relatives goes ahead to end the life of the patient.

From the various descriptions given to euthanasia and PAS and the various features that characterize them, it can be seen that in a way, PAS can be distinguished from euthanasia. Euthanasia and physician-assisted suicide almost have the same goal, bringing about painless death for the patient. However, they differ in both the motive of the action and the cause factor. Though in both cases the motive for the action is to do something for the best interest of the subject but the difference lies in the fact that in euthanasia the physician does an act based on what he feels is for the good interest of the patient while in PAS, he does an action based on what the patient feels is to his or her best interest. This distinction appears less necessary in a way, but it holds enough ground when it comes to giving a moral discussion on the two issues. Looking at PAS from all ramifications, the doctor only helps the patient to achieve his or her desire. He (physician) doesn’t often go deep into the actual reason for the action rather helps in the death of the patient based on the request for that. This brings in another distinction that can be seen between these two practices. The reasons behind the practice of euthanasia are always related to the critical ill-health condition of the patient. It involves always the physician bringing about the death of one who is critically ill, with immense pain and no hope of survival. But in PAS, other conditions might warrant the patient to make the request for PAS. It does not necessarily follow that only those with terminal illnesses make this request. Economic and psychological factors often make for the choice of suicide. Anxieties, depressions and frustrations of all kinds make one to ask for PAS. In this case, there appear to be a distinction between euthanasia and PAS based on the cause of the choices. With regard to the cause factor of the actions in both issues, the difference abounds. In euthanasia, the physician provides both the means and the action that cause the death of the patient, while in PAS, the physician provides the necessary means or information and the patient performs the action himself or herself.

1.1.1 ACTIVE AND PASSIVE KILLING (EUTHANASIA AND PAS).

In both euthanasia and physician-assisted suicide distinctions are always made between the two forms of killing: active and passive. Active killing means a direct action that results in death. This often takes the form of giving a lethal injection that causes the death of the patient. In passive killing, there is no direct act of killing. Here something is not done whose absence results in the death of the patient. This takes the form of withdrawing life-sustaining treatments.

F.M Kamm, in his article “Physician-Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value” made a crucial distinction between passive euthanasia and passive
PAS in one hand and active euthanasia and active PAS in another. For him in passive euthanasia, the doctor either does not start, or else he stops life-saving treatment, while in passive PAS, the doctor stops, or does not start non-life-saving aid and this enables the patient to end his life either actively or passively. Active euthanasia can still be distinguished from active PAS by the fact that in euthanasia the doctor (1) does the act that finally causes the death of the patient, and (2) definitely intends the death of the patient. In PAS, the doctor only may intend the death but the patient always intends this death and carries out the actual killing of him or herself.

These distinctions imply that in both passive and active euthanasia the doctor in a way plays some role in the death of the patient. The simple distinction here is based on the level of the role the physician plays in the two forms of euthanasia. A direct killing of the patient (by giving lethal drugs or injections) by the physician applies to active euthanasia while the indirect action (withdrawing of life saving treatment) that still results to the intended death of the patient applies to the passive. However the distinctions made in PAS tend to provoke some thoughts. Can there actually be any such distinctions? When Kamm talks of the doctor stopping and not starting non-life saving aid, I tend to make some deductions that probably might be what his distinctions imply. If Kamm says that in passive PAS the doctor stops or does not start any non-life saving aid this might mean that the doctor stops non-life saving aid but does not start it. If this is taken to mean what Kamm is saying then it implies that what is considered is the action of the doctor after the death of the patient. By not starting non-life saving aid, it means that the patient starts it, and by stopping it, it means stopping what has been started and in this case, his action comes after the act of suicide must have been done.

When the role of the physician is examined in the context of PAS and euthanasia it is viewed based on how the physician contributes to the death of the patient and not what he does after the death of the patient. If I take Kamm by his distinction, passive PAS will not be viewed as assisted suicide because by mere stopping of a non-life saving aid the doctor cannot be said to be assisting in a death. Assisting in the death of some one implies that the doctor provides the things needed for the actualization of the death, directs on how and when such should be done and stands by to watch it correctly done. In a way this looks more passive than active since the physician doesn’t do the direct or actual killing, but the patient. Thus one can affirm that passive killing and active killing can be distinguished based on the actions of the physician and that of the patient. The patient carries out an active action by directly doing the

---

action that results in his or her death, while the physician does a passive one by clearing the ground for such action.

However, these distinctions in PAS and euthanasia do not have any moral significance. In matters of terminologies one can make such distinctions, but when it comes to the moral significance they tend not to follow. In 1975, in an article in the *New England Journal of Medicine*, James Rachels criticized the famous distinctions made between active and passive killing. Rachels argues that this distinction, though still dominant in modern medicine and law, has no moral value and of course leads to decisions about death based on irrelevant factors. Rachels’ logic cuts across two ways: first, letting a vegetative patient die is just as bad (good) as killing him or her, second, killing a vegetative patient is just as good (bad) as allowing the person to die. There is nothing moral or immoral in the act of passive or active killing, rather, morality or immorality is determined by motives and results in the context of that act\(^{10}\). Most critics of Rachel focus their arguments on the actual cause of death in the two forms of killing. If a patient is allowed to die, doesn’t the disease kill that patient? But if someone acts directly to bring about the death of the patient, isn’t that person the cause of the death? In this case then he takes responsibility for the death.

As Jean Davies points out that just as rape and making love are different, so are killing and assisted Suicide\(^{11}\), acts of discontinuing treatment with the realization that patients will die of their disease does not constitute euthanasia. When discontinuation is done with the intention of ending life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is objectionable. But since discontinuation in other situations is morally acceptable, (without the intention of bringing about death, but may be to relieve pain), it is good not to refer to discontinuation under any circumstances as a form of euthanasia. Hence Dr. J.N Ekennia writes,

> The euthanasia debate is concerned with intentional action and omission- that is, with deaths that are deliberately and knowingly brought about in a situation where the agent could have done otherwise\(^{12}\)

---

\(^{10}\) Gregory E. Pence, *Classic Cases in Medical Ethics: Accounts of Cases that have shaped Medical ethics, with Philosophical, Legal, and Historical Background*, 2nd edition, 1995, USA, McGraw-Hill, Inc. p.81.


All the various forms of euthanasia and physician-assisted suicide almost have the same goal, bringing about painless death for the patient, though they tend to differ in who takes the action. In euthanasia, the physician provides both the means and the action that cause the death of the patient, while in PAS, the physician provides the necessary means or information and the patient performs the action himself or herself. But could there be a substantial moral difference between these two issues based on the difference in the person that takes the last action in the death of the patient? If at all there are, could these differences be morally significant. A physician who provides a patient with a deadly drug and instructions on how to use the drug to bring about his or her death bears as much responsibility as giving the person a direct lethal injection. PAS is in a way a form of voluntary euthanasia. I agree with the words of Daniel Callahan that in PAS the doctor or physician is knowingly a part, and a necessary part of the causal chain leading to the death of the patient. What matters in the case of PAS or euthanasia is the intention for the action. In most jurisdictions, the law holds equally responsible those who are accessory to capital crimes. Take for instance, if I give some one a gun with which I know he intends to kill another person and stand by while he does so, the law still holds me as responsible for the death as the person that pulled the gun. The same case is applicable to PAS. The physician who directly kills some one by giving injection or pills that results in the death of the person and the physician that provided the patient with all the necessary means to achieve death are fully blameworthy (or praiseworthy as the case may be) for whatever might be the result of the actions. In both PAS and euthanasia, the intention of the patient and the physician is to pursue a course of action that will end in the patient’s death. Hence both the patient and the physician have the same intention.

Dan. W Brock in his article “Physician-Assisted Suicide is sometimes morally justified” points out that in both PAS and euthanasia, the choice rests fully with the patient. According to him this is so because neither of the actions can take place without the patient’s desire for them: of course, in each case the physician must also be willing to play his or her own role. The patient acts last in the sense of retaining the right to change his or her mind until the point at which the lethal process becomes irreversible. In each of the

---

cases Brock maintains that the patient and the physician act together to bring about the death intended for.  

1.2 THE GENERAL CONCEPTION OF MORALITY

Most if not all-perplexing questions in ethical debates are found within the sphere of the term, morality. It is from the Latin word “mores, literally meaning tradition or folkways. This term morality is especially concerned with personally held ethical beliefs, theories of obligation and the social elements that reinforce ethical decisions. Though less inclusive than ethics, it encompasses a wide variety of areas related to all the field of ethics, namely: notions of obligation or duty, issues concerning the non instrumental good of other persons, responsibility, and the recognition of the distinction between moral and non-moral reasons.

Views of morality have varied from culture to culture and from one point of view to another. Usually morality applies to fields in which the choices made by individuals express an intention relative to other individuals not necessarily members of the particular society. Hence, there exists an academic dispute about whether morality can exist only in the presence of a society or in a hypothetical individual with no relationship with others. Many opinions hold that there cannot be any universal morality, and that morality is subjective to different cultures. Other views maintain that even though morality tends to differ from culture to culture but still there can be universal morality for which all mankind tend to abide by. Hence morality then can be viewed from two different perspectives, from the descriptive or normative perspective. From the descriptive sense morality refers to a code of conduct put forward by a society or some other groups in the society like the religious groups or even accepted by an individual for his or her own behaviour. Hence people often talk about Christian morality, Nazi or Greek morality. Taken in this descriptive sense, morality then tends to differ from society to society, group to group or from one individual to the other. On the other hand normative sense of morality refers it as the code of conduct that all rational persons would put forward for governing the conducts and behaviours of all moral agents. Here morality is seen to be universal and applies to all persons irrespective of society or culture.

14 Dan. W Brock, Physician-Assisted Suicide is sometimes morally justified, in Bid, P. 87.
1.3 THE GENERAL CONCEPTION OF PROFESSIONAL INTEGRITY OF THE PHYSICIAN.

The word “integrity” is a much-used term in various professional fields. Be it in the educational, legal, military, medical or even personal sectors. The word encompasses all the various aspects of a person’s character that make him act in accordance with the principles within a given value system. In the moral context it involves the whole moral character of a person and this most frequently allude to one’s personal integrity. It is used to describe the actions of people who act consistently from a firmly established character pattern. Persons of integrity do not stray from acting in accordance with strong moral principles even when it is personally advantageous to do so. He acts like the ideal man he is trying to be. This is perhaps what the ancient Taoist has in mind when he says that the way to do is to be. This then means that when we talk of integrity we mean the wholeness of the good character of a person in a given value system.16

When we restrict the concept of integrity to the professional systems we mean all the characters, the will, the desire and the ability of a person to play his or her role as a practicing professional. These specific roles include, responsibilities, duties and obligations of people within a particular profession as stipulated by codes or norms governing that profession. Professional integrity derives its substance from the goal or mission of that particular profession.

When we talk of physician’s professional integrity we then mean the will, character, desire and ability of a physician to play his or her active role, do his or her duties and obligations, as well as carry out the responsibilities due for physicians as stipulated by the codes governing the medical profession. It is quite wise to make clear who is actually a physician. The physician is one who plays a medical professional role in the treatment of a patient. Here is the doctor according to the Cambridge Advanced learners’ Dictionary especially one who has general skill and is not a surgeon. In the medical sector, a physician violates professional integrity by performing treatments that are not medically indicated and are not recognized or permitted by the code governing the medical sector. For instance, when fellow doctors bury the mistakes of their fellow incompetent colleagues rather than expose them, they fall short of their responsibilities to the goal of the profession.

16 I talk about the social character of professional integrity because the community or society is always involved at every stage of professional development. This is so because the existence of a particular profession results from the fundamental need of the society. For instance the fundamental need of the society for a good medical health care generated what is known today as the medical profession. For more details on this confer www.usafa.af.mil
The act of allowing a patient to die from an underlying terminally illness when the treatment is ineffective is fundamental from endowing the terminally ill with the right to request another to assist in the act of dying. As earlier pointed out, there is no stronger or more enduring prohibition in medicine than the rule against the killing of patients by the physicians. The fundamental obligation of physicians as stipulated in all the medical codes is the need to save the lives of the patients. The contents of the Hippocratic oath testify to this. The frequently quoted portion of the oath “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect…” points to the fact that the central focus of the responsibility of the physician is neither to cause nor to help in bringing about the harm that may result in the death of their patients. Here lies the professional integrity of the physician.
CHAPTER TWO:

2.0 THE MORALITY OF PHYSICIAN-ASSISTED SUICIDE.

Physician-assisted suicide has been a vital point in some debates in medical ethics. When one involves in assisted suicide, he or she brings about the death of another person with the sole aim or motive of benefiting the one whose death is brought about. Issues such as the autonomy of the individual person, the duty/obligation of the physician and the principle of beneficence play vital roles in decisions on PAS. Cases of PAS often bring into conflict these principles. As a result, there have been series of debates both from the ethical, legal and religious points of view. The central point of most of the debates is to discover the rationale behind the morality of PAS. If PAS is allowed based on the principles of autonomy and in some cases the principle of beneficence, is it then morally right to involve the assistance of the physician whose obligation is primarily to save the life of the patients? This is one of the provoking questions searching for answers in the debates. But in a bid to critically view the various arguments in PAS efforts must be made to know the background of this issue.

2.1 HISTORICAL OVERVIEW OF THE ISSUE OF PAS.

Debates about the morality of physician-assisted suicide is, for most part a phenomenon of the second half of the twentieth century but the existence of the act can be traced back to the Greek and Roman times. The ancient Greeks and Romans did not consider that life needed to be preserved at all cost. They in turn were tolerant of suicide in cases where relief could be offered to the dying. They believed in the maxim that “the unexamined life is not worth living” and placed priority not on living alone but on living well. G. Gruman maintains that prior to this epoch, in the prehistoric times, measures had being taken to hasten death. For him the Graeco-Roman antiquity was characterized by a generally recognised “freedom to live” that permitted the sick and despondent to terminate their lives, sometimes without side helps. Though Guman’s emphasis was on suicide, but his points stress the fact that suicide took different forms then. By saying that people sometimes carry out suicide without side helps proves that in some cases too people request the help of others in terminating their lives.

Darrel W. Amundsen in his article “The Significance of Inaccurate History in Legal Consideration of Physician-Assisted Suicide” quotes Alfred Alvarez as saying:

---

The evidence is, then that the Romans looked on suicide with neither fear nor revulsion, but as a carefully considered and chosen validation of the way they had lived and the principles they had lived by… According to Justman’s Digest, suicide of a private citizen was not punishable if it was caused by “impatience of pain or sickness, or by another cause” or by “weariness of life… lunacy, or fear of dishonour.”

The implication of this quotation is that the Romans acknowledged the act of suicide either done by oneself or another helping one to die. Though there were many conditions placed on this, the fact remains that in the ancient Roman times, people helped others to terminate their lives in cases of impatience of pain or sickness. The issue of the Hippocratic oath came up as a result of the practice of PAS in the ancient Greek. This oath dated back to the 4th century BC was meant for all ancient physicians to take though not all accepted it. The crux of the oath was to insure that physician didn’t indulge in actions that would directly or indirectly result in the death of their patients.

With the introduction of this Hippocratic oath in the field of medicine, there have been varying opinions on the issue of PAS. In this ancient period many physicians objected to this and argue that helping one in serious pain to die is the best thing he or she deserves or even needs. In the medieval era, Judaism, Islam and Christianity developed ethical traditions that opposed PAS and other forms of euthanasia. The centre of arguments in this period is that God is the sole owner of all lives and it belongs to him to decide when one should die. Thomas Aquinas sees every act of PAS, suicide and euthanasia as usurpation of the creator’s power over life and death.

However, upon entering the domain of science in the 16th century B.C, PAS increasingly came to connote measures taken by physicians to hasten death in cases of terminal and incessant painful illnesses. Francis Bacon, David Hume and Immanuel Kant approved such actions based on the motive of relieving pain.

It has only been in the last hundred years that there have been concerted efforts to look on the morality of PAS. There have been series of debates in most states of the world on the morality of PAS. In the 1970s and 1980s series of court injunctions in the Netherlands

---


culminated in the agreement being reached to ensure that no physician would be prosecuted for assisting a patient to take his or her life, as far as the physician adheres to the stipulated rules guiding the act. The Royal Dutch Medical Association developed the guidelines for which the physician should follow. These were accepted by Dutch prosecutors and have been used by Dutch physicians for the past two decades. Even before these debates in the Netherlands; there were other debates on assisted suicide shortly after the world war II. An example of such debates is the debate in Sweden over the assisted suicide of Birgit Hedeby in 1964. However, one of the striking modern debates on euthanasia and assisted suicide is the 1973 court case in the Netherlands, when a Dutch physician was tried for giving a lethal injection to her debilitated mother. The physician was convicted of murder, but given only a one-week suspended sentence. Subsequently, the Royal Dutch Medical Society proposed guidelines for physician’s participation in voluntary euthanasia, and the state agreed not to prosecute if these were followed. Although euthanasia and assisted suicide remain technically illegal in the Netherlands, an estimated three thousand six hundred cases occurred in 1995, representing approximately three percent of all deaths. Sixty-two percent of general practitioners in the Netherlands report that they have participated in euthanasia.

In 1980, Derek Humphrey, a former British Journalist, founded the Hemlock society in the United States. This was to help people with terminal illnesses to die painlessly and with dignity. The first legislative approval for voluntary euthanasia or PAS was achieved with the passage of bill in the Australia’s Northern Territory parliament around 1990. This bill faced a lot of challenges and in 1997 the bill was made ineffective by an amendment made to the Northern Territory (Self Government) act 1978 of the Commonwealth.

In 1997 legislation was introduced in Oregon in United States to permit PAS. Later in 1997, the supreme court of U.S.A ruled out the constitutional right to PAS. But since the court did not preclude individual states from legislating in favour of PAS, that is, since the individual states still have their independent laws guiding each of them, the Oregon legislation on PAS has remained operative. In November 2000, the Netherlands passed legislation to legalize the practice of PAS. The Legislation passed through all the parliamentary stages early in 2001 and became a law.


5 The Netherlands Department of Justice, press releases, [http://www.minjust.nl](http://www.minjust.nl)
2.2 PHYSICIAN-ASSISTED SUICIDE, ARGUMENTS FOR AND AGAINST.

There have been the debates on whether it is morally right for physicians to be part of or assist their patients to die. The proponents of PAS herald it as the most humane and dignified way to treat competent, terminally ill patients. They point to the sanctity of the person and the right to self-determination by ending “medical paternalism which sometimes leads to the imposition of coercive life-prolonging measures in a manner insensitive to the patient’s autonomy.”

Rosamond Rhodes in her article “Physicians, Assisted Suicide, and the Right to Live or Die,” provides analysis of rights and combined with her views on respect for autonomy and beneficence argues that if we already recognize people’s right to die as seen in the practice of passive euthanasia, then we must recognize people’s right to die as in active euthanasia because they are morally equivalent. If there is the right to die Rhodes argues invariably there must be another person that possesses the duty. If a patient has the right to die, does the physician have a duty to assist in dying? Rhodes argues that physicians have a duty to act for the good of their patients as expressed in the Hippocratic oath or the oath of Maimonides. Physicians have the duty to alleviate suffering. She concludes “when some need can only (or best) be met by ending life, the duty of beneficence provides a ground for both assisting in suicide and for euthanasia.” But does this sufficiently give a ground for the physician’s role in helping or bringing about the death of his patients?

The moral case in favour of PAS appears to draw so obviously upon a store of shared values, a pervasive consensus about freedom and the relief of suffering. The central ethical argument for PAS is that respect for individuals demands respect for their freedom of autonomous choices as long as those choices do not result in harm to others. People often have an interest in making important decisions about their lives in accordance with their own conception of how they want to live. In exercising autonomy or self-determination people tend to take responsibility for their lives and, since dying is a part of life, choices about the manner of their deaths and the timing too are part of what is involved in taking

---

responsibility for their lives. In his article, “A critique of three objections to physician-assisted suicide” Dan W Brock maintains that the most natural explanation about the issue of PAS is that our morality and law take seriously the distinction between individual persons and the right of each person to have substantial control over and responsibility for what happens to him or her. Since persons are embodied individuals and anything that happens to our bodies happens to us, one important component of this personal control concerns what is done to our bodies. If individuals should have significant control over their lives and what is done to them, this should include what is done to their bodies. The idea here is that individuals should have a protected sphere of control or sovereignty in which they cannot be interfered with without their consent and that control over what is done to one’s body is a core of that sphere.

This argument is more concerned with voluntary euthanasia. It stresses on the danger inherent in carrying out euthanasia without the consent of the patient, hence doing an involuntary euthanasia.

From the various arguments of the proponents of PAS I make a deduction. This deduction is that these arguments identify three main reasons for the support of PAS. These include:

1. The realisation of individual autonomy.
2. The need to reduce needless pain and suffering
3. The provision of psychological reassurance to the dying patient.

In stark opposition, Bernard Baumrin in his article “Physician, Stay Thy Hand,” provides a counter view about the role of physicians in assisting the death of patients. Unlike other opponents of PAS who argue from the point of view of slippery slope, Baumrin concerns himself with what is the duty of a physician. His argument rests on the

---


It may be worth noting that issue of autonomy does not show any distinction between PAS and euthanasia. The interest in autonomy is the view that individuals should control the timing and manner of their lives and deaths. We should note too that some people maintain a middle position in the issue of PAS. There is a key one-third of Americans whose opinions on PAS take this middle stand. They believe that circumstances can determine the morality of PAS. For them, in some cases, it might be ethically justified while in other cases it cannot. Interestingly, the only situation that can warrant a majority opinion for this is when the patient has a persistent and ceaseless pain. For more on this confer Ezekiel J Emmanuel, et al, “Euthanasia and Assisted-Suicide: Attitudes and Experiences of Oncology Patients, Oncology, and the Public”, in The Lancet 347, 1996, PP. 1805-1811. Confer also Daniel Callahan, “When Self-Determination Runs Amok”, in Hastings Centre Report 22, 1992, pp. 52-55.
fact that killing a patient can never be consistent with the goals of medicine. The practice of medicine according to him is embedded in a long tradition rooted in the ancient Oath of doing no harm. Physicians are part of a long tradition with certain moral principles and prohibitions. Acting in a way that is different would mean changing the role of physicians in the society. For Baumrin, doctors are expected to be advocates of preserving lives, to the extent that in war they are expected to remain neutral and treat the wounded victims of the enemy as well as those of their own group. So for him allowing for PAS would compromise the medical profession and our expectation.10

The act of allowing a patient to die from an underlying terminal illness when the treatment is ineffective is fundamentally different from endowing the terminally ill with the right to request another person to assist in his death. This calls for making a distinction between active and passive killing. The former represents situations addressed by living wills statutes and mainly concerns euthanasia. As for the latter, few issues are of greater personal or moral concern than whether to legally-sanction one person’s active assistance for another who wants to die. This aspect often concerns physician-assisted suicide. There has been an unavoidable tension within the medical profession founded on the inability to always sustain life while relieving suffering. The traditional doctor-patient relationship and the practice of medicine itself are transformed when a qualified patient can demand death as a treatment option. It is in line with this that the American Medical Association’s Council on Ethical and Judicial Affairs in accordance with the Hippocratic oath, maintains that physicians may intend to save life and relieve suffering, but they may not intend as their primary purpose the death of their patients.11 The fear in PAS is that if doctors are allowed to assist in killing patients they (doctors) would be desensitized about the value of human life. This permission would mean imputing more power to human action than it actually has and to accept the conceit that nature has now fallen wholly within the realm of human control. Hence W. Gaylin, L. R. Cass, E. D Pellegrino and M. Siegler in their work “Doctors Must Not Kill”, maintain, “If medicine’s power over life may be used equally to heal and to kill, the doctor is no more a moral professional but rather a morally neutral technician”12


One of the most common arguments against PAS is the one based on the slippery slope. The president’s commission on ethical problems in medicine and biomedical and behaviour research in Washington, DC 1983 goes thus:

The Commission finds out this limitation on individual self-discrimination (i.e., physician-assisted suicide) to be an acceptable cost of securing the general protection of human life afforded by the prohibition of direct killing.\(^{13}\)

This report expresses a concern for the general protection of human life. The implication of this report is that the “benefit” that might come from the act of PAS both on the side of the patient on the one hand and that of the physician on the other does not worth the sacrifice to the general protection of human life. Since so many situations are possible to prompt one to ask for assistance in dying (Psychological and economical situations, family pressures as well as financial cost of treatment) the right to physician-assisted suicide will slowly spread to the disabled and mentally competent adults that are not terminally ill.

From the arguments of the opponents of PAS, I make another deduction on the reasons why these group cry against any act of PAS. Their arguments are mainly based on the fact that this act reduces the integrity of human life. Ezekiel J Emmanuel in his article “What is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide” outlined some of the potential harms of legalizing these actions which opponents of PAS use in their arguments. These include that:

1. It undermines the integrity of the medical profession.
2. Creates psychological anxiety and distress in the patient from the possibility of euthanasia and PAS.
3. Calls for the coercion of patient to use PAS against their wishes
4. Calls for the provision of euthanasia or PAS to patients prior to implementing optimal palliative care interventions.
5. Makes for the provision of euthanasia or PAS to patients without their full rational informed consent. May be because of their mental illnesses or mental incompetence.

\(^{13}\) President’s commission on ethical problems in medicine and biomedical and behaviour research. Deciding to forgo life-sustaining treatment. A report on the ethical and legal issues in treatment decisions, Washington, DC: Government printing office, 1983.
6. Brings psychological distress and harm to surviving family members of the patient.  

As seen from the arguments of the proponents of PAS, the moral case in favour of this act appears to draw so obviously upon a store of shared values, a pervasive consensus about freedom and the relief of suffering. The respect for individual right to autonomy and self-determination play vital role in the arguments here. But the most striking issue that makes the morality of PAS problematic is the involvement of the other party in the act. The issue of PAS has less to do with when and how a person decides to die than it does with how and when people are allowed to kill others. John Stuart Mill, in his work, On Liberty argued that the one exception to our right to do with our persons, as we will is the right to sell ourselves into slavery. The principle of freedom does not require that one should be free not to be free. It is never freedom to be slaves of our own selves. To give a person the right to kill another is to give him the power to remove the freedom of the agent ones and for all. This is the most basic threat to, or violation of the right to self-determination. As Daniel Callahan points out, to ask another to be agent of my death, moreover, would cease to be simply an expression of my isolated autonomy. It would create a profound relationship between that other person and myself, transcending our individual acts. From the side of the person who killed me, his would be an irrevocable act, one that becomes his act as much as mine. From my own side, I would be recruiting an accomplice, asking him to take into his hands a decisive power over me, one that could not be recalled once he had acted.

However, considering the various arguments and opinions about PAS, I suppose that the principles of autonomy and beneficence by themselves are not sufficiently enough reasons to argue for the justification and non-justification of assisted suicide. My reason for this is primarily because in the concept of PAS the main issue of consideration is the suicidal act. The assistance of the physician is just an addendum. Not only health issues warrant the choice of suicide. Arguing on PAS based on autonomy and beneficence restricts the conception of PAS to only matters of health especially critical and terminal health conditions. In this way then one cannot see the actual difference between PAS and euthanasia Other factors do prompt for the request of PAS. Factors like psychological

---


depressions, anxieties, and all forms of economic and social frustrations often lead some people to make the choice of PAS. They would request the help of the patient because in some cases they would fear the pain they might encounter if they hang, shoot or stab themselves. If this is accepted which I think should, referring to autonomy as a ground for justifying request for PAS doesn’t follow because just as Beauchamp and Childress point out this right is not absolute in itself rather it is a prima facie right. Its respect depends on the circumstances surrounding the autonomous choice made. In some cases people or patients make irrational choices, which do not warrant any attention. When a patient makes irrational choice of PAS, other issues relevant in medical practices can then override his right. I will explain more all the things that make certain choices irrational later in this work.

On the other hand the issue of beneficence posits a question on how to know the welfare of the patient, and what actually constitutes this benefit for the patient. In some illnesses especially in those with severe pain and assured death occurrence, the welfare of the patient, his disease and sickness which the physician ought to protect, relieve and cure are incorporated in the pain and the solution tends to be death. I argue here too that this principle of beneficence taken in any way is not an absolute principle, and like the principle of autonomy it is a prima facie principle. Attention should shift from whether or not PAS should be allowed to how, when and in what conditions and circumstances can physicians respect the choice of the patient to help in bringing about his death and this would not violate their own obligations as physicians.

2.3 THE CHRISTIAN VIEW ON PAS

From the historical view of PAS and euthanasia it is observed that the early Christians also contributed in matters that relate to assisted suicide and some other health care issues. In recent time, and with the modern debates on this issue, there abound the Christian stand in the various arguments and debates about the morality of physician-assisted suicide. What Christians say about issues of morality especially as it relates to PAS is usually based on a reflection of their fundamental faith convictions. At least three of these convictions appear especially relevant to the question of whether it is acceptable for Christians to seek a physician's assistance in committing suicide in the midst of extreme suffering in one hand and whether the physician should respond positively if such requests are made. Glaring in the Christian argument against PAS are issues like: the dignity of
human life, the decision about life belonging to God, man not an “I” but a “thou”, and the possibility of changes (miracles)

A fundamental conviction Christians have is that man doesn’t belong to himself alone. Life, despite its circumstances, is a gift from God, and each individual is its steward. Commenting on life being a gift from God, Frederic Bastiat in his book *The Law: The Classic Blueprint For a Society* writes thus,

> We hold from God the gift, which includes all others. This gift is life – physical, intellectual and moral life.

> But life cannot maintain itself alone. The Creator of life has entrusted us with the responsibility of preserving, developing, and perfecting it. In order that we may accomplish this, He has provided us with a collection of marvellous faculties. And He has put us in the midst of a variety of natural resources… Life, faculties, production – in order words individuality, liberty, property – this is man.16

This clearly expresses how Christianity perceives human life. This conception points to the fact that since life is a gift given to men by God, that it belongs to God to take back His gift when He wishes and man was only given the injunction to use all the natural things God gave him to preserve this gift of God.

However, contemporary arguments for the "right" for assistance in committing suicide are based on the ideas of each individual's autonomy over his or her life. Though Christian views acknowledge that one has this right, but their stand is that this right is never absolute. It is always overridden when it comes to issues that are related to decisions about ending of human life. The decisions about when and how to die belongs to God to take they maintain and people should yield their personal autonomy and accept a special obligation that belongs body and soul, in life and in death to God. The Roman Catholic position about PAS is reflected in the March 25, 1995 encyclical “Evangelium Vitae” (The Gospel of Life.). Pope John Paul II emphasising on the inviolability of human life maintains that God is the sole dictator of our existence and it belongs to Him to say when one dies and/or lives. The choice of death involves the rejection of love of self and the renunciation of the obligation of justice and charity towards one's neighbour, towards the communities to

---

which one belongs, towards society as a whole and towards God. Hence, in this encyclical Pope John Paul II maintains that:

To concur with the intention of another person to commit suicide and to help in carrying it out through so called 'assisted suicide' means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested.\(^{17}\)

In a remarkably relevant way the Christian view on PAS rests on some of the words of the early Christian philosophers like St Augustine, Thomas Aquinas, Bonaventure, and others. Pope John Paul II quotes Saint Augustine as saying that "it is never licit to kill another: even if he should wish it, indeed if he request it because, hanging between life and death, he begs for help in freeing the soul struggling against the bonds of the body and longing to be released; nor is it licit even when a sick person is no longer able to live."\(^{18}\) The implication of all these is that man owes God an obligation and a duty since He made him. Certain decisions should be left in the hands of God, more especially decisions concerning how and when to die. C. S. Lewis provides an analogy to clarify how special moral obligations arise from a special sense of belonging:

Does it not make a great difference whether I am, so to speak, the landlord of my own mind and body, or only a tenant, responsible to the real landlord? If someone else made me, for his own purposes, then I shall have a lot of duties, which I should not have if I simply belonged to myself.\(^{19}\)

On August 7, 1998, the Lambeth Conference of the Anglican Communion said that euthanasia is neither compatible with the Christian faith nor should be permitted in civil legislation. In this conference it was viewed that withholding, withdrawing, declining or terminating excessive medical treatment and intervention…may be consonant with Christian faith in allowing a person to die with dignity." The 73rd General Convention of the Episcopal Church in July 2000 said, "…the Episcopal Church should continue to oppose physician-assisted suicide near the end-of-life because suicide is never just a private, self-regarding act. It is an act that affects those with whom we are in relation within the community, denying them the sense of meaning and purpose to be derived from

\(^{18}\) \textit{Ibid.}
\(^{19}\) C. S. Lewis, \textit{Mere Christianity}, New York, Macmillan, sixth printing, 1966, p. 73.
caring for us as we die. Moreover, it threatens to erode our trust in physicians, who are pledged to an ethic of healing. Finally, it denies our relationship of love and trust in God and sets us up as gods in the place of God.²⁰

Christians on all the sides of the argument on PAS share certain convictions. The fundamental one as explained above is a common commitment to the sovereignty of God and to life as good in relationship to God's purposes. This positions aims at protecting human dignity and upholding compassion towards those who suffer intolerable physical pain and immense emotional suffering while dying. It lifts up principles of social justice as critical issues in this debate. Finally, it recognizes that situations of dying often create conflicts between the goodness of physical life and other goods or purposes in life.

However, the Christian arguments are mainly based on religion and faith. The Christians draw their morality from God and thus maintain that whatever that goes against the wish of God becomes immoral. Though most of their arguments are religiously based, the Christian view of PAS in some cases posits some rational arguments. Arguing against PAS based on the dignity of human life, views human life as of fundamental value.

CHAPTER THREE

3.0 PROFESSIONAL INTEGRITY AND THE DILEMMA IN PAS.

From the discussions so far there is the indication that physician-assisted suicide is only one of many clinically and ethically distinguishable practices in end-of-life care. Most commonly, life-sustaining treatments are withheld or withdrawn when patients refuse such treatment. The ethical and legal consensus about such practices is well established. Recent voter initiatives and court decisions have reflected public interest in physician-assisted suicide. Many people fear a painful and protracted death or desire more control over the dying process. Some fears have been justified in a way. Our societal emphasis on "cure" and the medical emphasis on “intervention” have sometimes been at the expense of good end-of-life care. We have been slow to embrace the practice and principles of hospice, and dissemination of state-of-the-art palliative care, especially pain control techniques, has been incomplete. Reimbursement disincentives for comfort care have exacerbated the problem, and cost-control pressures that discourage expensive long-term care loom large over care at the end of life.1

However, physician-assisted suicide is a different type of act, and is far more controversial. In physician-assisted suicide, medical help is provided by a physician to enable a patient to perform an act that is specifically intended to take his or her own life, for example, overdosing on pills as prescribed by the physician for that purpose. This chapter discusses the role of the physician in assisted suicide and how the act comes in conflict with the professional integrity of the physician in question.

3.1 BACKGROUND CASES IN PAS.

There have been various cases of physician-assisted suicide, but for the sake of this work I will focus the background case for my discussion and argument here on Dr. Jack Kevorkian, his suicide machine and his assistance in the death of Janet Adkins. I will also consider Dr. Timothy Quill and his assistance in the death of his patient Diane. The actions of these two physicians and the nature of the request made by the different patients will help in a way to explain the dilemmas physicians encounter in assisting in the death of their patients.

3.1.1 DR. KEVORKIAN AND THE SUICIDE MACHINE.

Dr. Jack Kevorkian, a retired pathologist and one of Metropolitan Detroit’s famous citizen has led the fight to make assisted suicide a right of all citizens by actually helping terminally and in some cases non-terminally ill people to die by their own hands. Born in 1928 in Pontiac, Michigan Dr Jack Kevorkian received a medical degree with a specialty in pathology from the University of Michigan in 1952. After publishing several controversial papers in the 50s and 60s, he became chief pathologist at Saratoga General Hospital in Detroit, where he remained until the late 70s.

He began to form his view on euthanasia and assisted suicide during his residency at the hospital at the university of Michigan. Here it was noted that he decreed the waste of the bodies of condemned prisoners and proposed that physicians render such prisoners unconscious and then use their bodies for risky medical experiments. However, this led him to be forced to leave when the (university) officials heard of his proposal. But, Kevorkian did not just recommend using condemned criminals for experimentation. In his article published by the German Journal Medicine and Law, he stated that experiments could be performed on anyone who might face “imminent death, all living intrauterine and aborted or delivered foetuses.”

At this point one may be wondering how Dr. Kevorkian became convinced in the ethicalness of doctor-assisted suicide. He explains that he arrived at this conclusion after observing a severely emaciated middle age woman dying of cancer. He observed this woman while he was an intern and later wrote about the experience in his book, Prescription: Medicine, published in 1991. In 1986, he became aware that doctors in the Netherlands were practicing euthanasia. He had been working again on his ideas about experimenting on death row inmates and thought he could include patients who were euthanized. He hoped he could combine his aspiration for medical experiments on the dying with a new campaign for assisted suicide. He wrote articles about this new obsession detailing his thoughts on the ethics involved in euthanasia and his ideas were so controversial because his thoughts reflected a total wish to engage in assisted suicide based on his argument that doing such work is the function or obligation of the physician to the patient.

2 Isabel Wilkerson, “Physician Fulfils a Goal: Aiding a Person in Suicide” in New York Times, June 8, 1990

Although Kevorkian has always sought ways to increase the availability of subjects for medical research and organ transplantation, he has never been a medical researcher or a surgeon.


Information about Kevorkian and assisted dying from Heritage House Literature, an organization that opposes the practice.
It was during this time that Dr Kevorkian gave a name to the new branch of science he was developing. The word “obitiatry” showed up in adverts he posted for patients for this new medical specialty. In 1988, Kevorkian's article, "The Last Fearsome Taboo: Medical Aspects of Planned Death," was published in Medicine and Law. He defined his intended system of arranged deaths in suicide clinics. In 1989, he invented his first death machine called the “Thanatron” meaning "death machine,” but famously regarded by him as “mercitron.” In June 1990, Kevorkian assisted in his first suicide, Janet Adkins a 54-year-old woman from Portland, Oregon who suffered from Alzheimer's. She and her husband were long-time Hemlock society members, and so advocate euthanasia and PAS in some cases. From the diagnosis by the doctor in Portland, she understood that she would be dependent on her husband for feeding and bathing. She did not want to take her own life in case she messed it up, and her own doctors wouldn't help her. After hearing about Kevorkian, the husband of Janet Adkins contacted him to employ his services. After the brief conversation, Kevorkian agreed to meet with her and the family to discuss their intentions and eventually carry out the suicide. He had already prepared authorization forms signifying Janet’s intent, determination, and freedom of choice, which she readily agreed to sign.

Through in this method, Kevorkian believed he had established informed consent, but as a former pathologist, he had not been Adkins’ attending physician and further lacked the special training necessary to evaluate a patient’s mental state. In her suicide note that she wrote the night before she died, Janet Adkins maintained that she decided for the following reasons to take her life. She also said that the decision is taken in a normal state of mind and is fully considered. I have Alzheimer’s disease and do not want to let it progress any further. I do not choose to put my family or myself through the agony of this terrible disease.

Janet Adkins was the first of dozens of Kevorkian "patients" whose names are actually known. In the fall of 1991, he assisted in the double suicide of two women patients, one with multiple sclerosis and the other with chronic vaginal-pelvic pain. In May 1992, he helped another victim of multiple sclerosis to kill herself.4

However, in March 1999, a jury found him guilty of second-degree murder in the death of Thomas Youk, an Amyotrophic Lateral Sclerosis (ALS) sufferer, and was to serve a 10-25-year sentence in prison in Michigan. This would make him not to be eligible for

---
parole until he is 77 years old. There was a movement founded with the motive to have him released early due to his age and health, though opponents continued to claim that he should serve out his sentence like any other convicted "murderer," despite the fact that his "victim's" family continues to stay in touch with him. The case of Janet is the most outstanding case that has been provoking varieties of arguments up till date. Kevorkian was charged with murder in this death, but the medical trappings of the machine seemed to help persuade the trial judge that Kevorkian’s acts were medical in nature. Relying on this the judge dismissed all charges, ruling that Janet had caused her own death. The decision of the Judge on this case was boosted more from the fact that Michigan had no specific law against assisting a suicide.

Dr. Jack Kevorkian operates on a simple philosophy: People have a right to avoid a lingering, miserable death by ending their own lives with help from a physician who can ensure that they die peacefully. Hence his famous axiom, “When society reaches the age of enlightenment, then they’ll call me and other doctors Dr. Life.”

3.1.2 DR. TIMOTHY QUILL AND ASSISTED-SUICIDE.

Dr. Timothy E. Quill received his undergraduate degree from Amherst College (1971) and his M.D. from the University of Rochester (1976). He completed his Internal Medicine residency in 1979 and a Fellowship in Med/Psych Liaison in 1981, both from the University of Rochester School of Medicine and Dentistry. Currently, Dr. Quill is the Associate Chief of Medicine at the Genesee Hospital, a Professor of Medicine and Psychiatry at the University of Rochester School of Medicine and Dentistry, and a primary care internist in Rochester. He has published and lectured widely about aspects of the doctor-patient relationship, including partnerships, communication, barriers, delivering bad news and somatization. He has focused extensively on end-of-life decision-making.

In 1991, Dr. Timothy E. Quill also received media attention after disclosing that he had prescribed a lethal dose of barbiturates for a cancer patient who was terminally ill. He published this account in a Medical Journal and was prosecuted for murder after the appearance of his article. However, the grand jury refused to indict him. The case of Dr. Timothy and his patient Diane is frequently cited as a contrast to Jack Kevorkian’s cases.

7 Gregory Pence, Ibid, p. 72.
In 1990, Diane was suffering from leukaemia and at a point she developed acute myelomonocytic leukaemia. She had been a patient of Dr Quill for over three years. As a result of the good doctor-patient relationship between Quill and Diane, he explained the nature of Diane’s illnesses to her. All treatments of these would almost inevitably cause infections, loss of hair and nausea. But with no treatment at all, death would be certainly the case in matters of days, weeks or at most several months. Reflecting on the information and the chances of survival coupled with the processes that would be involved Diane decided to forgo treatment though began to worry intensely about a lingering death. Later she concluded that she wanted barbiturates so that she could kill herself. Dr. Quill though worried about the whole scenario wrote a prescription for barbiturates after he had made sure that his patient was not irrationally depressed.

As said above, the case of Dr. Quill and Diane is often described as contrasting in several ways with the Dr Kevorkian cases. In the first instance, Dr Quill has known his patient for a long time and has been her doctor for quite a long period of time. More so, he offered a course of treatment that might allow her to survive, but the patient refused this. He helped her die privately and without publicity at the time; he preserved her anonymity; he presented his account in an established medical forum; and he was not a “specialist” in assisted dying. Some critics who are strongly opposed to Jack Kevorkian have reacted positively to Timothy Quill.

3.2 THE PERSON OF THE PATIENT

One significant feature in the issue of PAS is the nature of the person of the patient. Apart from abortion, there is no controversy in medicine more contentious or polarizing today than the controversy over physician-assisted suicide. Yet, it is not immediately obvious why this issue has become so acutely important. Proponents of assisted suicide usually invoke a prototypical scenario to illustrate their position: Consider the patient riddled with widely metastatic cancer, facing imminent death, and suffering from severe, uncontrollable pain. Does not such a patient have a right to ask his or her physician to give him the means to end his suffering once and for all? And does the physician not have the right to respond without committing a crime

Myelomonocytic leukaemia is mainly found in elderly people. It is associated with hypercellular bone marrow, usually dysplastic, with increased myeloblasts, plus an intermediate population of cells.


9 Gregory Pence, Ibid, p. 73.
These are extremely compelling questions. Accordingly, this scenario is the one that has been posed to the public in most polls whose results appear to show that the majority of people are in favor of physician-assisted suicide. Few would argue that this terminal, pain-wracked patient does not have a right to expect his physician to do whatever it takes to relieve his suffering. Few would expect physician to deny the desperate pleas of the patient. Most would believe it unethical for a doctor to deny those pleas. Many too presume the importance of individual autonomy, stressing the right of autonomous decision makers of the patients to determine for themselves what will or should be done to their bodies.10 This individual autonomy as pointed out by Raanan Gillon involves deciding for oneself on the basis of deliberation, intending to do things as a result of those decisions and sometimes going ahead and doing those things so as to implement the decisions.11 The emphasis on the right to individual autonomy here is based on the presumption that the good relationship that should exist between the doctor and the patient is rooted in the autonomy of the patient. This is the right of self-determination and is often stressed in such a way that professionals who act against their patient’s wishes even if it is to save the lives of the patients are often seen as morally blameworthy.

Another issue that plays a vital role in PAS is the issue of beneficence and in some cases along side with non-maleficence. Benefiting some one often entails avoiding harming that person. This is the reason why these two concepts or principles always go together in discussions and arguments. The traditional moral obligation of physicians even as stipulated in the Hippocratic oath and other medical codes is to always provide net benefits to the patients. To achieve these moral objectives, Gillon maintains that physicians and other health care workers are committed to a wide range of prima facie obligations. He writes.

First we need to ensure that we actually can provide the benefit we profess (hence professionals) to be able to provide… We also need to make sure that what we are offering actually constitutes net benefit for patients-and not just for patients in general but for the particular patient concerned. Interestingly, in order to do so, we must once again respect the patient’s autonomy… This assessment of how much benefit or how much harm a proposed intervention will provide with turn to a large extent on the perceptions of the patients concerned.12

---

12 Ibid, p. xxiv
The implication of this stipulated obligations is that, important in most moral codes and obligations is the issue of self-determination of the patient or what Gillon refers to as “empowerment”- doing things to help patients and clients to be more in control of their health.

However, many controversies arise when these principles come in conflict with each other. In the case of PAS, the patients takes the decision to end his or her life, requests the help of the physician and the physician faces the problem of deciding which way is better to follow in such request. Respecting the autonomy of the patient matters for him and keeping to his obligations and regulations as a medical professional matters to him as well. Hence there becomes the need to strike a balance. As Gillon, Beauchamp and Childress would opine, these rights are not absolute in themselves, so they can be overridden in certain circumstances. However, my task here is to discuss and as well argue on the autonomy-based argument of the morality of PAS, considering issues like the decision-making and its rationality.

3.2.1 THE PATIENT AND THE PRINCIPLES OF AUTONOMY AND BENEFICENCE.

Recent developments in medical ethics tend to unfold the reality that moral responsibility of actions and omissions in medicine are best conceived in terms of basic rules, rights, virtues and fundamental principles. Though rules, rights and virtues play more vital roles in health care ethics, principles still provide the most comprehensive starting point in issues within this area. They are deeply embedded in the tradition of medicine and health care ethics in that they point to an important part of morality that may be, has been traditionally neglected, but now need to be placed at the foreground.\(^{13}\)

The issue of the patient’s autonomy is based on the principle of individual autonomy, rooted in the liberal Western tradition that stresses the importance of individual

---

freedom and choice. It is loosely associated with several ideas in biomedical ethics as privacy, voluntariness, self-determination, self-mastery, choosing freely- the freedom to choose ones own moral position and what should happen or be done to ones live. This principle of individual autonomy involves accepting responsibility for ones choices.

Historically the term autonomy comes from the ancient Greek words: “autos” (self) and “nomos” (rule or law) referring to political self-governance in the city-state. However, this issue has come to be applied in ethics especially in the area of biomedical ethics, thus shifting its meaning from being what concerns the entire city-state or a group within the state to what concerns a person as an individual. This makes for the issue of individual autonomy, which has given rise to the right to individual autonomy rooted in the principle of autonomy. Beauchamp and LeRoy Walters explain what this personal autonomy entails. They write:

…personal autonomy has come to refer to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interference by others and from personal limitations that prevent choice. “Autonomy,” so understood, has been analysed in terms of freedom from external constraints and the presence of critical mental capacities such as understanding, planning, and deciding.14

The nature of this concept, individual autonomy has given rise to the demand for its respect. It is one thing to be autonomous and another thing to be respected as an autonomous person. To respect an autonomous person is to recognize the person’s due capacity and perspective, his or her rights to hold certain views, make certain choices and take certain actions based on personal values and beliefs. This means that whenever this issue of autonomy comes into vogue, it is always characterized by (i) self-determination of the agent in question and (ii) the need to recognize this self-determining agent as entitled to determine his or her own destiny with regard to considered evaluations and view of the world.15 This relates to what is expressed in the Kantian conception of autonomy. Kant views autonomy as based on treating persons as ends not as means. As ends in that they have the right of determining their own destiny, have their own opinions and correspondingly act upon their opinions.

15 Ibid, p. 23.
The principle of respect for individual autonomy has long being the necessary ground of the proponents of PAS. The crux of the argument here is that since people are embodied individuals, anything that happens to our bodies happens to us. People should have significant control over their lives and decide on what should be done to their lives. If we take the expression of Kant, that individuals should be treated as ends not as means, then the individual should have a protected sphere of control or sovereignty and these cannot at any circumstance be interfered with. In the debates about the morality of the case of Dr. Kevorkian and his assistance in the death of Janet Adkins, proponents of PAS argue that the Alzheimer disease characterized by devastating loss of memory, resulting from irreversible degeneration of neural cells reduced the quality of Janet’s life. Since her mind was her life and quality of life mattered so much for her, Janet wanted to die with dignity intact, so had the right to make such request from Dr. Kevorkian. On his own part, Dr. Kevorkian as a physician owes it as a duty and obligation to respect the autonomous choice of Janet his patient. Thus, refusal to even consider the PAS option would have definitely amounted to a form of patient abandonment. This reflects what G.G Miller and Howard Brody articulate in their article “Professional Integrity and Physician-Assisted Suicide”. While weighing the arguments for and against the involvement of physician in assisted suicide, they assert as argument of the proponents:

A system which would allow PAS by those physicians who are willing to perform it and would allow those opposed to refuse to participation will promote the value of relief of suffering and respect for patient’s choice without compromising the moral integrity of any physician.16

Though my task here is to discuss the issue of autonomy as it relates to assisted suicide, it is a point worth nothing that the right to individual autonomy does not guarantee a duty or obligation for the physician. A doctor that assists a patient in his death does not do this based on the fact that he or she is bound to do that. The role or duty of a physician involves more than simply acceding to patient requests. Some would argue that if the primary objectives of the physician were to cure their patients, relieve their suffering, work towards their welfare and do all things that benefit the patients, then in cases where the

death of the patient would bring more comfort, give less pain and help to relieve suffering, the physician has it as a duty to respect any request made towards this. This proposition depends on the fundamental assumption that suicide results from a poor quality of life and that people with health problems and disabilities always have a lower quality of life than people without health problems or disabilities. Here there is the assumption that a rational consideration of quality of life is the motivation for suicides and that assumption that the course and prognosis of an illness or disability is predictable and can be accurately forecast.

Like all other members of society, people with chronic illnesses and disabilities experience a full range of emotions. Some are distressed, perhaps even suicidal, but others with the same illnesses and disabilities are enjoying life. People without disabilities also experience a full range of emotions. Some are distressed, and some are suicidal, while others are enjoying life. Suicide is no more or less rational for members of either group. People choose to commit suicide because they experience isolation, boredom, anger, betrayal, humiliation, or a variety of other negative emotions. The belief that disability or illness is a rational reason to commit suicide is based only on negative ideas about illness and disability.\textsuperscript{17} Hence once we accept the priority of these claims, Callahan maintains, the implication would be that there would be no logical basis on which to deny any request for euthanasia from any suffering patient.\textsuperscript{18}

The welfare of the patient is the goal of medicine and bioethics. Clinical therapies are aimed at promoting health, preventing diseases and curing the diseases in case they manifest. Among the most quoted principle in the history of the codes of medical ethics is the maxim “primum non nocere” Above all, do no harm. Since it is obvious that request for suicide can be as a result of so many factors, which in some cases have nothing to do with the health condition of the person, total justification of physician’s assistance in deaths based on the principle of autonomy of the person entails obedience to all request for suicide even the irrational choices.

Another ethical principle that plays efficient role in the issue of PAS is the principle of beneficence. This principle expresses the obligation of the physician to help others (Patients in particular) further their important and legitimate interest by preventing or removing harm. The prevention of harm is not mainly associated with the principle of beneficence. It is more related to the issue of non-maleficence. These two concepts are in


most cases intertwined in such a way that they are often envisaged as pursuing the same
goal—taking steps in helping others, not merely the omission of harm-causing activities but
also working towards the good of the others. In medicine these principles are being
applied to the relationship that exist between the patient and the physician. The welfare of
the patient is the goal of medicine and health care. Thomas Percival furnished the first
well-shaped doctrine of health care ethics. In making this formulation he argues that non-
maleficence and beneficence fix the physician’s primary obligation and in some cases
triumph over the patient’s right to autonomy especially in serious circumstances of conflict.
He writes:

To a patient… who makes inquiries, which, if faithfully answered, might prove fatal
to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is
suspended and even annihilated; because, its beneficial nature being reversed, it would
be deeply injurious to himself, to his family and to the public. And he has the strongest
claim, from the trust reposed in his physician, as well as from the common principle of
humanity, to be guarded against what ever, would be detrimental to him…

Various arguments both for and against PAS stem from this range of duties
requiring abstention from harm and positive assistance to some one. I combine the
arguments for and against in relation to the principle of beneficence because both sides
often draw their points from the principle. The opponents of PAS would maintain that the
primary commitment of professional in health care sector is to protect the patient from
harm and to promote the welfare of the patient. For them this entails that the physician’s
primary function is to alleviate pain by providing adequate treatments that would enhance
the health of the physician. For them this principle entails the promotion of the good
interest of the patient and as such assisting one to take his or her life becomes a reverse of
this goal. On the other hand the proponents of PAS maintain that what is good to the
patient depends on the patient’s conception of that. For them since the goal of medicine is
to avoid harming the patient and working towards the benefit of the patient, in severe
painful illness whereby the only solution in relieving pain is the death of the patient and the
patient opts for that, then it becomes an obligation of the physician to assist the patient.

19 Tom L. Beauchamp, in Raanan Gillon, Ibid, pp. 7 and 8.
20 Percival, T, Medical Ethics; or a Code of Institute and Precept, adapted to the Professional Conduct of
However, I consider these opinions as relevant in a way and irrelevant in another. One of the factors that often distinguish PAS from euthanasia is very well concerned with this principle of beneficence and non-maleficence - the motive of the action. This principle emphasizes that the motive of the physician must always be towards what benefits the patient and not merely what the patient feels benefits him or her. This distinguishes this principle from the principle of individual autonomy. The principle of beneficence plays more roles in euthanasia while in PAS the principle of autonomy often take upper hand. Figures have shown that most requests for PAS are always based on what the patient feels beneficial to him or her. When Dr. Quill announced his assistance in the death of Diane most critics question why he responded to [Diane] as he did, what self-scrutiny he brought to bear on his own urge to comply, and how he reconciled this with the arguments that physicians who are moved to so respond should nonetheless resist.21

First, Quill had been Diane's provider for at least eight years. While one might argue that we cannot know how often he saw her or how well he knew her, the fact remains that they had a long-term relationship and that he knew a good deal about her, including her history of alcoholism, her three-year abstinence at the time of her diagnosis, and her "strong sense of independence and confidence."22 In addition, Diane's acute myelomonocytic leukaemia, if untreated, would have resulted in her death within, at most, months. The extremely painful course of treatment Diane refused had only a 25 percent chance of success; Diane made clear that she wanted to spend her remaining time with her husband and son. Quill tells us that he did everything he could to ensure fully informed consent, he clarified the odds, and made sure she knew "what to expect if there were no treatment."23 Though he continued to hope that she would change her mind. There was something about her giving up a 25 percent chance of long-term survival in favour of almost certain death that disturbed him; Quill did everything he could in the meantime to keep her comfortable. When she asked for help in dying, he did not casually prescribe the requested barbiturates but rather met with her to discuss her intentions and to assess her


23 Ibid, p. 692.
mental state; convinced that she understood the consequences of her decision and that that decision reflected her core values, he agreed to provide her with the prescription.

The fact relevant here is that Quill never agreed with Diane because he understood very well as a professional physician that such decision is not to the patient’s best interest. Quill experiences little self-doubt. He did not agree with Diane's decision and yet helps her to effect it. In this case one can infer that PAS cannot be justified based on this principle of beneficence and non-maleficence. Medicine though in the technical sense is described as a practice, with its own set of internal goods and defining rules. These goods and defining rules are embedded in the codes of medicine. Hence, any action that violates these internal values tends to be contrary to professional integrity, which is a distinct or special virtue that is binding for physicians because of their professional role.

However, the controversial problem that always confronts these principles of autonomy and beneficence as with other moral principles is the need to be able to interpret their consequences for particular context and to determine precise limits in their applications as on how to handle situations of conflicts. Such conflicts appear in cases of PAS where by the physician faces the dilemma of either respecting the autonomy of the patient that requests for assistance in death or refuse that and there by keeping to his fundamental role and obligation as a professional physician. These conflicts give rise to certain controversies. The controversies involve problems about what the condition should be, under which a person’s right to autonomous determination and expression demands actions by other people. Hence the issue of physician integrity in assisted suicide. In a bid to tackle the problem of these conflicts and controversies and to argue on what should operate in matters of conflicts between the autonomy of the individual person, the principle of beneficence and non-maleficence and the integrity of the physician, it is advisable to look into the nature of choice making of the patient. This entails, considering the competence of the patient, the rationality of such choice and the circumstances surrounding such choices.

3.2.2 THE RATIONALE BEHIND CHOICE MAKING OF THE PATIENT.

In various discussions in biomedical ethics, autonomy of the patient is closely allied with rationality. Making autonomous choices and respecting such choices are always

---

judged in terms of the rationality of such choices. As Thomas Mappes and Jane Zembaty point out, an autonomous individual is characterised as one who is capable of making rational and unconstrained decisions and acting accordingly. The claim to such right and the need for its respect depends solely on the circumstances surrounding such claims. Here three terms play vital role in considering the rationality of choices and decisions. First is the issue of competence of the individual in making decisions. This entails that rational decisions are based on decisions made in the absence of coercion and constraints. Second is the reason for such choices. Here we talk about the reasonable ground for making autonomous choices. The third issue concerns coercion and this emphasises the importance of making unconstrained decisions.

3.2.3 COMPETENCE OF THE PATIENT

Competent patients are morally and legally entitled to refuse medical treatment, though how far in advance such refusals can be made and exactly what they can encompass are matters for debate. As a general principle, competent patients have first, responsibility for their own health, and should be permitted to make decisions about their health. A competent patient is one who has the capability of deciding on what is good to his or herself. He or she is capable of choice. Thomas Mappes associates competence with rationality and maintains that one can be judged to be competent when he can make rational choices and this rationality of individual choice is based on these criteria: When individuals are properly capable of choosing the best means to some chosen ends. And when the goal sought for is beneficial to him or her in its entire ramification.

However, the situation changes if the patient's choice is suicidally motivated - that is, motivated by the intention to avoid life itself, rather than some particular treatment. A person who refuses treatment with this motivation is suicidal, no less than a person who actively intervenes to end his/her own life, (For example, if someone takes an overdose, both the overdose and the person's subsequent refusal to have his/her stomach pumped out are suicidal.) and requests the third party’s involvement in that.

3.2.4 CIRCUMSTANCES SURROUNDING CHOICE MAKING IN PAS.

Drawing from most of the arguments in PAS, it is clear that the circumstances that are always presented as surrounding the choice of PAS are mainly connected to issues

---

concerning the terminal health conditions of the patient. The arguments from the autonomy of the individual though emphasises more on justifying PAS based on the need to respect the right of the individual, but still the conditions that should warrant such choice are more related to health issues. Advocates of PAS contend that if a person is suffering from a terminal illness, is unlikely to benefit from the discovery of a cure for that illness, as a result of the illness either suffering intolerable pain, or only has available a life that is unacceptably burdensome, has an enduring competent wish to die and then unable to achieve this without help, then he or she has the right to request for PAS.

However, these reasons for PAS seem not to separate PAS from euthanasia in any way. The core issue in focus here is “suicide” that calls for assistance of the physician. Though the involvement of the physician in the issue of suicide often gives a conclusion that the agent must be the patient, still we should not waive aside the possibility of some one who is not a patient to request for this. There are other conditions not quite related to the health of the patient especially the terminal health condition that often give room to choices of PAS. Though the health condition of the patient is the main pronounced condition for the choice of PAS, we have to consider other factors that tend to lead one to make this choice of PAS along side with the health condition. These conditions include first and foremost the health condition of the patient. Here it is contended that when a patient is suffering from a terminal illness, unlikely to benefit from the discovery of a cure for that sickness, either suffering from intolerable pain, or only has available a life that is unacceptably burdensome, has an enduring, voluntary and competent wish to die and in some cases unable without assistance to commit suicide, then the patient often has the inclination of requesting for PAS. These conditions are often summed up in the headings

- Severe discomfort
- Loss of dignity
- Fear of uncontrollable symptoms
- Actual pain
- Loss of meaning
- Being a burden.

It should be acknowledged that these conditions are quite restrictive, indeed more restrictive than some would appropriate. The conditions concern only to PAS for those who are only terminally ill. It does not include the bringing about of the death based on other conditions.
Other conditions that prompt the choice of PAS are the social and economic factors. These factors are mainly associated with anxieties and depression. Some people are misguided in thinking that depression is merely a state of mind that people can "snap out of" if they are willing. This is not true. Depression is a real illness if I may put it that way, just like heart disease or diabetes. And, as people deal with any chronic disease, they must learn how to recognize depression and control it throughout their lives.

If depression goes untreated, it can turn into a life-threatening disease. Depression is an illness that causes a disturbance in an individual's emotions and feelings, what is referred to as mood. Most people experience a down mood from time to time throughout their lives. True depression is suspected when people consistently find themselves in depressed moods every day over a period of two weeks or more.

Most often, depression produces a sad mood. However, some people experience indifference, apathy, and loss of pleasure or irritability instead. In addition to disturbing one's mood, depression can interfere with several basic body functions including changes in sleep, decreased or increased appetite, sluggishness, restlessness, fatigue, loss of concentration and poor memory. People with depression may feel excessive shame or guilt and dwell on thoughts of death or dying, including ideas about suicide. Depression, loneliness, domestic violence, economic and social pressure and drug abuse all contribute to suicidal feelings. Amira El-Noshokaty in an article in Al-Ahram weekly online gives an insight on how depression can be fatal in one's darkest hour and eventually lead one to such decisions as PAS in Egypt. He writes.

The principal symptom of depression is a generally despondent and disheartened mood, making someone feel down and generally view life negatively… People who are depressed loose interest in activities, resulting in a negative effect on their work, studies and appearance. They also withdraw from social situations and may begin eating and sleeping less… In some cases, people are predisposed to it. In others, depression can be caused by social circumstances, together with an individual's ability to cope and capacity to adapt to difficulties. Domestic violence and poverty are examples of social pressure that can trigger depression and suicide. Feeling lonely alienated, having no one to share your thoughts with or having a troubled emotional relationship can also make an individual depressed. 27

27 Amira El-Noshokaty, "Depression can be fatal in one’s darkest hour: The stigma surrounding depression and suicide in Egypt, in Al-Ahram weekly online, 16 - 22 October 2003, Issue No. 660-11. This report of Amira Published in Cairo by AL-AHRAM established in 1875 with aim of integrating into the people of Egypt and their neighbours the idea of depression and anxiety.
The analysis of this report of Amira El-Noshokaty is that, typically, if people are suffering from depression, their mood will prevent them from living their lives as they normally do. Stressful life events, like a death in the family or financial problems, can trigger depression. In some cases, people find themselves depressed for no apparent reason. Hence persistence of these depressions and anxiety reduces the quality a person sees in his life and this eventually makes people often times request for death and would like to have a helping hand in this.

3.2.5 THE POSSIBILITY OF IRRATIONAL CHOICES IN PAS.

Challenged by a number of forces within and outside the medical profession, in the recent times, the traditional paternistic approach to the issue of decision-making in medical care has been overridden. Recently physicians and patients have tended to move towards shared decision making. It becomes reasonable that patients and physicians should collaborate so well in making decisions concerning the health of the patient. As earlier observed most of these changes in medical practices are rooted in the need to respect the right of the individual. However one point worth noting here is that there arise some situations whereby the patient makes irrational choices. The task here is to discover actually what shared decision-making implies for a physician’s responsibility when an apparently competent patient’s choice appears to be irrational. Here two issues are at play: the responsibility of the physician and the right of the patient to make choices in his or her life. Hence one can observe that certain conflicting values underlie shared decision making in medical care. These values in matters of irrational choices and in some cases rational choices tend to conflict with each other. They include first the well-being of the patient, which concerns the responsibility of the physician to protect the patient from harmful consequences of his or her choice. Second then is the need to respect the right of the patient.

A sound discussion on this issue demands that there be made a taxonomy of the different sources and forms of irrational decisions or choices because as Beauchamp points out, distinguishing choices that are truly irrational from those that are merely usual often requires complex, difficult, and controversial judgements.28

RATIONAL DECISION MAKING.

A clear understanding of irrational decisions owe much to the good knowledge of knowing the standard of judging rational decisions and choices of patients. Pauker, S. G, and Kassirer, J. P, in their article “Decision Analysis” assert that any discussion on irrational decision-making must rely on a description of rational decision-making. The summary of the standard of making this judgement is what the mathematicians would call “balancing of equation.” This balancing of equation in medical care often brings in the issue of the principle of Justice, which is regarded in much respect as the other principles of autonomy and beneficence. This balancing of equation means that in matters of decisions and choices about health care, patients must weigh the benefits and risks of alternative treatments or no treatment, according to their own moral values and then select the alternative that best promotes those values. On the part of the physician, he ensures that the patients are well informed about their health conditions. This duty of the physician obliges the patient to use the correct information about relevant alternatives and take proper decision on the choice of treatment.

IRRATIONAL DECISION MAKING

In irrational choices one can say that any choice made against the stipulated standard of rational decision makes the decision irrational. An irrational choice is one that fails to promote a set of basic aims and values that belong to the physician or to standard guide lines of medical practice. These irrational choices arise as Brock and Wartman maintain from,

1. The bias towards the present and near future in which case people tend to prefer a restoration of function now rather than later and would go for a loss of function that would occur as far in the future as possible. When one refuses to undergo a painful experience now he makes an irrational choice if by undergoing it he can avoid a much worse experience in the future.
2. The conception “it won’t happen to me”
3. Fear of pain or the medical experience
4. When what the patient does makes no sense and quite contradictory to the standard of rational choices.
5. When there is a framing effect: This is based on the way choices are formulated and presented in most cases. This often has major effect on decisions. Brock gave an example that a surgical treatment if presented as substantially extending the
lives of 70 percent of patients that select it, or as potentially killing on the operating table of 30 percent of those who select it. Though both characterisations might be true, but which is used, or emphasised, may have a substantial effect on the rate of selection of the surgery.

6. The individual and the social rationality here consider the impact of such choices on the family and the society at large.

7. Public health and the Individual benefit.\(^{29}\)

Coming down to the issue of PAS there have been varieties of opinions on what should trespass if situations arise where by the choice of the patient to take his or her life becomes irrational. Some have concluded that in shared decision making and in matters of the life of a patient, proper respect for the patient’s autonomy takes precedence of all other things and must be respected even when conceived as irrational. The argument here is that the right to autonomy and self-determination of the patient automatically imply that the preferences of the patient ought to be respected in all circumstances. I believe that such a conclusion is not called for. This fails in a big way because there is the denial of the difference between the sometimes conflicting values that underlie shared decision making and the respect of the patient’s right. In the first instance these are two values that often have equal rating. Though they are often equal, still in some situations one gives way for the other. When something is said to be irrational, it means it is negative and doesn’t benefit. When a patient makes the choice of suicide and does that without involving another person he can be said to be “exercising his right fully.” But when he requests another person that has his own right to protect and obligation to keep then it becomes a different issue apart from respecting or exercising fully ones right. There must be need for striking a balance in both situations because both principles of beneficence and autonomy and all other obligations in medical ethics are all prima facie and so are liable to revising. Hence, when a physician properly judges a patient’s treatment choice to be irrational, attempts to challenge that choice through persuasion are common and proper. Non-coercive and non-manipulative attempts to persuade patients of irrational and harmful nature of their choices do not violet their right of self-determination. Instead, they reflect an appropriate responsibility and concern for the patient’s well being.\(^{30}\)

In the same view, George, P. Smith, maintains that though the phenomenon of medicine is recognised as a relationship of persons (patient and physician), medical science


\(^{30}\) *Ibid*, p. 110
seeks the causes and pathogenesis mechanisms of diseases and works essentially towards a right and good healing action. For him what might be properly viewed as the moral centre of medicine occurs when, having considered all the medical actions that can be done- the physician concludes and proceeds to recommend what ought to be undertaken; or in order words, what is in the best interest of the patient$^{31}$. Though this position seems to rest the entire medical decisions in the hands of the physician, Smith maintains that the values of physician and patient may intersect and connect, but their respective moral agencies must be given equal respect.

3.3 TABLE FOR ISSUES, AND REALITIES IN DECISION MAKING IN PAS

Here I try to bring out the various concepts that play important roles in making the choice of PAS by an individual and in respecting the choice by a physician. These concepts are quite outstanding in such a way that their applications and operations contribute in a big way to the understanding of the morality of PAS.

<table>
<thead>
<tr>
<th>Autonomous decision</th>
<th>This is mainly based on the principle of autonomy whereby the patient possesses a right of self-determination. This right should not be taken to be absolute rather it is a prima facie right and so in some cases can be overridden by other rights.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rational/Irrational decision</td>
<td>The choice of suicide is not rested on issues of disability and terminal illnesses alone. Depression and other mental disorders are commonly present in suicide. People with medical problems commonly experience deppressions that often lead to the choice of suicide. When the benefits of these deppressions out weigh the benefits of continuous life, one can be said to be making rational choices. Other factors like</td>
</tr>
</tbody>
</table>

Economic and social factors often push people to suicide. In most cases, the benefits of continuous life outweigh that of the suicide choice, hence one making such choices in such condition is said to be making an irrational choice.

<table>
<thead>
<tr>
<th>Free from coercion and influence.</th>
<th>Studies show that physicians give the information that will elicit the decision they want. This makes some decisions not to be free from external constraints. When choices are made out of wrong information, or amidst constraints, that is an irrational decision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require assistance</td>
<td>Very few people who are competent to request suicide actually require assistance to complete the act. Important in PAS is the assistance of the physician. I argue here that giving assistance means making more preferred the choice of suicide.</td>
</tr>
<tr>
<td>Equal access and accommodation</td>
<td>Other citizens are discouraged from suicide, not assisted to kill themselves. Easy methods of suicide are often prohibited in order to prevent suicide. If suicide is to be assisted, it should be assisted for all, not prevented for some while assisted for others. But if suicide is not encouraged, its assistance should not be encouraged.</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

4.0 PAS VERSES PROFESSIONAL INTEGRITY OF THE PHYSICIAN.

From the discussions in this work we can observe that the aspect of PAS and in some cases euthanasia is not just a matter of arguments that involve these practices in the abstract sense. Certain concrete and empirical factors play vital roles in the act. Prominent among these are the patient and the physician. That the patient has this right or the other is never a point that needs debates, but the problem of PAS lies in the participation of a physician. From the meaning of integrity earlier discussed one can deduce that what makes for the pride of any particular group in the society is their integrity. Medicine can be described as a practice (in the technical sense) with its own set of internal goods and defining rules. Any action that tends to violate these internal values and goals of medicine is contrary to the professional integrity of the field.

However, my concern in this chapter is to consider the interplay of these two concepts: the integrity of the medical physician and the activities of PAS. It has been noted in this work that the integrity of the physician is mainly rooted in the principle of beneficence and non-maleficence. Hence the physician first and foremost plays the role of a healer, advocate, comforter and protector of life. However, the advent of the principle of autonomy and self-determination makes the relationship between the physician and the patient more intense in such a way that priorities are given to the right of the patient more than given to the obligation, right and duty of the physician as a medical professional. But the issue then is, does the patient’s right to self-determination call for the physician’s total adherence? If yes what becomes the case if the choice made by the patients comes in contrary to the obligation and duty of the physician. Shall we say here that when faced with such decisions the physician is in dilemma? I think the answer is yes, because, the physician’s dignity and obligation lies in the codes of the medical line. This code has given room for both cases and in more concrete manner the principles are all medical principles that need to be followed not only by the physician but also by all.

I will like to look into this dilemma the physician faces in such cases as PAS. This will give room to assess the possibility of solving the dilemma.

---

4.0.1 THE DILEMMA OF PHYSICIANS IN PAS.

In recent times, medicine is beginning to experience some momentous shift in its systems of care, allocation of resources, rights and futility of care. Care at the end of life is a very crucial aspect of the medical practices that experiences such cataclysmic shifts due to the multiple ethical dilemmas it poses. In the request for PAS the patient tends to make some requests owing to his or her basic right to self-determination. He (patient), in making such requests demands that the physician responds positively to it. The physician on his own side faces some series of choices in accepting this request. Most of these choices include his obligation as a physician to help his patients achieve his or her basic interest, hence the need to assist him. The fundamental obligation of the physician as a professional in medicine plays important role in making the choice of assisting the patient to die, hence against his professional integrity. These choices tend to be extreme in a way that the denial or respect of one violates what obtains in the other. In a bid to understand very well how the physician faces a dilemma in PAS, it is necessary to understand how and when dilemmas occur and how and when the practice of PAS becomes a dilemma to the physician.

4.0.2 WHEN DO DILEMMAS OCCUR?

Dilemmas occur almost in all aspects of human life. They occur both in the social, political, economic and ethical fields. But our concern here is more related to dilemmas in ethical issues. Mariano, C. and his co-editors in the book “Best nursing practices in care for older adults incorporating essential gerontologic content into baccalaureate nursing education” maintain that ethical dilemmas can be defined as 1) a difficult problem seemingly incapable of a satisfactory solution, or 2) a situation involving choice between equally unsatisfactory alternatives. This definition is not suggesting that all the dilemmas in life are ethical dilemmas as already stipulated above, rather that ethical dilemmas arise when moral claims conflict with each other. Beauchamp maintains that dilemmas occur whenever good reasons for mutually exclusive alternatives can be cited; if any one of reasons is acted upon, events will result that are desirable in some respects but undesirable in others. This implies that in dilemmas, an agent ought to do something and at the same

---


3 Tom L. Beauchamp and LeRoy Walters, Ibid, p.3
time morally ought not to do it or ought to do another thing. In most if not all cases of dilemma the moral reasons behind each of the alternatives are good reasons and neither of them outweighs the other. But the problem faced about these dilemmas is to know why it is becoming so rampant that dilemmas occur in ethical issues. Hence the question what are the things responsible for dilemmas?

Though it can be deduced that dilemmas occur as a result of variety of factors, but in the ethical aspect of dilemma, it has been observed that dilemmas occur as a result of the conflicting nature of ethical principles and codes. Some people might argue that the principles or codes are not conflicting rather the interpretations given to them. Melanie Phillips and John Dawson maintain that there is an underlying conflict that links all medical dilemmas, the conflict between absolute principles, which say that something is inherently right or wrong, and utilitarian principles, which stress the consequences of an action.4 This distinction is mainly based on the disagreements that always associate the interpretations given to the medical practices. Take for instance, in the case of abortion, leaving aside the problem that people disagree over where life begins and over the value to be placed on the foetus, the conflicts here arises in the varied opinions of those who say that the question of right or wrong depends on circumstances and those who condemn out rightly any act of abortion.5

However, with the certainty of frequent occurrences of dilemmas in medical practices, ethicists and other moral thinkers have sought ways these dilemmas can be prevented or if already in action can be solved. Talk to the ethics experts, and they'll tell you the best defence against ethical problems is a good offence. By looking out for foreseeable conflicts and discussing them frankly with colleagues and clients, practitioners can evade the misunderstandings, hurt feelings and sticky situations that lead to hearings before ethics boards, lawsuits, loss of license or professional membership, or even more dire consequences. Beauchamp and Walters discussed ways out of dilemmas. According to them the problem of frequent occurrence of dilemmas in medical practices could be reduced by,

1. Obtaining objective information about different issues surrounding ethical practices.
2. Providing definitional clarity of these issues thereby avoiding the misplacement of meanings.

---

5 Ibid
3. Adopting a general and objective code for the medical practices and particularly for moral professions.

4. Analysing critically arguments that come up in various moral debates

Many of the arguments in the debates about PAS always gear towards finding ways of reconciling the two principles in conflict in the act. To understand clearly the things involved in PAS, it is quite necessary to first of all understand why the dilemmas occur and/or what makes for these dilemmas in PAS.

4.0.3 **THE PHYSICIANS DILEMMAS IN ASSISTING DEATH.**

When Dr. Quill gave the report about his assistance on Diane to take her life, he indicated his ability to convince her that the choice being made doesn’t reflect her best interest. Dr. Quill did this because first and foremost he is a physician that has it as a duty to care for his patient and secondly he feels that engaging in such act would be contrary to his professional integrity. But on the side of his agent, Dr. Quill felt for her, and wanted to respect her autonomous decision as a competent patient. Speaking out of his own agonizing experiences with patients, and the clinical criteria he proposes that emerge out of these frontline experiences, Quill lauds the two main directives of the Hippocratic oath: to prolong the lives of patients and to minimize their suffering. Quill's main thesis is that when one is treating a dying patient, minimizing suffering must take precedence over life extension, even though this contradicts traditional medical training and practice. However, even amidst Quill's opinion as regards which of the operations takes precedence, he considers the fact that, as physician, he owes it as an obligation to ensure the health care of his patient.

Ethical dilemmas in managed care derive from three competing premises. The first premise, a fundamental tenet of the medical profession, is that the physician is ethically required to provide the best possible care for the patient. This entails that what the medical profession demands from the physician is to work towards the welfare of the patient, cure the diseases and relieve pains and suffering through cure. The next competing premise is an ethic of society. The society in most cases preaches the ethics of distributive justice. This ethic of distributive justice holds that in a society with limited resources, not all needs could be met, but the resources should be firmly distributed. The ethical dilemmas in medical care most commonly result from the conflict inherent in balancing these competing principles. In giving physicians the task of implementing both mandates, society often demands that the physician plays a "double agent", simultaneously achieving the often-
incompatible goals of maximizing a single patient's welfare and society's goal of minimizing health care costs. This demand of the society does not only refer to the cost in health care, it points also to the fact that people are jointly related in the society such that what happens to one affects the other. This society’s demand is that if the physician is faced with the choice of PAS, he should consider the impact his action can have on the society the patient belongs. Here emphasis are placed more on the family of the patient that is making the request of PAS. The third competing premise is the patient’s right to self-determination. This demands that the patient has the right over his or her life and makes the choice of how and when to live or die. The patient or agent demands that the physician must comply with his wish and that failing to do so amounts to violation of his autonomous right. This demand of the society, that of the patient and the demand of the medical profession in which the physician operates in, puts the physician always in a fix in deciding how his action can bring about what is demanded of him by his profession, what the society wants from him and what the patient requests to be granted him or her.

Sigmund Freud once said that any true ethical choice involves agony. For the physician, when the patient makes the choice of death a conflict exists between both the urge and the mandate to relieve pain and suffering and the centuries-old prohibition against medical killing, understood by many to be a fundamental of medical ethics and one of the things that make for the integrity of the medical profession. This is the force that prevents physicians from administering lethal injections, even in those U.S states that allow capital punishment. This prohibition as earlier pointed out is specifically proscribed in the Hippocratic oath, where it stands as a fervent promise of professional self-restraint: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect ... In purity and holiness I will guard my life and my art."6 The oath has also been reaffirmed in the professional codes of modern medical societies; the American Medical Association's code of Medical Ethics, for example, explicitly precludes physician-assisted suicide, on the grounds that it is "fundamentally incompatible with the physician's role as a healer, and would make it difficult or impossible to control, and would pose serious societal risks."7

---

Howard Brody, in his article “Assisting in Patient Suicide is an acceptable practice for Physicians” outlines some of the arguments against PAS that when reflected upon put the physician in dilemma when such requests are made. He writes thus:

1. Opposition to PAS is not merely a matter of personal moral choice. Any proper understanding of professional integrity would require physicians to see that they can never be true to their role as healers while directly causing or participating in the patient’s death.

2. Safeguards are illusory. As soon as PAS becomes a routine practice, abuses are bound to occur, probably in considerable numbers…

3. While defenders of PAS assume that a reasonable system of hospice and palliative care options is in place and available, this is not so; and endorsement of PAS may further delay the day when our health system makes a true commitment to access to good palliative care.

4. Perhaps as a matter of social policy, a small number of patients should be allowed to choose suicide in the face of advanced medical illness; and others should be allowed to assist them. But we should be extremely wary of physicians being placed in the role of the helpers… we should be wary of the medicalization of terminal suffering and the assumption that physicians and drugs provide the proper answer to the human anguish of facing terminal illness and death. And we should be wary of this even if it were to develop that PAS does not constitute a violation of physician’s professional integrity.

5. Assisting a patient’s suicide is, on its face, admission of incompetence. Proper care of dying patients, with close attention to their physical, emotional, and spiritual needs, will almost always reveal ways to relieve suffering and so to dissuade the patient from suicide.

To assist the patient’s suicide is to take the easy way out and to fail to put enough time and energy into the case to be able to render truly competent terminal care.

---


The argument of Howard Brody does not completely condemn PAS. He made references to the arguments of those against PAS as a background for his own argument. He offers a cautious endorsement of PAS as a clinical option for U.S physicians. But he arrived at this by somewhat circuitous route in that he still viewed the arguments against PAS as what demand considerable respect and allegiance. I can say he in a way played the middleman. In these opposing arguments, Howard Brody made references to different works. They include:

Though it is believed that the Hippocratic oath discourages any intentional act of the physician that would result in the death of the patient, it is worth noting that this oath and modern medical ethics understand well the limits of our medical art: To prolong the natural process of dying is inappropriate when death is unavoidable. Sometimes a fine line may exist between letting someone die and actively causing his or her death. Some decisions can be made by the physician in consultation with both the patient and specifically permitted members of the patient's family. Accordingly, to protect our desires and wishes, it is incumbent on all of us to compose living wills and advance directives. This is merely a suggestion on how to address the issue of dilemma in PAS. The fact remains that physicians always encounter conflicts and dilemmas when there is a request for them to assist in the death of the patient. The personal concern of the physician notwithstanding, the professional integrity of the physician puts him into a fix in issues of PAS.

CHAPTER FIVE

5.0 EVALUATION AND CONCLUSION

This work has faced two important principles in the health care sector whose conflicts contribute in a big way to the dilemmas physicians always encounter in the end of life decisions of the patients especially in the issue of physician-assisted suicide. The principles of autonomy of the individual patient and the principle of beneficence owing more to the obligation of the physician tend to be conflicting each other in the issue of physician assisted suicide. The integrity of the physician as earlier noted always comes in conflict when faced with the request for the assistance in PAS. Though most arguments do not see any conflict in such issues and most doctors don’t see any problem in helping their patients to relieve the pains they have through death, still when it comes to deep reflection on the role the physician plays in such issues and the role he is supposed to play as a professional physician, there are indications that the fundamental role of the physician (if played well maximizes the integrity of the profession) becomes a dilemma for the physician in accepting the request for PAS. This was the main focus of the discussions and arguments in this work.

5.1 EVALUATION

This work followed critical responses to some of the problems and questions that are always associated with PAS. How is assisted suicide a dilemma to the professional integrity of the physician? If competent patients have legal and moral rights to refuse treatments that would prolong their lives (deaths) in cases of deteriorating illnesses, or request for a treatment that would cause their deaths, should there be a similar right/duty to enlist the assistance of the physician to help patients cause their deaths? Does the patient’s right of self-determination call for the physician’s total adherence? If yes what happens in matters of irrational choices/decisions of the patients? Are there any conditions that should warrant the ethical permissibility of PAS? These are the problems I focused on while addressing the dilemma of the physician in death assistance of the patient.

As I pointed out in the introduction, this work followed systematic stages and approach in dealing with these problems and questions. In the first part of this work I recognised that certain problems tend to emerge in health care ethics as a result lack of clarification of terms. Here I made every effort to indicate those things that distinguish a particular medical practice from another one. Realizing that PAS and euthanasia are often
viewed to mean the same thing, I pointed out that though PAS in a way relates to
euthanasia, but their differences abound. These difference range from the motive of the
patient/physician in the actions to who is the real actor in the practices as well as what
factors lead to the choices in the practices. Considering the issue of euthanasia, I gave the
various distinctions in the forms of euthanasia. Voluntary euthanasia associated with
competent decision and consent, non-voluntary characterised by no consent as result of
incompetence, and involuntary described as lacking consent while competent. In the
distinction of two forms of killing, active and passive, I discovered contrasting opinions in
such distinction. Some arguments see no difference in the two forms while others maintain
that they differ. James Rachels plays a serious role here because he stands to argue that
there are no distinctions as such between killing and letting someone die. Reacting to the
different opinions in this distinction, I maintained that taken in a literal way one can see
some differences between the two forms of killing, but coming to the moral relevance,
these distinctions cannot hold because both the action and omission are intentionally geared
towards a goal, which is the death of the patient.

This first part of the work brought into clarity the general conception of morality.
Morality where most if not all ethical debates rest on needed to be explained in order to
have a good ground for judging a particular ethical or in the case of this work medical
practice to be right or wrong. Researches on this concept revealed that from its etymology
morality means tradition or folkways. This etymological meaning of the term makes its
conception to be varied from one culture to another. Though some people argue in a
normative sense that there can be a universal morality, but I feel the application of morality
in a big way depends on the circumstances and conditions on ground.

The general conception of professional integrity of the physician was considered in
the explication of terms. A better understanding of this as indicated in the work rests more
on understanding the key words, integrity, profession and physician. Since integrity means
the total character of a person to work in accordance to the operations of a given value
system, a professional meaning one who does a type of work, considered as a group and
physician meaning a medical doctor, especially one who has general skill and is not a
surgeon,¹ physician professional integrity then means all the various characters, desire and
ability of a physician to play his active role as stipulated by the profession.

¹ Cambridge Advanced learners’ Dictionary, United Kingdom, Cambridge University Press 2004
The second part of this work considered the arguments in the debates about the morality of PAS. Considering the controversial nature of PAS, I maintained that there have been series of opinions and arguments, all moving towards the morality of the act. These debates and arguments though tend to be a phenomenon of recent times, but there are indications that there were traces of them in the ancient days. The ancient Graeco-Roman conception of life and the formulation of the Hippocratic oath are all indications that the problem of whether a physician should assist or not assist in the death of the patient manifested in the ancient days. The early Christians’ words and theocratic arguments on the nature and value of human life prove the existence of such issues in history. My concern here was to address the problem of PAS in history, tracing it back from the ancient time, medieval era, modern period and the contemporary epoch. The debates in the Netherlands, Oregon, and other parts of Europe and United States, the formation of the Hemlock society and Hospice groups were traces of forums where the issue of PAS has been critically discussed.

However, I considered the various arguments about the morality of PAS. These arguments have been focused on the controversies around the practice. Critical look into these arguments I observed that three different and often opposing positions tend to emerge. There are the opinions of those that accept PAS and argue for its justification and legalization based on certain reasons for which the need for the respect of the individual right to autonomy is glaring. This moral case in favour of PAS draws upon a store of shared values, a pervasive consensus about freedom and the relief of suffering. There are other opinions that out rightly reject any act of justifying PAS. Their arguments among other reasons, point to the fact that such act diminishes to the zero point the fundamental value and dignity of human life. This in a way relates to the Christian view of PAS, which I discussed later. Another strong argument opponents of PAS always bring out is that any assistance a physician renders to the patient in taking his or her life violates the fundamental obligation of the physician. This argument is rooted in the principle of beneficence, which in a way maintains that physicians should work for the welfare of the patient by relieving diseases and deaths. These opponents see this as drawing mainly from the Hippocratic oath, which is meant for every physician to take.

Reacting to these positions, I argued that the principles of autonomy and beneficence by themselves are not sufficient to justify or not justify assisted suicide. My reason for this is primarily because in the concept of PAS the main issue of consideration is the suicidal act. The assistance of the physician is just an addendum. Not only critical
health issues warrant the choice of suicide. Arguing on PAS based on autonomy and beneficence restricts the conception of PAS to only in matters of terminal and critical illnesses. Other factors do prompt the request of PAS. Such factors include, psychological depressions, anxieties, and all forms of economic and social frustrations. If this is accepted which I think should, referring to autonomy as a ground for justifying request for PAS doesn’t follow because just as Beauchamp and Childress point out, this right is not absolute rather prima facie. Its respect depends on the circumstances surrounding the autonomous choice made. On the other hand the issue of beneficence posits a question on how to know the welfare of the patient, and what actually constitutes this benefit for the patient. In some illnesses especially in those with severe pain and assured death occurrence, the welfare of the patient, his disease and sickness which the physician ought to protect, relieve and cure are incorporated in the pain and the solution tends to be death. I argue here too that this principle of beneficence taken in any way is not an absolute principle, and like the principle of autonomy it is a prima facie principle.

My argument went likely towards the third position in the debates on PAS, those who maintain a middle ground. Here I join to opine that attention should shift from whether or not PAS should be allowed, to how, when and in what conditions and circumstances can physicians respect or not respect the choice of the patient to help in bringing about his death and avoid conflict and dilemmas.

The crux of the work appeared in the third part of this thesis. Here I dealt with the professional integrity and the dilemma in PAS. I used the cases of Dr. Jack Kevorkian, his suicide machine and his assistance in 1990 in the death of a 54-year-old woman, Janet Adkins from Portland in Oregon, suffering from Alzheimer as well as the case of Dr Timothy Quill and the assistance of Diane suffering from leukaemia as the background cases in this work. These two doctors and their actions differ in a way. Dr Kevorkian does this act as a job and is convinced that in all things what he does is never contradictory to any medical principle or code. The action of Dr Quill was an opportunistic one. He did all he could to convince the patient to opt for treatment, but she refused and to respect her wish Quill prescribed the medicine that caused the death of Diane. These cases point to the fact that a lot of things are needed to be put into consideration in discussing this issue of PAS. Hence in a bid to make clear my points in the argument, I considered the person of the patient and the nature of his or her request. This part of the work dealt very much on the patient’s right to autonomous choice and decision, which most advocates of PAS point at, in their arguments. This right to autonomy is always characterised by the self-determination
of the patient and the need to recognise this self-determining agent as entitled to determine his or her own destiny with regard to considered evaluations and view of the world.

Here, I addressed the second question or problem of concern for this work. If competent patients have legal and moral rights to refuse treatments that would prolong their lives (deaths) in cases of deteriorating illnesses, or request for a treatment that would cause their deaths, should there be a similar right/duty to enlist the assistance of the physician to help patients cause their deaths? I pointed out as an answer to this question that the right to individual autonomy in itself does not guarantee a duty or obligation for the physician. A doctor that assists a patient in his death does this not as professional duty he is obliged to do. The role of the physician as I noted involves more than simply acceding to patient’s request especially when it comes to issues pertaining to life and death. Clinical therapies are aimed at promoting heath, preventing diseases and curing these diseases in case they manifest. This marks the core duty of the physician and is the reason why there are always controversies and difficulties when this request is made. The doctor is always in a fix when faced with such request because he sees his integrity in jeopardy if he accedes to this request. He considers a lot of things, does a lot of counselling and prescribes alternatives to the patient before ever he accedes to this request.

In considering the things involved in the choice of the patient, the physician weighs the rationality of such a choice. The third problem of this work, (Does the patient’s right of self-determination call for the physician’s total adherence? If yes what happens in matters of irrational choices/decisions of the patients?) was addressed by considering the rationale behind choice making of the patient. Here I discussed what makes for a competent decision of the patient. Among these are the rationality of his or choice and the conditions that warrant such choice. I argued here that among the things that distinguish PAS from euthanasia is the fact that certain things outside the domain of terminal and critical illnesses make the patient to make the choice of PAS. I considered some economical and social issues that often put one in stress, anxiety and depression. These depressions often lead one to death choices. But when choices are made as a result of depression, do we then suppose that this is an irrational choice that needs not be acceded to?

This problem led me to finding out what actually makes a choice rational or irrational. I categorised the standard that makes a choice rational to the mathematical “balancing of equation,” arguing that any choice made when the considered benefits have been weighed to be more than the risk of alternative tends to be a rational choice. In the case of PAS, when the benefit of death is more than the benefit of alternative treatment
(prolongation of death), any choice made by the patient with regard to PAS becomes a rational choice. The contrary of this makes the choice irrational. However, the problem one always encounters here is who weighs the balance of benefit and risk? Most people maintain that the patient is the best Judge in his or her own case and so should know what is of high benefit for him. This of course is rooted in the principle of autonomy. But I argued that in weighing the benefit, two things are involved: Treatment to ensure health and the issue of “valuing” life. About the treatment, the physician tends to be at a better position to know the extent a particular treatment can work, and in valuing life, the patient knows best if he or she values a particular life he is living. The cordial relationship that is expected to exist between the physician and the patient entails that both work together to decide what benefits the patient. Is not the work of the physician alone neither is that of the patient alone. Both play active roles in decisions about the treatments and non-treatments of the patient.

In a bid to argue clearly whether or not the physician encounters dilemmas when a patient makes the choice of PAS, I tried to bring out the various things that bring about dilemmas in medical care. Acknowledging that dilemmas occur in almost all aspects of life, I limited my study to the dilemmas that occur in ethical issues and with emphasis on the dilemmas the physician has in the choice of PAS. Dilemmas occur in two ways. The first is in a difficult problem seemingly incapable of a satisfactory solution and secondly in a situation involving choice between equally unsatisfactory alternatives. Here there are equal reasons to make choice of each of the situations such that the choice of one violates the other. This is exactly what happens when a patient chooses that the physician assist in his death. I argued here that ethical dilemmas in medical care derive from three competing premises. The first premise, a fundamental tenet of the medical profession, is that the physician is ethically required to provide the best possible care for the patient. The competing premise as an ethic of society. This concerns ethic of distributive justice and it holds that in a society with limited resources, not all needs could be met, but the resources should be firmly distributed such that all the aspects of the society would benefit from any particular choice made in the health care profession. The third premise is the need to consider the choice of the patient in question. The ethical dilemmas in medical care most commonly result from the conflict inherent in balancing these competing principles. In giving physicians the task of implementing both mandates, society often demands that the physician plays a "double agent", simultaneously achieving the often-incompatible goals of maximizing a patient’s welfare and society's goal of minimizing health care costs. More so,
the society demands that any action of the doctor on the patient must reflect what is beneficial not only to the patient or the immediate family, but to the entire society in which he or she belongs. The patient on his own side demands too that the physician maximizes his (patient) choice and the doctor's fundamental medical obligation by acceding to whatever request he has made concerning his or her life. This demand of the society, the demand of the patient and the demand of the medical profession in which the physician operates in, puts him (physician) always in a fix in deciding how his action can bring about what is demanded of him by his profession, what the society wants from him and what the patient requests to be granted him or her.

5.2 CONCLUSION

From all I discussed in the work and all the arguments that flourished throughout the work I would say that the argument on the dilemma of the physician in PAS from the professional integrity point of view may be easily misunderstood because, this concept tends to be seldom appealed to in most debates about medical ethics. The striking point in PAS is that when confronted with the choice of PAS, the physician sees himself in dilemma not merely because of his personal, religious or philosophical moral objectives but because of his medical professional integrity. My main argument in this work is not mainly to support the practice of PAS by physician, nor is it to kick against physicians participating in such act, but to bring into focus the fact that physicians encounter various problems when the request for PAS is made to them.

Most advocates of PAS see no conflict if a physician accedes in helping the patient who is suffering from a very terminal and painful illness that would eventually result to death. They maintain that assisting such a patient; the physician morally meets his obligation. Though, I don’t totally deny this fact, but my argument is that, even in such a situation of terminal illness, the physician encounters some conflict with his medical obligation which requires him to relieve suffering, pain and disease by cure. This is the reason why the act of PAS undergoes series of stages, questions and counter questions before it is carried out. This is so because the physician would like to ensure that what he is doing does not in any way affect the integrity of his profession. In another development, I argue that the case of terminal and painful illness is one out of several reasons that prompt for the choice of PAS. Issues like psychological depressions; anxieties and frustrations of all kinds often lead one to ask for assistance in his suicide. If PAS is generally justified via the argument of advocates that the doctors don’t encounter any dilemma in assisting the
death of one suffering a painful illness, invariably we should then accept that in all cases of PAS, the physician’s actions don’t go contrary to the wishes of the medical profession. In the fourth part of this work, I brought to view the various things in the request for PAS that put the doctor in dilemma. My argument is that when the choice of PAS is made in any circumstance or situation the physician encounters problems arising from three different premises. From the need to respect the choice the patient has made, moving to the need to discover the demands of the society in which the patient belongs and down to what the medical profession requires of him to do.

However, my argument does not look on these dilemmas as the reason why PAS should or should not be justified, but see them as challenges for the medical profession. Having dilemmas does not imply that the situation is so impossible to tackle rather it raises a big task for physician and the medical profession to look to ways of either avoiding the dilemmas or resolving them. In view of this I make suggestions and recommendations on the way and manner in which the dilemmas could be avoided or resolved.

Since it has been obvious that the goals which define both the medical practices and medical ethics are the ability or to put in a more professional term the obligation of the physician to heal, prevent illnesses and help the dying patient to achieve a peaceful death, it then demands that the physician must pursue these goals in the approved manner and way. I follow in the words of Howard Brody that the physician does not practice incompetent medicine, cause harm disproportionate to benefit, fraudulently misrepresented medical knowledge, or abandon the vital interest of her patient. PAS would be incompetent medicine if palliative care could be a better alternative for relieving suffering. The harm of death might be disproportionate to any benefit of relieving pain and an early death might appear to violate rather than serve the interest of the patient if palliative care is a better alternative. This mirrors to what I argued in the possibility of a patient making irrational choices. There is the need to balance the equation of benefit and harm and this rests on joint actions of the physician and the patient.

However, my opinion here does not suggest or create a moral right/duty to PAS on the part of the patient and the physician respectively. I agree with Lord Acton’s conception that liberty cannot be based on the satisfaction of individual appetite. As Zachary R. Calo points out in his article, “The kingdom of Man in America: Economic Freedom and Prosperity in Moral and Theological perspective” the benefit and privileges that freedom

---

creates are wholly dependent on meeting the obligations and sacrifices that freedom requires. He writes,

This perspective is captured in Acton’s statement that “liberty is not the power of doing what we like, but the right of being able to be do what we ought.” ... Alan Keyes recently articulated a similar position when he stated that “freedom is not another kind of empty licentiousness.” Freedom in other words does not grant people “the right to do what is wrong.”

The physician is not obligated to assist the patient when the request is made but, only after detailed study of the particular case which in some cases entails trying the alternative palliative care. Physicians must retain discretion in doubtful and confusing cases and sometimes must refuse to accede to the assistance even if the request appears so rational. I would say then that it is only when PAS is restricted to the narrow class of patients who autonomously makes the choice and have demonstrated beyond reasonable doubt that their suffering cannot be relieved by any other practicable means, then we can say that there is no violation of the physician’s professional integrity.

---


Zachary R. Calo made references to Michael Novak’s demonstration on how the modern liberal project has rejected Acton’s vision Novak maintains that liberal is now associated with radical individualism and insistence of doing not what one ought to do but what one feels like doing. This is from Michael Novak, The Catholic Ethics and the Spirit of Capitalism, New York, Free press, 1993, p.197.

He also gave the quotation from the speech of Alan Keyes, which he delivered in New Hampshire on February 19, 1995 as part of his presidential campaign.

It is nice to note that Lord Acton described as "the magistrate of history," was one of the great personalities of the nineteenth century and is universally considered to be one of the most learned Englishmen of his time. He made the history of liberty his life's work; indeed, he considered political liberty the essential condition and guardian of religious liberty. It is in his name that The Acton Institute for the Study of Religion and Liberty in the United States was founded.
BOOKS


Pence G. E, *Classic Cases in Medical Ethics: Accounts of Cases that have shaped Medical ethics, with Philosophical, Legal, and Historical Background*, 2nd edition, USA, McGraw-Hill, Inc 1995.


**ENCYCLOPAEDIA AND DICTIONARIES:**


**JOURNALS, ENCYCLICAL AND NEWS PAPERS**


*Journal of American Medical Association*, Vol. 2691988

*Los Angeles Times*, July 5, 1987, Sec.6.

*New York Times*, June 8, 1990
Newsweek, April 15, 1996.


REPORTS AND UNPUBLISHED ARTICLES

Amira El-Noshokaty, “Depression can be fatal in one’s darkest hour: The stigma surrounding depression and suicide in Egypt,” in Al-Ahram weekly online, 16 - 22 October 2003, Issue No. 660.


**INTERNET SOURCES:**


Kevorkian - the Right to kill in
http://www.abortionfact.com/literature/literature_9318rk.asp

Lois Snyder, JD and Daniel P. Sulmasy, OFM, MD, PhD, for the Ethics and Human
Rights Committee, American College of Physicians–American Society of Internal
Medicine, Vol. 135, Issue 3, August 2001, pp. 209-216, in Annals of Internal Medicine,
http://www.annals.org/cgi/content/full/135/3/209

The Netherlands Department of Justice, press releases, http://www.minjust.nl

The Oath and Law of Hippocrates.” Vol. XXXVIII, Part 1, in The Harvard Classics,
edited by Charles W. Eliot, New York: P. F. Collier & Son, 1909–14, from
http://www.bartleby.com/38/1/1.html
