

A Social Justice Value Approach Regarding Physician-Assisted Suicide and Euthanasia Among the Elderly

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Abstract

Social justice, as the primary form of justice, incorporates other forms: commutative, contributive, distributive, and restorative justice. This article integrates the various forms of justice and the social work values in addressing the issues regarding physician-assisted suicide and euthanasia among the elderly.

KEY WORDS: Physician-Assisted Suicide, Euthanasia, Social Justice, Social Work Values

1. Introduction

Understanding social justice is a challenge for social workers, because they are sometimes unaware of the role social justice plays when implementing policies and practices related to issues such as physician-assisted suicide and euthanasia in older adult populations. Social justice, as the primary form of justice, incorporates four other forms of justice:

- *Commutative justice* defines the relationships of a member within the group culture and fosters equality for fair standards of reciprocity in society.
- *Contributive justice* advocates that individuals become productive participants in society and that

society has the obligation to empower them to participate.

- *Distributive justice* requires that the allocation of resources be evaluated from many perspectives so that many individuals in society have their basic needs met.
- *Restorative justice* seeks to reconcile conflicted parties in a way that enables them to find common ground for a new, more equal footing in broken relationships. (Himchak, 2005; Reisch, 2002).

All four forms of social justice encompass the human rights perspective as defined in the Universal Declaration of Human Rights as “inherent, equal and inalienable rights of all members of the human family and the

foundation of freedom, justice and peace in the world” (U.N. General Assembly Preamble, 1948, p. 1; Axin & Stern, 2006). Within the last decade, the social work profession has adopted the human rights perspective as the basic principle undergirding the formulation of social work policy in designing programs, the implementation for social work practice in services and the utilization of theory-based research methodology (NASW Code of Ethics, 2003). Since social justice is the overarching value, this article integrates social work values and end-of life decisions with various forms of justice. It also addresses these forms of justice in relation to several issues that are major concerns among the elderly. These issues are individual and cultural autonomy, family autonomy and decision-making, ethical dilemmas for health care professionals, and the legalization of euthanasia and physician-assisted suicide.

Physician-assisted suicide and euthanasia are rapidly becoming serious ethical dilemmas in all aspects of society, primarily because of advanced medical technology that rather easily allows the prolongation of life. Hence, complex ethical issues regarding physician-assisted suicide and euthanasia emerge not only among medical people, but also among the religious, legal, and social work professions, as well as the general population. There is a shift in attitudes regarding physician-assisted suicide and euthanasia. Public opinion polls, for instance, conducted from 1936 to 2002 found that Americans radically changed their attitudes regarding both physician-assisted suicide and euthanasia (Allen *et al.*, 2006; Emanuel *et al.*, 2000; Logue, 1993). The shift is largely due to the belief that individuals have the right to end their lives when they perceive their quality of life is significantly diminished and/or when invasive medical innovations that prolong life become too financially costly (Allen *et al.*,

2006; Emanuel, 2002; Logue, 1993; Loewy & Loewy, 2002).

Although policies concerning physician-assisted suicide and euthanasia affect all populations, this article focuses specifically on the geriatric population, because they are the fastest growing vulnerable group of Americans with the greatest numbers consisting of the frail elderly, 75-85 years of age. By 2030, the number of older persons (aged 65 years and older) in the United States is projected to increase to 66 million, making the issues of assisted suicide and euthanasia more prominent (U.S. Census, 2000). The majority of this population includes culturally diversified women who are widowed, living on limited incomes, and living with functional disabilities. Although Caucasian older adults continue to represent the majority of the aged population, minority elderly groups are growing rapidly. By the year 2050, there will be 22 million minority elderly (U.S. Census, 2000), most of whom will be African-American, Hispanic, and Asian (Angel & Hogan, 1992).

2. Distinctions and Terms

Before entering the heart of this article, it is essential to define the relevant terms, which are often muddy in popular literature. First among the concerns is understanding of death, especially as different people in different cultures perceive it. In general, individuals and societies envision *death* in three ways: as the antithesis of life, as a part of life, and/or as the end of life. *Thanatology* is the study of death and death related behavior, and *orthothanasia* is the science of dying a natural death. Religious and cultural beliefs; science and medical technology; and the ethics and values of the medical, legal, and social work professions (Pellegrino, 2001) have influenced both

concepts. Both concepts are at the core of the euthanasia and physician-assisted suicide debate.

The word “euthanasia” originates from the Greek language meaning "good death": eu, well; thanatos, death (Beauchamp & Childress, 2001). A good death requires that the individual has clarity in decision making and self-awareness in accepting death (Cameron, 2002). In today's society, the word *euthanasia* generally means the act of taking a terminally ill person's life for merciful reasons, generally known as "mercy killing" (Porter & Warren, 2005; Marker, 2006). However, physician-assisted suicide refers to a physician providing the means (such as medication or other interventions) of suicide to a competent patient who is capable of carrying out the chosen intervention (Allen *et al.*, 2006; Gesundheit *et al.*, 2006; Marker, 2006). In considering, euthanasia as a good death, the individual needs to understand and accept the fact that physician-assisted suicide and euthanasia terminate life, but it might not be a good death (Pellegrino, 2001).

The difficulty regarding the right to die is further confused by the failure to understand the differences between active and passive, and voluntary and involuntary, euthanasia and physician-assisted suicide (Rodgers, 1996; Shapiro, 1994). First, active or positive euthanasia involves a direct action to end a person's life for merciful reasons, for example, by administering a lethal injection. Passive or negative or indirect euthanasia is the failure to provide necessary care for survival, or the process of allowing people to die when they could be kept alive by medical or other interventions (Chaloner, 2007; Ersek, 2005; Gesundheit *et al.*, 2006; Porter & Warren, 2005). Furthermore, both the active and passive forms of euthanasia can be:

- voluntary, i.e. with the consent of the person,
- involuntary, i.e. against the expressed will of the person,
- non-voluntary, i.e. when it is not possible to obtain consent because of the incapacity of the person (Chaloner, 2007; Ersek, 2005; Gesundheit *et al.*, 2006; Porter & Warren, 2005).

3. Active and Passive Euthanasia

Whereas failing to be precise in the use of terminology often causes confusion about the moral justification of the practice of active and passive euthanasia, the differences between active and passive euthanasia are not a mere matter of “semantics.” Rather, they are based on the objective reality of three factors: cause, motive, and means (Atkinson, 1983; Gesundheit *et al.*, 2006). In the case of the terminally ill person, some argue that the ultimate cause of death is the disease or illness, and active euthanasia is just hastening the death process. Whereas the ultimate cause of death in active and passive euthanasia may be the disease or illness, there are major differences between them. In active euthanasia, an individual who does something directly to cause the death, whereas in passive euthanasia the cause of death is the natural course of the disease or illness, brings about death (Atkinson, 1983; Ersek, 2005; O'Rourke, 1991). The intention of the individual who hastens death is also a significant factor in the distinction between active and passive euthanasia. In active euthanasia, the intention is to directly terminate the person's life for merciful reasons; whereas, the intention of passive euthanasia is to allow life to end naturally by natural causes (Chaloner, 2007; Marker, 2006). The practice of passive euthanasia is generally accepted among the general population and among health care professionals, because it allows patients to make choices about life support, such as choosing not

to use life support or choosing to withdraw life support interventions.

The principle of double effect is often at play in terminal sedation when one intends to relieve pain through medication while realizing that the medication may also hasten the death. In other words, there are two effects from the same act. An action intended to achieve a “good” effect (such as relieving pain and suffering) is justifiable, despite the possibility of an unwanted secondary effect (such as hastening death) if the intent of the clinicians is the “good” effect. For example, if a patient is administered morphine with the intent to relieve pain, the action is morally acceptable regardless of any secondary outcome (Marker, 2006; Porter & Warren, 2005).

4. Individual Autonomy and Rights

The predominant ethical principle in the controversy about physician-assisted suicide and euthanasia is personal autonomy or the rights of the individual. Miller (1981) describes three senses of autonomy at work in medical ethics. First, autonomy as free action implies that the action is voluntary and intentional. Second, autonomy as authenticity implies that the action is consistent with the individual’s value system, character, and life plans. Third, autonomy as effective deliberation implies the action is considered when the individual initiates the decision, has knowledge of the consequences, and reaches an informed decision.

Two concepts are important when defining autonomy: the right to life as an inalienable right, and the right to life as a predominant right. Implied in the basic inalienable rights of life, liberty, and pursuit of happiness is the idea that these rights are nontransferable and God-given. As an inalienable right, the right to life implies the right to preserve and protect life (Allen *et al.*, 2006; Callahan, 1994; Feinberg,

1977). The right to life as a predominant right is also a human right, because it is connected with human well-being and belongs equally to all humans (Callahan 1994; Feinberg, 1977). The rights of life, liberty, and the pursuit of happiness are nontransferable rights, but the right to life is a precondition to the other rights.

The value of commutative justice from the human rights perspective provides a value-oriented approach on the autonomous rights of older adults in their attitudes toward physician-assisted suicide and euthanasia. Commutative justice defines relationships among a group’s members. It respects the individual person’s dignity and worth by seeking equality based on fair standards for reciprocity in human relationships. It also rejects the encroachment on others’ rights. From a commutative value-oriented approach, the social worker in respecting the individuals’ dignity and worth not only encourages self-determination of the older adults’ choices but also empowers them to define themselves as people who have self awareness, life plans and values regarding their choices. It helps them to identify their conceptualization of death and the underlying values regarding end-of-life decisions. Utilizing a value-oriented approach in assessing the older adults’ perspectives of death encourages individuals to create a biographical summary of their life and death history regarding end-of-life decisions. It is essential for the social worker to explore the older adults’ biological and biographical context and meaning of life as well as exploring all treatment options regarding end-of-life decisions. Older adults need to know that they are not only free in making their decisions, but that they are informed and understand the consequences of all treatment options (Miller, 1998).

5. Autonomy and Culture

Commutative justice is considered to be intrinsic to social work, because social workers respect the inherent dignity and worth of all individuals and empower individuals to define themselves in the context of their cultural belief systems. Social workers treat each person in a caring, respectful manner mindful of individual differences and cultural and ethnic diversity.

Culture provides a sense of identity for individuals in their affiliation to the group. Whereas culture is usually understood as ethnic affiliation, it also includes one's religious affiliations, practices, and spirituality (Haley *et al.*, 2002). Research studies (Blackhall *et al.*, 1995; Werth *et al.*, 2002) examined the culture-concept of autonomy regarding medical decision making among four groups of elderly: Asians, Hispanics, African Americans, and European Americans. These studies indicated that although there were differences attributed to religion, gender, and age, ethnicity was the most important factor in making major decisions. Asians and the Hispanics favored a more family-centered model in making medical decisions, whereas African Americans and European Americans favored an autonomous model. Role obligation or filial responsibility was identified as the most significant factor for decision making among the four groups of older adults.

Cultural influences regarding physician-assisted suicide and euthanasia are well documented, with studies highlighting different spiritual beliefs concerning disclosure and consent, family decision-making, and treatment decisions (Enes & Vries, 2004). Religion and intergenerational family ties play a major role for African Americans in making decisions regarding physician-assisted suicide and euthanasia. The majority of African Americans adhere to a Christian spirituality, with 83% claiming Protestant affiliation. While the Baptist, 14% identify as Catholic

(Ellison & Sherkat, 1990; Enes & Vries, 2004). Documented studies also indicate that Hispanic Americans have strong family and religious ties that urge them to offer instrumental and adult daily living care-giving as well as affective support within the immediate and extended family. This care giving crossed generational and intergenerational lines. In the year 2000, there were about 31 million Hispanic Americans residing in the United States, with one million of these Hispanic Americans age 65 years of age and over. The fastest growing group of Hispanics is the "old old" elderly, people age 85 and over. This will have a great impact on Hispanic adults in the next few decades as they face aging parents, and grandparents. In terms of religious affiliation, most Hispanics identify as Roman Catholic (Bastida, 1988; Cuellar, 1990; Enes & Vries, 2004; Haley *et al.*, 2002).

Among Asians, the Chinese are the fastest growing population in the United States (Ferrans & Hsiung, 2007). A large part of this growth is attributed to a lower mortality rate and longer life expectancies for this ethnic group (Ferrans & Hsiung, 2007). Moreover, strong Confucian beliefs that emphasize filial piety and family responsibility affect their view on issues such as physician-assisted suicide and euthanasia (Gelfand & Barresi, 1987; Scharlach *et al.*, 2003; Yeo & Hikoyeda, 1992). Because the Chinese elderly are very concerned about saving face, having respect for their physicians, showing family loyalty, and a sense of duty in completing life tasks, physician-assisted suicide and euthanasia are rarely spoken about. In fact, even discussions about end-of-life treatment options can be interpreted as disrespectful of the elderly in the Chinese-American community (Haley *et al.*, 2002).

It is imperative that social workers who work with the elderly and the infirm are ethnically,

culturally, and spiritually competent. They need knowledge and awareness of ethnic beliefs and values before engaging in discussions about physician-initiated suicide, euthanasia, and/or end-of-life decisions when working with older adults. Ethnic and spiritual personal beliefs may or may not be congruent with the predominant ethnic cultural beliefs or the religious doctrines of organized religions, but knowledge of these beliefs will build awareness and sensitivity. The role of the social workers is to prevent and to eliminate domination, exploitation, and discrimination against any person or group on any basis whether cultural, ethnic, or spiritual.

6. Family Autonomy and Decision-Making

All individuals by virtue of their human nature have social needs. Human relationships enable people to meet their needs and provide an important vehicle for change. Autonomous decisions encompass the individual's values in the context of human relationships such as family and friends and involve personal responsibilities to others and to the good of society. Among the elderly population, two concerns are paramount. First, society has the burdensome responsibility of managing the quality of life of the ill and frail elderly while grappling with the escalating costs of health care. Second, many families cannot afford quality health care for their elders and provide much of the care themselves. The care-giving responsibilities for family members are stressful and costly (Haley *et al.*, 2002; Mackelprang & Mackelprang, 2005; Pifer & Bronte, 1986). A national study indicated that the burden of caring for the elderly led to depression among family caregivers, especially those caring for terminally ill patients (Emanuel, *et al.*, 2000). Many elderly rely on their families as their major source of care-giving (Circirelli, 1997; Haley *et al.*,

2002). They perceive the interests of family as part of their own interests and are concerned with the impact their decision (about euthanasia or physician-assisted suicide) has upon the family unit (Emanuel *et al.*, 2000; Hardwig, 1990). The complexity of the physician-assisted suicide and euthanasia debate has been heightened by the tension between the competing rights and autonomy of the elderly and their families. In addition, they may feel guilty for considering or promoting euthanasia or palliative care.

Contributive justice advocates for the elderly person, the family members, and the health care professionals as participants in determining the treatment options that serve all parties and promote the common good of society. Social workers recognize the value of human relationships as central to the profession (Congress, 1999). Social workers promote the general welfare and development of individuals, families, and communities. Contributive justice is utilized by promoting family autonomy, because family autonomy is based upon a common set of family values that is the common ground for family deliberation and decisions (Thomasma & Graber, 1991). Shared decision-making by the elderly and family members empowers the elderly to develop interdependence rather than dependence. Moody (1988) suggests family negotiation as the process of informed consent in shared dialogue among health care professionals, family members and the patient. Family members list the following issues as central for them when making end-of-life decisions for the elderly with chronic illness: attachment, cultural expectations, and avoiding institutional care (Haley *et al.*, 2002). Individual family members make decisions based on their family values and commitments despite differences and disagreements among family members (Roberto, 1999). Family loyalty and respect are the main values for

making end-of-life decisions, regardless of whether the decision was made by the individual for him/herself or for other family members (Leichtentritt & Rettig, 2001).

A research study by Terry *et al.* (1999) indicated that terminally ill patients preferred a proxy's choices to their own for the following reasons: Many of these patients believed that the proxy's judgment was better than their own. The relationship between the proxy and the terminally ill patients clouded the judgment of the terminally ill patients. Trying to please the proxy, the terminally ill patients valued the proxy's interests as being more important than their own. These reasons were based on emotional attachment and a long-standing history with the terminally ill patients. On the other hand, there are many reasons for decision-making by family members. Among them are one's concept of family, finances, age and health of the caregiver, geographical proximity, competing obligations, and stress of care giving (High, 2003).

Conversely, there are many barriers in making decisions about death among family members, including culture, education, knowledge of the health care system, and the delegating of all decisions entirely to the family (Haley *et al.*, 2002). Social workers seek to strengthen relationships among people at all levels in order to promote their well being. Contributive justice explores the avenues in relationships that empower older adults and their family members to become collaborative participants in making decisions about end-of-life care. Social workers understand that relationships between and among people are important vehicles for change. Therefore, social workers, in developing their expertise, are also challenged by the social work value of integrity that integrates authenticity and trustworthiness in engaging people in the

helping profession and in promoting their well being at all levels. This requires that social workers have clarity about their personal and professional value system regarding the issues of physician-assisted suicide and euthanasia.

7. Ethical Dilemmas for Health Care Professionals

The dilemma that challenges the health care professionals' ethics regarding physician-assisted suicide and euthanasia focuses on the following bioethical principles: Autonomy, Beneficence, and Non-maleficence. Arguments favoring physician-assisted suicide and euthanasia include the following:

- Autonomy: respects the individual's right to choose and to make his/her own decisions to preserve free choice and human dignity.
- Beneficence: Doing good means helping a suffering patient maintain control and end suffering in a compassionate manner.
- Non-maleficence: The inability to relieve suffering is interpretive as causing no harm, and destroying trust between the health care professional and the patient (Chaloner, 2007; Ersek, 2005; Marker, 2006; Rodgers, 1996).

Arguments against physician-assisted suicide and euthanasia include:

- Autonomy: Honoring the sanctity of life overrides the right of individuals to terminate life. Autonomy does not include the right to engage others in terminating life and unethical practices.
- Beneficence: Assisting an individual to terminate life is patient abandonment.

- Non-maleficence. To assist an individual to terminate life destroys trust and violates the ethical traditions of health care professionals (Chaloner, 2007; Ersek, 2005; Marker, 2006; Rodgers, 1996).

The two principles, beneficence, and non-maleficence, are encompassed in the Hippocratic Oath and the Code of Medical Ethics. Physicians believe it is their professional duty to save life, because human life is sacred. This “sanctity of life” view is strongly held by many opponents of physician-assisted suicide and euthanasia (Hurst & Mauron, 2006). This principle originated from Judeo-Christian world view and is based on the belief that God is creator of all life and is sovereign over life. Human life is a gift from God over which humans have stewardship but not absolute control (Callahan, 1994). At the same time, sanctity of life is not solely a religious concept. Life always has a value, despite its quality or lack thereof, because life and the dignity and respect for the individual originate from the fact of just being human (Thomasma & Graber, 1991).

Proponents of physician-assisted suicide and active euthanasia use the concepts of medical invasiveness and self-determination in their arguments favoring the quality of life and death with dignity. Quality of life, they suggest, is more significant than the quantity of life; thus, the right of self-determination allows the individual to determine what it means to die a dignified death. In the theological sense, the quality of life is based on the sanctity of life principle that God is the creator of life, but it also favors human intervention in terminating life as an act of co-creating partnership with God. The secular perspective of the sanctity of life fosters the belief that an individual creates his /her own personal dignity and destiny (Callahan, 1994). Individuals do have the right

to a dignified death. This right includes controlling the invasive and aggressive medical technology that distorts death, and the restoration of death to its natural process, thereby deinstitutionalizing death.

Research studies indicate that the elderly prefer maintaining life, regardless of its quality. The value of life is increased when it is not related to health issues alone (Lawton, *et al.*, 2001). However, the ethical dilemma for many elderly regarding decisions about end-of-life health care is the scarcity of their resources. Distributive justice commands that the goods of the society are distributed in the fairest way; therefore, the most seriously injured would have access to their basic needs. Reamer (1995) presents four main criteria for distributing scarce resources: equality, need, compensation, and contribution. These criteria challenge health care professionals and social workers to strive to ensure access to needed information, services, resources, and equality of opportunity. Reamer (1990) states that the “mission of the profession has been based on the enduring assumption that members of society assume an obligation to assist those in need, especially those who seem unable to help themselves” (p. 36). Social workers seek to promote the responsiveness of organizations, communities, and social institutions to individuals’ needs and social problems. Social workers have the ethical responsibility to promote the general welfare of people and their environments (NASW, 2003).

8. Legalization of Euthanasia: A Slippery Slope

One of the strongest arguments against legalization of physician-assisted suicide and active euthanasia contends that if these acts are legalized and initially restricted to the terminally ill, they will eventually extend to the vulnerable people in society, including the disabled, the senile, the mentally ill, and the chronically ill

elderly. The law, which now protects the lives of all people in society, will then sanction an easy and permanent solution to rid society of the burdensome and vulnerable people. Physician-assisted suicide and active euthanasia, rather than non-palliative care for the terminally ill, will become the preferred treatment and the expected duty of the physician to perform (Ersek, 2005, *Gesundheit et al.*, 2006; Werth, 2002). The President's Commission Report (1982), *Deciding To Forego Life-Sustaining Treatment*, insists that the "slippery slope arguments must be carefully employed lest they serve merely as an unthinking defense of the status quo. Where human life is at issue, valid concerns warrant being especially cautious before adopting any policy that weakens the protections against taking human life" (p. 29). John Rawls makes the moral distinction between individual acts and social practices in that "certain acts may be deemed morally right in and of themselves, but such isolated cases do not provide sufficient warrant for the establishment of sound social policies" (Arras, 1982, p. 287).

In July 1981, the President's commission defined the concept of death, which led to the Uniform Determination of Death Act (UDDA). The UDDA states: "An individual who has sustained either 1. irreversible cessation of circulatory and respiratory functions, or 2. irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards" (G.P.O. *Deciding to Forego Life Situation Treatment*, 1982, p. 9). The commission concluded that in defining death, we also make a public statement on the treatment of all patients.

Two major landmarks in public policy regarding end-of-life decisions are the Patient Self-Determination Act of 1991 (PSDA) and the

Diversity Committee for Last Acts 2001. The Patient Self-Determination Act requires that all hospitals, skilled nursing facilities, home health care agencies, hospice organizations, and health maintenance organizations serving Medicare and Medicaid patients must obtain information regarding the living will and power of attorney for health care. "Individuals have the right to make their own medical decisions and to formulate advance directives to effect those decisions when the individual is incapacitated" (G.P.O. *Living Wills*, 1990, p. 186). The Diversity Committee for Last Acts 2001 states "providers are well advised not to presuppose patients' views, beliefs, or motives based on any superficial knowledge or stereotyped beliefs" (Schmidt, 2001, p. 1). Social workers who are well informed about life and death issues in the light of cultural and religious beliefs and practices, advanced directives, and the legislation related to them, will be more competent in assisting clients to express their desires and to make choices that include their cultural and spiritual beliefs. Such knowledge enhances social work intervention by empowering the elderly to use their autonomous rights related to advanced directives while helping family members, through counseling, to negotiate difficult end-of-life procedures.

The moral problem of the slippery slope, which also contributes to the social climate perspective, is clearly an important issue. Justice includes both equality and equity and has two dimensions: individual rights and the common good of society. Thus, the potential of the slippery slope must be considered not only from the perspective of the individual, but from its effects on the society. The primary goals of social work services are to help people in need and to address social problems (Congress, 1999, p. 19). The social work value of service requires responsibility on the part of the individual and society as well upon society to look at underlying attitudes

regarding the basis of help. These two attitudes are “cause and effect” and “condition.” The rationale for “cause and effect” service is based on analyzing the cause of the need. The question for service is, “What caused this to happen?” The rationale for “condition” is based on the fact that one is in need of service regardless of the cause of need. It is interested in providing a solution to existing conditions and alleviating the situations creating the conditions. The question for service is, “What can we do to help?” (Tropman, 1995).

Restorative justice seeks to reconcile conflicting parties to find common ground (Shiman, 2004). It considers the basic moral test of any community or society to be in the way in which the most vulnerable members are faring. The concept of restorative justice is further developed by John Rawls’ conception of justice. In the Original Position, “the people in a society choose the principle that minimizes the worst possibilities for any group so that the greatest benefit of the least advantaged is provided and protected” (Rawls, 1971, p. 12). The ideal of social justice challenges social workers to advocate against injustices in society. Social workers advocate for living conditions conducive to the fulfillment of basic human needs and to promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice. Social workers pursue change with and on behalf of vulnerable and oppressed individuals and groups to address poverty, unemployment, discrimination, and other forms of social injustice. They also expand choice and opportunity, such as in end-of-life decisions, and they promote justice (NASW, 2003). Restorative justice seeks the common ground for all voices to be heard, in particular the “cry of the poor.” Whereas physician-assisted suicide and euthanasia are actions

taken by individuals for their own good and they may be justified in particular circumstances, these actions may not be something that benefit the society as a whole.

9. Conclusion

In facing any ethical dilemma, social workers are obligated by the NASW *Code of Ethics* to incorporate the six core values of their profession--service, social justice, dignity and self-worth, importance of human relationships, integrity, and competence--in assessing the situation. The priority of social workers must be to enhance the client’s quality of life and to encourage the exploration of end-of-life decisions within the cultural and spiritual context of the lives of the elderly. However, “social workers may not personally participate in an act of suicide when acting in their professional role” (NASW, 2003, p. 9). Furthermore, it is inappropriate for social workers in their professional role, to deliver, supply, or personally participate in the commission of an act of assisted suicide.

Integrating the core values of the social work profession with the various forms of social justice clarifies the issues surrounding the ethical dilemma of physician-assisted suicide and euthanasia. Commutative justice defines the individual autonomy of older adults’ relationships as members within the group culture and fosters equality. Contributive justice advocates for the elderly, family members, and health care professionals in becoming participants in decision making. Distributive justice requires the fair allocation of resources; restorative justice seeks to reconcile conflicting parties to find common ground (Shiman, 2004). The social justice and human rights approach empowers social workers to protect the rights of the marginalized and people at risk, providing services without judging their worthiness. The social justice and human rights approach

challenges social workers to bring the concerns of the poor and the vulnerable, in this case older adults, to all levels, national and international, into concrete actions. Every program needs to have in its last analysis and main purpose to service the human person. Such programs should reduce inequalities, eliminate discrimination, and empower the individual to progress in human and spiritual development. Promoting the true development of people requires the desire, the right, and the responsibility to ensure justice for all people. Securing justice requires the desire, the right, and the responsibility to promote equality for every human person and to foster solidarity with all people in society.

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