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Article 53

Physician-Assisted Suicide, Euthanasia, and Counseling Ethics

Russell Fulmer

Fulmer, Russell, PhD, LPC, is an Assistant Professor at Emporia State University in Emporia, Kansas. Dr. Fulmer is a Licensed Professional Counselor whose interests include ethics, interdisciplinary approaches to counseling, and the impact of regulation on counseling.

Abstract

Physician-assisted suicide and euthanasia are distinguished and discussed in the context of the counselor's role in helping terminal clients. An aging population coupled with the proposed legislation in many states to legalize physician-assisted suicide could mean these issues will become more paramount to the counseling profession. Potential ethical dilemmas are discussed using the biopsychosocial model, five pillars of ethics, and an existing health-care model as guidance.

Physician-assisted suicide, euthanasia, and end-of-life issues represent a point of convergence for medical and counseling ethics. Health care professionals work directly with terminal patients, some of whom make requests to physicians for help in ending their lives. The counselor's involvement with end-of-life issues is indirect, but vital nonetheless. Counselors may see clients diagnosed with a terminal illness. Counselors play an important role in these cases, with a primary goal to help the client enhance their quality of life (Shallcross, 2012).

With end-of-life issues, the ethical implications and potential for dilemmas are numerous. The 2014 American Counseling Association Code of Ethics address end-of-life issues in the context of preventing foreseeable harm, legal mandates, and confidentiality considerations (American Counseling Association, 2014). Although not explicitly addressed in the ethics code, physician-assisted suicide and euthanasia raise unique, if not extreme, ethical questions. As more states legalize or have proposed legislation for legalization, counselors may encounter more clients dealing with these issues in particular (Biller-Andorno, 2013). This article addresses the ethics of physician-assisted suicide, euthanasia, and related concepts from a counseling ethics perspective.

Physician-Assisted Suicide and Euthanasia, Distinctions

Any discussion of related actions should start with a clarification of said terms to elucidate as clearly as possible the meaning of each term. The term euthanasia implies active voluntary euthanasia. This requires a patient requesting death and a physician

complying with the patient'request. In another form, involuntary active euthanasia, patients oppose the procedure. The closest examples of involuntary active euthanasia are death penalty cases. State-sanctioned instances of licensed-physicians assisting state-sanctioned inmate deaths,, presuming the prisoner opposes the death sentence, qualify as involuntary active euthanasia. A third form is non-voluntary active euthanasia, wherein a person who lacks decision-making capacity and cannot express a preference is the recipient of euthanasia. A comatose patient who is not only taken off all life-sustaining devices but subsequently given a lethal dosage of medication is an example of non-voluntary active euthanasia. Apart from the death penalty in some states, active euthanasia is illegal in all fifty states (Lo, 2009).

Distinct from active euthanasia is passive euthanasia, which stands for the withdrawal or withholding of life saving intervention. Passive euthanasia does not involve actively inducing death, but rather not saving a life, or not initiating a procedure that could prolong life. Declining life support or abiding by a do-not-resuscitate order are both examples of passive euthanasia. Although ethically controversial like active euthanasia, passive euthanasia is legal in all fifty states (Orfali, 2011). The major ethical distinction between passive and active euthanasia is the presumed agent of death. Passive euthanasia is commonly thought of as allowing-to-die, rather than killing, with the patient's disease tagged as the culprit. With active euthanasia, the physician is inferred to be the agent of death.

Physician-assisted suicide (PAS) differentiates itself from both types of euthanasia. With PAS, a physician provides the means for death with the patient bringing about the act itself. In cases of PAS, patients are the direct agents of their own demise. Physicians are part of the means to the end. Some ethicists believe that the moral responsibility of the physician is lessoned by the direct action of the patient in PAS as opposed to euthanasia (Beauchamp & Childress, 2008).

The Biopsychosocial Model

Counselors and other qualified mental health professionals enter the PAS process by way of helping to alleviate mental illnesses that may be driving a patient's request to end his or her life. Of the states where PAS is legal, Oregon, Washington, and Vermont, with aid-in-dying provisions in New Mexico and a legal precedent for defense in Montana, it is common to have provisions stating that patients must obtain counseling to ensure that their free choice and not depression is the motivating force behind the request (Manning, 2014).

This collaborative effort between medical doctors and mental health professions showcases the biopsychosocial model in action. Legally, ethically, and clinically, the whole person is being addressed. Physicians make medical diagnoses and identify the terminal disease responsible for impending death. Nevertheless, even pernicious biological disease does not exist in a vacuum. Patients with cancer, for instance, will make decisions about their prognosis according to their psychological state in the context of their culture. Psychologically, depression is associated with suicidality (American Psychiatric Association, 2013). The question is then begged, are thoughts pertaining to the cancer or depression responsible for a person requesting PAS? States require patients who request PAS to seek counseling mainly to attend to this question. Counselors, trained

in the arts of empathy and diagnosis, are equipped to help clients and physicians alike by ensuring their clients are in satisfactory mental health and possess decision-making capacity (Shallcross, 2012). In this process, counselors are guided by their ethical code, which is an applied form of principle-based ethics.

The Five Pillars of Ethics

Counseling ethics are a form of applied ethics. Other disciplines have applied ethical codes, such as business and medicine. Applied ethics are the most practical version of ethics, but in principle should be extensions of normative and meta-ethics (Huemer, 2008). Correspondingly, the substance of most ethical domains, especially applied ethics, are five prima facie pillars. Prima facie alludes to principles whom *at first sight* carry with them merit and authority. In essence, a prima facie principle should be followed and clinicians should conduct their behavior in alignment with each principle.

For end-of-life questions such as physician-assisted suicide (PAS) and euthanasia, ethicists usually draw from an ethical code and the five pillars of ethics in order to make a decision on what to do about addressing the question. Not having a standard or ethical theory for guidance can muddy the ethical waters in these emotional issues. Each pillar offers a directive speaking to the ethical validity of an issue and advocates likewise (Page, 2012).

1. Autonomy, or self-rule, or self-governance, is the right of individuals to make their own mental health and health care decisions. Autonomy would endorse both PAS and euthanasia presuming the person is an adult with decision-making capacity. Autonomy would not oppose collaboration of client, counselor, and physician in making decisions, but would stress that ultimately it is the client who has the right to decide yes or no, and the counselor and physician also have the right to decide whether to participate in the process.
2. Non-maleficence offers the dictum *do no harm*. The prime ethical imperative is to, above all else, do not hurt or further harm a client. Depending on perspective, non-maleficence would endorse or deny PAS and euthanasia. The result of PAS and euthanasia is client death, which seems the ultimate in harm. However, requiring a client in extreme physical pain to continue in agony may be construed as harm as well. Non-maleficence creates a dilemma within itself in this case.
3. Beneficence, or the promotion of goodness, likewise is an ethical-pillar dependent on perspective. Does promoting well-being presuppose life at all costs? Or, does beneficence recommend alleviating suffering and hence insinuate the ending of life? Beneficence illustrates how seemingly straightforward guidelines like *do good* are relative to frame of reference and personal value systems.
4. Fidelity is a principle that advocates for promise-keeping and loyalty. A counselor following the fidelity directive is obliged to keep his or her promises to clients. Thus, if a counselor promises to help clients locate a physician willing to help end their life with PAS, then the counselor is ethically compelled under fidelity to do so. In this sense, fidelity is a second-tier principle regarding PAS and euthanasia that comes into play predominately once a decision has already been made.
5. Justice is the fifth pillar and speaks of equality, obeying the law, and properly allocating social resources. The first definition, equality, would suggest that all

clients have equal access to PAS and euthanasia if they are available and legal. This leads to the second meaning, obeying the law, which tells counselors to follow the legal statutes of their jurisdiction. A proper allocation of social resources implies that finite resources, such as time, be allocated in a fair manner. A counselor who devotes more time than usual to a terminal client while shortening their normal time with other clients would not be acting just, as this action violates both the first and third definitions of the principle.

Ethical Dilemmas

Each of the five pillars is ethically binding and the basis of much legal protocol in the United States. Autonomy in particular is the ethical source of the doctrine of informed consent (Rehbock, 2011). Non-maleficence is the driving ethic behind mandatory reporting of child and elder abuse. Justice encompasses the whole of the law, and most ethical codes, including counseling, stipulate that practitioners observe laws foremost (Barnett & Johnson, 2010). Yet, the law is not always explicit in its directive. Rather, laws more often set parameters of acceptable behavior and give counselors and other professionals ample room to exercise clinical judgment. It is in this realm that ethical dilemmas are likely to occur.

Ethical dilemmas are the result of two or more ethical principles coming into conflict. When principles collide, a conundrum or dilemma ensues that typically has no clear answer. When a decision must be made, however, one principle ultimately must take precedent over another. Most ethical issues invoke each principle to varying degrees and PAS and euthanasia are no exceptions. Disputes about both the ethical viability and legal permissibility about PAS and euthanasia usually revolve around two imperatives, that of liberty and that of life. The pro-PAS side stresses autonomy while the opposition demands that the sanctity of life be recognized.

Favoring the legalization of PAS, and perhaps euthanasia by emphasizing the primacy of autonomy, is relatively straightforward, but opposing it by appealing to ethical principles is ripe for disagreement. As previously mentioned, both non-maleficence and beneficence lend themselves to disputing the ethical permissibility of PAS and euthanasia. Drawing a connection between *do no harm* and not killing or indirectly causing death is clear cut. Similarly, claiming that promoting well-being is inconsistent with directly or indirectly causing death is logical. However, non-maleficence in this context is ostensibly at odds with making a terminal person suffer. Requiring prolonged agony does not appear to align with non-maleficence. Doing good, as stated by beneficence, is likewise conflicting with enabling intense pain when it could be eliminated. The ethical debate of PAS and euthanasia seems to be autonomy against versions of non-maleficence and beneficence. Because ethical principles are paired against each other, PAS and euthanasia are ethical dilemmas waiting to happen for both physicians and counselors. In medicine, there exists already a model that helps health care professionals make decisions and clarify their role in sensitive end-of-life matters.

Health-Care Decision Making Standard

Physicians employ a decision-making model that helps to clarify how health care decisions and treatment options will be carried out (Lo, 2009). The model has three standards.

1. Subjective standard, by way of informed consent. Adult patients who are legally competent have the right to accept or decline treatment. This standard presumes the patient is lucid and can either verbally state his or her preference or has an advance directive such as a living-will that clearly outlines their preference. While the physician can give advice and educate the patient on their diagnosis and prognosis, it is ultimately the patient who decides.
2. Substituted-judgment standard. If a patient is incapacitated or otherwise unable to verbally express their consent for treatment, or does not have a living will, then a surrogate decision-maker decides for the patient. Of note is the surrogate is to decide on treatment based on what the *patient* would want, not what the surrogate deems best. The patient may have previously designated a surrogate by appointing them their durable power of attorney (DPA). Within an advance directive like a living-will, the patient could have appointed an individual to make decisions for him/her in case he/she loses consciousness, and this person, the DPA, has legal authority to make these decisions above any other family member or friend. Nonetheless, the DPA is legally obliged to make decisions based on the previously expressed wishes of the patient or in accordance with the patient's values.
3. Best-interest standard. In cases of an incapacitated patient with no advance directive or immediate family, physicians decide the healthcare treatment regimen based on what a reasonable patient would desire. Physicians are to make decisions based primarily on non-maleficence and beneficence in accordance with normal, acceptable standards of care in their jurisdiction.

In this model, autonomy takes precedent as the first standard. The subjective standard recognizes patient autonomy as the foremost ethical obligation. Using this model with PAS and euthanasia, adult, competent patients have the right to participate. Specific provisions aside, such as requiring patients to seek counseling before any procedure is carried out, ultimately the patient and a consenting physician could carry out PAS or euthanasia. Hence, a precedent-setting model already exists that permits PAS and euthanasia in health care. Furthermore, *indirect* cases of physicians hastening death that are not technically PAS already occur and are legal. This is explained using the doctrine of double effect, a doctrine also used regularly by counselors.

The Doctrine of Double Effect

The doctrine of double effect (DDE) talks of the permissibility of an action that produces desirable effects but also unintended, undesirable effects. The doctrine acknowledges that some actions have two or more effects, one that was intended, the others that were not, even if they were foreseen (Edmonds, 2013). In health care, one example of DDE is giving opioids to relieve pain, but knowing that the drug may also hasten death. Another example is removing the uterus of a pregnant woman with uterine

cancer, all the while knowing the procedure will cause the death of the fetus. In counseling, re-creating a past trauma in order to reframe it and allow the client to habituate to the malicious feelings associated with it is the DDE in action.

DDE entails ethics involving both intention and consequence. The bad consequence (e.g., hastening of death) is trumped by a well-intended action, initiated due to somber circumstances. Courts have consistently upheld DDE presuming four criteria are met. One, the act is considered beneficent. Two, the intended effect is good, such as eliminating cancer. Entrenched within this criterion is the knowledge that harm may be foreseen. However, the harm cannot be the intended outcome. Three, there are no alternatives to producing the desirable effect. Four, the positive, intended effect is significant enough to compensate for the harmful effect (Shaw, 2002).

DDE is not only legal, but clinically pragmatic. Few actions produce but one effect, in mental health, healthcare, or any field. Although DDE is not synonymous with either PAS or euthanasia, it does represent a series of cases wherein death occurs, knowingly and ahead of time, by the action of a physician.

Conclusion

With the legalization and introduction of bills to legalize physician-assisted suicide by states across the country, counselors are likely to encounter more clients struggling with life or death decisions. Although the ethics code of the American Counseling Association does not directly address either PAS or euthanasia, counselors are encouraged to help enhance their client's quality of life, respect their choices, and keep their confidentiality (American Counseling Association, 2014). Embedded in the idea of respect for choice is the ethical principle of autonomy. Apart from cases of abuse, autonomy has been the paramount ethical pillar that guides counseling ethics. In the end, clients are free to make their own decisions. Counselors are tasked with respecting clients, empowering them, recognizing their value systems, and not imposing their own values onto clients. While it may be important for counselors themselves to develop their ethical beliefs about PAS, euthanasia, and end-of-life issues, it is equally important to respect client's beliefs. Counselors can and indeed should help a client considering PAS with any mood disorder or any other mental illness that may be the impetus behind a PAS request. Though in the end, when confronted with a sensitive life or death decision, it is clients who should have the right to choose. This is a position with solid ethical justification.

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