The Right to Die

By

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Thesis: Physician-Assisted Death and Euthanasia should be permissible as long as procedural safeguards are in place.

iii. Abstract

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In this thesis, I argue that, with certain procedural safeguards in place, physician-assisted death (PAD) and euthanasia are morally permissible and should be an option for terminally ill patients. The first chapter introduces the history of PAD and euthanasia in the United States focusing on Oregon and Washington. Chapter two focuses on PAD in The Netherlands. Chapter three reviews philosophical arguments regarding PAD and details certain procedural safeguards such as medical friendships, consultations, and multiple opinions, which help to guarantee the moral acceptability of PAD and euthanasia. These safeguards also contribute to a relationship of beneficence from the physician to her patient. In addition, I will analyze ways in which PAD and euthanasia can be carried out without traveling down the slippery slope toward killing another human beings against their wishes. I also respond to criticisms of the Oregon Law set forth by Kathleen Foley, M.D. and Herbert Hendin, M.D.. In the conclusion, I take stock and I will summarize the ways in which my thesis addresses the most common arguments against PAD and euthanasia.

Introduction

The debate regarding whether or not doctors have the right to help others die has been around since the fourth century B.C.E. The idea that it should be illegal to help someone commit suicide derives from one of the Biblical Ten Commandments: Thou Shalt Not Kill. In the medical community this idea is reinforced by the Hippocratic Oath, which states that: *I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan*. [1]

Doctor Jack Kevorkian was one of the first physicians to challenge the traditional constraints, bringing the debate regarding PAD and euthanasia into the public eye. During the 1990s, he assisted many patients suffering from debilitating, life-altering, and terminal, diseases to suicide. Mr. Thomas Hyde was a thirty-year old construction worker with a wife and a two-year old daughter, suffering from Lou Gehrig's disease. He was paralyzed, unable to swallow, and would choke on his own saliva if he did not have an artificial suctioning device. Dr. Kevorkian videotaped Mr. Hyde attesting to his experiences of unbearable suffering and to his desire to die in order to end that suffering. To enable Mr. Hyde to fulfill his wish, Dr. Kevorkian fitted a respiratory mask over Mr. Hyde's face. The mask was connected to plastic tubing, which led to a small cylinder of carbon monoxide gas. Mr. Hyde grabbed onto a string that pulled loose a paper clip, releasing the carbon monoxide. Approximately twenty minutes later he was pronounced dead. This case is only one of the 120 cases in which Dr. Kevorkian helped terminally ill people end their suffering. In another case, Dr. Kevorkian was convicted of 2nd degree murder and ended up spending seven years in prison because he aided a 52- year-old man who had Lou Gehrig's disease, to die. The case was videotaped and televised on the program 60 Minutes. The distinction

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[1] "Greek Medicine - The Hippocratic Oath." *U.S National Library of Medicine*. U.S. National Library of Medicine, 02 July 2012. Web. 21 Jan. 2013.

between the Hyde case and the other 119 cases in which Dr. Kevorkian helped others end their life was that, in the Hyde case Dr. Kevorkian he administered the drug directly to his patient. In the other 199 cases the patients administered lethal drugs or other life-ending mechanisms themselves. Dr. Kevorkian paid for this difference because he was convicted of mercy killing i.e. euthanasia. [2]

On Euthanasia

It is important to clarify that euthanasia is not suicide but is instead a term used for mercy killing. Mercy killing is an act of homicide that is usually carried out to end the life of a person who is experiencing unbearable suffering from extreme, incurable pain or illness, whereas suicide is the action of killing oneself intentionally. Suffering is defined as enduring of hardship, often accompanied by pain. Pain is not a necessary requirement for suffering, for some, suffering can be defined as “having an itch you cannot scratch.” There are different types of euthanasia: voluntary, involuntary and non-voluntary. Patients who express their desire to be euthanized are said to participate in “voluntary” euthanasia. Euthanasia is involuntary if patients refuse permission to perform it. It is non-voluntary if performed on patients whose permission cannot be secured because they not in a conscious state. An example of a non-voluntary euthanasia patient would be someone who is unconscious and in a persistent vegetative state. The person’s parents or significant other, also known as a surrogate, might theoretically make the decision based upon what the incapacitated individual would have wanted, it could be a substituted judgment of what the decision maker would want in the same circumstance, or a physician can make the

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[2] Munson, Ronald. "Chapter 7: Euthanasia and Assisted Suicide." *Intervention and Reflection: Basic Issues in Bioethics*. Belmont, CA: Wadsworth, 2013. N. pag. Print.

decision. There is no consent or legal will given by the patient in this case, thus making it non-voluntary euthanasia. A case of voluntary euthanasia would have a person explicitly state their wish to consent to euthanasia. In his book *Practical Ethics,* Peter Singer defines involuntary euthanasia as involuntary when the person killed is capable of consenting to their own death but does not do so, either because she is not asked or because she is asked and chooses to go on living. Singer acknowledges that there is no difference between killing someone who chooses to go one living and killing someone who has not consented to being killed. To kill someone who has not properly consented can only be regarded as euthanasia when the motive for killing is the desire to prevent unbearable suffering on the part of the person who is being killed. While his analysis of involuntary euthanasia is appropriate for cases where there is a terminally ill patient, I do not believe that it satisfies the broad range of potential unwanted killings, such as shooting.

There is also another category of euthanasia, passive or active. While I acknowledge this category, it is important to note that in the current field of bioethics it is no longer used. This subcategory allows for six different types of euthanasia: voluntary passive, voluntary active, involuntary passive, involuntary active, non-voluntary passive and non-voluntary active. The difference between active and passive euthanasia is based upon *how* the patient dies. Active euthanasia is the term used to describe a patient's death resulting from a lethal medication or some other "unnatural" cause. Passive euthanasia can also be considered withholding treatment or allowing the patient to die. There could be medical treatment available to keep the patient alive, but the patient has refused treatment from a machine or has died from a natural cause. Passive euthanasia is often seen as more morally permissible than active euthanasia because no person is accountable for the death since the patient died from natural causes. [3]

PAD can be viewed as a form of voluntary-active or voluntary-passive euthanasia. In order for physician-assisted death to occur, the patient must give consent to perform the acts themselves. This is viewed as active euthanasia because the patient is prescribed a lethal dose of a medication, which is not considered a natural cause of death. [4] When a patient asks a doctor to withhold all treatment and let their body die, this can be viewed as voluntary-passive euthanasia since it is by the consent of the patient to withhold all treatment and die a natural death.

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[3] Ronald Munson, Euthanasia and Assisted Suicide, Intervention and Reflection: Basic Issues in Bioethics pp. 555
[4] Ronald Munson, Euthanasia and Assisted Suicide, Intervention and Reflection: Basic Issues in Bioethics pp. 555

Chapter II: Milestones in Physician-Assisted Death in The United States

Karen Quinlan 1976

The issue of the right to die made head way in the United States in 1976, when the New Jersey Supreme Court sided with Karen Ann Quinlan's parents, who wanted their comatose daughter to be disconnected from life-supporting devices. Karen Quinlan was a twenty-one-year old when she slipped into a critical comatose state after it is believed she had taken Darvon and Valium and an excessive amount of alcohol while out celebrating a friend's birthday. She was placed on a respirator to assist with her breathing and was also in a coma where her condition was not improving and was considered to be irreversible. Karen was in a persistent vegetative state and eventually needed a nasogastric tube to be inserted to provide her nutrition. She was not pronounced brain-dead as her brainstem was still functioning. Karen's family struggled with the idea that their daughter would never regain consciousness and agreed that Karen would not want to live a life where she was kept alive through the aid of machines. The family wanted to remove the respirator, but physicians refused since Karen's wishes were not explicitly stated. This case was brought to court, where it was ruled that the respirator should not be removed since Karen's wishes were unknown. The Quinlan case was then appealed to the New Jersey Supreme Court who ruled in favor of the Quinlans, citing that the constitution's implied right to privacy allowed the family of a dying patient to decide to whether or not to let the patient die by disconnecting life support. The Court ruled that the father was Karen's guardian and the physicians who would disconnect the life support were given legal immunity. Physicians decided that it would be best to wean Karen from life support instead of discontinuing it, resulting in Karen living for another 10 years. This case raised questions about the moral significance of end of life care, as well as the necessity for patients to ensure that their end of life decisions are known either through a living will or health care proxy. The Quinlan case took the life support debate and surrogate decision making to the public eye and came to symbolize mercy as an issue for both patients and families. Instead of Karen dying a quick, dignified death, she died a slow withering death that lasted over a decade. [5]

Hemlock Society 1980

The Hemlock Society, formed in 1980 by Derek Humphrey, was created to help people with terminal illness die painlessly and with dignity. There are limits on what the society advocated for, such as, the law should only be pertinent to people who are both competent and terminally ill- not for invalids, mental patients, or comatose patients. [6] The society produced books, usually written by Derek Humphrey, which gave detailed instructions on how to kill oneself quick and painlessly. The First Amendment protects these books from being banned, and allows some of Humphrey's books to be best sellers. Many people have resorted to these books because they were afraid that their physician would not offer them the type of care they are looking for. [7]

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[5] Munson, Ronald. "Chapter 7: Euthanasia and Assisted Suicide." *Intervention and Reflection: Basic Issues in Bioethics*. Belmont, CA: Wadsworth, 2013.

[6] Pence, Gregory E. "Chapter 3: Physician-Assisted Dying." *Classic Cases in Medical Ethics: Accounts of Cases That Have Shaped Medical Ethics, with Philosophical, Legal, and Historical Backgrounds*. New York: McGraw-Hill, 1995.

[7] Pence, Gregory E. "Chapter 3: Physician-Assisted Dying." *Classic Cases in Medical Ethics: Accounts of Cases That Have Shaped Medical Ethics, with Philosophical, Legal, and Historical Backgrounds*. New York: McGraw-Hill, 1995. pg. 67

Nancy Cruzan 1990

In 1983 Nancy Cruzan swerved off the road, resulting in her car flipping. Nancy was thrown from her car into a ditch. When paramedics found her, she had not taken a breath for 15 minutes. The paramedic team tried to bring Nancy back to consciousness, but could not succeed. Five years later, the Cruzan family finally accepted that their daughter would never regain consciousness and her condition would not improve. They then embarked on a long and painful legal battle to remove Nancy's feeding tube and to allow her to die. [8]

After several lawsuits between the Cruzan family and the state's attorney general in the Missouri court system, the U.S. Supreme Court took on this case and it was first ever right to remove artificial nutrition/hydration case. The Cruzans lost the case in a 5-4 decision, which stated that the family had not provided clear and convincing evidence that Nancy Cruzan would not want to have her life artificially preserved. However, it can be argued that they won in principle because the court stated that it was permissible to disconnect a feeding tube although the state could safeguard this by requiring clear and convincing evidence that it is what the patient would have wanted. In 1990, the Cruzans presented the case to Missouri Courts with clear and convincing evidence that Nancy would not want to live with her life artificially preserved. This time around, the court system ruled in their favor and in December of 1990, the Cruzans stopped feeding her; later that month Nancy died. After the Cruzan case, federal government passed a law requiring all persons entering a hospital in the United States to be told about advanced directives. Advanced directive, is a written document that allows a patient to give explicit instructions regarding

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[8] Munson, Ronald. "Chapter 7: Euthanasia and Assisted Suicide." *Intervention and Reflection: Basic Issues in Bioethics*. Belmont, CA: Wadsworth, 2013.

medical treatment to be administered if the patient is terminally ill or permanently unconscious. [9]

The Oregon Death With Dignity Act 1994

In 1994, Oregon voters to legalize physician-assisted suicide within the state of Oregon passed a referendum. The law was enacted in 1997 and became known as the Death with Dignity Law. During this year there was also a ballot measure to repeal this Act, but it lost 60% to 40%. This Death with Dignity Law allows physicians to prescribe lethal medications to terminally ill patients. By terminal illness I mean a disease that cannot be cured or treated and that is expected to result in death of the patient within a short period of time, typically six months. In order for a patient to receive they must be an Oregon resident, 18 years of age or older, be capable of making decisions, and must be suffering from a terminal disease. The patient must make an informed decision when choosing physician assisted death, meaning they have explored all other options and provided all available information, and that PAD is still the option they wish to choose. After the patient is sure that PAD is the course that they want to take, the patient must make one written request and two oral requests. The written request "substantially in the form" provided in the Act must be signed, dated, and witnessed by two persons in the presence of the patient who can attest that the patient is capable of making a decision voluntarily and is not being coerced to sign the request. Within the written request the patient is asked to specify

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[9] Munson, Ronald. "Chapter 7: Euthanasia and Assisted Suicide." *Intervention and Reflection: Basic Issues in Bioethics*. Belmont, CA: Wadsworth, 2013.

whether or not they have family to inform, and if they do whether, or not they have informed their family of the decision that they are making.

Once a patient receives a prescription, within seven days of writing the prescription, the patient must submit to their doctor another written request for PAD and their consent to proceed with PAD. The attending physician and the consulting physician must express their compliance with the patient. If the patient was requested to obtain a psychiatric consultation, the psychiatrist/psychologist must also express compliance. Fifteen days must pass between the first oral request and the second request as well as fifteen days between the first request and when the physician writes the prescription. Ten days after the medication is dispensed, the pharmacy dispensing records must be submitted to the physician. The attending physician must submit a physician follow-up ten days after the patient's death. [10]

The Death with Dignity act has allowed many Oregonians the ability to end their suffering from life threatening conditions. Since 1997, a total of 1,050 people have had a Death with Dignity Act prescription written and 673 patients have died from ingesting medications prescribed under the act. In 2012, 115 prescriptions were written under the provisions of the Death with Dignity Act, compared to 95 in 2009. There were 67 (58.3%) patients actually died from ingesting the medicine. Eleven patients with prescriptions written in 2011 died after ingesting the medicine in 2012. Of the 65 patients who died from taking the medicine, the median age was 69 years (42-96). Similarly to previous years, 97.4% of decedents were white, 42.9% had a baccalaureate degree and 78.5% had cancer.

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[10] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

Loss of personal autonomy caused 93.8% of people to decide to choose physician-assisted suicide, a decreased ability to participate in enjoyable life activities caused 93.8% of patients to choose PAD, and loss of dignity caused 78.5% of patients to choose PAD. Approximately 97% of patients who followed through with physician-assisted death were enrolled in hospice care at the time of death. This statistic shows that patients are exploring other types of palliative care before ultimately deciding to follow through with physician assisted death. [11]

Supreme Court Decisions

In 1997, a unanimous Supreme Court decision was made that ruled that the Constitution does not guarantee Americans the right to commit suicide with the help of a physician, leaving the issue to state legislatures to decide. This ruling was demonstrated in two different cases: Vacco v. Quill 117 S. Ct. 2293 (U.S. 1997) and Washington v. Glucksberg, 521 U.S. 702 (1997). Both of these cases are similar in that they both involved three physicians and three terminally ill patients, who have all since died. In Washington v. Glucksberg, Dr. Glucksberg wanted to overturn the Washington law that makes promoting suicide a felony, on the grounds that the statute violates the Due Process Clause of the Fourteenth Amendment. In Vacco v. Quill, the three physicians and patients were challenging the New York state law against aiding a suicide attempt. The Court presented moral and legal arguments in its ruling and acknowledged that the terminally ill can endure

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[11] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

great agony. However, they believed that the American tradition of condemning suicide and valuing human life was a much more important issue. The result of this ruling upheld New York and Washington laws that make it illegal for doctors to give lethal drugs to terminally ill patients. Also, the court ruled that it is up to the individual states to decide whether or not physician-assisted suicide should be legalized. [12]

Death with Dignity in Washington 2008

In November 2008, the state of Washington became the second state in the United States to legalize physician-assisted death. The vote passed with 58% of the votes in favor and 42% voting against the bill. The Washington statute is very similar to that of Oregon. The patient must be 18 years of age or older and a legal resident of Washington state with a diagnosis of a terminal illness that will lead to death within six months. The ability to make a conscious and voluntary decision for oneself is also a requirement. The attending physician must be licensed in the same state as the patient. A consulting physician must certify the diagnosis made by the attending physician and must also certify that the decision is solely of the patient. Unlike the Oregon Death with Dignity Act, the attending physician must request that the patient must notify their next-of-kin regarding the request for a lethal prescription. The Washington Act also states that if a person chooses to request a prescription, the status of the patient's health or life insurance cannot be affected. Not every physician in Washington must comply with the law and has the right to deny participating in physician-assisted suicide, but however should explain and willingly participate in other palliative care options. In 2011, 103 people requested a prescription to

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[12] Kamisar, Yale. "Chapter 4: The Rise and Fall of the "Right" to Assisted Suicide"." *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins UP, 2002. Pg. 75-77

end their life. Out of the 103 requests, 70 people used the prescription and 19 people died without having to take the prescription. [13]

This past November 2012, a Death with Dignity Act for the state of Massachusetts was narrowly defeated with 51% of votes opposing and 49% in favor. Due to the closeness between the opposing and favorable votes, this topic will continue to be at the forefront of the political debate. If this ballot had passed, it would have closely resembled that of Oregon. Within the coming years, it is expected that bills similar to the Death with Dignity Act will be presented in many more states. [14]

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[13] Washington State Department of Health. "Death with Dignity Act: Washington.". N.p., 5 Mar. 2009. Web. 5 Jan. 2013. http://www.doh.wa.gov/portals/1/Documents/5300/DWDA2009.pdf

[14] Johnson, Carolyn. "Assisted Suicide Meausre Narrowly Defeated; Supporters Concede." *Boston.com*. The New York Times, 07 Nov. 2012. Web. 05 Jan. 2013. http://www.boston.com/2012/11/07/dying/gBqan95E7zK3elChciPBOP/story.html

Chapter III: Physician-Assisted Death in The Netherlands

Since 2002, the Dutch have had a great deal of success dealing with PAD and euthanasia. In the Netherlands there is a cultural commitment to social equality and solidarity and their health care policy reflects these ideals. National health insurance for low wage earnings was introduced in 1941. In 2006, the Dutch established the policy that every resident of the country needed to take out subsidized private insurance. Since 1968, costs for rehabilitation, home care and nursing home stays are covered by a national long term health care scheme. Every resident in The Netherlands is required to register with a general practitioner to insure quality and continuity of care. Usually a general practitioner serves an entire family, which allows the general practitioner to better serve each patient because they know the family health history and the behaviors of each member of the family. Because general practitioners know each patient so well, they are responsible in most cases regarding termination of life requests. [15]

Dr. Postma 1973

Before becoming the system that it has evolved into today, the euthanasia and PAD process went under evaluation and change during the 1970s and 80s. Euthanasia became a topic on the Dutch societal agenda following a 1973 case involving Dr. Trus Postma-van Boven, a general practitioner. Dr. Postma whose 78-year-old-mother was suffering from a

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[15] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 34-82

cerebral hemorrhage that left her paralyzed on one side of her body.[16] At the wish of her mother, Dr. Postma allowed her mother to die with an injection of morphine. Dr. Postma went to trial for her actions and was given a conditional jail sentence of one week with a year's probation. The reason for her sentence was due to the fact that her mother was not in the terminal phase of her illness and that Dr. Postma could have found other ways to help her mother deal with her suffering. For Dr. Postma's mother, all other options for care were exhausted and nothing felt like the appropriate course of treatment, thus the reason for choosing PAD. This case raised awareness regarding self-determination and the role it plays in euthanasia and PAD. [17]

The Wertheim Case 1981

Self-determination also played an important role in The *Wertheim* Case. Ms. Corry Wertheim-Elink Schuurman was arrested for assisting in the suicide of a 67-year-old woman in the spring of 1981. At this time, the District Court observed that suicide is not unacceptable in all situations and that the assistance of others can sometimes be indispensable. [18]

> In the court's view, to justify assistance with suicide it must be evident that the physical or mental suffering of the person was such that he or she experienced it as unbearable; that this suffering as well as the desire to die were enduring; that the decision was made voluntarily; that the person was well informed about his or her situation and the available alternatives, was capable of weighing the relevant considerations, and had actually done so; that there were no alternative means for improving the situation; and that the person's

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[16] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 38

[17] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 38

[18] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 40

> death did not cause others any unnecessary suffering. The decision must not have been taken solely by the individual who provided assistance, and a doctor had to be involved. [19]

Since, Ms. Corry Wertheim-Elink Schuurman was not a physician but was a voluntary euthanasia activist, the District Court found her guilty of the offense of assisting suicide.

Changing the System 1984

Ms. Elida Wessel-Tunistra, a member of the Second Chamber of Dutch Parliament, felt it was wrong that the issue of euthanasia was left to judges and prosecutors to decide instead of the physician. [20] In 1984, she proposed a bill to Parliament that would make euthanasia and physician-assisted suicide legal if the assistance was given in a responsible way "to a patient whose condition is terminal or to a patient whose physical or mental suffering is unbearable."[21] In addition, the patient must have made a voluntary and well-considered request. To ensure that the patient was certain that euthanasia or PAD was the decision that they wished to make, a consultation with a second doctor was required.

The Royal Dutch Medical Association (KNMG) agreed with Ms. Wessel-Tunistra and published a position paper regarding euthanasia in 1984. In this position paper, the board defined euthanasia as "conduct that is intended to terminate another person's life at his or her explicit request." They wanted to drop the distinction between euthanasia and PAD to use the same terminology and criteria for both. I believe however that there is a distinction between PAD and euthanasia, with respect to the person who injects the medicine. Patients

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[19] *Nederlandse Jurisprudentie* 1982, nr. 63:223

[20] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 42

[21] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 42

inject the medicine on their own, then there is no question whether or not they wanted to end their life. When a physician injects the medicine, it is easier to slide down the slippery slope of killing another human. The concept of euthanasia and PAD should only be discussed within the doctor-patient relationship and a physician should be the only one allowed to engage in actions that terminate life. If euthanasia were to be accepted by the board, the following criteria were to be met:

1) The request for euthanasia must be voluntary.
2) The request must be well considered.
3) The patient's desire to die must be a lasting one.
4) The patient must experience his or her suffering as unacceptable.
5) The doctor concerned must consult a colleague. [22]

The safeguards were put into place to ensure that the decision was at the will of the patient and that the patient understood the consequences of their decision. To date, the Royal Dutch Medical Association is the only national medical association that has taken a positive stance on euthanasia and its legalization. In 1998, SCEN (Support and Consultation Euthanasia in the Netherlands) was created; it acts as a service for general practitioners to consult if they are dealing with a case where a patient has requested euthanasia. By mandating a consultation, certainty can be assured regarding whether or not all of the criteria have been met.

During the 1998 elections, D66, the political party that introduced the first euthanasia in 1984, introduced another bill to legalize euthanasia. This bill would soon become known as The Termination of Life on Request and Assisted Suicide Act of 2002.

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[22] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 43

Within this bill were criteria for due care, that a doctor who meets the criteria and reports the death of his or her patient to the coroner on the appropriate form cannot be guilty of an offense. The criteria that are included within this bill state that the doctor must:

- be satisfied that the patient's request was voluntary and well considered;
- be satisfied that the patient's suffering was unbearable and that there was no prospect of improvement;
- have informed the patient concerning his or her situation and prospects;
- have discussed the situation with the patient and together with the patient, be convinced that there was no reasonable alternative in the light of the patient's situation;
- have consulted at least one other, independent, doctor who must have seen the patient and given a written opinion on the due care criteria listed in the four previous points; and
- have terminated the patient's life or provided assistance with suicide with due medical care and attention.[23]

The Second Chamber of Parliament accepted the bill in November 2000, with forty votes against it and 104 votes in favor of it. In April 2001, the First Chamber accepted the bill with 46 senators in favor and 28 opposed. This law was deemed effective on April 1, 2002. There was not much disapproval over the passing bill since many people realized that not much was changing and that practices that were performed were now legal. Since the bill was passed, the reporting of euthanasia cases rose from 18% in 1990 to 80% in 2005. After

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[23] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 56

the law was put into action, the number of euthanasia and PAD cases decreased. In 1990, there were approximately 2,700 cases of euthanasia while in 2005 there were only 2,425 cases.[24]

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[24] Heleen Weyers "The Legalization of Euthanasia in The Netherlands" from Physician-Assisted Death in Perspective by Stuart J. Younger and Gerrit K. Kimsma, pg. 56

Chapter IV: Philosophical Debate

Killing is Morally Wrong…in Certain Cases

People argue that life is sacred and something that should be valued. Consequently PAD and euthanasia must be morally wrong because they both destroy human life. In "Life is Sacred: That's the Easy Part," Ronald Dworkin states, "We almost all accept…that human life in all its forms is *sacred*- that it has intrinsic and objective value quite apart from any value it might have to the person whose life it is. For some of us, this is a matter of religious faith; for others, of secular but deep philosophical belief."[25] However, I believe that to argue that life is sacred, one must presume that there is a higher power, something that would allow us infinite power. Since, there is no proof that there is a higher infinite power, this is merely a suggestive statement rather than something that should be Immanuel Kant also argues that human life is sacred, and attaches a great importance to human life. [26] Kant argues that people should always be treated with respect to their personhood and dignity. I will argue throughout the reminder of this paper that allowing a person the option of PAD actually respects their personhood and their dignity more than by making them participate in palliative care if that is not what they want to do. As Peter Singer discusses in his book, *Practical Ethics*, when people argue that life is sacred, they generally are specifying human life opposed to animal and other life forms. I will argue that even if you believe there are

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[25] Dworkin, Ronald. "Life Is Sacred: That's the Easy Part." *The New York Times Magazine* 27 June 1993

[26] Kant, Immanuel. *Foundations of the Metaphysics of Morals, and What Is Enlightenment?*New York: Liberal Arts, 1959

differences between humans and animals, no being should be forced to withstand unbearable suffering.

Everyone usually accepts that although PAD may be morally suspect it is not immoral to mercifully kill an incurably suffering animal. Recently, I had adopted a puppy from a local human society that had become gravely ill within a few days of owning her. After bringing her to the vet, I learned that the dog was suffering from a deadly diseases- *Parvovirus* and had a 30% chance of survival. The vet felt it was best to test other treatment options before putting the dog down because there was a chance that she could recover. The puppy was kept on pain medication and I was assured that she would not feel any more pain. After four days of no improvement and new complications, the vet believed that there was not much more he could do to save my dog. My options were either to continue giving my dog pain medications until she passed away naturally or to allow the vet to inject my dog with a lethal medication, allowing her to pass and no longer suffer. I chose the latter option because even though the first option allowed my dog to feel no more pain, the rest of her life, whether it was a day or two weeks, would have been spent in the vet clinic. After seeing what a lifeless creature she had become, the choice to put her down was simple for me to make. While I cannot know exactly what my dogs wishes were, I believe that she would have wanted to live a life where she could frolic and play, instead of being sick and in a veterinary clinic for her final days.

While making the decision for my dog, I spent time considering how the suffering of an animal is any different from the suffering of a human, if it is different at all. As Peter Singer argues in Practical Ethics, “If a being suffers, there can be no moral justification for refusing to take that suffering into consideration." [27] Whether or not animals and humans have the same moral standing, it is very difficult to deny Singer's statement. If one were to view a being suffering and chose to do nothing about it, I argue that the person is acting immoral to not help end the suffering of the being. Suffering is suffering regardless of what type of being is experiencing it. Critics may object that people are not equal to animals. I agree. Animals and humans are not equal. This is why we should allow humans to be given the option of PAD. Even though they are unequal, animals and humans are similar in the fact that one can know when suffering or extreme discomfort is being experienced. So the moral issue is, what purpose is served by end-of-life suffering? Suffering is justifiable only if it serves some greater purpose. The suffering experienced through a surgical procedure will eventually give way to relief and comfort that the surgical procedure was intended to fix. Many Christians believe that their suffering experienced on Earth leads to the greater purpose of making it to Heaven at some point. If you do not believe this, end-of-life suffering is pointless and serves no purpose. My dog had no way of voicing her suffering other than cowering and whimpering with her head down. Humans on the other hand, have the ability to voice their opinion and let others know what they are feeling by speaking to us directly when they ask to be relieved of pain and suffering, when palliative care fails to provide relief. Why should we put animals to sleep without knowing if they are truly suffering or not and fail to allow humans the same privilege even though we know they are suffering?

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[27] Singer, Peter. *Practical Ethics*. New York: Cambridge UP, 2011. Chapter 3, Pg. 95

Autonomy & Heteronomy

To deny a terminally ill patient the right to PAD at a point where suffering or pain cannot be relieved is prima facie wrong. A prima facie duty establishes that a certain class of behaviors is wrong. Many people seek out the option of PAD because their terminally- ill discourse has evaded their sense of personhood in the sense that they may be able to do anything on their own or a person may feel that they have lost their say in important decisions regarding their medical treatment. A way to uphold their personhood is to respect their personal autonomy. Autonomy is the state of being in which a being is self-governing and experiences independence or freedom as the will of one's actions. In Oregon 2012, 93.5% (72/77) of the people who received a prescription of seconal for suicide felt that the disease was destroying their autonomy and that PAD was their only way maintain their sense of personhood.[28]

Heteronomy refers to an action that is influenced by a force outside of the individual. Heteronomy is the opposite of autonomy because it does not allow for the individual to be self-willing. A common example of experiencing a heteronomous event is constituted by some of the effects of suffering from a common cold. When suffering from a cold, a person has no control over when they are about to sneeze, when their nose is going to run, when a fever is going to strike or when a coughing attack is going to occur. For most people, a common cold lasts only a few days and then the body returns to its normal state. While these examples are something that almost every person has experienced throughout their life and it would be inane for anyone to request PAD over any of these, they serve the

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[28] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

purpose of demonstrating what it is like to have no control. A 'normal' human being has no control over whether or not their heart is beating or at the pace their heart is beating. We grant people the ability to make an autonomous decision to decide what type of treatment to undergo when their heart is beating irregularly or does not beat strong enough to pump blood. The terminally-ill patient has option other than palliative care to relieve their pain, there is nothing more they can do to treat their deteriorating body. For a person with the common cold, they are eligible to take some form of cold medicine and choosing to take the medicine is their autonomous decision. For a terminally ill patient, their body will never return to a state where they feel as if they have control. Consider the example of my dog suffering from *Parvovirus*. She had no control over when she could go to the bathroom or vomit, and her walking away and hiding among a bed of pillows generally followed these actions. Her behavior signaled to be that she was ashamed and embarrassed by what she had done. Similarly, a human being who has no control over their bowel movements would feel embarrassed and ashamed- especially if they knew they would never regain control of those functions. During the 2012-year, 27/77 recipients of a prescription under the Oregon Act, felt as if they had lost control of their bodily functions. [29]

Gregory Pence gives us a sense of heteronomy at the end of life by comparing a person's life to a business.

> One way to put the argument for patients' autonomy with regard to assisted dying is to compare a person's life to a business: if I own a business that is making money, it makes sense for me to keep it open; but if the business is losing money, I would be imprudent to wait until there was no money left at all before closing. Similarly, a terminally ill patient owns

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[29] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

> his or her body and need not “stay in business” till the very end. [30] [31]

The terminally ill heteronomous patient in this case is similar to the business that is failing, in the sense that everything is slipping away and will soon be lost. If the business were to stay open even though it was failing, there is the potential for large amounts of money to be lost. Keeping a terminally ill patient alive while their body is in deterioration to the point that the person will soon have no control over any bodily functions is needlessly cruel, as I believe forcing a business to stay open while they are losing money is cruel. Since it is wrong to permit suffering when it serves no greater purpose, it is wrong to prevent a terminally ill patient who wants to maintain autonomy from getting relief through PAD.

Pence’s example presupposes that a business would not close if it were thriving; it makes no sense for a terminally ill patient to end their life, because there is still a viable life to live. Therefore PAD should only be an option for terminally ill patients whose suffering cannot be relieved by other means, such as palliative care or hospice.

Opponents of PAD may raise the argument that if respecting autonomy is so important, it would be necessary to respect the autonomy of a person who is not terminally ill and is requesting to partake in PAD. As a relatively healthy person, there are plenty of options to choose from with regards to medical treatments, whether it is choosing between surgery, homeopathic care, rehabilitation, dietary changes, there are generally multiple alternatives for a person to choose from. As a terminally ill patient, there is the option to partake in palliative care or to partake in PAD. Unless one is a resident of Washington or Oregon, this option is not available, thus leaving the terminally ill patient with only one

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[30] Brandt, Richard, quoted in Susan Ager, “When Suicide Is The Last Hope,” *Detroit Free Press*, June 8, 1990.

[31] Pence, Gregory E. "Chapter 3: Physician-Assisted Dying." *Classic Cases in Medical Ethics: Accounts of Cases That Have Shaped Medical Ethics, with Philosophical, Legal, and Historical Backgrounds*. New York: McGraw-Hill, 1995.

option: palliative care. Allowing PAD would give the terminally ill patient an option regarding their end of life treatment, thus respecting their autonomy. It is a physician's duty to help the sick and PAD, in some cases, may be the only way the physician can help the patient. Allowing a terminally ill patient the option to choose PAD does not give them greater autonomy than a 'healthy' person, it grants them the opportunity to express the same amount of autonomy that a 'healthy' person can.

The Oregon and Washington *Death With Dignity Laws* legalize PAD thereby promoting the autonomy of human beings by offering new options for terminal patients choosing end of life treatments. As described in Chapter II, under these laws, a patient has the option of PAD and is able to make the autonomous decision to take a lethal dose of seconal. For many terminally ill patients, participating in PAD is one last exercise of their personal autonomy.

Misdiagnosis and Mistakes

Many people will argue that PAD should not be allowed because there is the chance that the physician made a mistake in the diagnosis and that the patient could live much longer than expected. If PAD were legalized, there could be a risk that a patient would die too soon and lose valuable months -or more- of their life. Physicians are not able to specify exactly when a person is going to die, but rather they can make educated guesses as to how long a person has left to live based upon the nature of the disease and how fast it is progressing. There have been cases where doctors are astounded to discover that a patient who was suffering from a terminal illness was able to live months longer than what doctors had expected. *How To Die In Oregon*, an HBO documentary, depicts such a case. Cody Curtis, a 54-year-old wife and mother demonstrates the emotion, on-again, off-again symptoms that are associated with terminal liver cancer. Curtis had received surgery, which seemed promising at first, but the cancer had returned and began to take over her body. Her physician told her that she would have six months or less to live and what her options would be for treatment. Curtis wanted to be able to live the remainder of her life normally and to the fullest that she could. She requested to obtain a prescription for lethal barbiturates in the event that she felt she would not be able to survive another day. "It's very comforting to know they are here," she says. "It's my choice when to take them and whether to take them." [32]

Curtis set a date six months from the time she received the prescription for the barbiturates to when she would physically take the pills, but in the meantime would enjoy her life to the fullest. The six months passed and to Curtis' surprise, she began to feel better, like her old self pre-cancer. Her physicians were shocked at how she was feeling and could not explain what was occurring or how much longer she would have left to live. Curtis decided that she would know when the time was right to take the lethal pill. A few months later, her body began to shut down and she was unable to leave her bed for longer than a few seconds; she knew that it was time. Due to the Death with Dignity Act in Oregon, Curtis was able to pass with her family by her side and when she felt that it was the appropriate time. Her family was very thankful that their loved one was given a chance to end her life

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[32] Richardson, Peter D., dir. *How To Die In Oregon*. HBO. 2011. Television.

when she felt it was necessary. It is also important to note that even though Curtis had a prescription for the pill, she was not required to take the pill until she was ready. [33]

In the case of Cody Curtis, her doctors had made a mistake in predicting how long she had left to live. This mistake could have prevented Curtis from making the memories and experiencing the things that she did during her last few days. Opponents of PAD would argue that it would be morally wrong to deprive someone of the chance to make those memories. In Oregon, there is no requirement stating that if you are prescribed the pill, you must then take the pill. Months may pass by before a person feels ready to take the pill and a person may decide after receiving a prescription that they do not want to take the pill at all. In fact, many people decide not to take the pill. In 2012, 115 patients were prescribed the pill, however, there were 77 reported deaths by PAD during 2012. [34] While there is the likelihood that a physician can make a mistake as to how long a patient has left to live, no patient is mandated to take the pill until they feel they are ready, or they may decide that they may not want to take the pill at all.

Both the Oregon and Washington *Death with Dignity Laws* have implemented a procedural safeguard so that misdiagnosis does not occur. Before a patient can become eligible to receive a prescription, an attending physician as well as a consulting physician must examine the patient to determine the diagnosis and prognosis. First the attending physician makes the diagnosis and determines if the patient is eligible for PAD. If the patient decides that PAD is the desired course of treatment, then a consulting physician will assess the patient. The consulting physician is given the patient's medical records to

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[33] Richardson, Peter D., dir. *How To Die In Oregon*. HBO. 2011. Television.

[34] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

determine if the attending physician made a correct diagnosis and prognosis. If the two physicians agree, the consulting physician must, in writing, confirm the attending physician's diagnosis that the patient is suffering from a terminal illness, and that the patient is eligible for PAD.

By receiving multiple diagnoses, the risk of misdiagnosis is slim. However, this is not to say that it will *never* happen, since almost anything is prone to error. As a society, we grant a great deal of prestige upon physicians and often forget that they are human. Making mistakes is part of human nature and we are never 100% certain of anything. To argue that someone should not follow through with a particular surgery because there is a risk that they will die due to physician error is really no different than arguing that someone should not partake in PAD because the physician could make a misdiagnosis. Physicians go through rigorous training to help those who are sick and millions of people trust their physicians to perform a surgery correctly and not make a mistake, so why don't we trust our physicians when they make a diagnosis regarding terminal illness?

Medical Friendships

The physician-patient relationship is a fiduciary relationship, meaning that it is based upon confidence and trust. The physician relies on the patient to disclose all relevant information regarding an illness or injury, so that the physician can make an accurate diagnosis. The patient trusts that the physician will do all they can in their power to help and create the best course of treatment, as well as trust that the physician will refrain from revealing confidential information. This relationship has been centuries old and is referenced in the Hippocratic Oath. Historically, the patient has done whatever the physician has suggested based upon the belief that the patient would always benefit from the physician's actions. Due to changes in our society and patients being able to retrieve medical advice from numerous sources such as the internet, the relationship has transformed into shared decision making, where the patient is given options in their course of treatment. This transformation of the relationship allows for the patient to act as an autonomous agent. Many opponents of PAD believe that allowing PAD to occur undermines this physician-patient relationship. It could be argued that giving a deadly drug to a patient is not a way of treating the patient, but is instead an easy way out. I will argue that with certain safe guards in place, PAD is no different than providing any other treatment for the patient.

Gerrit Kimsma and Chalmers Clark have studied the physician-patient relationship in The Netherlands, focusing primarily on the impact that PAD can have. [35] Their studies have shown that involvement with dying patients is emotional for all involved: patient, physician, family, caregivers, etc. As soon as a patient makes the request for PAD, the relationship between the physician and the patient changes, to all allow for greater intimacy, psychological involvement, and mutual respect.[36] Their research has shown that Dutch physicians report that while they are in favor of the availability of PAD, they hope that they will never see an occasion where it occurs. Kimsma and Clark argue that this discomfort is key in preventing the physician-patient relationship from being harmed.[37] I

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[35] Clark, Chalmers C., and Gerrit K. Kimsma. "Chapter 17: Shared Obligations and "Medical Friendships"" *Physician-assisted Death in Perspective: Assessing the Dutch Experience*. Cambridge: Cambridge UP, 2011. Pg. 264

[36] Clark, Chalmers C., and Gerrit K. Kimsma. "Chapter 17: Shared Obligations and "Medical Friendships"" *Physician-assisted Death in Perspective: Assessing the Dutch Experience*. Cambridge: Cambridge UP, 2011. Pg. 264

[37] Clark, Chalmers C., and Gerrit K. Kimsma. "Chapter 17: Shared Obligations and "Medical Friendships"" *Physician-assisted Death in Perspective: Assessing the Dutch Experience*. Cambridge: Cambridge UP, 2011. Pg. 265-266

agree; if there is a sense of discomfort felt by physicians who have to perform PAD, then it is unlikely that a physician will push for the patient to undergo PAD.

The ethical principle of beneficence argues that one must do well for another. [38] Beneficence connotes acts of mercy, kindness, charity and the promotion of the goods of others. This principle is often applied to medicine stating that the physician should always do what is best for the patient and never cause the patient harm. It is expected that a physician cares about the well-being of their patient and the patient relies upon the physician to provide the appropriate care. Requested death in the face of miserable suffering is a benefit for some patients and a physician looking to uphold the ethical principle of beneficence should be allowed to act in such a way to benefit the patient.[39] Physicians are well suited to make the decision if patients are making end of life decisions as an autonomous choice or if it is a choice they are making because they are unaware of all other possible treatment options. Through palliative care, a physician is able to alleviate the pain a person is feeling. However, for some patients this is not enough, thus the reason for wanting PAD. It is also the obligation of a physician to make sure that if a patient decides they wish to participate in PAD, that they fully understand the consequences of their action and understand that there are alternative treatment methods.

Doctors have developed institutional practices for making and implementing end-of-life decision-making. One of these practices is to ensure that the physician and patient maintain a healthy and positive relationship while discussing end of life care, in other

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[38] Beauchamp, Tom, "The Principle of Beneficence in Applied Ethics", *The Stanford Encyclopedia of Philosophy (Fall 2008 Edition)*, Edward N. Zalta (ed.), <http://plato.stanford.edu/archives/fall2008/entries/principle-beneficence/>.

[39] Beauchamp, Tom, "The Principle of Beneficence in Applied Ethics", *The Stanford Encyclopedia of Philosophy (Fall 2008 Edition)*, Edward N. Zalta (ed.), <http://plato.stanford.edu/archives/fall2008/entries/principle-beneficence/>.

words a medical friendship. Chalmers Clark and Gerrit Kimsma refer to this relationship as a 'medical friendship.' [40] They interviewed many Dutch physicians who participated in PAD and an overwhelming number of physicians stated that if PAD were to be permissible a personal relationship was absolutely necessary. [41] If the physician and the patient have a friendship, there is less of a contractual relationship and the ability to have a discussion regarding what is best for the patient comes more free flowing and natural. PAD is one of the most ethically-at-risk situations in a physician's career.

Having a medical friendship with a patient will protect the patient's control over their destiny as well as the physician's choice in aiding the patients in their decision-making. If the physician and the patient have a medical friendship, the patient will be more likely to express their true desires and concerns. Just as it is easier to discuss personal problems with a close friend, it would be easier to discuss medical issues with a physician who is your friend. The physician will be able to form a better understanding as to what the patient's exact wishes and wants are, because they will know the person on a more personal level, making it easier to determine how the patient is truly feeling.

Aristotle states, "…If friendship consists more in loving than in being loved…it seems that loving is the distinctive virtue of friends."[42] In his *Nicomachean Ethics*, Aristotle defines three forms of friendship: those based on pleasure, on utility, and on virtue. As Clark and Kimsma point out, the necessity for a physician-patient relationship is "the reciprocal of love of similar virtue that makes the category of virtue necessary for a complete

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[40] Clark, Chalmers C., and Gerrit K. Kimsma. ""Medical Friendships" in Assisted Dying." *Cambridge Quarterly of Healthcare Ethics* 13 (2004): 61-67. Printed in the USA.

[41] Clark, Chalmers C., and Gerrit K. Kimsma. ""Medical Friendships" in Assisted Dying." *Cambridge Quarterly of Healthcare Ethics* 13 (2004): 61-67. Printed in the USA.

[42] Aristotle. *Nichomachean Ethics*. Book Eight, viii:1159a9-60a9

friendship.” [43] I agree with Clark and Kimsma in saying that a true friendship is based upon the reciprocity of virtue, and that the physician and the patient should take the similarity of moral goals seriously. If there is the mutual understanding, the physician can be sure to be clear as to what the patient is expecting and looking for, therefore enabling the patient to express exactly what they want to be done and the physician being able to tell the patient whether or not that would be a good course of action. This is not to say that the physician should try and coax the patient into doing what would be preferable for the physician but rather should listen to the patient and abide by what they are wishing for- so long as it is permissible.

Not only does the patient experience an impact regarding end-of-life decisions, but these decisions also impact the physician. While intimate relationships are important, there does need to be some emotional boundaries. If the physician becomes too clouded by emotions, he or she no longer can make an appropriate decisions based upon the patient’s best interest instead of what his desires and wishes are. This is also an issue many family members face if they are the surrogates for a dying patient. When a person’s feelings for someone or something become so powerful, their judgment can become clouded. Instead of following a patient’s demand to die, the physician may decide to keep the patient alive because they feel a strong attachment to the patient and do not want to lose them.

Cody Curtis had formed a wonderful relationship with her physician while she was going through the process of deciding whether or not PAD was the right option for her. *How To Die in Oregon* shows conversations between Curtis and her surgical oncologist, Dr. Katharine Morris. Dr. Morris admits that it is a very shocking contrast between something

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[43] Clark, Chalmers C., and Gerrit K. Kimsma. ""Medical Friendships" in Assisted Dying." *Cambridge Quarterly of Healthcare Ethics* 13 (2004): 64. Printed in the USA.

that supports her values and the reality that she would be writing a prescription that would end someone's life. Both Curtis and Dr. Morris admit that since Curtis decided she wanted to pursue PAD, they formed a very strong bond and friendship. Dr. Morris did not tell Cody when she should take the pill, but provided her with a strong support network for whatever she chose to do. Dr. Morris was present when Cody decided that the time was right for her to take the pill, and Dr. Morris helped Cody's family to make sure that the pill was prepared in the proper way. The movie does not show Curtis in her last moments, but can hear Dr. Morris giving comforting words to Cody and her family in the last few minutes. The relationship between these two is a model for how every medical friendship should be. Curtis was able to make her own medical decisions, with the help and support from her physician, who was able to provide input regarding what she believed was best for Cody. Since the two were able to have such a great friendship, Cody was able to make her decision regarding end of life caring, knowing that her physician would be behind her every step of the way.

Slippery Slope

Opponents of PAD may object that if it became an option for patients to choose from, they may feel pressured, from the physician or from family members, or inclined to choose this option over other palliative care forms. A slippery slope argument is an informal fallacy that asserts that some situation will lead gradually but unavoidably to a disastrous event. Applying the slippery slope argument to PAD would result in killing all terminally ill patients. It could be argued that once you allow the killing of some terminally ill patients, it will gradually become more and more acceptable to kill terminally ill patients who do not meet all of Oregon and Washington's criteria. According to Nat Hentoff- a disability rights advocate who opposes PAD- our society is already on a slippery slope toward killing terminally ill patients.[44] Hentoff refers to the *Karen Quinlan* Case. He argues that Karen was not an adult, not rational, dying and that therefore the decision to let her die was not "voluntary." We do allow surrogates to such as Karen's father to make decisions regarding end of life care. Situations such as this can lead to abuse, if no advanced directive is in place, explicitly stating what the patient would want. Karen was not able to speak for herself because she was a skeletal figure in fetal position, unable to state her specific wishes. Karen's father had made the decision that he believed Karen would have wanted and was required by the court to produce clear and convincing evidence that he was representing Karen's wishes. Since this case, it has become much more common and highly suggested for all people to have advanced directives, to ensure that their wishes regarding medical decision-making will be granted. Oregon and Washington both prevent situations like this from arising in PAD by creating the requirement that the request for PAD must come from the patient himself or herself and that they must be in a competent state of mind.

Another potential slippery slope argument is that physicians may begin recommending PAD to terminally ill patients, which could coax the patient into believing that it is their only, or best, option of treatment left. PAD should not be recommended to a patient, but should be given as an option. If a physician were to recommend it, patients would automatically believe that it is their best treatment option and decide not to investigate into other options. Some people fear that physicians will be pressured by high medical costs and will urge PAD on the poor and the elderly. Families can also be crippled

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[44] Nat Hentoff, "The Deadly Slippery Slope," Village Voice, September 1, 1987.

by the costs of terminally ill patients. Another worry is that the family may pressure the patient into PAD because they cannot afford to pay the medical bills. This is why it is extremely important for the physician to make sure that the patient's decision to pursue PAD was their sole decision without any outside influence.

When physicians are discussing treatment options with terminally ill patients, PAD should not be the first or the only option given. A physician should explain palliative care and what exactly that is. Money should not be brought into the context of the conversation, because then it would allow the patient to make their decision based upon monetary issues rather than making the decision based upon what they truly want. This economic criticism is not pertinent to the Oregon and Washington *Death with Dignity Laws*. Since the statutes specify that participation under the act is not suicide, insurance benefits should not be affected. The Medicaid program of these states (paid by federal funding) ensures that charges for services related to the Act are paid only with the state funds. In 2012, 51.4% of PAD participants had private insurance cover the costs and 48.6% of participants had Medicare, Medicaid or other Governmental funds cover the costs. [45]

To prevent the physician from pressuring the patient into choosing PAD, a consulting physician should be present in the decision making process to ensure that the decision is solely the patient and made solely by the patient and not outside influence. This will also help in deciding whether or not the patient is a competent adult making the decision. If there is any question to competency, the patient should be referred to a psychiatric evaluation to clarify that the patient has made a clear and conscious decision.

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[45] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

Criticisms to the "Oregon Experiment"

Kathleen Foley, M.D. and Herbert Hendin, M.D. argue in their book, *The Case Against Assisted Suicide*, that Oregon has not been successful in showing the United States how PAD should work. [46] One reason for this argument is that they believe since there is no requirement in Oregon for physicians to take courses in pain management, palliative care, or the evaluation of a suicidal patient requesting PAD, that the physician is not capable of requesting feasible alternatives. The concern with this point is that if a patient requests PAD, they should then be sent to speak with a physician who is knowledgeable about palliative care, but this is not a requirement in Oregon. Foley and Hendin believe that by not making this a requirement for the Oregon law, offering palliative care becomes a legal regulation to be met, rather than an integral part of end of life care, so that PAD does not seem like the only option. [47] My response to this argument is that since there is no mandated date that a patient must take the lethal dose of seconal after receiving the prescription, the patient has the option to explore other options. By requiring multiple requests for PAD both written and oral, the patient has explicitly made known what their wishes are.

If medical friendships are formed, as I detailed earlier in this chapter, the physician and the patient have a fiduciary relationship, where the physician is able to get to know the patient and understand their true desires and wishes. This would enable the physician to determine if PAD is something that the patient is requesting because that is their true desire or if it is being requested simply because they do not know their other options.

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[46] Foley, Kathleen M., and Herbert Hendin. "Chapter 7: The Oregon Experiment." *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins UP, 2002. Pg. 144

[47] Foley, Kathleen M., and Herbert Hendin. "Chapter 7: The Oregon Experiment." *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins UP, 2002. Pg. 147

During 2012, 97.0% of patients who died with the assistance of PAD were enrolled in hospice care either at the time the prescription was written or at the time of death.[48] This statistic shows that patients are in fact aware of palliative care and are utilizing their right to participate. PAD is sought when they believe palliative care is not alleviating their suffering.

Foley and Hendin also criticize the Oregon law for not requiring the physician to ask to see the patient's family. "How can the physician be sure there is no coercion unless the physician has met the family and seen the interaction among them and with the patient?" [49] They believe that unless a physician is able to see the interaction between the family and the patient, then they cannot be sure that there is no coercion. Not informing the family may prevent the opposite from occurring. It could prevent a caring family from persuading a patient to not go through with PAD even though that is their wish. Foley and Hendin acknowledge this point, but argue that this could lead to a family feeling cut off from what a loved one was going through and could create a great deal of suffering for the family. [50] Does the family in this scenario experience suffering any differently than if a patient had a terminal illness and was going to die, but chose to not tell the family? I believe that the family would still experience a great deal of grief and guilt for not being able to be by the terminally-ill patient's side through their last days. After all, throughout the process of PAD

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[48] Oregon Public Health Division: Oregon's Death with Dignity Act-2012: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. January 14, 2013

[49] Foley, Kathleen M., and Herbert Hendin. "Chapter 7: The Oregon Experiment." *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins UP, 2002. Pg. 158

[50] Foley, Kathleen M., and Herbert Hendin. "Chapter 7: The Oregon Experiment." *The Case against Assisted Suicide: For the Right to End-of-life Care*. Baltimore: Johns Hopkins UP, 2002. Pg. 158

one of the goals is to respect patient autonomy and if it is their decision to not inform their family, then so be it.

Chapter V: Conclusion

I have argued in this thesis that PAD is morally permissible. I have used Oregon, Washington and The Netherlands as examples of cases where PAD has been executed successfully.

In 1994, change was brought to the way end of life care was handled in the state of Oregon. The *Death with Dignity Act*, allowed qualified patients to end their life with the assistance of a physician. Under this act, citizens of Oregon 18 years and older, suffering from a terminal illness, who are competent and aware are eligible to pursue PAD. Under this act, it is not required that once a patient receives a prescription, they must take the pill. In fact, a person who receives a prescription may decide that they do not ever want to take the pill. This act has allowed 544 people to put an end to their suffering with the assistance of PAD.

In 2008, the state of Washington passed their very own *Death with Dignity Act*, modeled after the existing act in Oregon. This act allows citizens of Washington who are 18 years or older, suffering from a terminal illness and who are competent and aware to participate in PAD. As seen in the Oregon Act, if a person receives a prescription, it is not mandated under the Act that they take it.

PAD in The Netherlands is then examined, which has been legalized in The Termination of Life on Request and Assisted Suicide Act of 2002. PAD was allowed in The Netherlands since 1984, but the bill that was passed in 2002 included criteria for due care, that a doctor who meets the criteria and reports the death of his or her patient to the coroner on the appropriate form cannot be guilty of an offense. Euthanasia in this country is also allowed on similar grounds to PAD. The Netherlands have put into place similar criteria to Oregon and Washington to make sure that the request for PAD is solely of the patient and that the patient understands other options such as palliative care.

After laying out how PAD works in the United States and in The Netherlands, I engage in philosophical debate. I have explored the importance of maintaining personal autonomy, the concept of medical friendships, the issue of mistakes and misdiagnosis as well as how to avoid a potential slippery slope.

When making end of life decisions, I argue that palliative care should be thoroughly explained by the physician and an explored option for the patient. PAD, if put into practice, should always be the exception and never the rule when it comes to making end of life decisions. After exploring these issues, I have reached the conclusion that with certain procedural safeguards in place, PAD is morally permissible and should be an option for terminally ill patients.

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