

The Right to Die Dilemma

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Abstract: *The issue of the right to die presents an ethical dilemma of medical ethics, legislation, and principles regarding the patient's care and autonomy. This paper examines how the "right to die" issue has legally and ethically evolved and how these healthcare concepts, such as conscience clauses and Dignity, Empathy, Autonomy, and Respect (DEAR), have impacted this evolution. The paper also examines how healthcare providers have an ethical obligation when it comes to the right to die with dignity and respect for the patient's autonomy and choice.*

Keywords—right to die, patient autonomy, DEAR, conscience clause

The right to die is a concept based on individual autonomy; including the idea that one is allowed to decide whether to end their life or request their life to be ended to relieve them of suffering (Urofsky, et al., 2020). A person invoking this right can end their own life if they have a terminal illness or have incurable pain. However, this issue has been long debated in the medical sector for years because of the morality behind the act. Furthermore, in healthcare, there are concepts such as the Conscience Clauses, and DEAR (Dignity, Empathy, Autonomy, and Respect) (Stanford & Connor, 2019).

"The right to die" has been a central and continuing issue since the term "bioethics" was introduced (O'Dell MS, 2011). Physician assistance in a patient's death is a level of conflict between patient autonomy and provider Hippocratic oath regarding do no harm. In some circumstances, advanced treatment technologies prolong a person's life, increase patient suffering while not adding to the quality of life. Furthermore, the establishment of informed refusal and consent rights, conscience clauses, ethical decision-making processes, and other significant principles of healthcare ethics and law have added to the dissonance of the evolution of this issue (Halbert, 2016).

Chung, et al. (2016) argues that today, the right of dying in its utmost glaring aspect, draws from similar movements, goals, and values of those from the mid-20th century. On the other side Halbert (2016) notes that today, the right-to-die idea is hindered by the common concern that patients who are defenseless might be ill-treated. Also, the advancement in the end-of-life palliative care has impacted the evolution of the right-to-die concept.

The most crucial impact to the right-to die issue was the Quinlan court verdict (Re Quinlan, 1976). That resulted in the emergence of the lawful guideline concerning informed consents and autonomous choice rights. The court's verdict and others have been identified as knowledgeable consent milestones. Resulting in both the court and healthcare ethics literature increasing and strengthening the autonomy of patients' decisions. The historic timeline and background of the right-to-die issue, as well as other legal and healthcare ethical considerations, will persist in informing policy in the

future issues of assisted dying, euthanasia, death dignity, and the right to die (Golijan, 2020).

Medical ethics have evolved using morality-based paternalistic and deontological models to describe ethical practices. Progressively, current ethical practices are supported by handling patients with dignity, empathy, autonomy, and respect for the individual (Golijan, 2020). According to Finlay (2016), healthcare providers encounter dilemmas regarding the right to die. Those who believe life is fundamentally valuable oppose taking life and taking any action on the patients' desire since the end of life is something granted only by nature. On the other hand, this denial overlooks the autonomy of the patient's concerns. With this, does the physician have an obligation to agree with this request respectfully, with empathy, and with consideration of the patient's autonomy? Does the state have the right to enforce its will over the patient's will? This is the dilemma healthcare provider's encounter.

Legal and bioethics interpretations have repeatedly overlapped on individual rights. Autonomy is the keystone of the right-to-die and the physician-assisted-suicides (PAS) issues (Halbert, 2016). Freedom is the core idea in the autonomy argument, an individual desire to be in control of their existence. Thereby, a PAS request can be reflected as an illustration of the core right of having their own life as well as its conditions in their control. The notable autonomy principle is a characteristic of healthcare ethics that demonstrates an overriding function of individual right towards defining their own healthcare and related decisions (Hartling, 2021).

Halbert (2016) states that respecting an autonomous choice necessitates, at least, acknowledging the individual's rights to having opinions, making decisions, as well as selecting action paths centered on individual beliefs/values. However, Mentzelopoulos et al. (2016) and Brassfield et al. (2019) argue that respect for individual autonomy often clashes between the patients' and healthcare providers' values or interests. It is frequently simple for physicians to comply with personal preferences and rights within the procedures of health care provision when seeking healthcare. However, one should note that these preferences and rights might result in ethical dilemmas when the patient no longer seeks curative care.

Empathy is another important aspect to the right-to-die issue, and thus, physicians, as well as family members, can end the patient's life as a humane act. Under the assumption that no human should be obligated to undergo endless suffering and the belief that medical intervention cannot alleviate the suffering, while the single manner of evading the pain is through the patient's death, then the patient's life could be terminated to show mercy (Keene & Lee 2019). On the other hand, O'Dell MS (2011) argues false understanding of empathy and compassion might occur and that killing is not empathy. To depict empathy in a situation like this would imply taking care of the hurting patient, not killing them. However, under the condition of relieving intolerable suffering, empathy has contributed to the right to die evolution. Assisted suicide, euthanasia, and mercy killing can now be vindicated to be the sole choice or necessitated by the principle of beneficence to lessen patient suffering (Finlay, 2016).

Fear of losing dignity is often behind the choice of physician assisted death. According to Golijan (2020), there is no uncertainty that everybody desires a death with dignity. However, Hemati et al. (2016) argue that the vast controversies regarding dignity significances and implications when dying are noteworthy. Care providers have an obligation of respecting the patient's dignity. Therefore, the main concern is the patients' dignity is respected as it is the foundation of autonomy. Basically, dignity is a form of expressed autonomy. From respect being the initial principle, it follows that patients possess the liberty of deciding to shorten their own lives towards sustaining a particular quality of life while protecting/keeping their dignity.

In latest years, the discourse regarding the function of the conscience clause within healthcare policies and practices has been growing (Buchbinder et al., 2016). Secular and religious moral principles or other sources of ethical insights can influence conscience decision making parameters (Buchbinder et al., 2016). Undoubtedly, the considerations of conscience are relevant since health providers might face situations where they are obliged towards carrying out actions or denying life-supporting medication in a manner inconsistent with their ethical principles. Today, almost all US states have conscience clauses because physicians' conscience plays a complex role in end-of-life care (Stahl & Emanuel, 2017).

Healthcare providers perceive conscience to be vital for the practice of medicine in an ethical manner, even in the absence of moral conflicts or dilemmas (Mentzelopoulos et al., 2016). Thus, while patients have the right of expressing their autonomy by requesting PAS, healthcare providers also have their own autonomy. They are not obligated to conform to the end-of-life requests from patients as their autonomy does not override the physician's autonomy (Stahl & Emanuel, 2017). It is crucial to emphasize that a conscience clause safeguards the provider's right of refusing to get involved in PAS based on their ethical reasons. Therefore, conscience clauses have played a role in stalling the right-to-die movement (O'Dell MS, 2011). Physicians are not obliged

to agree with the patient's request for assisted dying and as care professionals are protected under these clauses.

In many discourses of palliative care, questions of passive euthanasia are raised. Concerns over letting someone die become tangled with concerns over not assisting someone to live. Fears arise over quality of life and the life-support decisions centered on this criterion. Discussions surrounding the distinctions between passive and active euthanasia are introduced to outline the suitability of palliative care (Dierickx et al., 2018).

Euthanasia remains a complex topic debated for many decades worldwide. Multiple aspects such as protections in morality, legislation, and precedents might come to play in these discourses (Rachels, 2017). Passive euthanasia involves withdrawing or withholding life-support medications in the presence of futile or non-beneficial treatment. Rachels (2017) outlines that passive euthanasia, in the eyes of the law, is not a criminal offense as the physician is spared from lawsuits since this practice does not contravene the law. Some studies also argue that there exists a moral difference between letting die and killing as there are substantial differences between passive and active euthanasia. Thus, their moral obligations may vary.

In numerous parts of the world, and for a lengthy period, the advocates of palliative care and euthanasia (active or passive) have been wedged in disagreement. According to Dierickx et al. (2018), from the mid-twentieth century founders to the modern approach to palliative and hospice care, the advancement of effective palliative care, increased the capability to sustain human life via biomedical technologies. However, advancement in palliative care seems to impede the right-to-die philosophy since, with these technologies, patients at the end-of-life stage can still have a good quality of life without the need to hasten their death.

Do not resuscitate (DNR) orders are ethically, legally binding, and acceptable and should not be confused with PAS or euthanasia. The order involves written order that if a cardiac arrest were to happen, life-sustaining medication should be withdrawn or withheld (Sumrall et al., 2016). The patient holds legal and ethical rights to decline cardiopulmonary resuscitation (CPR). The DNR, which falls in the right-to-die category, is strongly supported by the autonomy principle towards the patients' choice concerning their medical matters (Hoeftler & Kamoie, 2019). However, although DNR orders are legally binding and have multiple laws promoting this practice when suitable, this practice is not balanced. Often, the DNR practice fails its purposed aim of the promotion of patient autonomy and prevention of non-beneficial care interventions and medications (Hoeftler & Kamoie, 2019).

In offering lawful and ethical ways of recognizing options long pursued by terminally ill patients, the 2019 New Jersey Death with Dignity Act is the current state to support the autonomy of patients' medical choices in healthcare ethics (Gilleard, 2022). While advancements in treatments have enhanced the likelihood of curing severely ill patients as well as extending their life expectancies, there is extensive

acknowledgment that extending lives might not be the suitable objective in all situations. Therefore, other criteria ought to direct the process of end-of-life healthcare decisions. In particular, death hastening is currently deemed a suitable end of life decision in medical care. This approach includes PAS as well as voluntary euthanasia (VE) (Hoefler & Kamoie, 2019).

Currently, end-of-life practices of PAS and VE are discussed globally, and various nations have applied this practice. In the US, the District of Columbia and eight states, the right-to-die laws are sanctioned for people suffering from fatal diseases with a life expectancy of less than six months. In countries like Belgium, The Netherlands, and Luxemburg, individuals with fatal illnesses or being non-terminally ill with intolerable pain with no prognosis for improvement is also a lawful prerequisite for hastened death (Fontalis et al., 2018). On the other hand, in nations that have passed laws to decriminalize the right-to-die issue, there must be a voluntary intent from the patient to express their personal will.

The right to die issue is still a significant subject concerning individuals across the world, factors mentioned earlier, such as DEAR, where respect for patients' autonomy, provider and family members' empathy, and the concern for dying with dignity have contributed to the evolution of this movement. On the other hand, healthcare ethics, including the conscience clauses, have contributed to the ethical and legal considerations regarding PAS and other forms of assisted dying. And while medical advancements continue to achieve remarkable feats in extending the lives of people, the right to die is fundamentally a human right that should not be ignored.

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