Assisted Suicide

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Abstract

Does the process of dying have to be slow, painful, and undignified? Proponents for assisted suicide argue that suffering in dying is a plight that many doctors and nurses force on their unwilling patients. How should health professionals respond when a patient dying of an incurable disease begs for a quick and easy death? The nurse's role in assisted suicide is an issue that should concern all nurses. The author examines the background of the arguments for and against assisted suicide. By putting these components into perspective and examining relevant issues, possible resolutions are proposed.

Introduction

A slow, painful, undignified death is a fate that most of us would not wish on our worst enemies. Proponents for assisted suicide argue that suffering in dying is a plight that many doctors and nurses force on their unwilling patients. When a patient dying of an incurable disease begs for a quick and easy death, how should health professionals respond? The question of assisted suicide, and in particular the nurse's role in assisted suicide, is a topic that concerns all nurses. A look at the background, the arguments for, and the arguments against assisted suicide may suggest answers.

By definition, assisted suicide is a type of *euthanasia* or "good death," a term associated with ending a patient's suffering by causing death (Webster, 1995). Euthanasia is categorized as either active or passive. *Active euthanasia* or "mercy killing" refers to actions taken with the intention of ending a patient's life (Potter, 1997). Active euthanasia is illegal in most settings, and some people consider it to be the same as murder. *Passive euthanasia* refers to allowing a patient to die, making no attempt to hasten or prolong the process even if the means are available (Potter, 1997). Allowing a patient to refuse life sustaining treatment and removing a feeding tube at the patient's request are examples of passive euthanasia. The patient will die, but the cause will be a natural process.

It is called *suicide* when a person takes his or her own life, and *assisted suicide* when a person helps another to take his or her own life. Assisted suicide straddles the line between active and passive euthanasia. The caregiver generally provides the means of death, but the patient takes the action. The term *assisted* has many shades of meaning; some examples of how it moves from passive to active may help to explore the ethical controversy. Example one: A physician assists by writing a prescription for a lethal drug, knowing that the patient plans to kill himself. Example two: A nurse assists by leaving the prescribed lethal drug at the patient's bedside. Example three:

A patient is very weak and has difficulty with purposeful movement. The nurse assists the patient by placing the medication in the patient's hand, helping the patient place the medication in the mouth, and holding a straw to the patient's lips to allow drinking fluid and swallowing the lethal medication.

The Case for Assisted Suicide

A basis question that must be asked is why do patients request assistance in suicide? In an editorial in the New England Journal of Medicine, Scanlon (1996) writes, "It represents not only the ultimate claim to self-determination, but also a response to the egregious inadequacies and inhumanity that often characterize the care of the dying and critically ill" (p. 1401). The ANA (1994) position paper on assisted suicide states that "requests for assisted suicide can be related to numerous factors including unrelieved pain and other symptoms, depression, feelings of loss of control, fear of isolation, concern for family and a sense of hopelessness" (p. 3). The American Society of Clinical Oncology Task Force on Cancer Care at the End of Life states that "patients fear a lonely, painful, inhumane, technological attempt to delay or counter forces of nature that cannot be altered, and that the process of their dying will be out of their control" (Schnipper, 1998, p. 1987). Therefore, it seems clear that patients request, even beg for assistance in dying, not because they desire death, but because the alternative is so repugnant.

"The central argument supporting assisted suicide is based on respect for patients' autonomy" (Haddad, 1997, p. 18). The United States judicial system has consistently confirmed the patient's right to decide his or her life's course and the patient's right to die. With the 1976 Quinlan case and the 1990 Cruzan case the right to refuse treatment became law. The Patient Self-Determination Act of 1991 required hospitals to inform patients of their right to refuse treatment, order ongoing treatment halted, and refuse future treatment even if these refusals will result in death. Assisted suicide may be seen as a logical extension of the patient's right to self-determination.

Additional ethical arguments involve the principles of beneficence and nonmaleficence. With modern medicine focused on curing disease it is an unfortunate reality that when a cure is no longer possible, many patients are left to suffer horribly as they live out their last days with little or no relief. The patient, the family, and the nurse caring for the patients are all affected. Healthcare professionals often avoid dealing with these patients, and physicians worried about legal issue are reluctant to prescribe sufficient amounts of pain medication (Alspach, 1997). Why should the patient be forced to endure such agony when it is not necessary? "If dying patients have no rights in relation to the timing and means for terminating their life, does this imply that they have the obligation to die slowly? To die painfully? To die devoid of dignity: To die financially impoverished?" (Alspach, 1997, p. 16). The ANA (1994) recognizes the problem even as it disagrees with assisted suicide:

Nurses witness firsthand the devastating effects of debilitating and life-threatening disease and are often confronted with the despair and exhaustion of patients and families. At times, it may be difficult to find a balance between the preservation of life and the facilitation of a dignified

death. Nurses need to recognize their own feelings of sadness, fear, discouragement and helplessness and realize the influence of these feelings on clinical decision making. These agonizing tensions may cause a nurse to consider intentionally hastening a patient's death as a humane and compassionate response, yet the traditional goals and values of the profession militate against it (p. 2).

Supporters of assisted suicide argue that it is a violation of the principal of nonmaleficence, that it is doing harm, to allow a patient to remain in pain when death is requested and the means is available (Kaveny, 1997).

Case Against Assisted Suicide

The participation of health care workers in patient suicide is troubling for many reasons. Among these reasons are a fear of escalating use, a belief that patients would not choose death if better palliative care were available, and the moral-ethical unwillingness of most nurses to participate in patient suicide (Wlody, 1997). Churchill and King (1997) noted the following in the British Medical Journal:

The most widely feared abuse associated with the legalization of physician assistance in death is the gradual extension of such practices to include those not terminally ill, and the expansion of physician activity beyond assisted suicide to active euthanasia, both non-voluntary [when patients are unable to request or consent] and involuntary [when patients are competent but do not request or consent]. (p. 138)

This concern is known as the "slippery slope." At this time only patients in the terminal stages of incurable illness are considered candidates for assisted suicide. Once the prohibition against taking a life is lifted, once death becomes a choice, what is the stop this choice from being offered to others? Kavney (1997) asks the questions, "First, by what rationale may this liberty interest be limited to the terminally ill? Is not the interest equally if not more important to those afflicted with severely debilitating chronic diseases, since they fact a longer period of suffering?" (p. 129). Factors such as caregiver convenience and economic priority could intrude into the decision-making process. Persons with durable powers of attorney would be able to decide that their patient with Alzheimer's disease or on a ventilator would not want to live further. "Studies have shown that most health-care costs can be traced to expenses incurred in the last months of life. Employers and insurance companies could achieve great financial savings by encouraging patients to choose assisted suicide at the 'appropriate' time" (Kavney, 1997), p. 130). This slope is indeed slippery.

The practice of medicine with its emphasis on cure can often come in conflict with the practice of caring. When a cure is no longer possible, the cure vs. care controversy becomes crucial. Offering a patient an early death may be an acceptable medical alternative, but is it an acceptable

nursing alternative? Can nurses fit assisted suicide into their moral and ethical foundation? Assisted suicide may lessen suffering, but can it be considered caring or healing?

Nurses are consistently oriented to the provision of care that promotes well being in the people served (ANA, 1995). In 1980, the American Nurses Association (ANA) defined *nursing* as "the diagnosis and treatment of human responses to actual or potential health problems" (Potter & Perry, 1997, p. 216.) In 1995, the ANA expanded the definition of nursing to include:

"…attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation; integration of objective data with knowledge gained from an understanding of the patient or group's subjective experience; application of scientific knowledge to the process of diagnosis and treatment; and provision of a caring relationship that facilitates health and healing" (p. 6).

The preamble to the *ANA Code for Nurses: With Interpretive Statements* tells us that nursing judgement is based on universal moral principles such as autonomy [self-determination], beneficence [doing good], nonmaleficence [avoiding harm], and justice [treating people fairly]. "The most fundamental of these principles is respect for persons" (ANA, 1985, p. 1). The ethical dilemma for nurses lies in the tug-of-war between the ethical principles of autonomy and beneficence/nonmaleficence.

Despite the arguments that patients have the right to suicide based on self-determination, that right does not extend to nurse assistance in suicide. An editorial in the *National Catholic Reporter* declared, "It is emblematic of a cultural extreme in which individualism and individual autonomy is the good, outweighing any connection to community – even family – or any obligation to the larger society" (Anonymous, 1997, p. 28). Patients do not desire death for its own sake. Rather, they see death as the better alternative to pain and loss of control. This response to a health problem can be treated in other ways. "Nurses may provide interventions to relieve symptoms in the dying client even when the interventions entail substantial risks of hastening death" (ANA, 1985, p. 4). The widely accepted doctrine of "double effect" generally states that treatments often have both desired or good effects and undesired or bad effects. As long as the purpose of the treatment is the good effect – to minimize pain or enhance quality of life – it is acceptable, even if it speeds the process of death. The key is intent. A lethal dose of morphine given to stop a patient's pain is permissible, while the same dose given to cause death is not. The line has been drawn. Actions that allow death to happen in due course are acceptable. Actions taken to deliberately cause the death of a patient cross the line and are not ethically, morally, or legally acceptable.

The moral-ethical reluctance that nurses feel about assisted suicide is related to who they are and what they stand for. How can an ethical nurse, dedicated to healing, participate in an act that purposely ends a patient's life? (Volker, 1998) writes, "a request for [assisted suicide] is a potential response to illness. Whether assisting a dying patient to end his or her life constitutes healing is debatable, and opinions in this regard may vary depending on the perspectives and values of individual nurses and patients" (p. 43). Assisting in a patient's suicide does not have to be an acceptable nursing intervention. "Furthermore," Kaveny (1997) says, "there is a reason to question whether the availability of assisted death will give physicians, as well as members of

the broader medical community [including nurses] an excuse for not remedying profound inadequacies in the way the U.S. health-care system currently manages end-of-life issues" (p. 131).

The legal issue may no longer impede nurses from participating in assisted suicide, and the ethical-moral issues will be come all the more important. The Supreme Court recently ruled in Vacco v. Quill (1997) to uphold a New York State law banning assisted suicide. The court found that there is no fundamental right to assisted suicide. However, the court also seems to have left it up to the states to decide whether assisted suicide should be legal. The Oregon Death with Dignity Act allowing assisted suicide became state law in 1994. Other states are considering similar legislation, and some may follow Oregon's lead. Morally and ethically, most nurses do not agree with assisted suicide. Wlody (1997) examined several international studies and found that "common threads include the compassion nurses feel for patients' suffering and the finding that most nurses state that they do not and would not participate in assisted suicide (or euthanasia)" "p. 75). Even if an action is legal, it is not necessarily moral or ethical.

Summary

The question of assisted suicide presents a dilemma for doctors, patients, and nurses alike. The ethical dilemma of assisted suicide revolves around the conflict between the patient's right to autonomy and the nurse's ethical duty to the principles of beneficence and nonmaleficence. Assisted suicide does not have to become the only option to terminal illness. Rather than focusing our energy on helping patients to die, nurses and doctors could aggressively pursue palliative care options that support an end of life with dignity. Unrelieved pain and loss of personal control are frequent reasons for requesting assisted suicide. If these can be mitigated, requests should be much rarer. The laws are changing and the slope is slippery, but the majority of nurses believe that they should not participate in assisted suicide. The position of the ANA (1994) is that "nurses are obliged to provide relief of suffering, comfort and, when possible, a death that is congruent with the values and desires of the dying person. Yet, nurses must uphold the ethical mandates of the profession and not participate in assisted suicide" (p. 5). The American Association of Critical-Care Nurses' (1996) position is even more specific: "The profession's position is that nurses should not participate in acts of assisted suicide and active euthanasia. Such acts are inconsistent with the ethical norms of the profession and undermine the integrity of individual practitioners and the care they render: (p. 2).

Recommendations

Nurses can become active, aggressive patient advocates for better palliative care – even if the end result is a shorter life. Another option that deserves consideration is hospice, a philosophy of care that provides support for the patient while allowing death with dignity. Nurses must remain dedicated to caring for patients and dedicated to promoting maximum health, even in the midst of terminal illness.

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