



**“The Right to Die: Perspectives on Informed Consent and  
Medical Responsibility”**

**By Rohan Jayanth**

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Rohan Jayanth

Professor Molin

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### **Introduction**

Recent events have dramatically highlighted the ongoing debate regarding Physician Assisted Suicide, or PAS. In April of 2017, Charlie and Francie Emerick, married for 66 years, chose to end their lives together under Oregon State Law (Aleccia). The Death with Dignity Act allows residents to request a physician's assistance with administering a lethal dose of medication, provided that certain criteria are met. Charlie, who had suffered from Parkinson's disease, prostate cancer, and heart issues, and Francie, who had suffered from several heart attacks, both met the prognosis requirements from the state (Aleccia). Assisted suicide is an uncomfortable topic that deals with many issues regarding autonomy, death, and the uncertainty associated with death. Speaking of assisted suicide, Arthur Schafer, a Professor of Philosophy at the University of Manitoba, compared it to its most applicable analog, refusal of life-sustaining treatments; he alleges that "The right of a competent adult patient to refuse any undesired treatment, including treatment necessary to sustain life, is now deeply entrenched in most liberal democratic societies as both a social and a legal norm" (Schafer 526). While this is an excellent start for a discourse on the merits of PAS, one key factor that many arguments neglect is the principles of bioethics; more specifically, two principles that are central to this argument are those of autonomy and beneficence/non-maleficence.

This paper aims to answer the question: how do medical professionals assure that potential implementations of PAS comply with the tenets of bioethics? An ancillary line of

inquiry includes: to what extent do such practices respect the beliefs and wishes of healthcare professionals? In order to further analyze these topics, we must first clarify some important concepts and terms relevant to the discussion. Arguably the most important of these is bioethics, guidelines that the medical community uses to deem a procedure ethical. The three most relevant tenets of bioethics are: autonomy, that a particular procedure respects the wishes and sovereignty of a patient over their own body; beneficence, that procedures are performed with only good intentions for the patient's outcome; and non-maleficence, that the procedure carries no intentional negative consequences that the patient is not aware of and did not fully consent to. These three principles define the heart of the PAS debate; namely, 1) is this procedure beneficial for the patient, 2) can a patient be made fully aware of the negative consequences associated with dying, and 3) is the patient able to give fully informed consent under these conditions? The debate within academia is rather divisive, with many informed and logical arguments on both sides of the debate. While some rightly argue that the possibility of mistakes and even intentional abuses of such a legalized system would pose too great a risk, others argue for legalization of PAS, citing that there is almost no distinction between it and its closest legal analog, refusal of life-sustaining treatments (Heilig and Jamison 114; Schafer 526). Ultimately, a more productive discussion stems from analyzing medical professionals' responsibilities in PAS; specifically, what type of system could be implemented to mitigate risk and maximize benefit. This paper aims to analyze the validity of possible implementations of PAS through the lens of bioethics, as well as analyzing the role that medical professionals play in the maintenance of autonomy and beneficence in such a system. This paper will argue that a shared understanding of the objectives of treatment between physician and patient is paramount to properly implementing treatment;

therefore, the responsibility of medical professionals is to balance the patient's autonomy and treatment goals against the potential risks of any procedure in question, especially PAS.

This paper utilizes the tenets of bioethics as a critical lens. As bioethics governs all of medicine, it seems especially appropriate that the basic principles of bioethics should provide a basis for any academic argument regarding PAS. However, much of the scholarly debate is rightly centered around the very validity of informed consent, which is integral to medical ethics. This paper will first aim to show how the pure application of bioethical principles to the procedure of PAS leads to many problematic intricacies and contradictions. Then, this paper will visit the ideas of several academics, who believe that a modified or alternate interpretation of medical ethics, especially one that values the patient's perspective on the patient's best interest, is necessary to fully understand and debate PAS's validity as a medical procedure. Finally, this paper will attempt to explore the responsibilities of physicians in implementing such an interpretation of bioethics in medical practice.

### **Assisted Suicide: The Modern Debate**

The notion of assisted suicide has worked itself into many debates, both scholarly and popular, and while the granular aspects may occasionally evade discussion, the basic essence of the issue remains nearly universal and extremely salient. In the public, this debate seems to present a singular distilled question from which all other inquiry proceeds: "Is suicide by older adults ever a rational choice?" (Span). More importantly, it raises questions about the fundamental nature of death. Is assisted suicide a form of murder, or should the assistant not be culpable for the act? What actions define the separation between assisted suicide and other acts involving the death of an involved party? Questions such as these hardly have defined answers, and even medical professionals, such as Dr. Meera Balasubramaniam, "[have] not taken a

position on whether suicide can be rational” (Span). Even more inflammatory are the personal accounts, which, by their very nature, serve to polarize the public even further, creating sides either vehemently against or for assisted suicide. Accounts such as those of Sarah Lyall serve to remind us that not all of proponents of assisted suicide are devoid of regard for human life, but instead to show us an alternate perspective, perhaps one of “a person who wants to do the most important thing that her mother has ever asked of her;” a person of truly pure intentions, one who cares only for the well being of the involved parties (Lyall). It is from this sheer lack of consensus and understanding that a true exploration of the intricacies of assisted suicide is possible.

This comprehensive legal and ethical debate stems from a rather abstract question: to what extent should patients have control over their own life and death? However simple a question this may seem, it creates a serious number of paradoxical situations, especially for healthcare professionals. Furthermore, according to Francis Degnin, an accredited professor of philosophy, these are “not simply the result of sloppy thinking, uncaring indifference, or inadequate knowledge,” but arises as a result of how medicine defines morality (99). Instead, he argues that a true debate can only be held on PAS when the strongest arguments of both sides are considered seriously, and the implications of those arguments on the concepts of ethics and morality are accounted for (100).

Much of the PAS debate centers around the idea of consent, a topic with several layers. One concern that arises is the very basic issue of the right to die, or whether an individual has any control over ending their own life. Many proponents of PAS argue that it is simply an extension of autonomy, the right to self-sovereignty. However, Schafer presents a more nuanced argument for PAS. First, he acknowledges that “the principle of respect for autonomy is seldom

claimed to be absolute,” and that, more accurately, an individual’s choices are always considered with a great degree of weight (Schafer 524). He then continues his argument instead by comparing PAS to its most direct analog: withholding or withdrawing life-saving treatment, abbreviated WWLS. Schafer claims that since the right to refuse WWLS is integral to medical care in the modern world, it becomes harder to understand why “opponents of PAS are deeply worried about mistake and abuse when it comes to assisted suicide but apparently unconcerned when it comes to the no less serious possibilities for mistake and abuse when WWLS is at issue” (526). Schafer’s argument illustrates that in order to seriously understand the intricacies of PAS, either the validity of WWLS needs to be reconsidered, or the system by which we judge the validity of these more serious, life-altering procedures needs to be very carefully analyzed.

Another complexity with PAS arises after superficial agreement is reached on the issue of consent; the hypothetical situations that arise afterwards raise all sorts of troubling questions. One such situation comes from a study of dementia and Huntington’s patients, both neurodegenerative conditions which affect personality to varying degrees. In this study, a fierce debate surrounding advance directives, a legal notice of action, potentially including PAS, to be taken in the event of a specific medical condition’s onset. However, many opponents argue that the inability of humans to imagine ourselves with distinct and different circumstances can lead to an serious skepticism towards advance directives. According to this study, this argument is especially strong with cases of dementia, as some argue that the "predementia person and the same person same person with dementia are ‘literally’ two different people,” which would invalidate any advance directive made by the former (Draper et al. 78). Additionally, this idea of mental duplicity brings into question whether the latter person would even want to commit suicide, as suffering is entirely subjective. It calls into question whether “patients with advanced

dementia truly experience the suffering that they had once feared” (78). This is not to downplay the possibility that dementia patients truly suffer unspeakably due to their disease; rather, it is to open the minds of both patients and practitioners to the possibility that the current methodology of judging and executing PAS may require serious reexamination if PAS is ever to be validated by modern medicine.

### **The Medical Ethics of Physician Assisted Suicide**

Whenever academic debates concerning PAS arise, they inevitably center on the concept of bioethics, or biomedical ethics. This concept is a very elementary formalization of what it means for a procedure to be considered ethical by modern medicine. Modern Bioethics is comprised of 4 basic tenets: autonomy, justice, beneficence, and non-maleficence. By these four principles, an ethical procedure 1) respects the autonomy over self of a patient, 2) does not unfairly advantage any one sect of society, 3) is formulated with only good intentions and outcomes in mind, and 4) only allows negative consequences in the pursuit of a positive end goal. Bioethics, in its current incarnation, has proved an invaluable tool to modern medicine, allowing a reasonably objective view on the ethicality of many risky and controversial procedures. However, within the context of PAS, we see bioethics meet a great hurdle. Within PAS debates, we see the extremity of the procedure play havoc with the rules of bioethics, creating all manner of oddities and contradictions.

In order to understand where the current arguments regarding assisted suicide, we must first consider how the current system defines the practice, and what problems arise. One idea that is indispensable to the medical profession is the notion of informed consent. Often viewed as a composition of the various bioethical principles, it is defined as full and voluntary consent, given while entirely understanding all the risks and possible outcomes of the procedure in question. For

most procedures, this does involve accepting death as a possible consequence, but only as a side effect. Consider the example of a kidney transplant. The recipient understands that they may die during the operation, but the immediate goal of the procedure is to extend and improve the life of one patient, not to end theirs. This line of reasoning breaks apart in cases of PAS, however, where the intended goal is the onset of death. Some argue that “[since] death means that the necessary conditions for autonomy are lost,” medical professionals should not act in this way, which “[leads] to loss of autonomy” (Sjöstrand et al.). In this view, the action of assisted suicide leads to an active termination of all possible future agency, and so dramatically negated the autonomy of the patient. Regardless of the manner, death is seen almost universally as a negative outcome, and so a negative outcome being intentionally implemented into a procedure could be construed as unethical. In fact, some argue that this is a violation of the Hippocratic Oath, seen as a pillar of medicine in both the ancient and modern worlds. These arguments against PAS, stemming from discussions of both pure bioethics and the Hippocratic Oath, all fall prey to the same shortcomings; namely, they fail to analyze the merits of the system they use to explain the phenomenon in question. A more true and holistic understanding of the goals and relative ethicality of assisted suicide is only gleaned from actively questioning and reworking the framework by which we understand and judge medical ethics.

### **Moving Towards Ethical Assisted Suicide**

The current system for judging medical ethics is wrought with technicalities and intricate details; many of these details make it tremendously difficult to justify any extreme procedure with any modicum of certainty. Therefore, my aim in this section is to apply a line of reasoning to reconcile one of the oldest medical decrees with the ethical system of modern medicine. In doing this, it will become clear why analyzing the explicit details of any particular system is far



from an accurate reflection of that system. In order to accomplish this, we will consider the example of the Hippocratic Oath, the very cornerstone of ancient medicine.

The Hippocratic Oath makes a central claim that a physician's obligation is to their patients, and that their actions must be taken with ultimate beneficence towards the patients in mind. However, the Oath also makes many other provisions, forbidding doctors from prescribing deadly drugs to terminally ill patients, i.e. PAS, as well as helping pregnant women receive an abortion. However, Degnin argues that analyzing the intricacies and specifics of the Oath "could easily distort what is truly unusual about [it]" (Degnin 8). Instead, he argues, we should focus on interpreting the sentiment behind these claims and analyzing how these ideas contribute to the application of the Hippocratic Oath today (Degnin 8). By casting aside the inherent limitations of a strict code or regimen, and instead analyzing the motivating sentiment behind that code, Degnin provides a way for assisted suicide to be analyzed in a way that is both medically sound and ethically consistent with prior medical institutions. In analyzing the scope of the arguments presented today concerning assisted suicide, it seems clear that Degnin's focus presents a rational and productive avenue of investigation for the investigation of PAS today.

In order to further the scope of the argument, this line of reasoning can be applied to the bioethical concepts of autonomy, beneficence, and nonmaleficence. Regarding the concept of medical ethicality, Dr. Lauri's Kaldjian, a doctor of Internal Medicine at the University of Iowa's Carver College of Medicine, proposes that the medical profession is advantaged for being able to "circumnavigate philosophical questions about ultimate human ends in its pursuit of more proximate health-related goals" (Kaldjian 559). Kaldjian is proposing that it is in the very nature of medicine that focusing on the most final of circumstances a patient will encounter is not the most medically prudent plan. Instead, he proposes focusing on making the most informed chain

of decisions that most directly complies with the wishes of the patient. In order to do this, Kaldjian speaks of a collective set of understandings about the goals and nature of treatment, which shall be referred to as proximate healthcare goals. These goals are not an arbitrary monolithic construct, unchanging and unyielding to new ideas and procedures; instead, they represent a dynamic, a dialogue between physician, patient, and other involved parties. As a result, these goals are not only less future-oriented, but are fluid, changing to reflect the ever-changing reality of a patient undergoing treatment. These developments, which can range from a simple change in opinion to a substantial disagreement between a patient and a medical proxy, are not merely a result of a human fickleness. These changes serve to “remind us that the selection of goals is not only based on biomedical realities and available technology, but also on beliefs about matters as fundamental as the value of prolonging life, the acceptability of suffering, the significance of a given outcome probability, and the financial implications of treatment.” (Kaldjian 560). By instituting a system where contact and communication between physician and patient provides the basis for treatment, possibly the most basic tenet, the physician’s duty to the patient, is given the utmost importance.

Certain precautions in instituting any system of assisted suicide must also be taken. For instance, a study by Hans Thulesius et al. found it common, both in popular, professional, and academic circles to hold the opinion that “the patient must suffer from an incurable deadly disease and have a short life expectancy” (5). However, as stated previously, any system that deals in absolute thresholds is inviting contradictions and exceptions. Some medical professionals disagree on whether other groups should be intentionally ostracized from such a practice. The same study found “mentally competent and paralyzed individuals are challenging society and current legal structures,” providing yet another rebuttal to a clearly instituted

boundary (5). However, a more pressing concern comes from the opposite argument: that not all people that fall on the right side of the line truly meet the criteria. A study by Brian Draper et al. found that amongst dementia patients, "...there is already evidence that persons with mild cognitive change and early dementia are at risk of suicidal behavior, often in the context of comorbid depression" (Draper et al. 1). The same study presents significant and troubling evidence suggesting individuals who are cleared of their terminal diagnosis may still choose suicide out of a possible sense of guilt (Draper et al. 80). This presents a huge task to overcome, and it is abundantly clear that the simple distinction between terminal and non-terminal patients cannot provide a comprehensive outlook for when assisted suicide should be allowed. This system, when followed, accounts for neither the values and relative suffering of the patient, nor the expertise and discretion of the physician. Open communication between physician and patient provides a possible solution.

When dealing with cases of assisted suicide, it is imperative that treatment reflects a shared understanding between all involved parties of the goals and values of the patient. Importantly, Thulesius et al. found that embracing assisted suicide as an option requires "openness and awareness of dying to provide adequate symptom relief" (6). This does not merely reflect on patients; it is the responsibility of all parties involved to identify and discuss whether death provides a suitable alternative to other forms of treatment. However, when dealing with assisted suicide, it is important to recognize that the procedure must fundamentally be a patient request, and not an impersonal prescription. To ensure this end, Heilig and Jamison propose the use of continued directives, or legal directives that repeat a wish for death for a certain time frame to legitimize any request for assisted suicide (Heilig and Jamison 116). However, the sentiment is expressed, the simple goal is to reduce the chances that either

physician or patient will make an error in judgement. A system that “[integrates] the biomedical and ethical aspects of clinical judgement, we may help lessen the risk that ‘clinical judgement’ will merely express ‘the clinician’s judgement’” (Kaldjian 561). To that end, a system that honors educated discussion concerning the goals and values of treatment would facilitate a fairer consideration of all intricacies involved.

In order to see the efficacy of this alternate approach to patient care, we need not look further than cases where this procedure applies. In the situation described by Sarah Lyall, the options available to her mother are so inconsequential that she vehemently reaffirms her willingness to “commit murder on behalf of a dying person [she loves],” and although she agrees with her mothers wishes to end her life on her own decent terms, she still finds herself unable to directly kill her own mother (Lyall). In the case of Charlie and Francie Emerick, we see the case of a happily married couple, who had arguably lived well, wanting to end their lives together rather than face the horrible slew of conditions the world had dealt to them (Allecia). Real life accounts of this horrifying reality serve to remind us that of the roughly 8200 elderly who committed suicide in 2016, many may have been rationally searching for an escape for what promised to be a painful existence (Span). Instead of facilitating the despair that comes with terminal illnesses, a system that values the patient experience displays a respect for the relative value of life, death, and the quality of the experiences a patient has had. As a result, such a system is not only medically necessary for any mitigation of risk with PAS but is also a moral imperative for modern medicine.

## **Conclusion**

Assisted suicide represents an important distinction regarding the taboos of death. For many cultures, to die of happenstance or a worldly occurrence is considered natural, or even

divine providence; to take life from oneself, conversely, is viewed as unholy, an abomination against the gift of life bestowed by the world. As a result of this, suicide has generally been considered a taboo and the topic avoided throughout centuries of human history. Assisted suicide represents a threat to this stifling of discussion; in order to implement it, a true discussion about the merits of suicide needs to occur. In the context of modern medical practice, assisted suicide presents one of the most compelling and challenging ethical dilemmas for patient care. Many rightly fear for the potential abuses and the cultural or religious implications, and their worries are not unfounded; there is a cause for concern in any system that allows for an irreversible limitation of one's freedoms.

This paper aimed to propose a system by which a holistic understanding of the responsibilities that medical practitioners hold in implementing assisted suicide. We first explored the various ways in which assisted suicide is controversial, and how that controversy is used to fuel an ever-polarized debate in the popular scene. From there, this paper analyzed the ethics involved in medicine, and aimed to show that by casting aside semantics and steadfast rules, and instead utilizing direct communication, guidelines, and judgement, a better system for patient care can be achieved. The path towards a better healthcare system is wrought with challenges. By actively confronting these challenges, and in this case, the preconceived taboos surrounding these concepts, we can challenge our own notions of what constitutes ethical medical practices.

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