Physician-Assisted Suicide For Untreatable Chronic Pain

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Chronic pain is a challenging thing to comprehend unless it is experienced. For some people chronic pain is merely an inconvenience. But for other people, it is a debilitating condition that can make life nearly unbearable. Chronic pain drastically alters the lives of those who suffer from it. Such pain can lead to unwanted career changes and even permanent unemployment. When chronic pain affects a person’s ability to function on a day to day basis, they may begin to feel like a burden on their families and society as a whole. Chronic pain can lead to unmanageable physical pain as well as debilitating psychological problems.

Many countries allow patients to request physician-assisted suicide (PAS) in cases of terminal illness. Might it also be ethically permissible for policies allowing PAS to be expanded to patients suffering from unmanageable chronic pain? A survey of the relevant laws of several countries and the American Medical Association’s stance on the issue indicate that U.S laws and policies are in need of revision. The ethical permissibility of PAS may be supported using virtue ethics and be further informed by relevant literature on the matter. The conclusion that is ultimately reached that PAS may be appropriate in select cases of untreatable chronic pain.

Current Laws and Policies

There is no universal law or stance on PAS. The policies of different countries and areas of the world vary drastically. To reach a sound conclusion about PAS, it is important that the policies of several countries and organizations are explored.
The United States has opted to leave policies regarding the issue up to each state. In 1997, a Supreme Court case called *Washington vs. Glucksburg* ruled that “legalizing or criminalizing physician-assisted suicide (PAS) was a matter of states' rights; that is, a matter for each state to decide for itself” (Lagay). As a result, laws in the United States differ greatly from state to state. There are currently nine US states that allow PAS (Steinberg). One of the most commonly discussed policies established by these nine states is Oregon’s Death with Dignity Act. The Death with Dignity Act allows PAS when a patient is a decisionally capacitated adult, an Oregon resident, terminally ill, and expected to die in 6 months from said illness (Norman-Eady). Decisional capacitation requires that a patient understands their condition and the risks and benefits associated with available medical interventions. The patient must also be able to apply reason and values to their medical decisions. Oregon’s law prevents citizens of other states from traveling across the country to receive aid in dying. In turn, many complex interstate conflicts are avoided. Even so, the plethora of conflicting laws within the borders of the United States are a subject of political and social tension.

Belgium, on the other hand, has a very liberal euthanasia policy. The country allows people who are suffering from mental conditions, such as chronic depression, to request euthanasia (PBS NewsHour Interview). While this may be shocking to a United States citizen, it is quite normalized in Belgium. The two requirements for euthanasia in Belgium are the experience of constant and unbearable suffering and a condition that is incurable (PBS NewsHour Interview). Further, patients are not required, or allowed, to take the life-ending drugs themselves. This means that euthanasia (where the doctor administers the drugs) is legal, and PAS (where a doctor prescribes the lethal drugs) is not. This differs from the United States’ policy in that the doctor is required to play a more active role in the patient’s death. Since the
Belgium law went into effect, the number of deaths by euthanasia has steadily gone up. In 2013, 1,800 people chose to die by euthanasia. The law has even been expanded to include children, though, as of 2015, no such cases had occurred (PBS NewsHour Interview). Overall, Belgium law allows patients much more autonomy than the laws of the United States.

Another country with a similarly liberal law is the Netherlands. There, “the patient's suffering must be unbearable with no prospect of improvement. The suffering need not be related to a terminal illness and is not limited to physical suffering such as pain. It can include, for example, the prospect of loss of personal dignity or increasing personal deterioration, or the fear of suffocation” (Lewis). This is vastly different from the policies of some states in the United States because it allows for “suffering” to include conditions beyond terminal illness. In all U.S. states’ that allow for PAS, terminal illness is a requirement of making a request.

Contrastingly, the American Medical Association takes a harsh stance against PAS. According to the textbook *Clinical Ethics*, “the American Medical Association rejects physician-assisted dying as ‘fundamentally incompatible with the physician’s role as healer’” (Jonsen, Siegler, and Winslade 155). It is clear that the AMA does not believe that any room can be allowed for PAS.

All of the aforementioned policies have strengths and faults. For example, Oregon law states that a patient must make at least two requests to die, each at least 15 days apart. If questions exist about decisional capacitation, they must perform a psychological evaluation (Norman-Eady). This ensures that wrongful deaths are avoided and that patients are truly decisionally capacitated. However, 15 days is an extremely grueling amount of time for a person with a life expectancy of six months. Within this time, a person may be experiencing an exorbitant amount of pain and suffering.
Opponents of liberal policies such as those of Belgium and the Netherlands often resort to slippery slope claims. This fallacy consists of asserting, without evidence, that one step away from the status quo will result in an irreversible plunge toward disaster. Note that this maneuver is a fallacy, not a well-formed argument. The burden of proof is on the person suggesting that there is a slippery-slope, and advocates of this belief have not adequately proven their case. To do so would require solid evidence that euthanasia and physician-assisted suicide inevitably leads to the unjustified deaths of patients.

Doctors in Belgium are required to submit paperwork detailing each case of euthanasia and if a case is found to be problematic, doctors may face punishments as severe as homicide charges. This strict system of justice ensures that physicians are cautious if they want to keep their jobs. Further, two doctors must approve the request in physical cases and three doctors must approve the request in mental cases (PBS NewsHour Interview). This serves as yet another defense mechanism against wrongful death. While it is true that euthanasia rates in Belgium have gone up since they enacted the law, there are several logical explanations for this trend that do not involve the slippery slope. Patients may feel more comfortable expressing their desires to their physicians, and families may be having more open conversations about death. It is unreasonable to resort to the slippery slope when there are more sensible explanations readily at hand.

The American Medical Association’s stance on PAS is unnecessarily strict. While it claims to draw its basis from the physician’s duty to do no harm and to act as a healer, it fails to recognize the effect that suffering has on a person’s quality of life. There is a critical difference between being kept physically alive and having a quality of life that the patient believes to be
worthwhile. At some point, medical intervention may become so invasive that a patient would prefer the end of their suffering.

Applying Ethics

When looking at such a complex and divisive issue, it is helpful to look at the problem from the perspective of ethical theories, which provide even-handed guidance in nuanced situations. However, not every ethical theory is appropriately applicable to every issue. Take deontology, for example. Deontology suggests that the only ethical actions are those which can be universalized. For this reason, a deontologist may encourage a person to disclose the hiding places of Jewish stowaways to Nazis if asked, because lying is not universally acceptable. Clearly, deontology is the wrong tool for this job. When looking at PAS, virtue ethics can offer the most valuable insight into the issue at hand.

Virtue ethics is an excellent theory to apply to biomedical issues for several reasons. One reason that virtue ethics is such a great theory here is that it “emphasizes the virtues, or moral character” (Rosalind and Pettigrove). It is critical for physicians to be focused on giving the most compassionate and productive treatment to their patients. A physician should be motivated to help relieve their patients’ suffering and attend to their conditions to the best of their ability. As explained in The Stanford Encyclopedia of Philosophy, “a virtue ethicist [will point to] the fact that helping the person would be charitable or benevolent” (Rosalind and Pettigrove). A physician should not be biased or arbitrarily favor certain patients when giving care. The main goal of a physician needs to be helping the patient, not gaining fame or fortune.

Virtue ethics can also inform the four main principles of biomedical ethics: beneficence, nonmaleficence, respect for autonomy, and justice. Beneficence can be generally understood to
mean doing what is best for the patient, while nonmaleficence represents the duty not to cause harm to a patient. Each of these two principles can be informed by the virtues of compassion and sensibility. A virtuous physician must have the ability to hear a patient’s wishes and concede when one principle trumps another. In the case of PAS, beneficence becomes more critical than nonmaleficence when pain becomes so extreme that the patient no longer enjoys life.

It is also critical that physicians respect patient autonomy, the patient’s right to make decisions about their own medical care. A virtuous physician will strive to keep the preferences of the patient in mind when deciding on a care plan, while avoiding paternalistic tendencies and inserting their own preferences into the equation. To ensure that patient autonomy is respected, the physician must ensure that patients understand their options.

The principle of justice states that a physician must be fair when caring for a patient. If there are scarce medical resources involved in a decision, a physician must be able to detach themselves from emotional biases to make just decisions about allocation. Virtue ethics is an excellent theory for informing medical decisions because of its fluidity; more rigid ethical codes may suggest more ruthless solutions to medical problems and should not be considered here.

Opinions Within the Field

There is controversy on a global scale regarding PAS. Within the medical field, there is intense disagreement between professionals and the general population alike. It is important to look at perspectives from people both inside and outside of the field to understand the complexity of the issue.

Choosing Death, by the philosopher Peter Singer, provides an excellent anecdote of the thought that goes into a person’s decision to die. The short essay follows the story of Gillian
Bennett, an 85-year-old suffering from dementia. In explaining her desire to end her life, Mrs. Bennett remarks “I want out, before the day when I can no longer assess my situation, or take action to bring my life to an end” (93). This statement shows an awareness of deteriorating autonomy. Since she is unable to obtain PAS, she is being forced to make this choice sooner than she may have, had assistance been offered to her. Singer explains that “her husband, Jonathan Bennett, a retired philosophy professor, and her children supported her decision, but she refused to allow them to assist her suicide in any way, as doing so would have exposed them to the risk of a 14-year prison sentence” (93). The laws in her country forced her to alienate her family and remain secretive to protect them legally. This likely put a burden on familial relations. Further, it is clear from this statement that she is carefully considering the ethical implications of her choice. This is not a rash or hasty decision. Singer concludes his essay by explaining that Bennett believes a policy change would ease death anxiety and “enable people in her condition to live as long as they want—but not longer than that” (96). This point is well argued and articulate.

A similar story is shared in Singer’s essay *When Doctors Kill*. The essay details the life of Gloria Taylor, who suffered from Lou Gehrig’s disease (97). She is angry because suicide is legal in her country, Canada. Yet, PAS is illegal. As the text explains, “Taylor sees this as offering her a cruel choice: either end her life when she still finds it enjoyable, or give up the right that others have to end their lives when they choose” (97). In this way, it is almost discriminatory against those with disabilities for Canada to have policies against PAS. When looking at Canadian laws, it is nonsensical and incoherent that suicide is legal, but that PAS is outlawed.

Many philosophers use utilitarianism to advocate for legalizing PAS and euthanasia. In his book *The Elements of Moral Philosophy*, James Rachels does just that. Rachels describes the
case of Sigmund Freud, who had his personal physician, Max Schur, euthanize him (Rachels 101). He further explains that “utilitarianism takes a different approach. It asks: Which action available to Max Schur would have produced the greatest balance of happiness over unhappiness? ...Freud’s condition was so bad that he preferred death. Killing him ended his agony. Therefore, utilitarians support euthanasia in such cases” (101). Since utilitarianism aims to maximize happiness, it can be used to justify euthanasia in cases of unbearable suffering. Freud was suffering from cancer and bone decay, making him a candidate for euthanasia in the eyes of utilitarians. 

Even outside of the biomedical field, many people have strong opinions on PAS and euthanasia. Charles Lane expresses quite intense beliefs in his piece *Children are Being Euthanized in Belgium*. Lane remarks that “everywhere else in the world, the law reflects powerful human intuitions, moral and practical: that it is wrong to abandon hope for a person so early in life, no matter the illness” (Lane). There are several problems here. The first is that relying on “powerful human intuitions” as the sole basis for any opinion is dangerous and numerous historic trends support this fact. Secondly, terminal means terminal, regardless of age. It can certainly be conceded that children should not be eligible for euthanasia due to mental illness or pain. However, it is cruel to keep a doomed patient alive because of the possibility of a miracle. As it turns out, Belgian policy agrees that a child must be “in a hopeless medical situation of constant and unbearable suffering that cannot be eased and which will cause death in the short term” (Lane). Lane cannot get past the emotional reaction to the topic in order to think about it more critically, his beliefs may therefore be misguided.

However, not all arguments against euthanasia and PAS can be written off so easily. David Velleman, a professor of Philosophy who has devoted an extensive amount of time to
biomedical ethics, poses several concerns in his paper *Against the Right to Die*. The greatest concern he raises is that patients in situations where euthanasia would be a viable option are unlikely to be decisionally capacitated. He explains that “so although I do not favor a policy euthanizing people against their wills, neither do I favor a policy of euthanizing people for the sake of deferring to their wills, since I think that people’s wills are usually impaired in the circumstances required to make euthanasia permissible” (197). While it is important to ensure decisional capacitation, this can be achieved through detailed psychological evaluations. Such screenings are advocated for in the next section of the paper. Velleman goes on to suggest that offering patient’s the option to die may encourage them to consider new reasons to die (201). This contradicts advice commonly given to people worried about suicidal family members: it is best to talk to the family member because you cannot put the idea of suicide into someone’s mind, they are either considering suicide or they are not. This reasoning can apply to Velleman’s argument as well. If a patient does not desire PAS or euthanasia, offering it to them will not change their desire.

**What Needs to Change**

PAS must be universally legalized in the United States for cases of terminal illness and untreatable chronic pain. Allowing each state to make their own PAS laws creates complex legal issues.

From a standpoint of beneficence, it can be argued that there is not a meaningful difference between someone with a terminal illness and someone in chronic pain. In each case, a person is suffering immeasurably. If they have expressed that their suffering outweighs their desire to live, it is best to allow their suffering to end.
Even nonmaleficence can support PAS in these situations. At some point, being alive begins to harm a patient who wishes to expire. The best way to “do no harm” ultimately becomes ceasing medical intervention and accepting that the best way to end a patient’s suffering is to help them end their life.

As is expressed in Singer’s *Dying in Court*, “if the patient’s circumstances are such that it would be ethically permissible were the patient able to do it, then it is also ethically permissible for the physician to provide the means for the patient to do it” (98). While this quote is in reference to Canada, where suicide it legal, it is still applicable to the United States. The legality (or in the case of the United States, illegality) of suicide has no bearing on the ethical implications. United States’ policy prohibits suicide so that people can be involuntarily committed for mental health concerns if necessary. It does not follow from this that PAS is problematic in cases of chronic pain.

While PAS should be legalized in the cases mentioned, there must be limits and requirements. The commonly used waiting period, second opinions, and mental health screening should suffice. Patients should undergo psychiatric evaluation to ensure decisional capacitation and rule out any treatable contributing factors. The patient should be required to get at least two professional opinions on the matter to ensure that physician bias is not interfering in the decision. Finally, patients should have a waiting period of two weeks before being allowed to fill the lethal prescription. These constraints will help minimize hasty decisions about death.

During Hurricane Katrina, Dr. Anna Pou euthanized several patients in New Orleans. In this unfortunate situation, “Anna Pou’s patients did not seem to ask to die” (Pence 51). Since they did not ask to die, Pou compromised their autonomy. To avoid situations like this one, active euthanasia, where the physician administers the medication, should remain illegal for the
time being. While this may not prevent atrocities, it will make them legally actionable and hopefully reduce their occurrence.

Opponents of PAS often point to the experiments of the Nazis. For several reasons, this is not an apt comparison. As explained by Gregory Pence, “Nazi physicians administered the *Final Solution* to the ‘problem’ of how to cleanse Germany of racially inferior non-Aryan peoples” (Pence 44). The Nazi experiments were racially motivated and inherently unethical for that reason alone. It is worth mentioning, for the sake of appealing to the opposition and being abundantly clear, that PAS must be voluntary and consented to by the patient.

**Concluding Thoughts**

This piece has explored PAS laws across the globe. It is clear that people are not ending their lives in droves, even in countries with laws more progressive than are being advocated for here.

While there is widespread disagreement about physician-assisted suicide, it appears to be ethically permissible by the standards of virtue ethics. As a general rule, developed countries are moving towards legalizing PAS. Many countries where PAS has been legal are currently expanding upon these policies.

Untreatable chronic pain can have the same medical indications as a terminal illness, save for the “terminal” element. In both cases, a patient’s suffering may outweigh their desire to live. If a patient in either case expresses a desire to end their life and are found to be decisionally capacitated, they should be allowed to do so.

Normalizing PAS will encourage families to have tough and meaningful conversations that are uncommon in the current climate. Encouraging conversations about death will ease the
process of grieving for families that find themselves unsure of their loved ones’ desires once they are gone.

For those still skeptical, it is worth noting that many people do not end up using their lethal prescriptions. In Oregon “Of the 290 patients for whom prescriptions were written during 2019, 170 (59%) died from ingesting the medication” (Death with Dignity Act). Perhaps, that the option is available gives many patients a much-needed sense of control over their own lives. Whatever the reason, not every person who seeks out PAS ends up following through with it.

A policy change regarding PAS is necessary and has been for a long time. Many of the developed nations around the world are far ahead of the United States’ in this regard. PAS does not require physicians to play an active role in the patient’s death, making it far less objectionable than euthanasia. By allowing for PAS in cases of untreatable chronic pain, the United States’ will be offering its citizens a compassionate response to suffering on an institutional level.


