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The New Pro-Choice: Legalizing Assisted Suicide

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Library Use Statement

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Originally, based on a class discussion, I knew I was intrigued about the notion of "compassionate use" in relation to the medical testing of new drugs. We only briefly touched upon the subject in class, and I wanted to learn more about the topic through my paper. However, the topic was still very broad and general in my mind, and I decided to follow the advice of UCLA library's research tips when starting to research a new topic: doing a general search using various key words in the different online journal databases that are available for UCLA students. My first searches on online databases such as JSTOR, Pub Med, and the Web of Science using the key words "compassionate use" were relatively unfruitful, and I did not really find sources that would enable me to finish a 20 page research paper. Even so, through my initial searches, I stumbled upon discussions of physician assisted suicide. As I read more about the different types of assisted suicide, the ethical issues surrounding the topic, and the legal implications, I realized that having my paper focus on assisted suicide would be more feasible.

In this process of reading various articles on the subject, I realized that the notion of legalizing assisted suicide was not as recent as I originally thought it was; in fact, many literature exploring the ethics of the topic were published as early as the 1960s. This led me to think that writing about the history and changes in legalizing assisted suicide over the past several decades in the United States may be a possible route to take in terms of drafting a roadmap for my paper. While following this train of thought and searching for more articles that would enlighten me on this timeline, I realized that many journal articles did not focus solely on the United States, and that there was a wide variety of articles exploring legal changes regarding assisted suicide in countries all over the world, ranging from the Netherlands to Australia. Thus, I discovered that different countries around the world address the same issue of legalizing assisted suicide in various ways, leading me to transition from presenting the legal history of assisted suicide to presenting an international perspective of assisted suicide instead. I was attracted to these sources because they placed the issue of assisted suicide in an international context. Exploring the topic solely through the lens of American legislation may leave out important insights, as other countries in Europe have more radical ways of legalizing and regulating the use of assisted suicide.

After narrowing down my topic to assisted suicide, I first created an outline for my paper so I could find sources that specifically met those criteria that would allow me to present my ideas succinctly: definitions of assisted suicide, international legal perspective, arguments for and against legalized assisted suicide. There was a wide plethora of sources available at my fingertips, and I first started with the UCLA library catalog, and did several searches for print sources. In this process of searching for print sources, I realized that the electronic versions of the same material were available as well, which I utilized, saving me a lot of time as I did not need to physically visit the Powell or the Charles E. Young library to check out relevant sources. After this realization, I utilized many of the recommended library databases such as JSTOR and the Web of Science to search for online journal articles

In terms of winnowing down and refining my sources, I encountered many scientific journal articles that only referenced a specific research project, often involving patient surveys, including articles such as

“The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia”, and others that focused on a specific patient population, such as the mentally disabled. I found that these types of articles were too narrow for my paper, and I relied more heavily on articles that gave an overview of the country’s legal jurisdiction surrounding assisted suicide. When researching the various ethical and legal arguments for and against assisted suicide, I found that there were many sources on the subject, so I chose those that were published more recently to accurately represent modern perspectives on assisted suicide.

Overall, even though I did not need to seek the help of faculty, librarians, and classmates on finding sources for this research paper, the easy accessibility of UCLA library resources made my research process much smoother. Since I live off-campus, the ability to access UCLA library subscriptions to all online journal databases with the use of the UCLA VPN while not physically on campus was extremely convenient. I appreciated all of the UCLA library research guides, which helped make the entire research process much easier.

Christine Qin

Professor Miller

Honors 14: Interaction Between Science and Society

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The New Pro-Choice: Legalizing Assisted Suicide

I. Introduction

Suicide can be defined as either the decision to die when death is not imminent, or the choice to die in the circumstances of an already fatal and severely debilitating disease. End-of-life decision making has become more and more intertwined with the modern medical practice, as interest in assisted suicide has continually grown all over the world, especially in first-world countries that have high standards of medical care. Paradoxically, increasing focus on assisted suicide parallels the expanding capabilities of modern medicinal technologies to preserve life in situations of imminent death. It is evident that public policy and legal issues are closely tied with ethical problems posed by the relevant practice, and similarities surrounding the problems underlying the practice of assisted suicide are common to many countries. However, due to a variety of historical, cultural and political factors, the legal responses vary between these first-world countries in regards to the treatment of assisted suicide. The controversial topic results in responses that oscillate between the Hippocratic tradition that forbids any physician to actively bring about the death of a patient to legislation allowing assisted suicide as part of a legally protected patient right. Amidst the variety of legislative action and numerous rights-based arguments presented by both sides of the debate, it is evident that some form of legalization of assisted suicide is necessary, and should be allowed for not only patients who are in terminal

conditions. Ultimately, criminal law should not dictate nor prohibit private, personal, and final choices in regards to ending one's own life.

II. Definitions associated with assisted suicide

Assisted suicide encompasses several acts that intentionally help an individual to end his or her life, including voluntarily stopping eating and drinking (VSED), terminal sedation (TS), physician-assisted suicide (PAS), and euthanasia, all of which are last resorts to the standard treatments that fall under palliative care. The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO). However, the prevention and relief of patient suffering may not always be achievable, as high quality palliative care may fail for some patients. These patients may request assisted death, ultimately finding that the burden of continued life-prolonging treatment outweigh the potential benefits, especially if there is no guarantee of cures for terminal illnesses. As a result, VSED, TS, PAS, and euthanasia are presented as potential interventions of last resort for terminally ill patients who wish to have access assisted suicide options.

In regards to voluntarily stopping eating and drinking (VSED), a patient makes an active decision to discontinue all oral intake and is gradually allowed to die, primarily of dehydration. In the last stages of a chronic debilitating disease, many patients naturally lose their appetites and thus stop eating and drinking. Since this form of assisted suicide is a voluntary refusal of hydration and nutrition as part of life-prolonging treatments, it requires no participation by the physician. However, depending on the medical condition of the patient, the process may take several weeks, lasting 1-3 weeks longer if the patient decides to continue ingesting fluids. In

addition, physicians and family members may find the VSED process to be morally repugnant, as the patient's death due to dehydration and starvation may be difficult to support, especially as the patient will experience thirst and hunger. The patient may also lose mental clarity and resolve toward the end of the process, raising questions of whether the action of VSED remains voluntary (Quill et al., 2008).

As another means of assisted death, terminal sedation (TS) is likewise controversial. With TS, the patient is sedated to unconsciousness, usually through on-going administration of medication. Similar to VSED, the patient then dies of dehydration, starvation or other complications after withholding life-prolonging treatment. Death from TS may range from days to weeks depending on the patient's medical condition and clinical circumstances. Since patients are deeply sedated during this time period, they are believed to be free of suffering up until the point of death. TS can be provided to patients with severe physical limitations, and because physicians must administer medications and monitor effects, they are familiar with the medical and psychological conditions of the patients. By establishing a relationship with the patient and understanding the patient's needs, physicians can determine whether TS is a viable option, and help ensure that the patient makes a well-informed and voluntary decision before committing to terminal sedation. However, the final agents of terminal sedation are the physicians, not the patient, unlike VSED. In addition, not all terminal patient cases are appropriate for terminal sedation, as in the cases of "uncontrollable bleeding from an eroding lesion or refractory coagulation disorder, cannot swallow secretions because of widespread oropharyngeal cancer, or refractory diarrhea from AIDS" (Quill et al., 2008). Risks associated with this issue are contentious, as some argue TS can be carried out without explicit discussions with alert patients,

and heavily sedated individuals may still be suffering, but are simply unable to notify the clinician (Quill et al., 2008).

With physician-assisted suicide (PAS), the physician provides the means of information necessary for a patient to end his or her own life (Stone and Winslade, 1995). This encompasses providing a prescription for lethal medication and/or supplying such medication. Although the physician is ethically responsible for the assisted suicide, the physician's involvement is indirect: the patient must carry out the final act and ingest the drug by his or her own hand. Since the patient is given the choice of ingesting the lethal dose of medication, PAS is often regarded as voluntary. Even so, some argue that patients may be adversely influenced by external pressures, which impair their judgment on the matter. Other practical disadvantages of PAS include the fact that PAS is not always effective in all cases, and the patient may experience symptoms of vomiting, aspirating, or cognitive impairment. In addition, self-administration of lethal medication does not guarantee competence, and it is often suggested for the physician to be present when the patient ingests the lethal medication. However, this is a controversial issue as well, since requiring physicians to be present when the patient ingest the medication may coerce an ambivalent patient to proceed (Quill et al., 2008).

Finally, euthanasia involves the physician not only providing the means, but also actively administering the lethal injection at the patient's request, and/or setting up euthanasia devices such as Kevorkian's "Thanatron" (death machine, from the Greek word *thanatos*) and "Mercitron" (Quill et al., 2008; Lewis, 2007). A distinction is made between voluntary euthanasia, which is "carried out at the request of the person killed," involuntary euthanasia, "when the person killed is capable of consenting but does not do so" and non-voluntary euthanasia, which occurs "when the individual is incompetent to consent to or refuse euthanasia

and has made no prior decision” (Lewis, 2007). In addition, a differentiation is made between “active euthanasia” and “passive euthanasia,” in which the former refers to a deliberate act to end life, while the latter refers to the withdrawal or withholding of life-sustaining equipment (Lewis, 2007). However, these definitions are problematic in the sense that many physicians find this form of “passive euthanasia” to be active as well, arguing that there is nothing psychologically or physically passive about shutting down a mechanical ventilator when the patient is incapable of breathing without medical help (Quill et al., 2008). Bypassing the active/passive debate, if voluntary active euthanasia is administered, it has the advantages of being quick and effective. Patients who lack manual dexterity or the ability to swallow can choose this form of assisted suicide as opposed to VSED.

III. Historical and international perspective

Suicide is as old as mankind, and anthropologists have studied records of suicide in ancient western societies of Greece and Rome as well as African, Eskimo, Asian, and American Indian cultures (Burgess-Jackson, 1982). In many societies around the world, suicide has long been considered to be a felony or murder in the legal sense, or an act of immorality from a religious and/or political perspective. As Blackwell’s 18th century *Commentaries on the Laws of England* illustrates, “suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing in to his immediate presence uncalled for; the other temporal, again the king, who hath an interest in the preservation of all his subjects” (Engelhardt & Malloy, 1982). In this light, by criminalizing assisted suicide, the governing body can be regarded as preventing citizens from committing an offense against God by ending their lives prematurely, since in a religious context only God has the entitlement to decide one’s time of death. In addition to religion, politics also plays a part: by prohibiting assisted suicide, the

governing body is rescuing individuals from inflicting self-harm, protecting the state's interests in the productivity of its citizens, and preserving respect for life. Since many jurisdictions around the world categorize suicide as murder and aiding a suicide as manslaughter, it is unsurprising that assisted suicide in the medical world is similarly criminalized today. However, the treatment of legal sanctions surrounding assisted suicide varies from country to country: the Netherlands and Belgium, the United Kingdom, Australia, and the United States will be considered as representative examples.

1. The Netherlands and Belgium

Various medical cases spurred the assisted suicide debate in the Netherlands, shaping current legislation. In the 1973 Postma case, Geertruida Postma, a Dutch physician, helped her dying mother end her own life by administering euthanasia. While the Dutch court upheld that Postma committed a murder, Postma was eventually given a short, suspended sentence. This court ruling offered an opening for legal suicide by acknowledging that a physician need not always keep a suffering patient alive against his or her own will. In 1982, the Dutch government decided to review every case of euthanasia to decide whether the physician would be legally prosecuted. In 1985, the Dutch National Committee of Attorneys-General established the definitions of physician-assisted suicide and euthanasia that have been used in the Netherlands ever since: assisted suicide involves supplying or prescribing lethal drugs with the aim of enabling a person to end his or her own life, while euthanasia is the administration of lethal drugs with the aim of ending the life of a person upon his or her explicit request. In addition, the committee proposed "due care" criteria that had to be met to avoid legal prosecution, which were refined through case law. In the 1984 Schoonhein case, euthanasia was administered to a 95-year-old patient who was suffering from loss of eyesight, hearing, and speech under explicit

request. The Dutch Supreme Court ruled that the physician had acted in a situation of necessity and thus dismissed him from prosecution (Van der Heide, 2014).

As a result of the Postma and Schoonhein cases and a few other cases, the Royal Dutch Medical Association formalized the due care criteria. Before complying with the patient's request for euthanasia and PAS, the physician must assess that

(1) the patient's request is voluntary and well considered, (2) the patient's suffering is unbearable and hopeless, (3) the patient is adequately informed about his situation and prospects, and (4) there are no reasonable alternatives to relieve the suffering. Further, (5) another, independent physician should be consulted and (6) the termination of life should be performed with due medical care and attention. (Van der Heide, 2014)

As a general rule, physicians who comply with the due care criteria are not prosecuted. In 1998, the government established a system of multidisciplinary review, widely endorsed by physicians. From that time forward, all cases were first reviewed by one of five regional review committees, each consisting of a lawyer, a physician, and an ethicist, which determine whether the due care criteria are met. These committees advise the public prosecutor about the fulfillment of due care requirements, a reporting procedure endorsed by physicians. In 2002, the Dutch Termination of Life on Request and Assisted Suicide Act was passed, including a special exemption from criminal liability for physicians who terminate life on request of a patient suffering unbearably without hope of relief. The act was the first to legalize PAS and euthanasia worldwide, and also included specified age limits for patients: PAS and euthanasia are permitted for competent children ages 16 to 18, if parents are present in the decision-making process, and for children ages 12 to 16, provided that the parents agree with the decision (Raus and Sterckx, 2015). The Dutch law treats PAS and euthanasia identically in terms of legal regulation, and does not

differentiate between the source of suffering (physical or psychological), as long the suffering is unbearable (Van der Heide, 2014).

Likewise, the Belgian law allows physicians to perform euthanasia if certain conditions are met; however, the Belgian law does not regulate physician-assisted suicide. After 3 years of debate in parliament by the Federal Advisory Committee on Bioethics, the Belgian Senate voted to legalize euthanasia in 2001 following a series of unsuccessful moves in the 1980s and 1990s (Van der Heide, 2014; Lewis, 2007). The Belgian law also defines euthanasia as termination of life upon request, in addition to the following conditions: the patient must be legally competent, the request must be both completely voluntary and not the result of any external pressure, and the patient must be in a state of constant and unbearable suffering that cannot be alleviated by medical means (Raus and Sterckx, 2015). However, what constitutes physical suffering as opposed to psychological suffering is not made clear in Belgian law. In addition, there is no terminal illness requirement, and only certified physicians can have the authority to perform euthanasia (Lewis, 2007). Patients requesting euthanasia are required to be seen by an independent second physician to assess whether legal criteria are duly satisfied. Amended in 2014, Belgian law now includes euthanasia for competent minors, whereas stipulations prior to the amendment only included patients age 18 and above. However, a major difference exists between Belgian law and Dutch law: Belgian law only allows euthanasia for minors who are unbearably suffering due to physical causes, and euthanasia for psychological suffering is limited to patients over the age of 18 in a serious and incurable condition (Raus and Sterckx, 2015).

2. United Kingdom

Unlike many of its European neighbors, the U.K. has not been subject to the ongoing debates regarding assisted suicide that result in legal reform, as in the Netherlands and Belgium.

By the terms of the 1961 Suicide Act in England and Wales, deliberate acts of euthanasia are dealt with under the legal consequences of murder and manslaughter. The UK differentiates between active and passive assisted suicide, allowing the latter but not the former. Currently, a competent patient cannot legally be provided with the means to end his or her suffering by euthanasia. However, for disabled patients, courts have routinely permitted the withholding of life-sustaining treatment based on the ruling that their lives are of “insufficient quality” (McLean, 2008). From a disability perspective, this can be quite problematic, giving voice to the viewpoint that “society believes they would be better off dead, or better that they had not been born” (National Council on Disability). In the 1993 case *Airedale NHS Trust v. Bland*, the court ruled that it was acceptable to remove a young man from life-sustaining treatment, since the patient was in a permanent vegetative state due to a crash injury from a football game. Thus, the UK courts appear to uphold that if life is medically evaluated to have no quality, passive assisted suicide is permissible. In 1998’s *Pretty v. United Kingdom* case, patient Diane Pretty, who was in the final stages of motor neuron disease, challenged the legal prohibition of active assisted suicide in the 1961 Suicide Act. However, Pretty’s arguments at the European Court of Human Rights were unsuccessful; the court supported the terms of the Suicide Act, disallowing active assisted suicide for competent patients (McLean, 2008).

Despite current prohibitions in the UK, patients continue to seek assisted suicide. Reports reveal that UK patients have been traveling to Switzerland to take advantage of services of the right to die society, Dignitas. Founded in 1998, Dignitas has aided more than 2300 individuals die at home in Switzerland by providing lethal medication to those who suffer from terminal diseases or severe physical and mental illnesses. In light of public opinion in favor of a change in legislation, the Assisted Dying for the Terminally Ill Bill was introduced in the

House of Lords in 2004, permitting a competent and terminally-ill patient to sign a written declaration of intent to have his or her life ended through voluntary euthanasia. The patients have 14 days to revoke the declaration of intent if they change their minds. The attending physician must determine that the patient meets qualifications of being a competent and terminally-ill person who is suffering unbearably. The physician must then inform the patient of alternatives, and the declaration of the intent to die must be witnessed by two people, one of whom must be a qualified solicitor. While the Bill has not been passed in Parliament, it raises more points of debate on this contentious subject (McLean, 2008).

3. Australia

Australia passed the Rights of the Terminally Ill Act in 1995, legalizing PAS and voluntary euthanasia in the Northern Territory of Australia for the terminally ill, informed, and competent individuals who wished to end their own lives. Four individuals utilized the legislation after it was put in force in 1996, through a mechanism called the “Deliverance Machine.” This was a laptop computer attached to a syringe, which released the lethal drug into the patient’s arm after the patient answered a series of questions on the computer. Due to the controversial nature of the legislation passed, the Euthanasia Laws Act was passed in 1997, specifically overriding the Rights of the Terminally Ill Act, as a part of the Australian federal government’s move to actively work against reform. Even so, all state parliaments in Australia except for two have introduced numerous bills proposing a reform of the law regulating assisted suicide. Although these laws are not uniform across all Australian states, they generally follow common law, allowing patients to control the medical treatment they can be subjected to receive, in turn protecting physicians from legal allegations due to administering PAS or euthanasia (Rothschild, 2008).

4. United States: Texas and Oregon

Prior to 1973, Texas courts ruled that as long as neither physical nor psychological coercion is involved, assisted suicide is tolerated. The issue centered around the question of whether or not force, deception, or coercion was employed, rather than the question of whether or not an individual has convinced the other to perform assisted suicide. However, in 1973, the new Texas Penal Code made aiding suicide illegal, distinguishing punishment based on whether or not the suicide was successful, with penalties ranging from a fine of up to 5000 dollars to imprisonment for two to ten years. Thus, Texas legislation designated suicide caused by force, duress, or deception as criminal homicide. Under the court's ruling, aiding suicide is classified as a second-degree felony if the suicide is successful and a misdemeanor otherwise. Texan law differentiated between passive and active assisted suicide, as legal implications indicated that less criminal classifications were applied when the individual passively aided the suicide. If the individual acted as the agent of death, then the crime is automatically considered to be murder (Engelhardt and Malloy, 1982).

On the other end of the spectrum, Oregon was the first American state to pass legislation legalizing physician-assisted suicide in 1997 with the Death with Dignity Act, allowing mentally competent, terminally ill patients over the age of 18 to obtain a lethal dose of medication to end their own life (Downie and Lloyd-Smith, 2015). The Act prohibits active euthanasia, and eligible patients must make one written and two oral requests over 15 days, which are approved by a prescribing physician and a consulting physician. Interestingly, about 36% of patients who have obtained a lethal dosage from a physician never ingested it, suggesting that some patients were reassured by having the prescription to control the manner and timing of their deaths (Ganzini and Dahl, 2008). Opponents of the Act believed that patients requesting PAS would most likely

be the poor, the ill-educated, and the uninsured who lack access to adequate health care.

However, studies have shown that the majority of patients seeking PAS are financially well-off, highly educated, and have health insurance. Of the deaths between 1998 to 2006 due to physician-assisted suicide, 41% had a Bachelor's degree, 22% had college education, and 28% had a high school diploma; only 9% did not attend high school (Ganzini and Dahl, 2008).

Similarly, 62% had private insurance and 36% had government funded health care (Ganzini and Dahl, 2008). Physicians perceived that rather than financial concerns, lack of education, and poor social support, patients who requested PAS viewed the dying process as presenting too much risk of becoming dependent through pain, mental deterioration, living in a nursing home, becoming emotional, or losing basic functional abilities to talk, walk, or control the bladder.

IV. Arguments for Legalizing Assisted Suicide

1. Right to liberty, autonomy, and self-determination

As the foremost argument to legalizing assisted suicide, the right to liberty argument warrants that society must respect an individual's freedom, even if the individual engages in an act that might be self-destructive or immoral, as long as this freedom does not directly harm others (Engelhardt & Malloy, 1982). According to this argument, since freedom is a basic good, individuals have a natural and equal right to be free to decide their own fate, a fundamental concept of western civilization (Lewis, 2007). This libertarian view as presented by John Stuart Mill, contends that "with respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by anyone else" (Engelhardt & Malloy, 1982). Following this line of thought, individuals should be allowed to make their own choices regarding their lives because they are the best judges in matters concerning themselves. The commitment to freedom and liberty in the absence of harm

to the general populace recognizes that a “pluralism of moral convictions” exist in a secular society; in particular, “although one may not be able to agree about what constitutes good life, or good death, one can agree to let each make his own choices, as long as those choices do not involve direct and significant violence against others” (Engelhardt & Malloy, 1982). Given this libertarian view of the government as existing under a pluralistic society, proponents of this argument view that state as only functioning as a protective vehicle of individual freedom.

Recognition of the right of autonomy and self-determination is based on the condition of an ethical community not based on force, but grounded in rationality and peaceful manipulation. Under these conditions, “the state must operate as an enterprise for the realization of freedom insofar as that realization is to remain a moral endeavor, not an instrument of force against innocent individuals” (Engelhardt & Malloy, 1982). Thus, if the government forces upon its citizens an unconsented view of what constitutes ‘good’ and ‘bad,’ the notion of the government as a moral enterprise is violated. Arguments based in political theory contend that all governmental authority is derived from the consent of the governed who possess natural rights, which are delegated to the state. From this perspective, individuals are the origin of governmental authority, and will not recognize the government as having authority that individuals have not conferred upon. Thus, the individual, not the state, has the freedom and autonomy to be the supreme judge of his or her best interests. In the Canadian case *Rodriguez v. British Columbia*, Justice Sopinka upheld that “personal autonomy, at least with respect to the right to make choices concerning one’s own body, control over one’s physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these” (Lewis, 2007). In the

context of assisted suicide, the argument from a right to autonomy perspective is closely linked to the concept of individual control over the dying process.

2. Right to privacy

Arguments for assisted suicide from a right to privacy perspective are closely derived from the rights to liberty and autonomy. In accordance with the American constitutional context, suicide has been described as the “ultimate exercise of one’s right to privacy” (Lewis, 2007). Based on various court cases, proponents of assisted suicide connect privacy with constitutionally protected liberty interests, including the decision of whether to continue living. Although not direct cases on assisted suicide, in *Griswold v. Connecticut*, the court upheld the use of contraceptives based on the constitutional right to privacy, a notion expanded in *Roe v. Wade* to include the qualified right to determine what can be done with one’s own body. Following these precedents, in *Superintendent of Belchertown State School v. Saikewicz*, the court upheld that the right of privacy includes “the right of a patient to preserve his or her right to privacy against unwanted infringement of bodily integrity even if the patient is incompetent” (Engelhardt & Malloy, 1982). This case suggests a libertarian viewpoint of the right to refuse treatment and more generally the right to be left alone, supporting the principle that suicide and assisted suicide should not be prosecuted with legal sanctions. Similarly, in *Cruzan v. Director, Mo. Dept of Health*, proponents of assisted suicide have argued that “if the right to privacy protects the right to die naturally, it should also protect the competent, terminal patient’s right to choose a quick and painless death. The difference between a terminal patient’s choosing to refuse treatment and choosing a faster means of dying does not offer a basis for legal distinction” (Lewis, 2007). These cases establish the constitutional right to privacy as an expression of the sanctity of individual choice. Under this perspective, the value of life is degraded not by a

decision to refuse life-prolonging treatment, but by the failure to allow competent individuals to exercise their right of choice.

3. Right to dignity

In addition to the rights-based arguments listed above, supporters of assisted suicide have argued that the individual's interest in preserving his or her own dignity is part of the fundamental concept of freedom. According to legal scholar Dworkin, "indignity causes its victims distinctive and especially severe mental pain, that people resent and therefore suffer more from indignity than from other forms of deprivation. People denied dignity may lose the self-respect that dignity protects, moreover, and then suffer an even more serious form of distress: self-contempt and self-loathing" (Lewis, 2007). Thus, Dworkin emphasizes the mental and psychological suffering in addition to the physical suffering a patient may endure if forced to continue receiving life-prolonging treatment against the patient's will. Following this rationale, a right to assisted suicide can be based on a right to dignity, or a right to be free from indignity.

4. Right to equality, equal protection

Equality rights arguments in favor of assisted suicide focus on incompetent individuals, or groups who are physically unable to commit suicide without assistance, such as those who are physically disabled, mentally ill, or certain terminally ill patients. Proponents argue that individuals who would require assistance to carry out a decision to end their lives are denied the choice which is available to all other mentally competent adult persons, and that the legal prohibition of assisted suicide discriminates against them due to their physical disability, violating their right to equality and equal protection. This constitutes the basis of the argument that a blanket prohibition on assisted suicide results in disparate treatment of those who are unable to physically commit suicide without assistance.

In addition, equal protection arguments are made in regards to the right to refuse life-sustaining treatment. According to the proponents of assisted suicide in *Quill v. Koppell*, “the refusal of treatment is essentially the same thing as committing suicide with the advice of a physician and that for the State to sanction one course of conduct and criminalize the other involves discrimination which violates the Equal Protection Clause of the Fourteenth Amendment” (Lewis, 2007). Similarly in *Compassion in Dying v. Washington*, the court ruled that the ban on assisted suicide in the state violated the equal protection right. Creating an exception for patients on life-sustaining treatment to be administered assisted suicide while denying competent, terminally ill patients the same right leads to a situation in which the fundamental rights of one group are granted while those of comparable group are not.

5. Right to property

Proponents of assisted suicide have also argued that the right to suicide can be equated to the patient’s property right over his or her own life and body, as opposed to either God or the state. As political theorist John Locke states, “every man has a property in his own person; the nobody has a right to but himself. The labor of his body and the work of his hands we may say are properly his” (Lewis, 2007). Thus, since an individual has the basic property right over his or her own body, it is up to the individual to dispose of his or her own life as wished.

V. Arguments Against Legalizing Assisted Suicide

1. Right to life

Opponents of assisted suicide attest that the right to life is inalienable, deriving support from human rights documents including the U.S. Declaration of Independence. In this light, the right to life is a mandatory right, and cannot be waived, thus rendering any decision to take one’s own life an attempt to “alienate the inalienable, to give away that cannot properly be given

away” (Lewis, 2007). Proponents of the right to life believe that the right-holder can only exercise the right in one manner, to remain alive as long as possible, making it a duty not to take one’s own life or not to cooperate with others in its taking. On the other side, proponents of assisted suicide uphold that the inalienability of a right does not make it a mandatory right, but instead a discretionary right that can be voluntarily waived. The right itself is not relinquished, but rather the object of the right is relinquished. In this manner, the individual who chooses to receive assisted suicide would not lose his or her right to life, but rather his or her life. In other words, the refusal to exercise one’s right to life by committing suicide does not entail that one loses that right.

2. Right to autonomy

To refute the right to autonomy argument presented by proponents of assisted suicide, opponents argue that legalization instead poses a threat to the individual’s right to autonomy. The quality of autonomous choice is placed into question in an environment where legal assisted suicide is a possible option, since all personal choices to commit assisted suicide would be affected by societal and interpersonal influences, ranging from financial barriers, education level, access to palliative care, etc. in a culture infused with “media images of trivialized and superficially justified killings” (Lewis 2007). Opponents of assisted suicide believe that if assisted suicide is portrayed as a right, marginalized individuals in society would regard suicide to be an “acceptable, responsible or even expected option” (Lewis, 2007) Whereas previously when individuals were not provided with the option of legally requesting assisted suicide, suicide would not be considered a foremost choice at all: the unconsciously accepted autonomous choice would be to continue living (Lewis, 2007). By socially and culturally legitimizing the right to assisted suicide through legalization, society would increase the easy availability of suicide

assistance, leading many to view death as a foremost option rather than receiving treatment and/or therapy.

From a paternalistic and public welfare perspective, those against assisted suicide assert that the state is considered the guardian of the best interest of its citizens, and should not legalize, but rather intervene whenever there is a case of assisted suicide. The basis of paternalistic regulation is founded on the premise that the government is responsible for protecting the individual from self-inflicted harm, as in the cases of drug abuse, gambling, sexual relations, and thus also suicide. In addition, many believe that the government has the right to intervene in individual affairs for the sake of public welfare and promoting order in society. By being a citizen, opponents of assisted suicide argue that the choice to end one's life has been ceded to the state (Engelhardt and Malloy, 1982). However, this argument is problematic in the sense that how the government can determine the best interests of its citizens is unclear and therefore subjective.

3. Right to equality, legal protection

To counteract the right to equality and equal protection argument presented by supporters of assisted suicide, opponents assert that legalization may inappropriately encourage individuals to exercise their new right to request assisted death, having a disparate impact on marginalized groups, including people of color, women, minorities, and the mentally disabled. Members of these marginalized groups may be more likely to receive inadequate treatment and view assisted suicide as their only viable option. Along these lines, the New York State Task Force on Life and the Law argue,

No matter how carefully any guidelines are framed, assisted suicide and euthanasia will

be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care...posing the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care. (Dworkin, 2008)

The court refutes this in *Compassion in Dying v. Washington*, stating that “the argument ... is ludicrous in its face...that the poor and the minorities will rush to volunteer for physician-assisted suicide because of their inability to secure adequate medical treatment” (Lewis, 2007).

As studies of Oregon’s Death with Dignity Act have shown, those who are better educated, more financially well-off, and those who have access to medical care are more likely to request assisted suicide.

In addition, opponents argue that if legalization were restricted to certain groups of individuals, such as the terminally ill and physically disabled, these distinctions would violate the Equal Protection Clause from the Constitution. Allowing assisted suicide solely to those who are physically disabled would constitute prejudicial treatment, and regard their rights to life as less worthy of protection when compared with those of the physically able. In *Lee v. Oregon*, the court ruled that the Oregon’s Death with Dignity Act violates the Equal Protection Clause because the terminally ill are deprived of a benefit given to those who are not terminally ill (Lewis, 2007). However, this argument against legalization only concerns that form which legalization of assisted suicide may take, if jurisdiction allowed for this legal change.

4. Right to Property

As opposed to the right to property arguments presented by supporters of assisted suicide, opponents assert two rights to property claims, of which one is religious, the other political. The religious claim argues that God has property rights over our bodies and lives, and that individual

sovereignty is strictly limited. If assisted suicide is legalized, this would go against God's will and thus destroy God's property. This formulates the argument in terms of property rights, instead of one's sanctity of life or one's duty to live. The second political argument contends that rather than God, the government is the holder of property rights over its citizens' bodies and lives. Both arguments can be readily refuted. Proponents of assisted suicide argue that the first claim disregards the right of freedom of conscience and religion as presented in the U.S. Constitution. Many go so far as to state that religious arguments have no special force in a pluralist, constitutional democracy. As for the latter claim, commentators argue for the individual property right in life and the general right to self-determination.

5. Slippery slope argument

According to the "slippery slope" argument, allowing assisted suicide for competent and voluntary patients will lead to an expansion of vulnerable groups. Legalizing assisted suicide for the sake of the few will endanger the lives of a larger group of individuals who might succumb to these options due to depression, coercion, and untreated pain. As a result, physicians may exercise a degree of coercion and persuasion that is illegitimate, as physicians may be more inclined to readily choose ending of life as a way to resolve suffering for incompetent patients who are unable to speak for themselves, such as infants, those who are comatose, or those who have mental illnesses (Van der Heide, 2014). Even as the normalization of assisted suicide may result in a degradation of the worth of human life, error and abuse would inevitably occur if physicians and family members were authorized to aid a patient's death (Dworkin, 2008). Those in charge of the decision-making process may conclude that it is ultimately cheaper to give a lethal injection than to provide continuous care for a patient, when a chance of recovery may still be possible. In addition, many argue that allowing voluntary active euthanasia would result in a

slippery slope toward involuntary active euthanasia, which is less morally permissible (Feltz, 2015).

To refute the slippery slope argument, no evidence exists that the legalization of suicide or assisted suicide would have significant negative consequences. In a study done by Feltz (2015), results showed that on average, most people accept many forms of voluntary euthanasia while people are less likely to judge non-voluntary and involuntary euthanasia to be permissible. This suggests that individuals have no problem making important moral distinctions and feel no pressure to accept other kinds of assisted suicide given they accept voluntary euthanasia. Acceptance of active voluntary euthanasia does not necessary lead to acceptance of any less desirable forms of euthanasia, as this cannot be proven to be a cause and effect relationship (Lewis, 2007).

VI. Conclusion

As a society, we have already made the decision to decriminalize attempted suicide. Neither suicide nor attempted suicide is a crime in any state. This decision reflects the fact that such acts may be committed by individuals who are less than fully rational, or we do so to avoid stigmatizing the individual's family. For many, the policy reflects the societal belief that, in certain circumstances, people should have the liberty to end their own lives. Such decisions are up to each individual to make, and these decisions should be extended to those who are in the last stages of a terminal disease, in medical conditions that threaten their sense of autonomy and dignity, in a state of mind where they wish to no longer bear the burden of physical and psychological suffering. Perhaps the question now is not "should assisted suicide be legalized?" but "how should we legalize assisted suicide?"

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