An Unusual Form Of Treatment

Significantly, physician-assisted suicide is not allowed in all states. Physician-assisted suicide is when a doctor provides a patient with the means and knowledge to end their own life. In the end, the patient is the one that is committing suicide. Only ten states in the United States have legalized physician-assisted suicide. The majority of the country does not allow this form of treatment. Doctors that oppose assisted suicide believe that it is unethical because doctors should not have the power to hasten death. They believe that illnesses should run their natural course. While this topic has been argued for some time, there is still new research that is coming out to support the legalization. Although some doctors oppose the legalization of physician-assisted suicide because of the perceived violation of the Hippocratic Oath, physician-assisted suicide should be implemented because the emotional stability of patients and family will be improved, hospital efficiency will be enhanced, and positive health benefits will be increased. Of course, as studies show, some doctors oppose legalizing physician-assisted suicide because they believe that it violates the Hippocratic Oath. According to Joseph Marine, the author of “Hopkins Doctor: Physician-Assisted Suicide is Unethical and Dangerous,” published in The Baltimore Sun, the Hippocratic Oath forbids the use of physician-assisted suicide because it is unethical. He conveys that physician-assisted suicide is not regulated, so it does more harm to patients than good. Marine concludes by making it clear that assisted suicide will not be needed if palliative and hospice care programs are improved (n.pag.). In addition, John Glasson, author of a report titled “Report of the Council on Ethical and Judicial Affairs of the American Medical Association,” physician-assisted suicide jeopardizes the ethical integrity of every doctor. He states that terminal patients that suffer from chronic pain can be treated with an increased dosage of pain medication. He does not believe that it is right to accelerate death because illnesses should take their natural course. Psychiatrists are available to alleviate the suffering of terminal patients, Glasson concludes (n.pag.). Both authors oppose physician-assisted suicide because of the perceived violation of the Hippocratic Oath. They believe that terminal illnesses should be treated with increased pain medication and therapy. However, as evidence proves, the emotional stability of patients and family will be improved with the legalization of physician-assisted suicide. Kirsten Weir, in an article titled “Assisted Dying: The Motivations, Benefits, and Pitfalls of Hastening Death” published by the American Psychological Association, states that the debate about assisted death has become more advanced ever since Oregon became the first state to legalize assisted death in 1997. Because the topic has become more relevant, psychologists are researching the reasons why people are choosing this option and the potential benefits. Weir asserts that depression is not the reason that patients want to undergo assisted suicide. It is a myth that physician-assisted suicide is driven by depression and sadness. Weir continues the article by describing the research that psychiatrist Linda Ganzini did at the Oregon Health and Science University. By studying the moods and values of 58 terminal patients planning on assisted death, she proved that these patients wanted to have control over their own bodies. Their research, along with many others, has answered many crucial questions about physician-assisted suicide. They have helped answer the big questions that revolve around this topic. In Weir’s article, she describes the work of Elizabeth Goy, a psychologist, and associate professor. She makes it clear that the primary reason that terminal patients choose assisted suicide is to have control over the way that they are dying. As stated in the article, Goy found that patients want this control because they want to maintain their freedom and actions. Their increasing pain also is a worry of these

patients. Goy's research has also found that financial concerns or emotional burdens are not a reason that terminal patients choose assisted suicide. Weir explains that more research should be done to more fully understand the aspects concerning physician-assisted suicide. She expresses that it is important to know why people choose this method. Weir concludes by explaining the results of Goy and Ganzini's research. She expresses that research has shown that speeding up the death of patients does not negatively impact their family members. There were no differences in grief or depression between surviving family members of people who died by assistance or naturally. Weir ends by stating that families of patients who chose physician-assisted suicide said that they felt more prepared and accepting. As observations convey, legalizing physician-assisted suicide will enhance the emotional stability of patients and their families. Patients are allowed to take control of their own lives, and the families are more prepared for their deaths. More importantly, as data reports, hospital efficiency will be enhanced. Timothy Quill is a professor of medical humanities, medicine, and psychiatry at the University of Rochester in New York. In an article titled "Physician-Assisted Suicide is Ethical," Quill states that illegally practicing physician-assisted suicide is very dangerous. It is difficult to study when assisted death is improperly practiced because doctors are doing this secretly. Physicians risk being prosecuted if they admit to it. Quill conveys that there are many risks to this secret participation. No second opinions or proper documents will be conducted to ensure the patients' safety. Quill concludes by explaining a study that he did on the secret practice of physician-assisted suicide. He found that it is more secure if these practices are done publicly (n.pag.). Making assisted suicide legal in all states will strengthen hospital efficiency. It will reduce the risk for patients and close up the liabilities for hospitals.According to Aaron J. Trachtenberg and Braden Manns, co-authors of "Cost Analysis of Medical Assistance in Dying in Canada," published by the U.S. National Library of Medicine, health care spending in Canada will be majorly affected by the legalization of physician-assisted suicide. They investigated what future costs and savings are associated with the legalization of physician-assisted suicide. Because physician-assisted suicide is legal in Belgium and the Netherlands, the authors collected data from these countries. They then combined this information with Canadian data to estimate what their potential costs could be. Trachtenberg and Manns found that costs of physician-assisted suicide range from $1.5 to $14.8 million. While these numbers seem very high, they are well below how much money the country could save with the implementation of physician-assisted suicide. By legalizing assisted suicide, Canada could cut their spending by $34.7 to $138.8 million. The authors continue to explain that even if they have overestimated and underestimated the savings of physician-assisted suicide, the costs will vary the least balance out. Trachtenberg and Manns draw a conclusion to their study by reiterating that additional data on Canadian patients should be collected to get more accurate results. The article continues by stating that the Criminal Code of Canada's prohibitions on physician-assisted suicide has been removed. They explain that further planning should be done, and the consequences should be open to the public. Because each case is unique, it is difficult to estimate the actual cost of physician-assisted suicide. The authors describe a new plan that will offer physician-assisted suicide in a service fee set. If Canada uses a similar system of assisted suicide as Belgium and the Netherlands, their healthcare spending could potentially be reduced by tens of millions of dollars per year. They reemphasize that the savings will most definitely exceed the costs. Trachtenberg and Manns conclude by pointing out that while implementing physician-assisted suicide will cut costs in a major way, it should be not be used solely for this reason (n.pag.). Undergoing physician-assisted suicide is ultimately a personal decision, not one that should be driven by money. Furthermore, Thaddeus Pope, an expert on medical law and clinical ethics, explains the safeguards that have been put in place in states that have legalized physician-assisted suicide. Safeguards are used to protect hospitals and patients from

undesirable outcomes. In his article," Implementation and Practice of Physician-Assisted Death," published by the National Academic Press, Pope explains what the safeguards are. Some requirements for undergoing assisted suicide include a passed mental health evaluation, having a terminal illness, and a waiting period. There are many arguments against the regulations that go along with assisted death. Some believe that the current protections are too weak or too strong. When challenged that these safeguards are too weak, Pope responded by stating that it is the doctor's job to screen patients for mental health evaluations. Pope responded to arguments that the safeguards are too strong by stating that some places require screening for patients seeking a lethal prescription. To properly assess the patient's intentions, a mental health screening is required. Pope continues the article by expressing that the requirement for self-administration is too strict. Even though this action assures voluntariness, some patients are physically unable to self-ingest the lethal prescription. He states that the requirement of getting two physicians could be difficult. There could be a problem finding willing doctors, but some countries are allowing nurse practitioners to sign. While there is still debate about the safeguards, they are needed to give patients a safe way to go through physician-assisted suicide, concludes Pope (n.pag.). These safeguards protect the patients, physicians, and the hospital. Implementing these safeguards along with the legalization of physician-assisted suicide will allow for it to be practiced more safely. Most importantly, as the statistics reveal, positive health benefits will be increased if physician-assisted suicide is legalized everywhere. Jan Bollen, the author of "Potential Number of Organs Donors After Euthanasia," from the Journal of the American Medical Association, expresses that organ donation can be performed after patients have undergone assisted death. Because this practice is controversial, it is currently only allowed in Belgium and the Netherlands. The supply of organs available for transplantation could be increased if organ donation after assisted death is allowed. She asserts that this will only be done if the patient willingly volunteers to donate their organs. Legalizing organ donation after assisted death will not force all deceased patients to give up their organs. It will still be a voluntary process. Bollen continues the article by describing a study that her team conducted in Belgium. The main purpose was to see how many patients planning on assisted suicide could potentially donate an organ. Because her team was granted permission to view the history of these patients, they found that, in 2015, 684 organs could be potentially donated out of the 2023 patients that had undergone euthanasia. She explains that in 2015, the Belgian transplantation waiting list consisted of 1288 people, and 260 deceased donor kidneys were donated. She predicted that the number of kidneys could more than double if assisted suicide patients were allowed to donate their organs.It is only possible to be an organ donor if the patient is willing to donate and willing to die in a hospital, Bollen concludes (n.pag.). She ends by stating that the goal of organ donation from any patient included euthanasia should remain the same. There will be more positive health benefits if assisted death is ratified. It will increase the number of organs that can be donated, so more patients will have them in the future.According to Dr. Jan Hendrik van der Berg, in an article titled "Physician-Assisted Suicide: Death With Dignity," written by Mary Louanne Friend in the Journal of Nursing Law, the quality of life is just as, if not more, important than the quantity. They believe that terminal patients should be able to control how they die. Friend conveys that in Oregon, patients who are terminal and who have an expected six months or less to live are considered for physician-assisted suicide. Friend concludes by explaining how advocates of physician-assisted suicide want people to die with honor (n.pag.). She defines dying with dignity as dying without unnecessary suffering. Additionally, Dr. Peter Rogatz, co-founder of End of Life Choices New York and author of "Physician-Assisted Suicide is Ethical," increased pain management will not work on all patients. He begins the article by explaining how opponents of physician-assisted suicide claim this technique will reduce the need for assisted death. It is inevitable that some

patients will have pain that cannot be relieved by increased pain management. Rogatz goes on to explain that physicians should not have to risk their medical licenses or prosecution when all they want is to help patients die peacefully. He expresses that out of all of a physician's obligations, the most important one is to act in their patients' best interest. It is their duty to provide them with the care that helps them the most. While some believe that physician-assisted suicide violates the Hippocratic Oath, Rogatz argues that it does not give doctors a license to start killing their patients. Branding physician-assisted suicide as murder is an outright lie. Prescribing medication for a patient who wants to be gone is similar to going through with a Do Not Resuscitate order or removing a patient from their ventilator. Physician-assisted suicide is a way to give suffering patients a merciful death. Another point that Rogatz makes is that patients trust physicians that help them. Doctors who support physician-assisted suicide should not be feared. Their support for this form of treatment does not mean that they enjoy killing patients. Instead, they want to provide terminal patients with a way to die with dignity. Others also believe that if a patient wants to commit suicide, they can do so on their own. They do not need assistance from a physician to end their life. Rogatz explains that this concept is unrealistic. If there is a way for a patient to go peacefully, there is no reason why terminal patients should have to shoot or starve themselves. Physician-assisted suicide eliminates these harsh experiences and the high risk of failure. It allows patients a way to end their lives in a human way. Rogatz also describes the criteria for granting assisted suicide. By following the rules that go along with assisted death, the risk of abuse will be significantly reduced. He combats the myths that legalizing physician-assisted suicide will pose a greater danger to the elderly and disabled. Risks exist with anything, and risks for these patients can be lessened by sticking to the regulations. Opponents also say that the poor and uninsured will be abused by this system, but this is not the case. From Oregon data, he found that out of seventy patients, almost all of them had health insurance, most were in hospice care and most had at least some college education. Rogatz expresses that physicians who secretly go through with assisted suicide put themselves and their patients at unnecessary risk. If physician-assisted suicide was legalized, patients would at least have another option other than sitting in agony. The legalization would give patients assurance that they will be helped. Physician-assisted suicide is human, Rogatz concludes (n.pag.). He believes that patients who have carefully thought out going through with assisted death should be able to do it peacefully. It is not right for terminal patients who want to end their lives early to have to starve themselves when assisted suicide exists. Furthermore, Dr. Robert Klitzman, in an article titled "The Terminally Ill Should Be Allowed to Die" published by CNN, explains how his views toward assisted death have changed. When first beginning his residency, he did not understand why some patients would rather die than be treated more intensely. After gaining more experience, he learned more about the reasons why some decide to go early. Klitzman explains that while they know it may be hopeless, many doctors will continue treatment because they do not know what else to do. This can lead to increased resistance to the medication. Klitzman also explains that once someone hits a certain point in their health, life might not be worth the unbearable suffering of a disease that is untreatable. Klitzman concludes by expressing that terminal patients who seek physician-assisted suicide do not want to give up (n.pag.). These patients realize their fate, want to avoid unnecessary suffering, and prefer to die with dignity. Consequently, research has shown that physician-assisted suicide should be implemented because the emotional stability of patients and family will be improved. Physician-assisted suicide should be legalized in all states because it will allow patients and their families to handle adversity during a difficult time. They will be able to be more prepared and accepting of their loved one's inevitable death. More importantly, hospital efficiency will be enhanced. Legalizing physician-assisted suicide will make dying safer for the patients involved. Doctors put themselves and their patients at risk when they

perform assisted death under the radar. The legalization will protect the hospital from liability and potentially save them money. Most importantly, positive health benefits will be increased if physician-assisted suicide is legalized everywhere. As research has confirmed, organs donated from patients that have undergone assisted death could potentially help with the shortage of organs for transplantation. Health benefits will also exist in the number of patients whose suffering will be ended. Terminal patients will be prepared for their death if physician-assisted suicide is introduced. If doctor’s attitudes towards assisted death are altered, then patients will have more options during their final times of life.