The 20th century, with its rapid progress in medical science, has fundamentally changed the nature of the dying process in much of the Western world. Modern advances in medicine and lifesustaining technology have resulted in a dramatic increase in life expectancy and quality of life. However, these changes have also given rise to the concern that the dying process may be unnecessarily lengthened, leading to prolonged suffering and loss of dignity for many terminally ill individuals. This concern has increased public interest in the legalization of a range of end-of-life practices, including assisted suicide.

**Terminology**

Assisted suicide is defined as a situation in which a person with an incurable, terminal illness requests the help of others in ending his or her life. The person providing assistance typically supplies the terminally ill patient with the means or information necessary to bring about death. When such assistance is provided by a physician, the practice is referred to as physician-assisted suicide (PAS). Assisted suicide and PAS are often confused with another end-of-life practice, euthanasia. Specifically, euthanasia refers to the act of taking another person's life with the aim of alleviating suffering. Assisted suicide and euthanasia are distinctly different practices, because PAS allows patients to be the active agents in controlling the circumstances of their death, whereas in euthanasia, the person who performs the actions leading to death is someone other than the patient. Another practical distinction is that PAS usually involves a physician's prescription of a lethal dose of medication, whereas euthanasia often involves the administration of a lethal injection.

**Arguments About Assisted Suicide**

The distinction between assisted suicide and euthanasia is significant, given the heated nature of the debate surrounding legalization of assisted suicide. A number of arguments have been voiced in the public discussion surrounding this issue. Proponents of legalization argue that individuals have a fundamental right to personal autonomy and that assisted suicide allows terminally ill patients to maintain dignity and control at the end of life. It is further suggested that PAS can address terminally ill patients' concerns with maintaining autonomy and quality of life, whereas pain control interventions and palliative care may be ineffective in resolving these concerns. In addition, proponents argue that assisted suicide already exists as a hidden practice, so legalization can ensure that appropriate monitoring and safeguards are enforced. Finally, PAS advocates suggest that practices that relieve suffering and respect patients' autonomy are consistent with the physician's role and conform to current ethical and medical principles.
Opponents of legalization, on the other hand, often cite the sanctity of human life and the moral unacceptability of suicide as arguments against assisted suicide. Providing assistance in a patient’s suicide is explicitly prohibited by the Hippocratic oath, and some view PAS as inconsistent with the physician's obligation to preserve life. Apart from such moral and ethical objections, opponents often argue that adequate palliative care and pain management can eliminate patients’ need to resort to assisted suicide. They also voice a concern that the legalization of PAS may stifle progress in the hospice movement and thwart current developments in end-of-life care. Some fear that the legalization of PAS may put pressure on patients to choose assisted suicide in order to avoid becoming a burden to family and caregivers. Finally, opponents point to the danger of a slippery slope—the concern that, over time, PAS may be applied to those who are not terminally ill, as well as those who are physically disabled or have a mental illness.

The Practice of Assisted Suicide

Given the heated nature of the debate surrounding the legalization of PAS, it is no wonder that this practice is a legal option in only a handful of countries. At the time of this writing, only the Netherlands, Belgium, Switzerland, and the U.S. state of Oregon have implemented legal regulations that explicitly permit PAS. Some important differences exist in the way PAS is practiced in each of these areas of the world, so a discussion of cross-national variations is warranted.

The Netherlands has a long history of legal tolerance toward PAS and euthanasia, and both practices were eventually legalized in 2001 with a law passed by the Dutch Parliament. Under this statute, physicians can perform either euthanasia or PAS in cases where a patient has made repeated, voluntary, and well-considered requests and perceives his or her suffering as unacceptable. The physician must be convinced that the patient's situation is desperate, although a terminal medical condition is not explicitly required. Furthermore, the attending physician needs to consult with a colleague as well as document and report all actions taken. When parental approval is provided, the Dutch law also permits PAS for patients ages 12 to 18 years old.

A year after the Netherlands law was passed, Belgium followed suit by legalizing euthanasia. The Belgium law does not explicitly mention PAS because of cultural prohibitions against suicide; however, PAS is currently performed and considered an act of euthanasia in this country. The Belgium law is similar to Dutch practices in that it requires a patient's repeated, voluntary, and well-considered request for euthanasia and the presence of intractable suffering. A consultation with a second medical professional and the careful documentation and reporting of all practices are required as well. However, this law also includes more stringent criteria by explicitly requiring that the patient be 18 or older and suffer from an incurable medical condition. Thus, some similarities and differences exist in the way PAS and euthanasia are defined and practiced in Belgium and the Netherlands.

In contrast to the statutes in Belgium and the Netherlands, a unique legal situation exists in Switzerland, where the penal code implicitly authorizes assisted suicide (either by a physician or a lay person), provided that aid-in-dying is not motivated by a desire for personal gains. Although the Swiss penal code opens a possibility for the decriminalization of assisted suicide, it explicitly prohibits euthanasia as a form of murder.

Although international issues surrounding PAS are noteworthy, the legalization of PAS in the state of Oregon is of particular significance in the United States. In 1994, a state referendum supported the legalization of PAS in Oregon, when voters approved a measure to pass Oregon's Death With Dignity
Act (DWDA). The DWDA was eventually enacted in 1997, making Oregon the first state to pass a law allowing PAS in the United States. Under this act, a competent, terminally ill, adult resident of Oregon may request a physician's assistance in dying provided that certain regulations are met.

A number of requirements are built into Oregon's DWDA as a safeguard against abuse. In order to make use of the statute, a patient must first make two verbal and one written request for aid-in-dying, separated by at least 15 days. Next, the patient's terminal diagnosis and decision-making capacity need to be confirmed by the attending physician and a consulting colleague, with a referral to a psychologist or psychiatrist in cases where the patient's judgment may be impaired because of a mental health condition. Finally, the patient has to be informed of alternative end-of-life options, and the prescribing physician must suggest (but not require) that the patient inform significant others of his or her end-of-life decisions. Provided that these requirements are met, the attending physician may prescribe a lethal dose of medication, after which a report is filed with the Department of Human Services. Such regulations are designed specifically to protect patients' rights while respecting their personal dignity and autonomy.

The legalization of PAS in Oregon, the Netherlands, Switzerland, and Belgium has spurred a vibrant line of research examining the incidence and characteristics of end-of-life practices in these countries. The reporting practices in the Netherlands and Oregon, in particular, have generated an expanding body of data regarding incidence rates, demographic characteristics, and reasons for patients' requests for PAS. Available data suggest that only a small percentage of patients make use of PAS. Specifically, in 2005, 0.1% of deaths in the Netherlands and 0.12% of deaths in Oregon were the result of PAS. The most common reasons for requesting PAS in Oregon included concerns related to the loss of autonomy, dignity, or personal control, whereas fear of uncontrollable physical pain was a less important factor in patients' desire for assisted suicide. Such research findings enhance the humanistic perspective of this social issue.

In conclusion, assisted suicide and PAS have increasingly become a center of scholarly and public discussion. Informed participation in the assisted suicide debate requires knowledge of terminology and familiarity with the arguments regarding the legalization of this practice. Legalization has become an important aspect of the assisted suicide debate, and a number of countries (i.e., the Netherlands, Belgium, Switzerland, and the U.S. state of Oregon) have implemented statutes that permit PAS under certain conditions. One important outcome of the legal status of PAS in these countries is the proliferation of research on the practice of assisted suicide with the potential of furthering current understanding of end-of-life issues.

See also
End-of-Life Decision Making, Euthanasia, Good Death, Legalities of Death, Quality of Life, Suicide, Terminal Illness and Imminent Death

Further Readings

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