



**2023-2024 Undergraduate Ethics Essay Prize**

**3<sup>th</sup> Place**

**The Struggle with Assisted Suicide, For and Against**

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## The Struggle with Assisted Suicide, For and Against

One of the most contested and controversial current issues within the medical world is questions about the permissibility of assisted suicide. The practice is legal in only 10 of the 50 US states (and the District of Columbia) and 11 countries including Canada, Australia, and Switzerland (Swaim, healthline.com). Before delving into why it is controversial, I think it would be most helpful to define what exactly we are talking about. Assisted suicide (also seen as ‘physician-assisted suicide,’ ‘physician aid in dying,’ ‘medical aid in dying / MAID,’ and even ‘death with dignity’) is a situation in which a physician gives aid to a patient seeking to commit suicide. The way the physician aids the patient varies. In some cases, a physician may prescribe lethal doses of drugs to a patient while in others he may explain a method of suicide such that the patient can end their life without undue suffering (Vaughn, 528-529). In either case, the physician merely provides the means or knowledge for a patient to commit suicide. It is up to the patient to make the decision to actually carry out the act of suicide. Note that this is an important distinction between assisted suicide and euthanasia. Euthanasia is a situation in which the doctor makes the decision to end a patient’s life (with consent of course), and it is a topic separate from this paper with its own legal, ethical, and moral concerns and considerations.

Before getting to the ethical considerations of assisted suicide, it is worth narrowing our scope about the importance of the situational conditions when considering the practice of assisted suicide. We have already discussed the varying legality in general, but there are specific requirements within those laws. For instance, in the United States to be eligible for assisted suicide a person must be 1) 18 or older, 2) have a terminal illness with a prognosis of 6 or fewer months to live, 3) be mentally able to make their own medical decisions, and 4) to be able to ingest the medicine / perform the act themselves (Jordan, webmd.com). There are also additional

requirements such as letting patients know of their other options like pain control, having the right to change their mind, and the right to take back their request (Jordan, webmd.com). These criteria may change depending on where one is located, adding more complexity to the situation. For our purposes we will consider treatment for chronic conditions that are untreatable, incurable, or otherwise not alleviable regardless of terminality. This is a solid baseline for determining the overall moral status of assisted suicide without overly complicated scenarios.

Given the above I think it is quite clear why this is such a controversial issue. On the one hand we have physicians who are trying their best to do whatever they can for their patients, yet at the same time physicians take an oath to do no harm – and questions arise as to whether assisted suicide is doing harm or helping. At the same time there are questions as to whether a patient should be forced to live through suffering if there is only an exceedingly small chance of surviving long term, if there is any chance at all. I think that thinking about the situation through various ethical theories can help us settle on an answer. In this paper I will argue that people who have chronic conditions that are untreatable, incurable, or otherwise not alleviable have a moral right to assisted suicide.

To begin with we will first look at this problem from a quasi-utilitarian perspective. Utilitarianism is a view in moral philosophy that inspects the morality of an action based on its outcomes or consequence, specifically on if it maximizes pleasure or minimizes pain. It makes sense to consider this view because if we can establish whether an assisted suicide action truly generates net pleasure or pain, then we will have good grounds to either claim it morally acceptable or reprehensible. In her paper “Stop the Robot Apocalypse: The New Utilitarians,” Amia Srinivasan, a professor of social and political theory at the University of Oxford, addresses and discusses many of the more modern approaches to utilitarianism, including views from

William MacAskill. MacAskill is one of the more popular proponents of effective altruism, but it is a key component of his views that is most useful in the debate about assisted suicide: the idea of Quality-Adjusted-Life-Years or QALYs. This is a unit used by welfare economists that is useful for a variety of situations and comparison, where 1 QALY is equivalent to a single year of life lived at 100% perfect health (Srinivasan, 2). There is a standardized scale which weighs a year with AIDs without antiretrovirals as 0.5 QALYs and with antiretrovirals as 0.9 QALYs, or a year blind as 0.4 QALYs (Srinivasan, 2).

I propose that there is an argument to be made here based on the QALY rating people have and expect for their own lives. Rationally we can accept that we will not 100% perfectly healthy lives each and every year, so we must set some level from 0.0 to 1.0 QALY that we *expect* to have for the coming year, and we make this decision based on our circumstances. Or at least we have a minimum QALY rating we are willing to expect. What I am suggesting is that if we fall below this threshold then we experience some pain in ourselves that offsets the low level of QALYs. For instance if my minimum threshold is 0.20 QALYs, but I end up in a terrible accident and will have to be in constant pain along with many other drastic changes to my life that would result in my QALY rating being 0.10 for the rest of my life, then even though if I keep living I am contributing 0.10 QALYs to the societal total, the fact that I am having to live below my minimum quality of life imposes a greater harm to me (manifested perhaps through disappointment, anger, depression, etc.) than the benefits of those few QALYs to total society. This is the case if I am to keep living in my low QALY state. However, what if assisted suicide were an option? If I could end my suffering in a relatively safe and controlled way, then yes I would stop contributing my 0.10 QALYs to the societal total, but at the same time the negative impact of living below my QALY threshold would also be negative, and what we have proposed

is that this negative impact has much more bearing on me than my 0.10 QALY contribution does for society. Therefore, there are two options: continue to live with the low QALY score, very highly negative personal dissatisfaction, and produce a net negative in the world, OR through assisted suicide cease living and thus stopping my low QALY contribution but also stopping my highly negative personal satisfaction. Option one in this case has a net negative contribution while option 2 is less negative and likely closer to 0. Based on this reasoning a utilitarian would agree that assisted suicide is a moral right for such circumstances.

An objection that can be applied against assisted suicide that arises is the worry that assisted suicide programs ultimately end up having negative impacts on end-of-life care and “decreased quality of palliative care” (Krahn, 53). An argument based on these worries from the utilitarian perspective focuses on measuring the impact of changes in quality in end-of-life care before and after the implementation of assisted suicide. A study from Oregon, the first state to implement assisted suicide, argued that dying patient in the state were “nearly twice as likely to experience moderate or severe pain during the last week of life” compared to patients prior to the implementation of assisted suicide (DREDF). However, I do not think this argument is all that convincing. For one it requires that we consider the increase in reported pain during the final week of life to be attributable to permitting assisted suicide. However, for the sake of argument let us say that it does. Given this, the utilitarian would decide if assisted suicide is permissible based on whether the total amount of pleasure is maximized while the amount of pain is minimized. This means weighing the additional pains created by allowing assisted suicide against any pains saved by allowing it. The pain created that we are worried about is this doubling of the amount of pain in dying patients during their final weeks of life. Although this is significant, we also must consider the pain saved through a properly medically advised assisted

suicide, which, as I have discussed previously, carries an overall positive utility value. I think however if you weigh all the factors, including the pain avoided through assisted suicide, the avoidance of prolonged emotional and financial stresses on family members, and accelerated cycle for closure, the utilitarian would be forced to agree that there is more total utility in finding assisted suicide to be permissible than not.

Next, we will examine how assisted suicide under certain circumstances is a moral right from a theory of justice and fairness. We will specifically be engaging with the work of John Rawls, a well-known moral and political philosopher. He proports that justice is “the first virtue of social institutions, as truth is of systems of thought”, insisting that our social institutions truly must capture justice (Rawls, 125). In fact, Rawls makes it clear that justice is a *necessary* component of our social institutions, otherwise they are to be reformed or abolished (Rawls, 126). He extends this claim to include not just institutions, but laws as well. How does this help answer our question? Well, we have laws that allow or disallow the use of assisted suicide. We also have concerns about how just our society can be if we do not allow assisted suicide even if the right to it is just. To answer these questions, we need a way to identify justice.

This is where Rawl’s Original Position comes in. The original position is a form of thought experiment that can help us decide whether societies or certain aspects of society are just. This is done from behind a ‘veil of ignorance.’ Rawls recognizes that it is difficult for us to dissociate ourselves from our present beliefs and circumstances, and that as a result it is difficult for us to truly assign justice and fairness since we will be somewhat biased. As a result, when it comes to deciding something about society, Rawls asks us to consider the question from behind a veil of ignorance in which we know nothing of ourselves. In this situation we are much warier of outcomes that we would not normally even consider by virtue of our known characteristics. I

wish for us to apply this concept to the optionality for assisted suicide. It seems easy to dismiss assisted suicide if one never has to encounter it (even if we cannot truly know we will or will not). However, behind the veil of ignorance, we cannot be sure whether we are an individual who has a chronic condition as described previously. When we are within this ignorance, we are faced with the decision of looking at a society that does not allow for assisted suicide and asking, ‘would I accept a society that would not allow me to end practically certain suffering, but rather force (for lack of a better term) me to endure this pain’. I think we would all decline to accept this society from a position behind the veil of ignorance. This would suggest, according to Rawls, that such a society would be unjust. I would suspect if we changed our statement to ask acceptance for a society that would allow one to end suffering, then we would accept this aspect of society as just. What this suggests is that assisted suicide has a place within a just and equal society and should be considered a moral right.

While we are still considering a societal perspective, we should think about the fact that certain groups within society have unique perspectives on moral issues that we should consider. One key group’s voice that we should consider on this topic would be that of disability rights. The disability perspective is unique for a couple of reasons. For one, disabilities themselves seem to present an interesting case. The term itself is quite broad, with the CDC defining a disability as “any condition of the body or mind...that makes it more difficult for the person with the condition to do certain activities...and interact with the worlds around them” (CDC). Of course, this definition is incredibly broad and captures a variety of disabilities. The subset that poses an interesting question is the group of more-or-less permanent disabilities. Again, there is a large range still within this group, but for at least some these permanent disabilities come with terrible pains or overall poor qualities of life. Since these conditions seem to fall within the scope of our

investigation (as conditions otherwise not able to be alleviated), we seem to be saying that they should have a moral right to assisted suicide. However, there are a variety of objections we should examine from this very group's perspective.

One type of objection we should pay attention to are objections involving a worry about disrespect and devaluing the lives of disabled people by claiming that assisted suicide is a morally permissible thing. This is a worry that arises out of worries that allowing assisted suicide communicates that "disabled lives are not worth living" or are in some way "less worth living than other lives are" (Colburn, 683). Often these views result out of arguments that the disabled lack autonomy (in this sense meaning mostly being able to do things without the help of others), at least compared to non-disabled people, and that life without such autonomy is not worth living (Krahn, 52). Based on this, these arguments continue, society should allow "the right to end one's life under such circumstances" i.e., due to a (permanent) loss of autonomy (Krahn, 53). This line of reasoning does in fact seem to clearly imply that limited autonomy is less valuable in some way, which in fact disrespects people with disabilities. To further prove the point that it is a concern about the loss of autonomy over anything else, consider a statistic from the Oregon Department of Human Services. Oregon is one of the few states that has allowed assisted suicide for quite some time. Their survey, which looked at the programs over the course of a decade, revealed that loss of autonomy was cited by 9 out of 10 people who decided to engage in assisted suicide (Krahn, 53). Indeed, it seems that assisted suicide being morally permissible implies that a lack of autonomy is not worth living with, and this leads to a conclusion that being disabled is not a life worth living. If this objection stands then there are concerns about the rightness of assisted suicide.



The way to deal with the previous objection is to realize that it is, to some extent, almost hypocritical or inconsistent in some way. The key issue with the previous objection is that it argues that allowing assisted suicide undermines respect for and value of the lives of persons with disabilities. It argues that we should not find assisted suicide legally or morally permissible because of the way it impacts the valuing of certain lives. However, this logic is flawed, because in arguing that assisted suicide is wrong, the objection argues that no person (specifically individuals with terminal conditions) can make that decision and be morally right. Essentially, we are suggesting that people should not have the autonomy to make that decision! So here we have traded value and respect for one set of people at the cost of valuing another group of people's autonomy. This seems strange. I think it is a universal statement that people have a right to autonomy. However, I think we would be less certain about saying that what society *seems to imply* as valued (not even values with certainty) actually reflects what members of that society value. A quote from the British Medical Journal sums this up pretty well: "it is not for society to tell people what to value about their own lives...if we are serious about protecting autonomy, we have to accept that autonomous individual have different views about what makes their lives worth living" (Delamothe). The objection fails because regardless of what laws might say or how other people may think, only individuals decide what to value in their lives. The availability or morality of assisted suicide must be maintained for autonomy, so while the concerns about devaluing people with disabilities are certainly valid, the permissibility of assisted suicide does not have the impact that it may seem to at first because individuals have autonomous thought, and to maintain autonomy generally we cannot restrict the rights of other rational individuals.

Another objection stemming from this group deals with the fact that permitted assisted suicide seems to force members of various communities towards taking that option. The disabled

community is certainly one community, especially when we consider the overlap between it and poorer communities due to reliance on the government for a paycheck if they are unable to work. Often these issues compound and leave many people feeling as though they have no choice but to seek out assisted suicide. This has been an issue in Canada and other countries, where disabled people seek suicide as an option to escape poverty more than anything else (Global News). Furthermore, the decision to allow assisted suicide becomes more questionable within the context of our health care system. For instance, a piece from the Disability Rights Education & Defense Fund advocating against assisted suicide tells the story of two Oregonians with cancer. These two individuals were informed that their health plan would not pay for chemotherapy but would pay for assisted suicide (DREDF). This begs us to answer a question: how can we find assisted suicide permissible if it leads people to end their lives early?

This is again a valid concern, but I do not think that it serves as an effective argument against the permissibility of assisted suicide. I think it underscores larger issues within society that are just highlighted by the allowance of assisted suicide. For instance, the story of those in Canada who felt pushed to assisted suicide was due to poorness caused in part by having disabilities which stopped them from being able to work. Similarly, the fact that insurance would cover assisted suicide but not chemotherapy may well just be speaking to the attached price-tags than anything. It is unfortunate that these situations arise, but I do not think we can say that assisted suicide is the problem here. In the Canada case it is the lack of a good structure for assisting the homeless generate income, and in the Oregon case the issue is with how health care and health insurance is dealt with in that state. At this point the argument might be brought up that in establishing assisted suicide as permissible, we make it an option for those in hard situations. I think it is wrong to argue this way. The grim, but true, reality is that suicide is not a

new option in the way that proponents of the objection make it seem through blaming assisted suicide. One can argue that it makes it 'easier,' but ultimately the decision still comes down to an individual taking their own life, medically advised or not. As a result, I do not think it can be argued that assisted suicide is not morally permissible because it encourages people to take that option. Individuals considering such a choice are still faced with dealing with the gravity of their choices, advised or not.

At this point I would like to consider a new objection from the Kantian perspective. Shafer-Landau, a leading moral philosopher at University of Wisconsin-Madison, outlines a couple of important tenets of Kantian thought in relation to ethics and deontological thinking, and a key one that is discussed is the concept of "means," "ends," and the uniqueness of humanity. A Kantian will purport that humanity is special because of its rationality and autonomy, which also extends to other creatures (Shafer-Landau. 176). They will also purport that treating a creature with these traits as a "means" and not an "end" is morally wrong. In this case treating someone as a means just means dealing with them in such a way that he helps you achieve your goals while treating someone as an end means treating him with deserving respect (Shafer-Landau, 176-177). How then does this apply to assisted suicide? Well, the Kantian could raise the objection that any form of suicide (including assisted suicide) acts to treat themselves merely as a means, and that it disregards the self's autonomy. I like the way Iain Brassington of the University of Manchester puts it during his article in the *Journal of Medical Ethics*. He suggests that Kant would want to argue that any "suicide would be 'making use of his person merely as a means to maintain a tolerable condition until the end of his life'" (Brassington, 572). If this objection and argument are correct, then assisted suicide would be morally wrong because it violates a key tenet of Kantian thought: we would be treating people as a means.

Brassington however argues that this argument does not hold within the framework of Kantian thinking. Brassington makes the point that the issue of treating a person as a mere means is problematic because it involves denying their personhood (Brassington, 572). Yet for Kant to reach morality as a possibility he must assert that we belong to both the sensible world as well as a distinct intelligible world, and that it is this super-sensibility that makes humans have capacity for autonomy and is their source of value for why they cannot be mere means (Brassington, 572). The argument becomes that this special essence of personhood which makes us truly priceless is in us without being *contained* within us. And since personhood, whatever it may be, transcends the individual, then the destruction of self and of personhood are two separate things (Brassington, 573). The argument is quite complicated and predicated on believing one can coherently tie together Kantian thought from the source. Although this argument is quite “in-the-weeds” of Kantianism, it does a good job of fighting Kantianism with Kantianism.

I think that a less technical but still thought-provoking consideration in opposition to the point that assisted suicide violates self-autonomy and treats oneself as a means is the role of consent. As we have made clear, assisted suicide is only carried out with the express consent of the patient, and then only through the patient’s actions themselves – arguably another form of consent. Once a patient has given consent, by their own autonomy, and decides to maintain that consent then should self-autonomy still be a worry? We would be stuck in an infinite cycle on using self-autonomy to verify decisions made using self-autonomy, which we would then have to go verify and so on. One would think that by admitting and maintaining consent, we would be happy to accept this and not consider the consented action, whatever it may be, as a crime against a rational and autonomous being’s autonomy. That is, if consent is given, then assisted

suicide does not represent an intolerable action by Kantian standards and should be morally acceptable.

In conclusion, I think we can all agree that whether assisted suicide is a moral right for patients with chronic illnesses is a much more difficult and complex issue than what it appears at face value. Despite this however, I feel as though we have successfully demonstrated that assisted suicide is morally permissible because it allows an option to decrease overall suffering and pain in the world, it enables more just societies, and it truly does respect the autonomy of individuals. As a result, we can say that on the basis utilitarian ideas, theories of justice, and even Kantian thought that assisted suicide is in fact a moral right for appropriately suffering patients.

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