Physician-Assisted Suicide

Cory W. Childress ’19 and Jason A. Guzauskas ‘19

Physician-assisted suicide and its implementation into hospitals across the United States has been a rather controversial topic over the years, as those for and against it remain divided over the concept of an individual’s right to life. However, in this paper we will be focusing on the individual’s right to end their life in the cases of the elderly and the terminally ill using the aid of a physician. This topic is rather interesting because of the concept of the individual’s right to life, and how it pertains to those who have already lived a long life but don’t want to feel as though they are left wasting away as a burden to those close to them or those who are left with no other option but to suffer through living. In this paper, we will discuss the arguments being given by those for and against physician-assisted suicide, as well as giving our own opinions as we get involved into the discussion.

What *is* Physician-Assisted Suicide?

According to Bernard Sussman and Timothy E. Quill of the Hastings Center (2018), the definition of physician-assisted suicide is:
“the practice of a physician providing the means for a person with decision-making capacity to take his or her own life, usually with a prescription for barbiturates that patient takes himself or herself.” (“Physician-Assisted Death Glossary,” para. 1)

Elderly People and the Terminally Ill: Physician-Assisted Suicide and the Costs Involved

In terms of what the legalization of physician-assisted suicide would mean for the elderly is a right to end their lives on their own terms without waiting for death to come knocking on their door and a cheaper alternative to the traditional route of bedside assistance and doctor visits. In legalizing physician-assisted suicide, this would free the elderly of racking up an unnecessary amount of debt from doctor visits and bedside care via nurses and other machines. The two most popular drugs used to carry out physician-assisted suicide pentobarbital and secobarbital.

In regards to cost, Death with Dignity (n.d.) explains the costs of these two drugs:

Pentobarbital in liquid form cost about $500 until about 2012, when the price rose to between $15,000 and $25,000. The price increase was caused by the European Union’s ban on exports to the US because of the drug being used in capital punishment, a practice that is illegal and deemed deplorable; many international pharmaceutical companies don’t export the drug to the United States for the same reason. Users then switched to the powdered form, which cost between $400 and $500. The dose of secobarbital (brand name Seconal) prescribed under death with dignity laws costs $3,000 to $5,000. (“How Much Does the Medication Cost?,” para. 2,3)

To the naked eye, the costs of the liquid form of pentobarbital and the dosage of secobarbital may seem fairly high. However, when compared to the costs of traditional doctor visits, hospice care, and doctor visits it is very cost efficient. To put it into perspective, according to payingforseniorcare.com (2017), “the national average amount paid is $3,750 / month” (“Assisted Living & Memory Care,” para. 1) when a patient requires assisted living in their homes. Therefore, with the risk of racking up an immense amount of debt that would be left to their estate to cover after their death, it is imperative that the elderly be allowed to make the choice of whether to use the drugs necessary for physician-assisted suicide. The impending debt that would be left on the shoulders of the families after the passing of a loved one would be an unfair burden to place on them, especially when there is the possibility for a cheaper alternative if this practice were to be legalized.

While for the first half of the paper we have focused on the use of physician assisted suicide amongst our oldest citizens, we will now be focusing on young people with terminally ill diseases. The directional change from the elderly to those who are near death might not seem like such a distinction, but we are holding that the terminally ill have the same right to end their suffering for similar reasons to the elderly. The elderly and terminally ill are both nearing their final stages of life, but the main difference here is age. Our grouping differences are slim but are for safety. Defining what exactly is terminally ill is harder than one might imagine, as many

countries have a plethora of different lines in the sand to measure what truly is terminal. Here we will define terminal as anyone that a physician would say does not have a possibility of serving their disease.

Terminally ill patients are often themselves a member of those we are classifying as elderly but have the random chance to be any age due to the randomness of contracting a terminally ill disease. The reason we are drawing a line of who can receive physician assisted suicide at the person's age or level of sickness is to further play the role of the citizen's parent. Also, to clarify, elderly are those who have left the workforce for age, or are over the age of seventy. We want to keep the mentally ill from having an express lane to an early grave brought on by their perceived need to kill themselves. Suicide is already enough of a mess for people, we do not need to mass produce it.

While the possibility for it would be small, we would also like to try and prevent any path to murder physician assisted suicide would enable. One pill slipped into grandma's morning tea in order to obtain her inheritance is all it would take for the general public to condemn physician assisted suicide as inherently evil. The *British Medical Journal* (January 3rd, 1998) mentions how "euthanasia" has two main arguments against it, "doctrine of double effect" and "slippery slope", and how both will undermine its progression (p. 71). The first is the "doctrine of double effect" and an example would be a doctor giving a terminally ill patient pain relief with morphine, which in itself is nothing out of the ordinary and often expected, but the morphine eventually leads to the patient's demise (p. 71). "Slippery slope" is rather straight forward and states that if euthanasia were to become the norm then patients would abuse it and doctors would trust patients a lot less, resulting in the loss of care for those who need it and distrust all around.

The arguments for terminally ill patients are rather straight forward- if you already know that there is almost zero chance you will survive the disease then you should be able to at least die painlessly. Many of the terminally ill diseases are extremely fast acting, meaning they are often only diagnosed in their late stages, which leave those affected and their family few courses of action. The first course of action should always be the strongest possible effort in combating the disease. We do not want physician assisted suicide to be anything other than the last resort. There would need to be an incredibly small chance that the person could recover, as then we just extinguished a candle that still had wax to burn.

Amongst those we define as terminally ill are the people left, or born in, a vegetative state. These people have no means of living life to its fullest capacity and are often left to be cared for by family members. While removing a feeding tube or turning off a life support machine are not exactly the same as taking a prescribed pill, they still require a physician's assistance. In 1995 "artificial nutrition and hydration are medical treatments" as defined by the *British Medical Journal*, was in response to the cases of several people in persistent vegetative states such as a twenty-two-month-old child (p. 464). This decision may be small, but it puts the doctor's action on the same level of prescribing a pill of the same power and thus in the same realm of "normal" physician assisted suicide like that of lethal injection or by pill. It is worthwhile to mention that a polled sample of Brits believed withholding treatment with machines or tubes was different than prescribing a pill, as it was passive rather than actively killing a person. Whether it is the intent, or the act people have the biggest problem with we will never know.

Conclusion: Our Opinions on the Matter

I, Jason A. Guzauskas, believe we ought to have the right to a death assisted by our physician of choice and in as personalized a situation that can be permitted. I used ought over should in order to apply a moral imperative and ethic of care into my final decision. It is a moral dilemma due to the severity of what is at stake: someone's pursuit of happiness. When the time one has left is determined without their permission, they need to have one thing left that they are fully in control of, and that thing is their life. I have had my own times of deep sadness and can understand the wants of those yearning to kill themselves, but I would fight and die to keep anyone from having physician assisted suicide rather than it become the new shotgun. Going into this class, and this topic in particular, I was of the mindset that anyone should be able to take their own life, but that changed. I lost my dearest high school friend right before thanksgiving to his own hands and that right there showed me how no one should ever leave until they literally cannot stand it. Once dying is the only possible option to alleviate the physical pain then may they be cleared for whatever comes next.

I, Cory Childress also hold a similar stance to Jason's regarding physician-assisted suicide. I feel that it is imperative that this practice be legalized nationwide for the sake of lessening the burden for not the patient, but their families as well. If the option of physician-assisted suicide were made available to the elderly and the terminally ill, the amount of financial debt that looms over the head of the family of the deceased would be as minimal as they see fit, thus making the process of handling their affairs after their death much easier.
Above, you can see the costs of assisted living compared to that of the drugs used for physician-assisted suicide. As you can see, the costs of extended care to prolong an individual's life is astronomical when compared to physician-assisted suicide. Wouldn't *you* want the choice to go out on your own terms?

REFERENCES

- Bradley, P., Przygoda, P., Saimovici, J., Pollán, J., Figar, S., & Raithatha, N. (1998). Physician Assisted Suicide, Euthanasia, and Withdrawal of Treatment. *BMJ: British Medical Journal,316* (7124), 71-72.

- Cranford, R. (1995). Withdrawing Artificial Feeding From Children With Brain Damage: Is Not The Same As Assisted Suicide Or Euthanasia. *BMJ: British Medical Journal, 311* (7003), 464-465.

- Death with Dignity (n.d.). How Much Does the Medication Cost? Retrieved from the Death with Dignity website: http://deathwithdignity.org/faqs/

- Paying for Senior Care (Aug. 2017). Assisted Living & Memory Care. Retrieved from the Paying for Senior Care website: http://www.payingforseniorcare.com/longtermcare/costs.html#title5

- Quill, T. MD, Sussman, B. MD. (2018). Physician-Assisted Death Glossary. Retrieved from the Hastings Center website: http://www.thehastingscenter.org/briefingbook/physician-assisted-death/