Student's Name

Course

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Date

Physician-Assisted Suicide

Introduction

Physician-assisted suicide refers to the deliberate termination of one's life using a toxic matter with the indirect or direct help of a doctor. Physician-assisted suicide entails the process of offering a capable patient with treatment for him or her with the primary goal of terminating the patient's own life (Kamm 28). The phenomenon has its opponents and proponents. For example, some physicians believe that the practice infringes the basic principle of medicine and trust they should not take part in suicides since doing that way is incompatible with the physician's duty as a healer. On the other hand, proponents of the procedure claim that it is acceptable because physician-assisted suicide is in agreement with one's autonomy to decide the manner and point in time of his or her death (Kamm 29). Aside from that, the moral aspects of physician-assisted suicide should not be ignored because they are important. Accordingly, in virtually all instances of physician-assisted suicide, the suffering and pain felt by the patient cannot be relieved. Whereas it is significant to proceed in large extents to attempts and relieve the pain via traditional medicine, on many occasions, it is just insufficient. When the traditional method is not successful, occasionally more extreme means are essential. One of such approaches which have turned to be highly contentious today is physician-assisted suicide. This type of suicide is passionately discussed since it is not just a simple suicide, but an intended social agreement between at least two individuals. **This paper argues in support for the**

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physician-assisted suicide. The foundation for the claim for physician-assisted suicide in this paper lies in the doctrines of individual autonomy or self-determination and well-being. Self-resolution is crucial for this moral issue since an individual needs to be able to judge the way to live their life or die, in this situation.

Arguments for Physician-Assisted Suicide

First Argument: Autonomy to choose the Manner and Timing of a Person's Death

The main argument affirmed in support for physician-assisted suicide that every cable individual needs to have the authority over the decision concerning his or her life (Kamm 31). An individual needs to acquire the sovereignty to judge the way of his or her death and when he or she should die. Feeling the quality of life, escaping extreme suffering and pain, upholding dignity, attaining a feeling of control, and having other people remember an individual as he or she wants to be recalled should an underlying liberty interest. Supporters of physician-assisted suicide claim that this autonomy right, particularly at the conclusion of life, is greater than any assertion that life should be preserved. Further, the holiness of life is severely weakened when death is approaching and one's condition is life-threatening.

Objection to the First Argument: The Impact the Physician-Assisted Suicide poses on People taking part in the Suicide

When doctors assist in the demise of an individual, they bring to the patient/physician association a lethal cause. Using an agent recognized to be deadly links the doctor to the client in a method that one committing a planned killing links to the individual who is murdered, that is, as a person who lethally harms them using toxic materials (Rady and Verheijde 207). While it would be good for an individual to possess the self-sufficiency to judge the way an point in time of death, this resolution must be accounted for with regards to the impact it could pose on other

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people. Physicians involving in suicides will, in the end, turn to be resistant to their usual ban to terminating another individual's life (Kamm 33). This will probably have an effect on how these doctors, and those they work closely with, perceive the significance of the protection of life and the way they treat other individuals, particularly when they encounter their own adversities and hardships. Besides, it is not true that a terminally sick patient with less than a half-a-year to live and feeling extreme mental and physical decline can make an autonomous judgment. For this matter, it is not believed that the notion of autonomy leads to the legalization and support for the physician-assisted suicide.

Reply to the First Objection

It is the responsibility of the physician and other people working around him or her to respect the dignity and autonomy principles of the patient. Physicians have the responsibility to ease pain and suffering and respect the patient's autonomy and decision-making. The categories of pain and suffering not only entail psychological and physical troubles but also existential and interpersonal issues. For instance, a patient may view him/herself an expense to his or her family and cannot enjoy life. During this situation, patients' autonomy should prevail and their choice to end their life through the assistance of the doctors should be respected (Kamm 34). In spite of the available technology and counseling, medical involvements may not improve patients' pain and agony. In such situations, it is true and rational to claim that having the alternative for physician-assisted suicide entails a procedure of compassion that reveres patient autonomy. The impact that the phenomenon will present on other people involved should not be a major concern that should deter the respect for the patient autonomy. It is factual that the physician-assisted suicide impacts the lives of several persons, in particular to their family members and individuals assisting in the practice. Nevertheless, the reality that one possesses the right to live and possesses the autonomy

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of how to live it, the impact on others is inferior to the autonomy value (Rady and Verheijde 208). Therefore, the objection that the physician-assisted suicide will impact the lives of those involved is not enough to overturn the doctrine of the patient autonomy.

Second Argument: Death with Dignity

Another argument for the physician-assisted suicide is that individuals need to be allowed to die with self-esteem. An individual's last weeks of life needs not to be lived in pain from extreme physical and mental agony, reliant on other people for the sanitation, food, and drinking, with mental and physical weakening, and feeling deteriorating vision, mobility, and hearing (Kamm 40). Relatives, members of the family, and friends need not witness the decline and pain of a loved one. The last feelings of a loved one need to be full of respect, joy, and dignity. The phenomenon is morally good for people or patients who feel that it is better to die than continue being hospitalized with severe suffering. Majority of people are in favor of physician-assisted suicide if it can help end the pain and allow the patient to die with dignity. For example, in two recent surveys by Gallup, 70 percent of Americans agree with allowing physicians to terminate the patient's life by using painless ways, and 51 percent trust that physicians need to be permitted to assist the patient in suicide (Dees et al. 340). Again, a survey conducted by Medscape indicates that 54 percent of physicians advocate for the physician-assisted suicide (Kamm 42).

Objection to the Second Argument: The actual Reason Terminally Ill Patients wish to die

The reasons terminally sick patients or people seek for physician-assisted suicide is not the pain but the hopelessness and depression, which are the motivating factors for the patients to develop death wish. The argument that the mortally sick persons wish to die with dignity is rational and legitimate. However, it has some flaws and, therefore, can be objected. Studies

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indicate that hopelessness and depression, as opposed to pain, are the primary variables driving patients' desire to die. Several terminally sick patients are afraid that as their health status advances, their mental function, physical capability, and autonomy will deteriorate (Kamm 47). The patients will lose their feeling of autonomy and ability to take pleasure in life. Also, they fear to be a burden to friends, relatives, and family. These people desire their final remembrance to be tender memories. Due to these thoughts and fears, the fatally sick patients are forced to be depressed and become hopelessness and desire a facilitated death. Indeed, it can be said that no substantial relationship exists between the wish for a hastened demise and the existence of pain severity or pain.

Reply to the Second Objection

It is acceptable that the lethally sick persons can require hastened death because of the increased depression and hopelessness which result from their deteriorating conditions. However, the response to this objection is that the depression and hopelessness have their origin from the physical and mental pain which come with terminal illness. In some cases, the depression and hopelessness are temporary and, hence, cannot be considered as essential factors in fueling the hastened death in terminally ill patients. This is because the depression and hopelessness can be successfully treated or eliminated or the patients themselves can reconsider. Nearly 50% to 70% of mortally sick people interested in physician-assisted suicide reconsider their decision. (Dees et al. 345). Oftentimes, the patient can be right when he or she says that it is rather he or she dies than continue burdening the family, friends, and relatives with the stress and expenses to relieve the mental and physical pain during these extreme situations and, therefore, should be allowed to get assistance from the doctors to facilitate his or her death to avoid the imminent depression and hopelessness.

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Third Argument: No Errors in Prognosis and Diagnosis during the Physician-Assisted Suicide Decision-Making Process

Supporters of physician-assisted suicide claim that capable, terminally sick people with below half-a-year to live need to possess the privilege to terminate their life. Even supposing the prudence of this rule, supporters are assuming that doctors will manager to properly diagnosis a person's prognosis and condition, find out whether the individual is lethally sick, whether he or she has a few weeks to live, whether the individual is capable, whether the person is behaving because of the undue influence, and whether the individual's dejection and pain can be successfully treated (Dees et al. 347). Supporters of physician-assisted suicide challenge that physicians need to attain the precise prognosis and diagnosis 99% of the cases (Kamm 50). Supposing this to be true, if an individual's pain is truly unbearable even following the administration of pain treatment and family and psychological counseling, then the person has the option to stop accepting hydrate and nutrition. Confessedly, death in this way may be to some extent humiliating and unpleasant. If one does not wish to pass on this way, then that person generally has to realize the idea of suicide that is not assisted by physicians to be more agonizing than remaining alive in his or her current mental and physical status. Next, if an individual's status is such that he or she considers suicide which is not assisted by physicians to be more distasteful than continuing to live, then it is acceptable that the physician-assisted suicide would be the only option.

Objection to the Third Argument: The Undue Influence over the Patient or Person

One of the most disturbing features of physician-assisted suicide is the doctor's subjective interpretation of the information (Rady and Verheijde 210). The physician has to determine the terminally sick patient's application to die to be reasonable under the conditions.

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Such an evaluation will usually be largely a subjective finding. When finding whether an individual's judgment to facilitate death is reasonable, the physician will be deciding whether the physician him/herself would want suicide under similar conditions, or at the minimum can ponder someone reasonably wanting it (Dees et al. 348). The doctor is, therefore, making an independent judgment on the human life value under the situations. It can be said that the finding of the capability of a fatally sick patient will usually be skewed from the perspective of the physician and the observers in the decision-making process. If those people would select demise under the situations, or at the minimum consider it, then that person's choice is considered competent and rational. If those persons would unlikely select demise under the conditions, then the individual's judgment appears incompetent and irrational. The patients and the close people around him or her are made weak and unsure by sickness and approaching death while doctors hold medical expertise and experience with death and life circumstances. The doctor's capability to influence patients' decisions in suicide is significant, both by initial designing of the problem and alternative and selective control of facts presented for approval (Kamm 51). The possibility for abuse intrinsic in the doctor/patient association should be considered. The chances for unconscious or conscious manipulation are present, even for the well-intentioned doctor.

Reply to the Third Objection

The physician's decision to end someone's life is not just a mere activity that is done without objective consideration. Besides, doctors are always encouraged to conduct their duties within the professional ethics and principles such as the beneficence and uphold a healthy physician/patient relationship. Physicians always consult other colleagues to determine the rationality and competency of the terminally ill patient and the rationality of the request to have a hastened death (Rady and Verheijde 213). Thus, physicians, during these circumstances, observe

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objectivity, avoid influencing the patients' choices, and act as per the consent of the patient before making the final decision on whether or not to assist in the suicide.

Conclusion

It is found that physician-assisted suicide needs to be acknowledged and supported based on its moral viewpoint because of the claims that it is performed following the accurate diagnosis and prognosis of the rationality of the lethally sick patients, it is within the patient autonomy doctrine, and allows for patients to perish with dignity. Nevertheless, the arguments for this practice can be objected on the grounds that it is exposed to the issues of undue influence over the patients, fails to consider the impacts the act will have on others, and the severe pain is not the cause of the death wish but the depression and hopelessness of the individual. In sum, this paper concludes that, despite these objections, physician-assisted suicide is moral and should be continued for the benefit of the patent and the people close to them, including the family members and friends. Once more, the findings are limited because it is focused on the morality of the practice and does not account for the legality of the issue. Therefore, more research is required to integrate the morality and legality of the physician-assisted suicide to establish its continuation and support in the society.

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