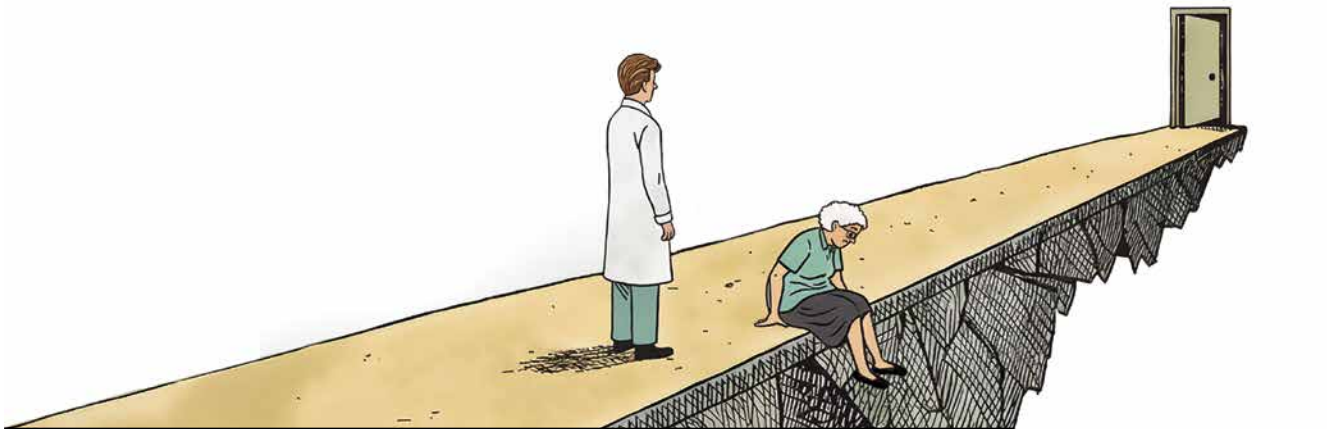
The question concerning Medical Aid in Dying



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On February 6, 2026, New York State joined 12 other states and the District of Columbia in legalizing medical aid in dying (MAID), adding to the growing landscape of legally sanctioned assisted suicide for terminally ill patients in the United States.[1] As a physician in palliative care who encounters immense existential suffering in my patients, but who has never practiced in a state where MAID was a legal reality, I feel compelled to make sense of the increasing public discourse and expanded legal access to this practice. This is not intended to be an argument for or against MAID, nor a proposal for or against its broader legal or clinical adoption. Rather, my aim is more phenomenological, to examine what is disclosed about suffering, medicine, and moral responsibility when medical aid in dying is experienced as an option by patients and clinicians. In this sense, MAID functions here less as a considered policy than as a lens through which deeper questions about the limits of medicine, the nature of existential suffering, and the physician's moral role come into view.

In *The Myth of Sisyphus,* Albert Camus begins by asking what he believes is the only truly serious question of philosophy, judging whether life is or is not worth living.[2] Camus ultimately reaches an answer to his own question by concluding that even in the face of the absurdity of our human condition—where man's desire for unity encounters the silence of the universe and no objective justification can be discerned for the meaning of our existence—we nonetheless have the freedom to be consciously present to our condition. In retelling the story of Sisyphus, Camus describes this act of conscious awareness, this rebellion to the absurdity of his fate, as providing sufficient justification for continued existence. Inspired by Martin Heidegger's methodology of inquiry, I will explore several concepts and questions that converge around MAID, to encounter what the ancient Greeks called *alethia,* literally, "the state of not being hidden," or for Heidegger, the knowledge that is revealed through the questioning, the disclosure, or truth of philosophy.[3]

Patient suffering

Eric Cassell, in his much-cited article, "The nature of suffering and the goals of medicine," defines human

suffering as having "its source in challenges that threaten the intactness of the person as a complex social and psychological entity."[4] It is not merely physical or bodily pain, but any insult to the integrity of personhood which can result in suffering. Dame Cicely Saunders, founder of the modern hospice movement, offers another framing of suffering in her concept of *Total Pain,* "as the suffering that encompasses all of a person's physical, psychological, social, spiritual, and practical struggles."[5] These definitions are useful for palliative care clinicians and others caring for patients with serious illness, in that they provide a multidisciplinary approach in our assessment of the patient in order to understand the various domains of suffering: physical, psychological, social, spiritual, and existential. Using this approach, we assess patients' physical pain, bodily symptoms, anxiety, coping, functioning, fatigue, spiritual distress, demoralization, social abandonment, and other insults to personhood. Cassell further points out that medicine has a moral obligation to alleviate suffering, which is the central tenet of palliative medicine.

The essence of MAID is concerned with our relationship to patient suffering, or more specifically with how we consider future suffering in a patient with a terminal illness. For advocates, it is an act of mercy to alleviate terminally ill patients' suffering and prevent the loss of dignity at the end of life. This suggests an orientation towards continued existence as being worse than death. Interestingly, the most common reasons for patients who have requested MAID are not related to physical suffering but are existential in nature: wanting to control the circumstances of death; fear of losing independence; and concerns about future pain or quality of life.[6]

For those of us who came of age prior to MAID being a legal option, the thought of hastening death through a lethal overdose was generally considered "an option of last resort." This framework suggests that other more conventional or less ethically fraught approaches have not been successful, or desired, and that the patient and physician consider this as the best option to address the problem of refractory suffering at the end of life.

What does this *unconceal,* or reveal? What truth is disclosed about the question concerning MAID when the suffering that is being addressed is refractory? We might compare MAID with another option of last resort, palliative sedation, which uses sedatives to induce unconsciousness in response to refractory suffering in terminally ill patients. Interestingly, the use of palliative sedation is most controversial in the context of treating existential distress. In a position statement by the American Academy for Hospice and Palliative Medicine (AAHPM), the authors write:

> [While] existential distress may cause patients to experience suffering of significant magnitude, there is no consensus around the ability to define, assess, and gauge existential suffering, to measure the efficacy of treatments for existential distress, and whether it is in the realm of medicine to palliate such suffering when it occurs absent of physical symptoms. Patients with existential suffering should be thoroughly assessed and treated through vigorous multidisciplinary efforts which may include involving professionals who are not usual members of the palliative care team (e.g., experts in psychological, family therapy, or specific spiritual services).[7]

In clinical practice, decisions regarding palliative sedation typically follow careful interdisciplinary deliberation. This includes confirming decisional capacity; excluding potentially reversible contributors, such as delirium, depression, or uncontrolled physical symptoms; and engaging psychiatry, spiritual care, ethics consultation, and family members, when appropriate. Even with these interventions, its use for existential distress alone remains morally fraught. Further, in circumstances where one cannot discern the existential or psychological experience of the patient—either due to a neurological "locked in state" or in disorders of consciousness—palliative sedation for "refractory distress" may be seen as more challenging to initiate, even with the appropriate disciplines involved.

This leaves us with several clinical and ethical questions relevant to MAID. When do we consider existential suffering to be refractory? What is our obligation to the patient when we cannot relieve their existential suffering? Should hastening the patient's death be considered the appropriate response to such suffering?

Physician responsibility

For most of medicine's history, medical ethics was largely concerned with the moral obligations of the physician. In the fifth century BCE, Hippocrates first described the duties of physicians in *Epidemics.* In short, physicians are required to help their patients, which includes the removal of harm. This gave rise to the dictum of physicians, *primum non nocere,* ("first, do no

harm"). In the fifth century CE, the *Formula Comitis Archiatrorum* discussed physicians' obligations to widen and deepen their knowledge. In the medieval period, there was Jewish, Christian, and Islamic scholarship on physician duty. Maimonides, Thomas Aquinas, and Avicenna all wrote about the physician's obligations to the patient and at least in Jewish scholarship, the obligations of the patient as well. In 1803, Thomas Percival's *Medical Ethics* discussed the professional responsibility of the physician and the broader social ethic of medicine. Arguably, the first code of modern professional medical ethics, proposed by the Manchester Medico-Ethical Association in the 1830s, described professional standards of behavior for physicians. And in 1847, the AMA published its *Code of Ethics,* highlighting non-maleficence and beneficence as cardinal duties of the physician. The twentieth century saw the rise of patient autonomy, a concept rooted in Enlightenment philosophy, particularly in Immanuel Kant's view of persons as autonomous ends in themselves and John Stuart Mill's emphasis on individual sovereignty over one's body and mind, limited only by harm to others. The conflict between patient autonomy and physician duties or obligations remains at the center of many ethical debates in clinical medicine.

According to proponents of physician-assisted suicide, the moral justifications for medical aid in dying include respect for patient autonomy, the physician's responsibility to relieve suffering, and the duty of non-abandonment. Opponents of MAID are concerned that the practice undermines an important moral code that dates back to Hippocrates: the prohibition to intentionally end a patient's life. In a recent American College of Physicians position paper on physician-assisted suicide, the authors write:

> The profession's most consistent ethical traditions emphasize care and comfort and that physicians should not participate in intentionally ending a person's life. MAID requires physicians to breach this specific prohibition as well as the general duties of beneficence and non-maleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter.[8]

Thus, we should consider whether MAID as a means to alleviate existential suffering or prevent the loss of dignity at the end of life is within the goals and scope of medicine. Perhaps there are some human problems that exist as we face the end of our lives that are beyond medicine, beyond the responsibility of the physician. Or should we include in the modern physician's duties the responsibility to control when a patient dies?

Existential distress

Human existence, according to Heidegger, or *Dasein* (literally, "being there," *da* – there, *sein* – being), is unique in that human beings are concerned about their own existence or their own being. "*Dasein* is ontically distinguished by the fact that, in its very Being, that Being is an issue for it."[3] In his explication of *Dasein,* Heidegger highlights three important elements. Human beings have "facticity" or "thrownness" *(Geworfenheit).* This concept encompasses the conditions of our existence that we do not choose but are unique to our existence, how we are *thrown into the world.* For example, we are born in a particular time and place, to a particular family, with a particular language, culture, etc. These are the unique elements that affect our "being-in-the-world." Another element is what Heidegger calls our "fallenness," or how we fall into doing and caring about things that others do and care about, which moves us away from our authenticity. We behave and conduct ourselves in certain ways that others around us also do, and fall into ways of being that are inauthentic. Lastly, we have our future existence. We are not static but incomplete beings constantly becoming ourselves, orienting ourselves in a future that is oriented towards our death. We have the freedom to radically redefine each moment and orient ourselves to our own becoming. If we are static, contingent only on our facticity and fallenness, then we remain inauthentic and limited in our existence. Our authenticity lies with our potential for becoming in each moment—recognizing that we are not merely the products of our "thrownness" or "fallenness." If, as Heidegger postulates, our most important task is to strive for authenticity, to orient ourselves to who we truly are and to our becoming, then death becomes the ultimate horizon that we are oriented to in our existence. For human beings, time comes to an end with our death and "if we want to understand what it means to be an authentic human being, then it is essential that we constantly project our lives onto the horizon of our death."[9] This is what Heidegger means by "being-towards-death." Heidegger famously responded at the end of one of his lectures in 1961 to a student who asked him how to live an authentic life: "spend more time in graveyards."[10]

When we project our lives onto the horizon of our

future death, we face "the possibility of no-longer-being-able-to-be-there," or "the possibility of the utter impossibility of being-there," or "the possibility of the impossibility of any existence *(Existez)* at all."[11] Whichever phrase best captures our subjective awareness of our death, Heidegger claims that anxiety is the proper mood associated with it. In other words, being-towards-death is essentially a state of anxiety. The American philosopher and Heidegger scholar Taylor Carman writes:

> [M]ortality has defined or at least characterized human existence for as long as recorded history testifies [Recall Gilgamesh crying: "Must I die?"]; moreover, mortality is salient for us precisely because it is the cause and occasion—perhaps the cause and occasion par excellence—of anxiety.[12]

Palliative care clinicians often describe this anxiety as one approaches the horizon of their death as existential distress. Since we do not have a consensus on its definition, it is impossible to determine the prevalence among individuals at the end of their lives. Anecdotally, and based on some qualitative research with cancer patients, it is relatively rare that such existential anxiety rises to the threshold of significant clinical distress.[13] Regardless, for Heidegger, this anxiety inherent in being-towards-death is part of our human condition; it is not a pathological state. When our patients' anxiety associated with being-towards-death leads to clinical distress and a request for MAID, how should we proceed? Certainly, before proceeding to alleviating this distress with a lethal overdose, other modalities and interventions should be considered. Clinical research in psilocybin-assisted therapy over the past few years suggests that it may be a promising approach to relieve existential distress or death anxiety,[14] in addition to well-established modalities, such as meaning-centered psychotherapy,[15] and dignity therapy.[16]

It should be noted that existential distress near the end of life may be entwined with religious and spiritual suffering. Patients may experience feelings of abandonment by God, unresolved guilt, fear of judgment, or conflict between faith-based hopes for divine intervention and the medical reality of no further treatments being of benefit. Such suffering often falls outside the physician's direct expertise and underscores the essential role of chaplains, clergy, and spiritually informed interdisciplinary care, reminding us that existential suffering often emerges within a moral and spiritual horizon that medicine must approach with humility.

Being summoned

The French existential philosopher Emmanuel Levinas invites us to consider the primacy of moral obligation in our relationship to others. For Levinas, this is our ontological starting point—that above all, we exist in ethical relationships. This is his idea of what he comes to later describe as "ethics as first philosophy."[17] In *Totality and Infinity,* Levinas describes our ethical relationship emerging out of our "metaphysical desire" for the Other, for that which is not me. For Levinas, this metaphysical desire is a desire for that which can never be known, "God," "infinity," all that is beyond our unique subjectivity and which humanizes our lives. Levinas describes this experience, metaphorically, as an encounter with the Other's "face." Levinas tries to describe this as: "the way in which the other presents himself, exceeding the idea of the other in me..."[18] In this form of encounter, one becomes overwhelmed with "infinity overflowing." The Other both commands and judges us. Levinas describes this experience of the face of the Other as an ethical relationship, and more like a conversation, or student receiving a teaching. In another work, Levinas goes further in describing this experience as a "summoning:"

> The face signifies in the fact of summoning, of summoning me—in its nudity or its destitution, in everything that is precarious in questioning, in all the hazards of mortality—to the unresolved alternative between Being and Nothingness, a questioning which, *ipso facto,* summons me.[19]

For Levinas, our ontological condition is born out of this phenomenological nature of the face as summoning. With this comes an asymmetric relationship, where we recognize a moral obligation, a responsibility to the Other, out of what we might call gratuitous love. For Levinas, the primary orientation to our being-in-the-world, in contrast to Heidegger, is an ethical one. If we were to transpose this into a clinical setting, when we experience the face of the patient as summoning us, this disrupts the traditional orientation of the physician standing above the patient with judgment and discernment, attempting to solve a problem, and instead places the physician below the patient, in moral servitude. How are we commanded or summoned by the face of our patient who is near the end of his life? How do we

respond when our patient cries out like Gilgamesh, "must I die?" Or, instead, when he asks, "can you help me die?"

In practice, responding to this summoning often begins not with answers but with more questions and deep presence. It may involve naming the suffering without attempting to resolve it, affirming the patient's continued worth, or explicitly committing to non-abandonment: I cannot take this suffering away, but I will stay with you. Such moments, often quiet, unstructured, and resistant to protocol, may represent one of the physician's most ethically significant acts; even when no further remedy is possible, we are summoned to bear witness and be in solidarity.

Final thoughts

The question concerning medical aid in dying brings forth a challenge—how to respond to a patient's existential suffering at the end of life while at the same time acknowledging the physician's moral duty to alleviate suffering, coupled with the historical and professional prohibition to hasten death. As physicians, we are summoned by the face of our patients at the same time we are confronted with our own mortality, a vicarious being-towards-death in the moment when a hastened death itself is being requested. The *alethia,* or knowledge revealed, is that there is a horizon which we can never reach, where our existential becoming, brought forth by our patient's request for a hastened death, encounters our moral obligation to alleviate their suffering. The questioning leads to further questions as we brush up against the subtle and mysterious nature of life. Whose life is this anyway? In the end, we (be)hold the moral weight of the relationship, grateful for the very ground upon which we stand and are summoned to respond. Our patient's subjectivity is beyond reach and irreducible to a single act of mercy. I tremble and ask for forgiveness.

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