



## 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,

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 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.

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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



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.

investigation (as conditions otherwise not able to be alleviated), we seem to be saying that they should have a moral right to assisted suicide.





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?







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