The Need for Physician-Assisted Suicide Debates

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Abstract

Increasingly our lives are being prolonged and more people are dying in medical institutions. However, the effects of medical advancement allowing longer lives have been more negative than positive. People are living longer or dying later, but in pain. Euthanasia and physician-assisted death have been discussed in-depth in some countries but unfortunately, the latter has been neglected in Japan. The purpose of this paper is therefore, to highlight the need for such discussions. In doing so, this paper will identify the underlying intentions of the "right to die" assertions and how they are related to physician-assisted suicide. Hopefully, beginning a dialogue among bioethicists in Japan would shed some light, leading to more general discussions on end-of-life issues.

The percentage of people who pass away at medical institutions in Japan has exceeded eighty percent. According to the Ministry of Health, Labour and Welfare (2006), the percentage of people who die in hospitals is 79.7%, and the total percentage (including hospitals, clinics, geriatric healthcare facilities, midwifery centers, and nursing homes) is 85.4%[1]. The number of people who are dying from infectious diseases continue to fall while those dying from chronic diseases are increasing every year. One reason is a medically prolonged period of life before passing away. Unfortunately, this prolongation of life in many cases is not a pleasant one.

It is not coincidental that as the percentage of people dying in medical institutions increases, the assertions of the "right to die" is increasingly heard. However, what people mean by using the term "right to die" varies greatly and is very much complicated. Indeed, there is a history of abuse of the "right to die," but the purpose of this paper is not attempting to define the "right to die" nor to argue for or against it. The purpose of this paper is to attempt to clarifying what people are demanding when they assert the "right to die"and use this to argue for the need to begin debates on physician-assisted suicide in Japan.

This paper will first briefly define the concepts of euthanasia, physician-

assisted suicide, and suicide. Secondly, this paper will examine the implications of the "right to die" in relation to other rights asserted. Thirdly, we will look at merits of physician-assisted suicide. Lastly, this paper will argue for the need for physician-assisted suicide debates. By examining what is asserted when people argue for the "right to die," it would hopefully shed some light on to the discussions of physician-assisted suicide in general as well as in Japan.

Euthanasia, Physician-Assisted Suicide, Suicide and the "Right to Die"

Euthanasia

The term euthanasia comes from a Greek word *euthanatos* (*eu-* easy or good + *thanatos* death) and means "easy death" or "good death" (Takahashi, 2003; Imai & Kagawa, 2004). Simply, this is a medically assisted death in which a physician plays an active role by actually injecting a lethal substance or lethal amount of a substance[2].

There are various types of euthanasia. One of the most common classifications used is methods and autonomy criteria. Using these criteria, the maximum number of euthanasia classifications is nine. The detailed classification of euthanasia has already been discussed elsewhere[3], so this paper primarily examines voluntary euthanasia (see Table 1 for other types of euthanasia).

Table 1
Classifications of Euthanasia[1]

Classification	Definition
Method	
Active	Intentional act of injecting lethal dose of a substance to relieve pain resulting in death
Indirect	Possibly hastening the timing of death by injecting pain reducing substances in an attempt to eliminate or alleviate pain
Passive	Hastening the timing of death by withholding or withdrawing treatments
Autonomy	
Voluntary	Euthanasia performed with patient's requests
Non-voluntary	Euthanasia performed without patient's request or his/her will is unknown
Involuntary	Euthanasia performed against patient's will

Physician-Assisted Suicide

An assisted suicide is a "death with assistance from others." This general definition of assisted suicide indicates the presence of one or more people providing an aid in committing a suicide. When there is a qualification as to who could aid, such as a physician, it is a narrower conception (such as a physician-assisted suicide). In either case of the definition, one is said to have assisted death when s/he provides a means of suicide. For example, in a case of a physician, providing a prescription for a medication or other chemicals[5] is seen indeed as giving assistance. As the term "suicide" implies, a physician-assisted suicide is a form of suicide.

According to Stone (1999), there are fourteen types of suicide, of which those by terminally ills are one of them categorized under the classification "escape from an unbearable situation." As he states, this category is not merely composed of suicides at the terminal stage. Other reasons may be persecution or chronic misery[6].

In suicide, the agent is the person who is dying and cannot be anyone else. Even in the case of physician-assisted suicide, the person who is dying is the person doing the act (e.g., taking the medication). Although the act which directly causes death is performed by oneself, because the act is clearly shortening the life of the individuals, it should therefore be distinguished from euthanasia, more specifically passive or indirect euthanasia.

Suicide

At a glance, defining suicide seems easy compared to euthanasia and physician-assisted suicide because suicide is common terminology, though it may not be openly discussed. Suicide is an act of killing oneself or more specifically, an act of bringing about death to oneself.

But, *what* is suicide? What acts can be classified as suicide? It is more difficult to answer these questions than it first appears because there are many possible interpretations of the "act of bringing about one' s own death." For example, some cases may be placed in the suicide category while other cases may be classified as accidental deaths depending on researchers, investigators, classification criteria, and cultures (Stone, 1999).

Another example illustrating this point is Karl Menninger' s division of suicide into three categories in his book *Man Against Himself* (1985). He classifies suicide into "chronic," (long-term suicidal behaviors including alcoholism, martyrdom, psychiatric illness, and antisocial behaviors),

"focal" (targeting specific body parts including self-mutilation, deliberate accidents), and "organic" (dying of illness[7], which could be cured, due to surrendering one's will to live) suicides. (Menninger, 1985).

Although Menninger's work demonstrates the difficulties in defining suicide, this paper will use the term suicide to mean any acts leading to a relatively immediate death to oneself. Therefore it would include any type of acute suicides (i.e., therefore disregarding Menninger's "chronic" and "organic" suicides), in the context of terminal illness other than physician-assisted suicide[8].

It is important to note that suicide is a voluntary act but when social pressures come into play, the act may no longer be purely voluntary. This point is important in the next section which examines physician-assisted suicide.

Other related concepts

There are some terms which are frequently confused with the concepts defined above. These are mercy killing and death with dignity (dignified death).

Euthanasia and mercy killing are sometimes confused and are interchangeably used, and this is not a groundless mistake. They have something in common; an agent from outside participates in bringing about death. The former, in the context of terminal illness, is limited to physicians but the latter is not necessarily performed by medical doctors. The agents of the latter type of killing are usually family members, relatives, friends, or caretakers, including nurses who sympathize with the patients' sufferings irrespective of their wishes. In other words, mercy killings are actions motivated by sympathy (Kai, 2003). Euthanasia by definition is only applicable to patients with terminal illness but mercy killings may occur for any "unbearable" situation perceived by the agent of the action.

Death with dignity is literally death chosen to maintain dignity. This usually is a choice made by the agent of action himself/herself. However, the difficulty in understanding this type of death lies in the meaning of "dignity." The word "dignity" has a wide variety of meanings as seen with the word "unbearable" in the section about suicide. This ambiguity of the term in turn leads to the ambiguity of the concept of dignified death[9].

A jurist Kai (2003) states that a death with dignity is the act of withdrawing life sustaining apparatus, and therefore the use of the term should be restricted to clinical settings. He equates dignified death with treatment withdrawal. However, in Japan, where withholding, not

withdrawal of treatments, is permitted, death with dignity in his use of the term is not appropriate.

These two types of deaths have some similarities to euthanasia. Even so, mercy killing and death with dignity should not be, at least, the topics of academic discussion in the context of terminal illness. Mercy killing is merely a kind of homicide while dignity could be one of the motivating factors in performing euthanasia, physician-assisted suicide, or suicide. Yet, dignity should not come to the forefront of the discussion or a main motive of committing such acts. Such concepts as quality of life (QOL) among others might be more concrete and are more quantifiable than the former concept[10].

What' s Behind "Right to Die" Assertions

The "right to die" may simply be understood as an expression of people's desires to decide at the end-of-life. Decisions about whether to continue or discontinue with life or about the timing of death would fall under this assertion. However, this paper will not, as mentioned above, discuss the definitions of the phrase. The factors leading to the claim of such a right or the contents of its assertion are more important than the definition of the "right to die."

A "right to die" has emerged in connection with end-of-life issues. Medical advancement which has allowed for prolongation of life, with or without consciousness, has led to a situation where people are faced with the possibly of "years of debility, dependence and disgrace" (Kass, 2003). People faced with such realities of life are increasingly wishing to decide themselves, about the end-of-life.

What has been presumed in the assertions of the "right to die"or any assertions relating to the end-of-life, is an alleviation of pain and suffering not necessarily restricted to physical ones. Pain and suffering are some of the primary concerns of patients with terminal illness. Thus, it is needless to say that among various classifications of euthanasia and physician-assisted suicide, alleviation of pain and suffering are of utmost importance and is the shared goal of terminal care. However, the means of goal achievement differ among classifications. What are some other reasons for such requests aside from pain relief?

In active euthanasia, patients want direct assistance of a physician and they want it painless, quick, and probably clean end. In the case of indirect euthanasia, patients specifically wish for alleviation of pain in a form of palliative care. Indirect euthanasia and palliative care are thus

frequently used interchangeably. Patients ask for direct assistance from a physician so that the methods used are direct and effective, even it may lead to loss of consciousness, sedation or death. Lastly, when people want passive euthanasia, they are requesting for withholding or withdrawing of medical treatment, in a way asking for indirect assistance from medical staff.

For physician-assisted suicide, patients are requesting indirect assistance specifically from a physician, and the means to be immediate and effective. Since physician-assisted suicide is a form of suicide and because this paper focuses on decisions about death at a terminal stage, a general discussion on suicide will be avoided here (see Table 2 for summary).

Kass eloquently recapitulates these patients' wants and desires using the language of rights. Possible interpretations of the "right to die" suggested in *Life, Liberty and the Defense of Dignity* (2002) are as follows:

(1) Right to commit suicide
(2) Right to refuse treatment even if or so that death may occur
(3) Right to be killed or to become dead
(4) Right to control one' s own dying
(5) Right to die with dignity
(6) Right to assistance in death

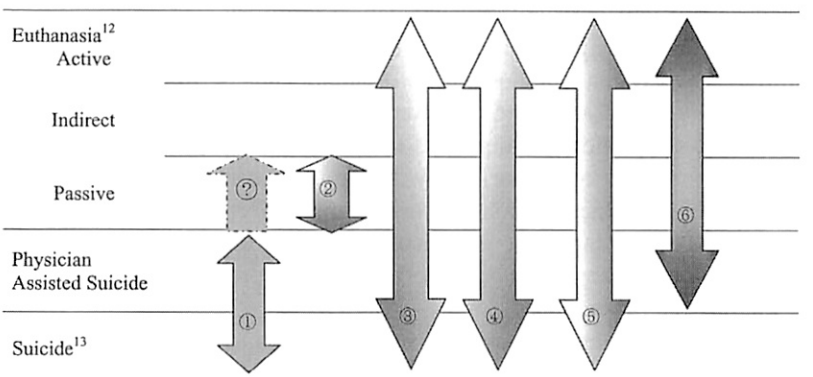
Discussions about the validity of these rights claims are laborious and this paper will not go into the details. However, people are increasingly voicing them and it is only proper to try to understand these "rights" as desires expressed by terminally ill patients.

Figure 1 illustrates the relationship between Kass' interpretation of a "right to die" in the end-of-life decisions and methods of bringing about death. The assertion of the first right, the right to commit suicide can be seen both in physician-assisted suicide and suicide. By definition, the second right is only applicable to passive euthanasia. The next three rights (i.e., a right to be killed or to become dead, a right to control one' s own dying, and a right to die with dignity) are seen in every category. The fifth right, the right to die with dignity encompasses suicide because suicide here is limited to that committed by terminally ill patients. Lastly, the assertion of the right to assistance in death is seen in all but suicide.

Table 2
Characteristics of Voluntary Euthanasia and Physician-Assisted Suicide

Classification	Role of physician	Patient involvement	Means of relieving pain	Intention of death	Immediateness of death
Euthanasia					
Active	Direct	Low	Injection of lethal substance	Intended	Immediate
Indirect	Direct	Low	Injection of pain-relieving substance; palliative care	Not intended	Mediate
Passive	Direct/ Indirect	Low	Withdrawing or withholding treatment	(Not) Intended	Mediate, Possible
Physician Assisted Suicide	Indirect	High	Consumption of a prescribed substance	Intended	Immediate
Suicide	None	High	Various	Intended	Immediate/ Mediate[11], Possible

Figure 1.
Means of Bringing About Death and the "Right to Die"



(1) Right to commit suicide; (2) Right to refuse treatment even if or so that death may occur; (3) Right to be killed or to become dead; (4) Right to control one's own dying; (5) Right to die with dignity; (6) Right to assistance in death.

Discussion

Demands for these rights extend to various end-of-life situations. By limiting the discussion to clinical settings, suicide is excluded from further discussions. If we assume that the fulfillment of the desires underlying these six rights suggested by Kass is of primary importance in terminal care, then the best methods seems to be through voluntary passive euthanasia or physician-assisted suicide.

These desires are also common in indirect and active euthanasia. Indirect euthanasia is already being performed in clinical settings, for it is a form of palliative care. Although it is not entirely impossible to attempt to argue for active euthanasia, there is a major obstacle which must be overcome, i.e., the slippery slope argument[14]. Though passive euthanasia seems to be the next appropriate means of fulfilling these desires, there are a couple of qualifications. First, a "right to refuse treatment even if or so that death may occur" is a mere description of the concept. Second, satisfaction of a "right to commit suicide" is questionable.

The assertion of the first right, the right to commit suicide can be seen in both physician-assisted suicide and suicide. This is questionable in passive euthanasia for this classification includes both withholding and withdrawing of medical treatments. Withholding of treatment would lead to natural progression of an illness, and in the case of terminal illness, it would eventually result in death. However, there are controversies about what actually causes death when treatment is withdrawn. In other words, is the act of withdrawing killing the patient or the illness?

There are also significant debates about whether or not there is a moral difference between withholding and withdrawing of treatments. In the United States, these two are perceived as non-distinct acts while in Japan, there is a significant difference. In the USA, if the treatments are withdrawn (e.g., respirator) or withheld, the cause of death is the progression of illness which had been temporarily inhibited by medical intervention. In Japan, it is speculated that withdrawing of medical interventions is as good as actively (hence, the expression "direct," Table 2) letting the patient die.

It seems that physician-assisted suicide appears to satisfy most number of the "right" claims and desires. Suicide has been excluded by limiting the discussion to clinical settings. Active euthanasia is difficult to argue for since there is a tricky challenge of the slippery slope argument. Indirect euthanasia has been already discussed above. In passive euthanasia, there is difficulty in establishing a clear distinction between

withholding and withdrawing of treatments. Hence, physician-assisted suicide appears to be the most ideal amongst them all. Unfortunately, the number of desires fulfilled alone does not necessarily point to the relative appropriateness among four means at the end-of-life. Changing the perspective might help in arriving at a proper means in satisfying the needs of patients.

The "right to refuse treatment even if or so that death may occur" merge with the third right (a right to be killed or to become dead) if it can be interpreted as a way of escaping from or alleviating pain and suffering; the right to escape from pain and suffering by dying (A'). It is possible to draw similar conclusions from the fourth right and the fifth. The desire to die with dignity is in a sense controlling the conditions of one' s dying. It can be translated as a right to have control in one' s dying (B').

There are then four rights including two new rights: a right to commit suicide (1), a right to escape from pain and suffering by dying (A'), a right to have control in one' s dying (B'), and a right to assistance in death (6). Furthermore, taken together, the first right and right A' can be understood as a request to allow termination of self to obtain desired ends (i.e., alleviation of pain and suffering; C'). The end results of this merging and reinterpretation processes are six rights compressed into three basic rights assertion. The common elements in all the "rights" claimed are the alleviation of pain and suffering (C') , to have control in one's dying (B') and the sixth right, assistance in death.

The number of patients' desires satisfied and the common elements both appear to attribute similar features to physician-assisted suicide as with other types of euthanasia, though one form of this might be more acceptable than the others. There have been numerous discussions on euthanasia in general as well as more specific ones on its types but not on physician-assisted suicide in Japan. This paper suggests opening discussions on physician-assisted suicide for there are merits in physician-assisted suicide which might be absent in euthanasia or suicide in general.

Also there are positive arguments for physician-assisted suicide. Two examples might be:

1) Provide some solutions to problems in euthanasia debates
2) Provide closure to both patients and family members

There are two possible solutions to some problems relating to euthanasia. First, physician-assisted suicide will reduce the physician participation. The "role of physician" in Table 2 indicates the degree of involvement by physicians in euthanasia, physician-assisted suicide, and suicide. By definition, euthanasia requires direct involvement i.e.,

physicians directly inject a substance, except in the case of withholding treatment (a form of passive euthanasia). For physician-assisted suicide, physicians have an indirect role of prescribing medication or a substance to be used, and the patients consume it themselves.

The second aspect is the confirmation of patients' will. Physician-assisted suicide allows for confirmation of patients' will. Competence, but not physical ability, is a prerequisite in voluntary euthanasia. So, patients with consciousness and competence may in fact are unable to verbalize or gesture their compliance or non-compliance with euthanasia. Suicide requires the patient to consume the substance, this in turn means that the patients have minimum to full physical ability. Although physician-assisted suicide does not resolve the problems of confirmation of a patient' s will, it can be circumvented because in physician-assisted suicide, incompetence is not an issue.

The above two aspects view physician-assisted suicide from procedural point of view. There also are three advantages from the perspective of the patients; allowing proper closure to patients and their family members. First, it allows for adequate grief work. Besides from active euthanasia and withholding of treatment, patients may not be consciousness enough in the last moments of illness when indirect or passive euthanasia are performed. Having full consciousness would allow for good-byes and farewells with loved ones. Second, it provides opportunities for self-actualization. In physician-assisted suicide, patients decide the timing of death and accordingly, they can "tie up loose ends" if they so desire. For the same reasons as the first example, there might not be enough time for reconciliation in cases of euthanasia. Third, patients and family members are able to be free from the stigma of suicide. For those who fear painful death or unforeseeable future, a pre-arranged death may be the only way out and those who want peaceful death might have that opportunity.

Active euthanasia is only legalized in Netherlands and Belgium, and one must go through the painful experience before being sedated in indirect euthanasia. Withdrawing of treatment after intervention has already been started is not permitted in Japan. Patients either let fate decide about their future or to commit suicide. Although Japan is generally more permissive on suicide than other countries, it is not without social stigma. Patients put their families at the risk of dealing with the social stigma and the family members must live through it.

Conclusion

Needless to say, there of course are drawbacks to physician-assisted suicide and further discussions are necessary before we can give rationales for or against it. Unfortunately, there are no such discussions yet in Japan. It is not clear as to why this has not been the topic of discussion. It may be due to the fact that assistance in suicide in general is a crime (自殺幇助罪). However, this has not been researched into much.

What are the views of jurists on issues of physician-assisted suicide? Would the same laws apply to physician-assisted suicide that applies to assistance in suicide? What are the opinions of the public, which is more permissible on suicide than many other nations of the world? These are just a few of the questions that need to be discussed.

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1 The total percentage of people dying at some type of medical institution has exceeded eighty percent in 1996 (80.5%). To be precise, 1,084,450 people died in 2006, and of those the number of people who died in hospitals is 864,702 and the number of people who died at medical institutions is 926,217.

2 Refusal or withdrawal of water and nutrition artificially delivered can be considered as a type of treatment withdrawal (Kass, 2003), thus as a form of passive euthanasia.

3 "The concept of 'indirectness' seen in Euthanasia" in *Research on Contemporary Society Centered around Bioethics 3*. Kumamoto University Research Association of Bioethics Report 2006.

4 Based on Takahashi (2003), Singer (1993), and others.

5 Here I have followed the example of Stone (1999) using the term "chemical" to mean any substance other than medications used in treatments but have effects to the human body and to which a physician may have access in clinical settings.

6 Although by definition persecution is not relevant to terminal illness, depending on the motives of committing a physician-assisted suicide (i.e., if motives are non-physical), the chronic misery is related to physician-assisted suicide. In other words, anything relating to terminal illness can be considered as an "unbearable situation."
7 The third type of Menninger's classification "organic" suicide is not dying of terminal illness. The purpose of his book is to examine the psychological factors underlying suicide (Menninger, 1985). Therefore, "organic" suicide is death of oneself caused by giving up the will to cure the illness due to various reasons unconsciously, and intentional infliction of harm to cause immediate death, i.e., the common understanding of the term suicide. The second type "focal" suicide corresponds with the common use of the term rather than "organic" suicide.
8 This would exclude those deaths resulting from psychological disorders, such as depression or hardship of life. To some, it may only seem reasonable to examine physician-assisted suicide because it *is* a type of suicide. However, if taking one' s life does not fit the definition of physician-assisted suicide, it is only perceived as a mere suicide motivated by an unbearable situation. Thus, it is not unreasonable to examine suicide at least briefly here.
9 For example, it is usually assumed that the agent of the action is the person who dies but because "dignity" is unclear, in an extreme case, mercy killing may come to be included in this category if it is driven to maintain the dignity of the person by another.
10 Though, it is not to say that QOL of a patient is easy to measure in any way. Rather, it is easier to give operational definition to QOL so that it would be measurable.
11 In case of suicide, the immediateness of death depends on the method of choice and therefore "possible" death may occur for non-completed suicide (attempted suicide).
12 Euthanasia here only includes those of voluntary euthanasia. Involuntary euthanasia and non-voluntary euthanasia are not included here.
13 Suicide here is limited to those seen at terminal stage. In other words, only those committed by terminal ill patients are included in this figure. This roughly corresponds to Stone's conception of an "escape from unbearable situations" (1999).
14 In the context of voluntary euthanasia, there is fear that allowing it would eventually lead to allowance of involuntary euthanasia when the will of the patient is absent or unknown, and to non-voluntary euthanasia where patients are "killed" against their wishes.