Physician assisted suicide (PAS) and euthanasia are practices that cause death through medical means. In physician assisted suicide, a doctor prescribes a lethal medication, which the patient self-administers. In euthanasia, a medical provider directly administers a life-ending medication. Both practices are carried out with the intention of causing death, unlike medical interventions intended to heal or relieve pain which may hasten death as a secondary, unintended effect.

There is no "right to die" in international law.

Such a right is not mentioned in any treaty. Some have argued that the well-established right to life includes a right to choose the manner of one's death, but most courts have rejected this argument, finding that state interests in the protection of life are valid. The Human Rights Council has published one, non-binding comment on the right to life suggesting that where the practices are legal they should have safeguards.

Only Switzerland, the Netherlands, Colombia, Belgium, Luxembourg, Canada, eight states in the United States, and one Australian state allow either or both practices. This is far short of level of practice needed to establish a customary right to to die or assistance in dying.

"Death with dignity" undermines human dignity.

Proponents of PAS and euthanasia often claim they promote "death with dignity" by giving a person the choice about their manner of death (autonomy) to avoid suffering. But this suggests that there can be death without dignity. This is not true; no one loses his or her dignity due to suffering or reliance on others.

Common arguments for PAS and euthanasia do not withstand scrutiny.

1. **Autonomy:** PAS and euthanasia are not solitary acts. Doctors have to act to provide or administer the lethal substance, and society has to accept these actions. Individual autonomy is always subject to limitations to protect the fundamental goods of society, including human life.
2. **Pain and suffering:** PAS and euthanasia are portrayed as compassionate actions, but in fact abandon the vulnerable to their suffering, rather than accompany them in it. Desire for hastened death is associated with pain, depression, and fatigue, all of which can be treated. Wanting to end suffering does not make any action ethical; intentionally ending human life, even for compassionate reasons, is wrong.

Physician assisted suicide and euthanasia pose serious risks to the vulnerable and society.

1. **Risks to persons with disabilities:** People with disabilities already experience difficulty receiving good medical and preventative care, including due to financial barriers, and discriminatory attitudes from healthcare providers. PAS and euthanasia promote the idea that it is better to die than to live with a disability. Many disability rights groups oppose PAS and euthanasia as a threat to their lives.
2. **Risk of coercion:** Assisted suicide may create a duty to die upon vulnerable persons. Accessibility, assistive devices, medical care, may be exorbitant and make people feel like a burden.
3. **Distortion of the doctor-patient relationship:** Assisted suicide and euthanasia violate the basic medical principle that life should be preserved, and undermine the security of a patient that his wellbeing is always sought. These practices may violate doctors' right of conscience as they may be required to perform these acts against their will. The World Medical Association's Declaration on Euthanasia states: **"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical."**
4. **Illusory limitations:** Jurisdictions that originally permitted assisted suicide for mentally competent, terminally ill adults have often interpreted those terms loosely, and several have amended the law to permit assisted suicide and euthanasia for non-terminal or treatable conditions, including mental illness, and even for children.

End-of-life care should ensure respect for human dignity.

1. **Doctor-Patient Relationships:** Patients who consider end-of-life care with their doctors are more likely to receive care in line with their wishes. Training doctors in handling discussion on end-of-life care can strengthen the doctor-patient relationship and imrpove end-of-life care.
2. **Palliative Care:** Palliative care is critical in end-of-life care as it seeks to alleviate pain and suffering while providing holistic treatment without hastening or postponing death. Ensuring this for every patient is in accordance with human dignity and can lessen likelihood of a desire for PAS or euthanasia.
3. **Psychosocial Care:** Terminally ill patients with depression experience psychological distress reinforced by physical pain and are thus likely to consider hastening death. Therefore, treatment plans must likewise address psychosocial wellbeing. Mental health treatment and interventions to restore a sense of meaning and purpose have had promising results.