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AND EUTHANASIA

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DEFENDING THE NEED FOR PHYSICIAN ASSISTED SUICIDE AND
EUTHANASIA

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DEDICATION

To Kayla, Kenzie, Kyler, and Robert.

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ABSTRACT

This work intends to defend the need for the United States to adopt a law such as Holland's Euthanasia Law to ensure the best possible medical interventions and options are provided to all. Medicine gives those who can receive it, the ability to improve their health and overall life. However, for those who are suffering from a terminal illness or incurable disease, it can only offer them a degree of comfort. Though for some of those suffering, comfort isn't enough and instead, they desire to end their life. This desire is something that should be considered a natural right for everyone however, currently Physician aid in dying or assisted suicide, is only legal in the states of Washington, Oregon, California, Vermont and Bernalillo County, New Mexico. The need for physician-assisted suicides or physician aid-in-dying, has long been a debated topic. What has failed to be realized though, is some providers already participate in some form or type of aiding their patients in dying. They allow for other types of end-of-life interventions to occur such as withdrawal of live support like mechanical ventilation, and refusal of artificial nutrition and hydration, and treatments are legal in the USA and less controversial in our society. However, there is no true difference in the patient deciding when to die and with a provider/family deciding to remove the patient from support? In this paper, the major focus is on the evidence that supports the need for physician aid-in-dying. Oregon was the first state to enact the Death with Dignity Act in October of 1997 and data shows the growth of support for physician-assisted suicides has continued to increase. Furthermore, with the continuing climb in healthcare costs, the need for physician-assisted suicides has never been more apparent.

Keywords: Autonomy, physician-assisted suicide, physician aid-in-dying, terminally ill, right to die.

Chapter 1: Introduction and Explanations

Introduction

Throughout history, physician-assisted suicide and euthanasia have been advocated as appropriate approaches in the care of patients suffering from unmanageable pain and distress due to an advanced disease. The “Right to die” or “dying with dignity” refers to the issues involved in the decision of whether an individual should be allowed to choose to die even though they could continue to live with the aid of life support or at a diminished capacity. This has been a long time debated topic for many years due to the ethical implications involved. A lot of the research done aim to answer the following questions: Is the right to die is universal, or does it only apply under certain circumstances, such as terminal illness, or does it exists at all? If we truly, as a society, respect autonomy, then how can we deny a patient’s request to die? If we no longer deny these requests made by patients then should doctors, who are traditionally committed to extending their patient's life, be involved in these acts? If doctors do elect to be involved in these types of acts, how can they then honor the conflicting requirements of non-maleficence, beneficence, and autonomy at the same time? A classic philosopher, John Stuart Mill, believed heavily in individual freedom. The importance of the individual freedom argument is essential since the United States is a liberal nation as demonstrated by the tradition of John Stuart Mill. Liberal meaning in its philosophical meaning which is, a concern for individual rights and liberties. In Mill’s work titled *On Liberty*, he explains the harm principle as well as individual liberty, which provides the foundation for how most of the current society views individual rights. For the most part, our society is made up of those who

strongly believe in respecting individual freedom. This is very apparent and rooted in our Declaration of Independence which states, that all people should have the right to life, liberty, and the pursuit of happiness.

Furthermore, for one physician, the decision to help his patients and end their suffering was more important. Dr. Jack Kervorkian was a physician in the United States who is best known for assisting his patients with their suicides (Bio, 2015). He coined the following phrase: *“My intent was to carry out my duty as a doctor, to end their suffering. Unfortunately, that entailed, in their cases, ending of the life. My ultimate aim is to make euthanasia a positive experience”*. He believed it was his duty as their physician to help end their suffering. However, in 1999, Kevorkian was arrested and tried for his direct role involving voluntary euthanasia. He was found guilty of second-degree murder and served eight years until he was paroled. Though Dr. Kervorkian's actions in aiding his patients end their suffering were brought into question, his intent to do right and help his patients was evident. Additionally, his actions were the catalyst that catapulted euthanasia and physician-assisted suicide into the public eye. Patients who are terminally ill or suffer from a disease which inhibits their ability to live a productive life and cannot be cured, should have the right to determine when to end their life and physicians should be allowed to aid in their request.

Explanation of Euthanasia and Physician-assisted Suicide

Before going any further, it is essential to provide an explanation of euthanasia and physician-assisted suicide. There are many interpretations of what physician-assisted suicide means and what it involves. According to The American Medical Association's *Code of Medical Ethics* (1997), physician-assisted suicide “occurs when a

physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" (p. 56). Another definition provided by Kathleen Foley (1995) explains that it is a physician providing a "causative agent", typically medication, that when taken will cause the patient's death. From the two definitions provided, the commonality of them is apparent therefore, for the sake of the reader, physician-assisted suicide will be viewed as a physician providing the necessary medical means or information for a patient to hasten death and end their own life.

Euthanasia also has many interpretations. For example, as explained by The American Medical Association's *Code of Medical Ethics*, Euthanasia is "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering" (p.55). The complexity involved with euthanasia exists since the discussion regarding euthanasia involves four different kinds. The first kind is known as passive euthanasia or negative euthanasia. As explained by Garrard and Wilkinson (2003), passive euthanasia involves the withdrawing or withholding of medical treatment that would, if received by the patient, prolong life. Furthermore, they explain there are three necessary conditions that must occur in order for passive euthanasia to occur (Garrard and Wilkinson, 2003):

- (1) A withdrawing or withholding of life-prolonging treatment must occur
- (2) One purpose of withdrawing or withholding this treatment must be to cause or hasten the patient's death
- (3) The need to hasten death is for the patient's best interest.

Active euthanasia which is also known as positive euthanasia, involves the use of treatments, including medications, designed to cause death quickly or sooner than expected (Flew and Twycross, 1975). What many believe to be the differences between these two has been a major focus in the ethical debate of euthanasia. Garrard and Wilkinson (2003) quoted James Rachels, who wrote one of the most well-known papers in medical ethics which said, “The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill patient.”

Voluntary and involuntary euthanasia are commonly considered forms of active euthanasia since it involves the use of treatments or medications designed to end life being utilized. Voluntary euthanasia is defined as the physician intentionally administering a treatment or medication, which causes the patient’s death. This occurs only after the physician has received the patient’s full, informed consent (Foley, 1995). On the other hand, involuntary euthanasia involves the act of a physician intentionally administering a treatment, usually medication, to cause the patient’s death. This is done without the patient’s full, informed consent (Foley, 1995).

Before I get started it is important to note a few things. First, though I believe it is necessary for the United States to adopt a law like the Holland’s Euthanasia Law, I do believe the ultimate decision should be left to the patient. This law should merely provide another option for those who desire to participate and their physicians and should not be forced or required by those terminally ill and suffering. Just as a person has the right to die to rid themselves of suffering and disease, a person has the right to

live in suffering and illness. Secondly, this work will not attempt to discuss the need for assisted suicide or euthanasia for patients suffering from any kind of mental health disorders do to the complexity of these kinds of disorders and lack of academia regarding the topic.

In this work, I will argue for the right to physician-assisted suicide by focusing on the patient's right to autonomy while explaining the need to support the United States adopting a law such as the Holland's Euthanasia Law. This practice, in my opinion, can only be made by a rational person and be a voluntary choice. Furthermore, this right is already given to patients in the form of passive euthanasia, where life-sustaining treatment is withheld or withdrawn per request of the patient. This will be further discussed when explaining some of the history of the debate regarding assisted suicide and euthanasia. As explained earlier, this work would not discuss mental health disorders however, it is necessary to explain some of the diseases patient who would desire to participate in euthanasia or physician assisted suicide might be experiencing. Though advanced directives exist, it is necessary to discuss the limitations in order to better support the need for allowing assisted suicide or euthanasia. Due to my argument relying heavily on the ability of the patient's rational and voluntary decisions, I believe that physician-assisted suicide is morally acceptable therefore, I will address the problem with the ethical arguments made against these practices. Additionally, I will be discussing the impact caring for a dying or terminally ill individual has on their family and friends, and finally by providing some personal testimonies and stories.

Chapter 2: The History and The Law

The History of Debating Euthanasia and Physician-Assisted Suicide

According to The New York State Task Force on Life and the Law (1994), the debate of euthanasia and physician-assisted suicide stems historically, consisting of arguments from Plato and Aristotle during the ancient Greece era, Augustine and Thomas Aquinas in the Middle Ages and continues today. These arguments, just as the arguments made today, involved views from those who support and those who oppose euthanasia and physician-assisted suicide. Some asserted that both assisted suicide and euthanasia were morally and ethically wrong therefore, should not be provided no matter the circumstances. On the other hand, others believed that assisted suicide or euthanasia are ethical depending on the situation however, professional standards, and the law should not be changed to authorize either practice. Finally, some advocate that assisted suicide, or both assisted suicide and euthanasia, should be recognized as legally and morally acceptable options in the care of dying or severely ill patients.

The word "euthanasia" was derived from Greek and simply means "good death". It was not considered to be the practice of killing a person out of generosity or kindness. However, the true issue with euthanasia or physician-assisted suicide is the concept of a person ending their life prematurely. Some Greek philosophers, however, argued that suicide would be acceptable under exceptional circumstances. For example, Plato believed suicide to be a cowardly and unjust act however, he also believed suicide to be an ethically acceptable act if an individual had a character either immoral and not able to change. He also or had lost control over their actions due to suffering. However, on

the other hand, Aristotle believed that suicide was an unjust act regardless of circumstances since it deprived the community of a citizen (Papadimitriou et al., 2007).

Though many proponents of assisted suicide and euthanasia argue individual self-determination as a key point, Plato believed it was irrelevant to consider the individual's desire to live or die largely when determining if suicide was an appropriate act. Instead, he argued that an objective evaluation of the individual's moral worthiness was essential and not the individual's decision about the value of continued life.

In contrast to Plato, the Stoics of the later Hellenistic and Roman eras focused more strongly on the welfare of the individual than on the community. They believed that, while life in general should be lived fully, suicide could be appropriate in certain rare circumstances when deprivation or illness no longer allowed for a "natural" life. The Stoics did not, however, maintain that suicide would be justified whenever an individual loses the desire to live. Unlike contemporary proponents of a right to suicide assistance, the Stoics believed that suicide was appropriate only when the individual loses the ability to pursue the life that nature intended.

Those of Christian faith however, argued against suicide. They believed it went against the word of God and therefore was morally wrong. However, by the sixteenth century, some philosophers began to challenge this argument. In his essays (1927), Michel de Montaigne argued that suicide was an act of personal choice and not a question of Christian belief. He wrote that suicide was an acceptable moral choice in some circumstances, mentioning that, "pain and the fear of a worse death seem to me the most excusable incitements". Others agreed and employed a more theological argument to challenge the religious forbidding on suicide. For example, in the early

seventeenth century, John Donne wrote that while suicide can be considered a morally wrong act in certain situations, it should be acceptable if performed with the intention of glorifying God and not when serving one's self-interest.

In the eighteenth century, David Hume defended the moral acceptability of suicide based on the rights of individual autonomy and social benefits. He argued that suicide would be morally acceptable if the good suicide provided for the individual, outweighed the loss to society. Furthermore, he did not believe that all suicides are justified however, argued that when an individual's life is plagued mostly by suffering and despair, suicide should be acceptable (State of New York, 2011).

Other philosophers, such as John Locke and Immanuel Kant, did not favor suicide. Kant believed suicide to be an action that violates moral responsibility. Additionally, he believed to end a rational human beings' life, it required self-preservation. Thus, suicide would compromise the fundamental value of human life. Furthermore, as argued by some contemporary opponents of assisted suicide and euthanasia, Kant also argued taking one's own life was incompatible with autonomy. Instead, he viewed arguments using autonomy as a reason for assisted suicide and euthanasia as a misunderstanding of the concept. Kant believed that autonomy, did not mean individuals are given the freedom to do whatever they desire. Instead he believed autonomy was dependent on one's rational understanding of universal moral rules and one's controlled desires. Locke, who also saw Kant's point of view, argued that life is like liberty. They both represent an inalienable right and therefore, could not be taken from or given away by anyone (Velleman, 1999).

Currently, five states have a “Death with Dignity” statute (Death with Dignity, 2016). Oregon voters approved the Death with Dignity Act at the ballot in 1994. In 1997, a ballot measure aiming to repeal the law was defeated and the Act went into effect shortly after. The Act served many attempts to nullify it and in 2006, The U.S. Supreme Court ruled that Oregon physicians can prescribe life-ending medication under the Act (Death with Dignity, 2016). From 1998 through 2005, 246 people died in Oregon because of physician-assisted suicide, accounting for 32.8 deaths per 10,000 deaths in Oregon during that timeframe. The Washington Death with Dignity Act has been in effect since March 5, 2009. It is similar to the Oregon legislation and has worked as intended since its implementation (Death with Dignity, 2016). Following a 10-year campaign, the Vermont state legislature passed the Act in 2013 after Governor Peter Shumlin signed it on May 20, 2013. The law went into effect immediately and Vermont became the third state to enact a Death with Dignity law, while also becoming the first to be passed through legislation (Death with Dignity, 2016). California is the most recent state to put an Act into effect. Governor Jerry Brown signed The California End of Life Option Act, into law on October 5. The bill should go into effect no later than February 2017 (Death with Dignity, 2016).

The Appeal of Autonomy and the Law

In the United States and most of the West, one of the overriding considerations in supporting physician-assisted suicide and euthanasia is the principle of autonomy (Glick, 2007). John Stuart Mill explained this best in his work, *On Liberty*. Individual liberty and the freedom to make personal choices has long been embraced in American society as fundamental values. Today’s culture, calls for individualism and self-

realization, which makes the principle of autonomy a very attractive topic. The pursuit of these values within a social context, has been accompanied by commitments to promote the overall good of those individuals belonging to society and to protect those vulnerable from harm (Mill, 2005). Many believe to exercise the principle of autonomy, there must be a balance against other fundamental values important to society, such as the reverence for human life. Another question presented by the current debate about assisted suicide and euthanasia explores the way in which society realizes the principle of autonomy. Additionally, topics such as how the tension between autonomy and other ethical and societal values should be resolved.

Those who support assisted suicide and euthanasia believe the respect for individual self-determination requires these practices to become legalized. Furthermore, they believe individuals have a fundamental right that allows them to direct their lives. This right encompasses the control over the timing as well as the circumstances in which their death occurs. Though advocate groups do not argue for an absolute right to commit suicide, a majority believe that in appropriate cases, suicide should be allowed to minimize suffering or improve human dignity. Some have also argued that a patient's right to self-determination regarding death is necessary to ensure a balance between the increasing availability and use of life-prolonging technology in modern medicine. Additionally, the patient's desire for a more holistic approach to end-of-life care versus allowing suffering to occur (Givens & Mitchell, 2009). In a survey performed in the Netherlands where euthanasia is legal, the conclusion found was the public had an acceptance of euthanasia in a hypothetical scenario which considered the importance of a dignified death, concerns of becoming dependent on others, or being a burden to

relatives. The results to this survey were interpreted as reflecting the desire to have more control over an individual's death experience while lessening the involvement of others. As concluded by the authors, both are aspects of the principles of self-determination and autonomy (Givens & Mitchell, 2009).

Additionally, those who advocate for assisted suicide or euthanasia suggest the physician's participation in assisted suicide or euthanasia is necessary and can support a choice embraced by the patient, which is consistent with his or her own beliefs.

Zimbelman (1994) believed a patient's claim for their "right to die" is encompassed in the moral principles of respect for individuals and should therefore, be shown due care and compassion from health care providers and relatives. Furthermore, providers should not become part of what is harming the patient or become part of their pain and anguish (Zimbelman, 1994).

In 1997, there were two cases involving physician-assisted suicide brought to the courts (William, 2006). In *Vacco v. Quill* and *Washington v. Glucksberg*, the Supreme Court ruled that there was nothing in the constitution that protected the right of a patient to participate in a physician-assisted suicide or euthanasia. In *Vacco v. Quill*, several physicians including Dr. Timothy Quill, argued that the New York state ban on physician-assisted suicide was unconstitutional. Their argument was affirmed by the Second Circuit Court of Appeals however, this was later denied by the Supreme Court. This resulted in the upholding of New York's law against assisted suicide. Additionally, in *Washington v. Glucksberg*, the Ninth Circuit Court of Appeals ruled a Washington state law against assisting suicide was unconstitutional. This was later reversed by the Supreme Court. In these two cases, the lower courts believed the state laws prohibiting

physician-assisted suicide were a violation of the Equal Protection Clause of the Fourteenth Amendment which states:

No State shall ... deprive any person of life, liberty, or property, without due process of law....

They argued for a constitutional “right to die” in the same vein as a right to privacy has been interpreted under the Fourteenth Amendment. Though the Supreme Court did not agree, they did allow for the states to decide future cases.

Though legal verdicts concerning cases of assisted suicide, advanced directives, and euthanasia lack consistency, legislation has also played a role in the long debate. American law had long clearly drawn a distinction between assisted suicide and euthanasia, treating euthanasia as a far more serious offense. In New York and many other states, though both practices are considered felonies, assisting suicide is usually classified as manslaughter, while euthanasia is classified as second-degree murder (State of New York, 2011). One of the first cases heard in a courtroom involved the use of an apparatus designed to allow patients to take their own life painlessly. This case resulted in murder charges being filed against Dr. Jack Kavorkian who was responsible for inventing the machine. Though he was cleared of all charges, Dr. Kavorkian’s eventually had his license to practice medicine suspended after he assisted two other patients against a court order (Anderson & Caddell, 1993). In another case, *Cruzan vs Director, Missouri Department of Health*” also tested the limits of legislative. The parents of a young lady requested the court to allow the discontinuation of nutrients. In this case, the Supreme Court ruled that medical devices such as gastrostomy tubes and

other methods of artificial nutrition were medical treatments and therefore, ruled in favor of the parents.

In the 1974 case, “People of the State of New York,” Vincent Montemarano was charged with murder by euthanasia however, was found not guilty after a trial. Eleven years later, Roswell Ward Gilbert was found guilty of first degree murder and sentenced to a life-time in prison. Though active euthanasia is still illegal, the inconsistency of legal outcomes, causes much conflict for physicians caring for patients suffering from terminal illnesses (Anderson & Caddell, 1993).

One of the very first “Right to Die” legislative proposed, was drafted in 1906 in Ohio however, it was not successful (Bio., 2015). The defeat would remain until a proposal made by Luis Kutner, an attorney, in 1969. Kutner proposed the use of a living will, a legal document that allows the patient to make their wishes regarding what medical procedures and treatments they want to be a part of known. It also allowed the patient to designate an agent, advocate, or surrogate to speak on their behalf when they are unable to do so.

In 1976, the New Jersey Supreme Court decided the matter of Karen Ann Quinlan, a 21 year-old woman who fell into a coma in April of 1975. Karen was put on life-sustaining equipment and her parents wanted to remove her from life-support. They wanted to end her and the family’s suffering however, the hospital denied their requests. The case made its way to the New Jersey Supreme Court, and eventually Karen’s parents’ request was granted. A judge decided the parents had the right to remove their daughter from life-sustaining equipment. Though she lived an additional nine years before passing from pneumonia, she was removed from the life-supporting medical

equipment. This case began the right of the removal of life-sustaining medical equipment (William, 2006).

A similar case appeared before the United States Supreme Court in 1990. This case involved Nancy Beth Cruzan, a 25-year-old involved in a car accident in 1983. As a result of her injuries, Nancy went into a persistent vegetative state. Her parents went through the court system requesting to have her feeding tube removed. A trial confirmed the parent's right to remove their daughter's feeding tube however, the Supreme Court of the State of Missouri reversed the decision. This case landed in the United States Supreme Court and they too ruled that while a competent person does have the right to refuse lifesaving treatment, an incompetent person must have "clear and convincing evidence" of what their desires involving the removal life-support and being allowed to die would be. Since there was not clear and convincing evidence of Nancy Cruzan's wishes, the decision made by the Missouri State Supreme Court was upheld. It was later determined by a Missouri court that clear and convincing evidence of Cruzan's wishes was available, which allowed the parents to remove the feeding tube, Nancy died 11 days after her feeding tube was removed.

Some proponents promote legalizing assisted suicide and voluntary euthanasia as a measurement of progress toward granting individuals further control over their end-of-life process. Individual beliefs regarding the significance of death and the meaning of life differ significantly. For proponents, establishing assisted suicide and euthanasia as an accepted alternative would promote and respect this diversity (State of New York, 2011). For others, however, the decisive principle of the patient, should be a right free of state interference when individuals voluntarily choose to end their lives. According to

Zimbelman (1994), individuals are naturally vested with an almost absolute moral and legal right to decide what kind of health care they are and are not to receive.

Furthermore, due to our society's respect for our rights to self-determination as well as for patient autonomy, there is no moral basis for the state or unnecessary third parties to be involved in the health care decisions of individuals specifically, those regarding life-and-death care and treatment. When differences on basic issues such as life and death are deeply invested, and involve prolific values, it is necessary for a society to allow each individual member to decide for themselves. Many believe that, even if pain can be alleviated, the individual's right to control his or her death should prevail. Pain management and hospice care are better than ever before and can provide a form of relief however, for many, this is not a solid option. The option they would rather exercise is that they no longer want to live, and they believe the decision to die belongs to them alone. Some believe that assisted suicide and euthanasia can promote autonomy in some cases however, the negative consequences of the practice far exceed the benefits (State of New York, 2011). Furthermore, many argue that the value of human life outweighs the claim to autonomy. Instead they argue definitively against allowing suicide assistance or direct killing, regardless of the benevolent motives.

Additionally, others argue that when an individual seeks to end their own life, it intrinsically contradicts the value of autonomy. According to Glick (1997), a commonly missed argument involves the position of the spiritual father of autonomy, John Stuart Mill. In his book *On Liberty*, he excluded from the freedoms conferred by autonomy the right for an individual to sell themselves into slavery as this was viewed as a self-defeating act. Though Mill never ruled out suicide, many make a case that

suicide is a greater violation of autonomy than an individual selling themselves. As the freedom or ability to sell oneself into slavery, the freedom or ability to end one's life should be limited for the sake of preserving the true meaning of freedom. Furthermore, Daniel Callahan believed it to be fundamentally and morally wrong for one person to give his life and their fate to another, regardless of the good consequences (Glick, 1997).

Another view argued when a patient's autonomy is the reason for justifying active euthanasia is whether a decision for suicide can truly remain an autonomous one in their current situation. The doubt lies in the patient's ability to make a true autonomous decision when they are being influenced by their family, friends, and society. Still others are more pragmatically concerned about the influence physicians would exercise in the decision-making process. These individuals question who, the patient or the doctor, truly benefits when this type of decision is made (Glick, 1997). At the foundation of the relationship between the physician and their patient is trust. When a patient dealing with an illness reaches a point of vulnerability and helplessness, they turn to their physician for guidance. Physicians are expected to exhaust all possible means to achieve a cure, deliver relieve, and help the patient cope with the process involved in the struggle until death occurs. However, during this process, the physician could grow frustrated with their inability to accomplish their mission in curing the patient and could suggest assisted suicide or euthanasia in efforts to appease themselves instead of the patient (Glick, 1997).

The most recent story involving a patient opting to take their own life with the assistance from a physician involves Brittany Maynard. According to a story published

by CNN told by Brittany Maynard herself, she was a 29-year-old woman who was diagnosed with terminal brain cancer. She had two surgeries, a partial resection of her temporal lobe and a partial craniotomy as an attempt to stop the growth of the tumor. However, her tumor came back more aggressive and she was given only 6 months to live. The doctors recommended she have full brain radiation however, after her and her family reviewed the side effects, they decided to not go through with it since as she explained, no treatment would save her life and the prescribed treatment would destroy what little bit of time she had left. Instead, she decided that she would prefer to end her life on her own terms with the aid of a doctor and specialized drugs. She moved to Oregon with her family, one of five states including Montana, Washington, New Mexico and Vermont that allow physician-assisted death and on November 1, 2014 she ended her life when her suffering became too great as authorized under Oregon's "Death with Dignity Act."

Chapter 3: Ethics, Religion, and The Medical Aspects

The Ethics

Discussions regarding the ethics of suicide also involve the assistance of committing suicide and the act of killing someone for benevolent reasons. When death is caused by intentional actions, this is commonly referred to as active euthanasia or euthanasia. In addition, the terms "euthanasia" and "passive euthanasia" are sometimes used to describe withholding or withdrawal of life-sustaining treatment. When euthanasia occurs at the request of the patient, it is often referred to as voluntary euthanasia while when it occurs to someone who lacks the capacity to consent or refuse is called nonvoluntary euthanasia.

Many people, especially those in the medical field, make a moral distinction between active and passive euthanasia. Due to the nature of the actions or because of differences seen on the impact these actions have on society, the acceptability of the two differ significantly. Many think it is acceptable to withhold treatment and allow a patient to experience a natural death however, to be involved by performing a deliberate act which results in the patient's death is never acceptable. Furthermore, some feel there are some intrinsic differences between assisted suicide and euthanasia. One example given is, when a provider writes a prescription for a lethal dose of medication, they are less directly involved in the patient's death in comparison to a physician who physically administers the medication that causes the death of the patient. With this kind of assisted suicide, the patient is the one responsible for taking his or her own life, usually without the presence of the physician.

Another factor considered is such as the physician's intentions may be more complex. A physician may provide the necessary information for their patient to commit suicide to make the patient feel more empowered however, may desire the patient not follow through. In addition, the patient's own actions intervene between that of the physician's involvement in the patient's death, therefore the physician's causal responsibility could be unclear. (State of New York, 2011).

Those who are for physician-assisted suicide, believe it is less subject to abuse than euthanasia. The patient is responsible for the final act when assisted suicide occurs therefore, they believe, more pressure or convincing a patient to commit suicide would have to take place in comparison to what it would take to gain an agreement for euthanasia. Additionally, a patient who becomes uncertain after requesting assistance in suicide could decide to not follow through on the suicide. Furthermore, the potential for intimidation or influence does not come from the doctor's actions in euthanasia, but also from his or her presence at the time of death. Some patients could be embarrassed or even intimidated to disclose any uncertainty to a physician on the verge of giving a lethal injection. This could also occur if they become concerned their doctor might be hesitant to administer the injection at a different time. Therefore, many distinguish the difference between situations when a physician assists a suicide by providing information or a prescription from situations when the physician is present at the time of the suicide and directly aids or supervises the act. Still, others are not concerned with this distinction, and believe that the physician's presence could show caring or a desire to accompany the patient in the final moments of life (State of New York, 2011).

Additionally, those who are for both practices think the risks of error and abuse are similar for both practices however, they believe with the appropriate safeguards, these risks and errors can be limited. Even more so, those who oppose both assisted suicide and euthanasia also believe both practices pose similar risks however, do not believe these risks are unacceptable. Much of those who stress the similarities between assisted suicide and voluntary active euthanasia still argue there are some differences between the two practices. Some believe that though both should be allowed, they prefer the option of assisted suicide since they believe this will minimize the possibility of any errors occurring. On the other hand, some oppose both practices and believe active euthanasia as being more problematic.

The Religious Debate

Autonomy can also be found in the religious debate. The religious debate surrounding the end-of-life issues can be summarized by two main focal points (Burdette, Hill, & Moulton, 2005). The first being the side of the religious spectrum where individuals prefer autonomy in deciding between life and death. This side, which is predominantly made up of Protestant groups, places an emphasis on the patient's right to control end-of-life care. Those for autonomy, argue that God's authority extends to matters of life and death and he has granted humanity the right of personal choice.

On the other side, there are those who believe in the absolute dominion of God and trust only him to determine matters of life and death. Many reject euthanasia because they believe it to violate the fundamental prohibition against killing or murdering someone (State of New York, 2011). They interpret this prohibition as a basic moral and social principle therefore, they believe killing is only necessary for self-

defense or when protecting others. This understanding has been made apparent from many diverse religious, philosophical, and personal perspectives. Those who argue against autonomy believe that God holds exclusive authority over the transition from life to death (Burdette, Hill, & Moulton, 2005). Research suggests that individuals who are liberal Protestants, Jews, and/or have no religious affiliation tend to generally support physician-assisted suicide. On the other hand, those who are conservative Protestant and/or Catholic tend to be more opposed to assisted suicide and euthanasia. Furthermore, research shows conservative Protestants and Catholics are generally against the removal of treatment or withholding of treatment in the event of an incurable disease (Burdette, Hill, & Moulton, 2005).

Opinions on assisted suicide and euthanasia are rooted in religious beliefs about the value and meaning of human life, it also resonates to and informs secular values and attitudes, including our laws. Assisted suicide is opposed by many due to its end state. Although it does not violate the ban against killing directly, many believe it renders human life dispensable and implicates physicians or others in participating in the death of the patient. Many believe that assisted suicide and euthanasia are not only a private choice made by another person however, involve others and their actions. Due to the involvement of others, assisted suicide and euthanasia are considered social and communal acts therefore, social, moral, and legal principles must be considered. A physician who assists with a patient's death is believed to be contributing to the results. Many believe this kind of power should never be given to one person regardless of whether the individual consents to it.

For some, assisted suicide and euthanasia are not inherently incompatible with self-determination, instead they believe if these practices were to be applied in the daily routines of medical practice and family life, it would undermine the autonomy of many individuals. In many cases, a patient who requests euthanasia or assisted suicide may have undiagnosed major clinical depression or another psychiatric disorder that prevents him or her from formulating a rational, independent choice. Other patients may feel compelled to end their lives because they lack real alternatives, due to inadequate medical treatment or personal support. Offering suicide assistance, but not good medical care, could be especially troubling for some segments of the population. As expressed by one doctor who manages a Latino health clinic, legalizing assisted suicide would pose special dangers for members of minority populations whose primary concern is access to needed care, not assistance to die more quickly (Burdette, Hill, & Moulton, 2005).

Many religious traditions are against the practices of assisted suicide and euthanasia since they violate the basic value of human life. Additionally, many religions view suicide as an unethical, sanctioned choice. They reject assisted suicide and euthanasia based on the general values, such as the appreciation for the life and value of members in the society, the individual's responsibility to society, and the obligations to all members of society (Burdette, Hill, & Moulton, 2005). Furthermore, differing religious views share a dedication to compassion for patients and those suffering from illnesses. They believe that this compassion should be expressed by offering care and companionship, not assisted death or medical killing, to the severely ill (Arkes et al., 1991).

The Catholic Church rejects assisted suicide and euthanasia. This is made apparent in the 1980 Vatican Declaration on Euthanasia, and affirmed several speeches made by Pope John Paul II. Judaism also shares similar views as well. The American Lutheran Church and the Episcopal Church also believes these practices to be ethically unacceptable. The Unitarian-Universalist Association, however, has expressed support for legalizing the practices (Burdette, Hill, & Moulton, 2005).

The Views of Medical Organizations

Professional organizations such as the American Medical Association, the American College of Physicians, and the American Geriatrics Society have explained their views in the debate about assisted suicide and euthanasia in recent years. Each of these organizations have consistently agreed that assisted suicide and euthanasia is the withdrawing or withholding of treatment, and this could potentially result in fatal side effects (American Medical Association, 1992).

Consistent reports from professional organizations claim most pain and suffering experienced by patients can be resolved still, some patients find their situation so intolerable that they request assisted suicide or euthanasia. These organizations believe that Physicians should explore their patients' concerns, investigate whether the patient is suffering from depression, and improve palliative care as needed. Generally, the organizations recognize that assisted suicide or euthanasia could be beneficial to a limited number of patients. They believe though, such actions are illegal, and by allowing physicians to participate in these kind of practices, damages to the physician-patient relationship could occur. Furthermore, they believe these actions pose risks to society specifically, those who are vulnerable.

Still, other medical societies have differing views. Though they have not explicitly supported assisted suicide and euthanasia, the American College of Physicians Ethics Manual has not definitively rejected these actions either. The manual recommends that physicians respond to patient requests for euthanasia or assisted suicide by investigating further into why the patient is making the request and addressing the patient's concerns. On the other hand, the American Geriatrics Society recommends physicians not provide interventions that directly and intentionally result in the patient's death. Additionally, they urge that the current legal prohibition of physician assistance to commit suicide and euthanasia remain unchanged.

The Council on Ethical and Judicial Affairs of the American Medical Association similarly states that "physicians must not perform euthanasia or participate in assisted suicide." They believe that though it may seem beneficial for some patients in some cases, allowing physicians to perform these types of actions would result in unacceptable risks including, mistaken or coerced deaths. Additionally, it could also have a negative impact on both the public's perception and the practice of medical practice.

Most of the disability rights advocates and organizations around the world oppose assisted suicide and euthanasia (Golden & Zoanni, 2010). This is because they believe risks exist for people with disabilities and believe society might create a devaluation of disabled peoples' lives. Furthermore, they oppose assisted suicide and euthanasia due to the direct impact it would have on the disability community and the overall society. .

Attitudes of the Public and Medical Professionals

The public's and physician's attitude supporting and opposing assisted suicide or euthanasia has also been seen throughout the debate. Surveys of public opinion gathered in the United States, Canada, and Australia has shown an increasing number of people support physicians providing painless euthanasia for patients with an incurable illness when requested by the family or patient (Teisseyre, Mullet, & Sorum, 2005). In the United States alone, amounts grew from 34% in 1950 to 53% in 1973 and 63% in 1991. In contrast, medical professionals were found to be less favorable. A survey performed in 1996, surveyed physicians throughout the United States found that 36% of respondents would be willing to assist in their patient's death by prescribing medication and 24% would be willing to provide a lethal injection, if assisted suicide or euthanasia was to become legalized (Teisseyre et al., 2005).

Physicians in France have been more reserved when advocating for physicians to intervene or assist with ending their patients' life. Nonetheless, physicians in France that work in intensive care have employed withholding or withdrawing life-supporting treatments for patients suffering from incurable illnesses. They have also occasionally administered drugs to hasten death (Teisseyre et al., 2005).

Other professional surveys performed have asked physician about their stance and behaviors related to physician-assisted suicides as well as euthanasia (Foley, 1995). Accordingly, 13% to 43% have been asked to participate in euthanasia or physician-assisted suicide while, 1% to 20% have performed some action that could be considered euthanasia. Furthermore, 28% to up to 70% of the physicians that participated in these surveys, said they would consider euthanasia if it were to be supported by legislation.

However, these surveys have limitations. Much of these surveys taken have been directed toward the attitudes of the physicians versus the physician's involvement in aiding with death. Additionally, they are difficult to compare due to the multitude of study designs, geographical location of surveys being performed, and time frame (Foley, 1995).

In a survey conducted in the United States in 1988 by The Hemlock Society, 5,000 California physicians were asked several questions about assisted suicide. Though only 12% of the polled physicians returned the survey, 57% of them reported they had been asked by their patients to assist in their death particularly by those suffering from a terminal illness with persistent pain. Approximately 23% admitted to taking steps to hasten death in response to a patient's request, the majority, approximately 81% admitted to doing it more than once. Furthermore, two-thirds of the respondents believed voluntary euthanasia as needing to be legalized with certain carefully defined circumstances. (Foley, 1995).

The Center for Health Ethics and Policy at the University of Colorado performed a survey on all licensed physicians in the state. Thirty-one percent of the physicians surveyed responded and of those, 37% admitted to providing medication to their patients with the intent of aiding in their patients' death (Foley, 1995).

In another survey performed in 1988, the San Francisco Medical Society surveyed its members and of the 1,743 surveyed, 676 were returned. 70% of those who responded believed that terminally ill patients should have the option of active euthanasia. 54% also believed, a physician should be allowed to administer the lethal

dose of medication to aid their patients with death and 45% would give consent if legalized (Foley, 1995).

In an article found in *The New England Journal of Medicine* (1996), the views of physicians in Oregon were surveyed because of the Death with Dignity Act being passed in November of 1994. The survey, which was conducted from March to June 1995, surveyed all physicians who might be eligible to prescribe a lethal dose of medication if the Oregon law was upheld. The physicians who received the survey, were asked to complete and return the confidential 56-item questionnaire. 70% of the 3944 eligible physicians who received the questionnaire responded back. 60% of the completed surveys indicated that physicians believed physician-assisted suicide should be legal in some cases. Additionally, 46% of the physicians that responded indicated they would be willing to prescribe a lethal dose of medication if it were to become legal. On the other hand, 31% of the respondents would be unwilling to prescribe a lethal dose of medication on moral grounds. The survey also found that 21% of the respondents had previously received requests from their patients for assisted suicide while 7% granted their patient's wishes and complied. The study concluded that physicians from Oregon exhibited a more favorable attitude toward legalized physician-assisted suicide. Additionally, it found that physicians in Oregon were more willing to participate as well as already participate in greater numbers than other surveyed groups of physicians in the United States. Still, a minority of physicians in Oregon opposed the legalization and participation of assisted suicide on moral grounds.

Additionally, in an article printed in *The New England Journal of Medicine* (2013), the two physicians explained their reasoning for not supporting Physician-

assisted suicide. Though they can understand why it is necessary for patients to be of sound mind during the end of their life, they believed that the art of healing should always remain at the core of medical practice, and the role of healer involves providing patients with hope and renewed aspirations despite tenuous and temporary. These physicians instead, advocate for palliative care.

Palliative Care became a huge focal point for the world of healthcare because of the start of the modern hospice movement in the 1960s (Vincent, n.d.). Though, palliative care is well known as being the type of care a patient receives toward the end of their life, it is something that is not solely reserved for the end of life. Many different definitions of palliative care exist and involves many aspects of medical treatment. According to the World Health Organization's definition of palliative care; palliative care provides relief from pain and other symptoms caused from the patient's illness or disease, It affirms life however, requires death to be regarded as a natural part of life, should not intend to hasten or postpone death, offers a support system to the patient and to the patient's family, integrates the psychological and spiritual components to the patient's care, encompasses a team approach to resolves the needs of the patient and their family, and finally, it should enhance the patient's quality of life (Vincent, n.d.). The goal of palliative care is to provide complete care for the patient.

Those physicians who oppose assisted suicide, believe that palliative care, provides the opportunity for patients to die healed (The New England Journal of Medicine, 2013). Furthermore, they believe part of a physician's duty, is to uphold the sacred healing aspects of medicine instead of destroying it by assisting in suicide or euthanasia.

The Role and Responsibilities of Physicians

Though any individual can assist with suicide or with causing death, the primary focus of the debate has been about assisted suicide and euthanasia generally being performed because of a physician's actions. The issues of assisted suicide and euthanasia can create a very challenging emotional situation for physicians. Physicians are responsible for determining how to best respond to a patient's suffering, or to a direct request for assistance in ending life. In these type of situations, physicians are naturally conflicted between their personal commitments, conscientious judgment, and, the policies designed to ensure no further harm to their patients occurs (State of New York, 2011).

The debate has resulted in some complex questions being raised about the duties and goals of physicians and medical profession. What is the physician's role when their patient requests assistance with suicide or euthanasia? How does this role fit into the overall goals of medicine? What kind of social impacts would this role and practices have on the physicians and on the physician-patient relationship? As the growing public debate continues, these questions have been the major focus of the medical community.

Medicine has traditionally been guided by the Hippocratic Oath, which explains physicians are not to harm patients. According to Anderson and Caddell (1993), a major aspect of the ethical debate against physician-assisted suicide is the result of these parts of the Hippocratic Oath. The oath, per some interpretations, clearly

explains physicians should not participate in euthanasia. Upon graduation from Medical School, physicians promise the following:

I will neither give a deadly drug to anybody if asked for it nor will I make suggestions to this effect. Similarly, I will not give a woman an abortive remedy. In purity and holiness, I will guard my life and my art.

The oath also commits the physician to employ therapeutic measures to benefit the patient. Though clearly opposed, the dilemma caused by the continued use of the Hippocratic Oath is its datedness. Physicians promise to not perform any abortions or surgeries as well as to keep a patient's medical information a secret from all besides relatives however, these directives are consistently not followed (Anderson & Caddell, 1993).

Still, others believe many aspects of physician-assisted suicide compromise physicians' long-standing ethical norms. In a 2011 annual report on the Death with Dignity Act in Oregon, it showed that fewer than 10% of the time an "assisted deaths" was performed, the physician was present. Those who oppose assisted suicide believe this is because the physicians have a moral intuition that intentionally facilitating or inflicting death is wrong (The New England Journal of Medicine, 2013).

Those who advocate for assisted suicide and euthanasia, to include physicians, urge that these practices fall into the professional role and responsibilities of physicians. They believe that part of the physician's responsibility to care for patients involves promoting patients' self-determination and improving their overall well-being. Furthermore, some agree that if it would be beneficial to the patient, it would be appropriate for a physician to assist suicide or perform euthanasia when these actions

are chosen the patient still, others believe the opposite. However, physician realize there is a conflict that exists since if a patient's suffering can only be eliminated with death, a physician would be conflicted with their obligations relieve suffering and preserving life

Many proponents consider assisted suicide to be less hazardous to the integrity of the medical profession than euthanasia. They believe that by eliminating the current rules imposed on physician-assisted suicide and euthanasia, the physicians could provide an appropriate option when necessary to each patient. Furthermore, a physician's willingness to provide these types of services would further demonstrate their commitment to their patients throughout their entire life.

In the United States, the act of committing suicide carries a very negative stigma. When a patient seeks a physician's assistance however, this would remove that stigma while demonstrating the decision for suicide was made from necessity and therefore justified under the circumstances. The physician's involvement would provide an approval from society, or more accurately helps counter what would otherwise be unwarranted social disapproval. The moral authority of physicians allows them to assist patients seeking to end their lives upon their request. Additionally, many believe physicians ultimately play a unique role in assisting with their patients' deaths. This is primarily due to the access to drugs as well as the knowledge they have to cause a quick and painless death.

Furthermore, many believe that only physicians should be allowed to assist suicide or perform euthanasia. Due to their knowledge and extensive schooling, physicians can discuss the patient's medical condition in addition to exploring

alternative means for alleviating pain and suffering. Finally, they can determine the reliability of the patient's judgment to ensure it is not impaired by any mental conditions. Physicians can also administer the lethal dose to allow for a quick and painless death for their patient. Most importantly, limiting the number of people authorized to assist suicide or perform euthanasia would allow for better accountability, protect against abuse, and ensure compliancy.

Providers should also play a vital role assisting as well since family members and friends might be hesitant to cause or contribute to a patient's death. Still others believe that another person, such as a family member or close friend, could help the patient through death. Regardless of the type of relationship the patient may have established with the physician or the unwillingness to comply with the patient's request, a family or friend could better assist. In some cases, family members or friends, have assisted the patient with suicide or with causing death. Some advocates believe these kinds of actions or "mercy-kills", should be considered as an acceptable defense to criminal prosecution.

Two of the major reasons many physicians and others oppose assisted suicide and euthanasia is the belief that these practices compromise the integrity of medicine as well as the patient-physician relationship. These individuals urge that medicine is to be devoted to healing and requires the promotion of life. By using medical practices and techniques to achieve death violates the fundamental values of medicine. Additionally, some argue that allowing physicians to perform these kinds of actions would compromise the trust their patients have for them, and damage the way medicine is viewed by both the public and physicians.

Furthermore, some who oppose assisted suicide and euthanasia believe that, regardless of the physicians' motivations being in compassion and well-natured, a physician abandons the patient when he or she deliberately causes the patient's death. Others note that physicians have great power and should show careful judgement when utilizing that power. Therefore, strict boundaries are necessary to ensure there is no misuse of power. Professional limitations might impinge on an individual physician's personal sense of vocation in some cases however, are necessary to accomplish public confidence in the medical profession as well as protect against abuse.

Others urge that the physician minimizes natural psychological barrier by relying on medical practices to assist suicide, leading some individuals to end their lives without facing the full implications of the act. Still, some argue that the decision to assist suicide or perform euthanasia is realistically not a medical judgment, and instead belongs outside the parameters of the patient-physician relationship. Therefore, it is necessary to oppose the thought that physicians should be granted special authority allowing them to assist suicide or perform euthanasia. Additionally, many think that assisted suicide and euthanasia would create more of an issue being performed by physicians than being performed by other individuals. The risk they believe physicians performing these types of actions consist of abuse in addition to the threat of the integrity to the medical profession.

Finally, some do not believe in the concept of killing or death as part of healing or a cure. Instead, they believe this type of medicine falls in line with periods in history when the professionals in the medical field were used to facilitate the end of human life. The practice of mass murder or euthanasia that occurred in Nazi Germany

do not resemble contemporary proposals for euthanasia however, they flourished because of actively killing the severely ill. Furthermore, they were built on proposals made earlier by German physicians and academics in the 1920s prior to the Nazis taking power (The History Place, 1997). As the policies, currently being advocated for in the United States, these proposals were meant to be for those who were severely ill, and mandated review panels as safeguards.

Chapter 4 Killing and Allowing to Die

The Debate Within the Debate

The current debate about assisted suicide and euthanasia has brought about questions regarding whether, intentionally killing someone versus allowing a person to die are ethically and morally different. These differences are generally described as the difference between “active euthanasia” and “passive euthanasia” where active euthanasia involves a doctor actively doing something to kill the patient, such as administering a lethal injection and passive euthanasia involves withholding or withdrawing life-support measures and allowing someone to die.

Medicine is forever changing and the debate about euthanasia and assisted suicide to a certain extent has played a role in this. Developments made in the medical field have provided an increased amount of treatment types and options that should be made toward the end of life. To withhold and/or withdraw life-sustaining treatment as requested by the patient have become widely accepted and to an increasing extent widely practiced. In fact, many physicians have played a role in the decision-making process as well as in actions to end life-sustaining treatment, allowing for them to control the timing and manner of the death of their patients.

Proponents believe these actions are like those involving assisted suicide and euthanasia. They focus on challenging the distinction between intentional killing, which is viewed as always wrong, versus allowing to die, which is widely accepted. For those who reject this distinction, policies authorizing assisted suicide and euthanasia are favorable while for those who oppose, no distinction exists between assisted suicide and euthanasia. Still others believe that regardless of the differences, nothing justifies a

policy allowing one practice while forbidding the other. This belief is commonly shared by those who support both practices and by those who oppose both.

Against the Distinction

Some believe that declining treatment is not the same in principle as actively taking steps to end a patient's life even though the intentions, motives, and outcomes might be identical in both situations. In each situation, they argue that the individual making the decisions, aims to end the patient's life. Many supporters of assisted suicide and euthanasia believe that currently, society accepts decisions to decline life-sustaining treatment. These actions, such as withdrawing a respirator or failing to provide artificial nutrition and/or hydration, effectively cause death therefore constitute killing. In most cases, ending a person's life is wrong since it deprives that individual of the benefit of continued life, and violates their rights. Still, patients decide to stop or withhold life-sustaining treatment because they perceive life as a burden and wish to die. They give up their own benefit from a continued life therefore, give up their own rights. This is exactly what would occur if the patient wanted to participate in assisted suicide or euthanasia.

Judith Lichtenberg (1983), claims that the action of killing and allowing an individual to die are, in themselves, morally equivalent. Only differences among situations is that they are asymmetrical regarding the motives, required efforts, probability of outcomes, etc. She tells us to imagine a situation where a person is stranded on a desert island that provides no food or resources. A sailor appears with a ship carrying plenty of food and resources. Now consider two scenarios. The first in which the sailor kills the stranded man, and the second in which he refuses to take him

aboard the ship or to share his food or resources with him. It appears the sailor's actions are morally equivalent in both scenarios. Denying the stranded man any help is the same as killing him. Why does it seem morally equivalent here and not in other cases? Lichtenberg answers this by explaining that the effort required of sharing any food or resources is essentially the same as the effort required to not kill the man. Furthermore, death is the certain outcome for the stranded man in either scenario. We would wonder why the sailor would leave the man in the face of certain death, just as we would wonder what motivated the sailor to kill the man. The only difference in these two scenarios is that, one involves killing the stranded man while, the other involves letting the man die. To analyze whether there is a moral difference between killing and letting die, one should strip away the external factors that may make the situation asymmetrical. Therefore, what is the difference between a doctor allowing a patient to die and actively killing a patient?

For the Distinction

Despite such claims, the distinction between killing and letting die, is widely accepted and supported, in society and in the medical field. Many believe that the nature of the action in each case is drastically different. Decisions to withhold or withdraw treatment allow the natural course of the disease to continue and cause the death of the patient. The decision maker determines that certain treatments are not necessary or appropriate, and the physician curbs their desire to impose interventions that would legally constitute battery. Furthermore, forgoing treatment does not always immediately result in a patient's death. Instead, the patient may continue to live longer than expected.

The AMA calls physician-assisted suicide an “inappropriate extension of the right to refuse treatment” and provides two reasons. First, it claims that the patient’s right of self-determination is a right to accept or refuse offered interventions however, it is not to decide what should be offered. The patient’s right to refuse any kind of life-sustaining treatments does not immediately give the right to insist that others act to bring on death. Secondly, it claims that when a life-sustaining treatment is declined, the patient dies mostly due to the underlying disease. The disease can take its natural course and death occurs as a result. Paul Ramsey in *The Patient as Person; Explorations in Medical Ethics*, argues that forgoing treatment is not simply an indirect means of killing. "In omission, no human agent causes the patient's death, directly or indirectly. He dies his own death from causes that it is no longer merciful or reasonable to fight by means of possible medical interventions." However, with assisted suicide or euthanasia, death is hastened by taking a lethal drug. Although a physician cannot force a patient to accept a life-sustaining treatment against his will, it does allow for a physician to provide a lethal drug to the patient. A physicians’ inability to prevent death, does not mean that the physicians can help cause death. This argument supports the moral distinction between killing and letting die.

This distinction in the nature of the acts of killing and allowing to die focuses on the differences in causation. On one side, the decision maker seeks to cause death and provides the means necessary. On the other, the decision maker accepts however, does not cause the person's death. One well-known argument that applies the distinction between killing and letting is the Supreme Court’s 1997 *Glucksberg* decision. In the decision, Chief Justice Rehnquist writes “Respondents contend that in *Cruzan* we

‘acknowledged that a competent, dying persons has the right to direct the removal of life-sustaining medical treatment and thus hasten death’...and that ‘the constitutional principle behind recognizing the patient’s liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication’.” Rehnquist argues against the respondent’s view and insists that the liberty interest in deciding to withdraw life-supporting treatment does not come from personal autonomy. Instead, he believes it comes from the history and tradition of the law, that touching someone without consent constitutes battery. If touching someone without consent is battery, and since medical treatment generally requires consent, one indeed has the right to refuse any unwanted medical treatment. Rehnquist continues by explaining that the decision to commit suicide with the assistance of another or a physician could be just as significant as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.” Rehnquist continues by saying that in the *Cruzan* decision itself, the court gave no indication that a right to refuse treatment meant there was a right to assisted suicide.

For some, the distinction considered most important is the difference between the consequences from killing versus allowing to die. Accepting the killing of individuals is open to abuse therefore, provides a greater risk to the sick and weak of society. Additionally, those who oppose assisted suicide and euthanasia argue that potential for the negative impact associated with active killing on those involved and on the society, are greater and abuse wider, than with just allowing the patient to die.

Patients have a strong moral and legal right to refuse treatment and when those decisions are respected and the patient can forgo treatment, this recognizes the patient's right. On the other hand, people do not have the same basic right to be actively involved in allowing others to assist them in achieving their death.

Chapter 5: Benefiting the Patient

Suffering and The Need for Relief

A major factor in the debate involves the patient's suffering and the need for relief. People suffer from many different causes and in different ways. They may experience pain, physical discomfort or distress as well as psychological distress. The goal of medicine is to relieve a patient's suffering. The debate about euthanasia and assisted suicide explores how to help suffering individuals find relief while protecting from harm. Furthermore, compassion for patients in pain or with unrelieved suffering is commonly addressed however, the disagreement focuses on how society can best care for these patients. Disagreement also exists regarding whether making assisted suicide or euthanasia legal would provide reassurance or become problematic for sick and/or disabled individuals.

Those who support euthanasia and/or physician-assisted suicide believe that these practices are the most effective way to help some patients experiencing extreme pain or psychological distress. Many believe that, in certain cases, a physician's compassionate desire toward their patients, provides the justifiable means for allowing these practices. Contemporary advocates urge that, regardless of the advances made in palliative medicine and hospice care, some individuals continue to suffer from severe pain and other physical symptoms that available treatments cannot reduce to tolerable levels. Still, some studies have shown that much of the patients suffering, receive inappropriate levels of palliative care. Though treatment facilities could manage the pain and discomfort levels, these patients are not receiving the necessary care due to

financial burdens and poor availability of care. Such situations could warrant euthanasia or assisted suicide to help with ending the patient's suffering.

In addition to physical pain and discomfort, many patients also experience psychological suffering. This type of suffering is harder to manage and control with treatment. Several doctors have confirmed this stating, "The most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, un[a]esthetic, absurd, and existentially unacceptable condition" (Brody, 1993). Some patients suffer because they experience things like anxiety, loneliness, helplessness, hopelessness, anger, and despair. Others suffer or struggle from losses they have already experienced or from anticipating losses and/or decline. Proponents of assisted suicide and euthanasia argue that only the patient should be able to determine when their suffering makes continuing life unbearable.

The number of patients who could receive assistance to commit suicide or participate in euthanasia is truly unknown however, this is already an increasing practice in the medical field. The majority of proponents believe that these actions would be utilized only in special situations, and should only directly affect a select few. Furthermore, they believe these practices would create much benefit to those who utilize them and their loved ones. Most patients suffering from incurable diseases or illnesses would be more at ease if they knew their physician would provide them with the means to end their life if their suffering grew to be too unbearable. Knowing that assisted suicide or euthanasia is available would also reassure members of society in general, including those who are not severely ill. "While relatively few might be likely to seek assistance with suicide if stricken with a debilitating illness, a substantial

number might take solace knowing they could request such assistance" (State of New York, 2011).

Those who are against the legalization of assisted suicide and euthanasia focus their concern on the needs of the patients who are terminally and severely ill. In their opinion, these individuals are abandoned all too often by society. This only adds to their struggle and suffering yet, society still rejects assisted suicide and euthanasia as a harmful response. Furthermore, they believe that the harm far exceeds the benefits these patients would receive from these practices. Currently medical procedures and advancements made in pain control have significantly reduced the number of patients suffering from intolerable and/or untreatable pain. Sedation to a comfortable state would be an option for rare situation where medications and alternative treatments cannot adequately control the patient's suffering. With the advancements made in palliative care, allowing assisted suicide or euthanasia could potentially deny the patients of routine medical treatment and support. Furthermore, it could lead to the premature death of patients who could have been alleviated of their pain and suffering.

Health care professionals play a vital role in not only relieving physical pain and suffering but, can also assist in relieving psychological distress by providing support to the patient. Those who oppose assisted suicide and euthanasia believe that by participating in these practices as a way to relieve psychological anguish or despair, the patient's best in mind is rarely met. However, many believe this is incorrect and instead believe there is no benefit by causing death (State of New York, 2011). Though some believe that assisted suicide and euthanasia could diminish psychological suffering for

some, the risk of potential harm is not outweighed by the advantages involved (Singer & Siegler, 1990).

Another major concern for those who oppose assisted suicide and euthanasia, is that these practices will become a means to treat and/or care for patients suffering physically and mentally. Society has long discouraged suicide as a remedy for psychological suffering, even though many individuals who consider suicide are anguished and find relief in the prospect of death. (Shneidman, 1992). Complying with a suffering patient's request may result in the patient receiving the incorrect kind of help, causing the patient's life to end prematurely. In a report given by two providers, they explained that hospice patients may ask for assists in causing their own death, a majority of the requests aren't serious nor repeated. They write:

New patients to hospice often state they want to "get it over with." At face value, this may seem a request for active euthanasia. However, these requests are often an expression of the patient's concerns regarding pain, suffering, and isolation, and their fears about whether their dying will be prolonged by technology. Furthermore, these requests may be attempts by the patient to see if anyone really cares whether he or she lives. Meeting such a request with ready acceptance could be disastrous for the patient who interprets the response as confirmation of his or her worthlessness (Pacholczyk, 2009).

Still, regardless if the patient can make rational and beneficial choices for themselves, allowing patient the option of choosing to end life would change the perception of their lives. More so if a patient is near death naturally, the patient's actions of dying are seen as responsible versus choosing to end their life prematurely.

Due to the societal stigma regarding handicaps and dependence, "the burden of proof will lie heavily on the patient who thinks that his terminal illness or chronic disability is not a sufficient reason for dying" (Velleman, 1992). Patients who are severely ill or have an incurable disease depend on others for a multitude of things such as physical care, companionship, and meaningful interaction. Family members might recommend patients to end their lives in order to end their suffering and burden to others however, even without these kind of pressures, patients sometime assume they are a burden to their friends and family therefore, consider assisted suicide or euthanasia. As state by Vellemen (1992), "The patient may rationally judge that he's better off taking the option of euthanasia, even though he would have been best off not having the option at all. ... To offer the option of dying may be to give people new reasons for dying"

Those who oppose assisted suicide and euthanasia urge that allowing these types of practices can not only have a negative impact on the patient, but for many others who would not use either practice. This is believed to be because these practices could act as a distraction and take attention away from the care that could otherwise be offered. This is especially true for those patients who symptoms continue despite attempts made to resolve them. The effort and expense of more aggressive treatment as well as the support needed to receive these treatments may seem less compelling (Dyck, 1992). Legalizing these practices could also lead to physicians or family members to use them as an excuse wanting to spend less money. This could also compromise the physician's effort to treat severely and terminally ill patients.

Chapter 6: Why and when it is Necessary

Does the “Right” to Die Exist?

There are three major factors supporting the existence of an individual's right to determining when and how they can elect to receive life-ending services from a physician. First, a person's right is protected by their constitutional rights. Those who advocate for the right to die have based their argument off of the Fourteenth Amendment's due process clause which states:

No State shall ... deprive any person of life, liberty, or property, without due process of law....

They assert that the verbiage used in the due process clause suggests people are responsible for their own life, liberty, and/or property. This therefore, suggests they should have the legal right to end their life if or when they choose to (Head, 2016). The verbiage used in the 14th amendment has been used to support the need for physician assisted suicides before in case of *Washington v. Glucksberg*. In this case, Dr. Harold Glucksberg as well as a group of practicing physicians, challenged Washington State's stance on banning physicians from assisting their patients in suicide. They argued that the Due Process Clause of the 14th amendment protected assisted suicide and the right to die therefore, making it a liberty interest. The district court agreed with Dr. Harold Glucksberg and the group of physicians, saying Washington's ban placed an undue burden on the constitutional right to exercise the personal choice by a mentally competent, terminally ill adult to participate in a physician-assisted suicide (Waimberg, 2015).

Secondly, providers are already participating in some form or type of aiding their patients in dying. End-of-life interventions such as withdrawal of live support, and refusal of artificial nutrition and hydration, and treatments, which are legal in the United States, are acts in which providers aid their patients in their death. Dworkin, Frey, and Bok (1998) wrote about this type of processes that occur every day in medicine. It is common knowledge that passive euthanasia is relatively common in our hospitals or in the homes of patients. Doctors rarely shy away from recognizing that they take part in withdrawing treatment at the request of terminally ill patients. However, very few doctors acknowledge that they prescribe, at the request of their terminally ill patients, medication that expedite the death process. In the first situation, the patient is on a life-support system, which the doctor may allow that it be withdrawn at the request of the patient. However, in the second, the patient is not on a life-support system, and the doctor may not allow a prescription at the request of the patient, that will help produce death. It is ridiculous to think that the fact that a terminally ill patient is or is not on a life-support system could produce such a different outcome morally in the two cases.

Realistically, both situations clearly demonstrate the patient and the doctor are acting together to bring about the patient's death at the request of the patient. Furthermore, a physician allowing the withdrawal of a feeding tubes and having the patient starve to death is acceptable however, providing the patient with a medication that would result in death is not acceptable (Dworkin, Frey, & Bok, 1998). Do not both types of treatment guarantee death and the relief of suffering? Do not both situations involve the patient and the physician making a decision together to produce the death of

the patient? Then how can there be a moral difference between the two situations? From the ethical standpoint, the activities a physician assumes in providing assistance in hastening death are the same as those often carried out by a physician who oversees a withdrawal of treatment. As a purely medical matter, there is little to distinguish a physician's activities in withdrawing treatment from activities in hastening death through other means (Lindsay, Beauchamp, & Dick, 2006). Additionally, when physicians refuse to participate in assisting with their terminally ill patient's suicide yet participate in removing their terminally ill patients from life support, the provider is demonstrating discrimination among how he treats and cares for his terminally ill patients since both ultimately would result in the same end-state.

Finally, the right to die exists due to autonomy. This is the right a person has to govern themselves or the capacity of a rational individual to make an informed, uncoerced decision. (Merriam-Webster, 2016). American society has long embraced individual liberty and the freedom to make personal choices as a part of each individuals' fundamental values. These values have commonly been pursued within a social context, and are often times accompanied by promises to promote the overall good of society as well as protect those vulnerable from harm (State of New York, 2011).

Arguing the Definition of Terminal?

A significant component involved in the debate of physician assisted suicides, is the debate on how to appropriately define what to consider "terminally ill". In Oregon, the first state to approve dying with dignity for those with 'terminal cases', terminal is defined as a condition which will "within reasonable judgement, produce death within

six months", while in the Netherlands terminal is defined as "concrete expectancy of death". (The Life Resources Charitable Trust, 2011). Placing a timeframe on the definition of terminal is absolutely pointless and unnecessary. Medicine is not an exact science therefore, placing a timeframe within the definition requires doctors to make an unreliable prediction. Additionally, placing a timeframe requirement promotes an acceptance of the patient's suffering which goes directly against the main purpose of medicine which is to relieve the suffering of patients. What should be the focus for legislation is that the condition is incurable or untreatable by medical treatment and the patient can no longer tolerate the suffering.

When the Right to Die Should Apply

There are some diseases or disorders that would meet the guidelines discussed above therefore, warranting the need for a law and the suffering patient to be able to seek relief by physician assisted suicide or euthanasia.

The first disease is **Alzheimer's, a type of dementia that causes issues with memory, thinking and behavior. According to the Alzheimer's Association (2016),** Alzheimer's is a disease that progressively worsens over time. In the early stages, those who suffer from it experience mild loss in memory however, once in the late-stage of Alzheimer's, individuals lose the ability to converse with others and respond to their surroundings. Alzheimer's is the sixth leading cause of death in the United States. Eventually, they become severe enough to hamper daily tasks. **It is currently, the most common form of dementia,** accounting for 60 to 80 percent of all dementia cases. **Despite popular belief, Alzheimer's is not a normal part of aging.** The top known risk factor of this disease is increasing age, and though the majority of people with

Alzheimer's are 65 and older, Alzheimer's is not just a disease experienced by the elder. Approximately, 5% of people with this disease, experience early onset Alzheimer's which can appear in the patient's 40s or 50s. The image below shows the changes that occur to the brain of individuals who suffer from Alzheimer's diseases:



Illustration 1: Degeneration of the Brain as a Result of Alzheimer's Disease

(via dreamstime)

The disease's pathology consists of seven major stages and a cure has yet to be found. The cost of caring for somebody suffering from Alzheimer's are significant. The average cost of providing care for someone with Alzheimer's is approximately \$60,000 per year. A private room in a nursing home costs on average, more than \$82,000 per year. For a resident in an assisted living community suffering from dementia costs approximately \$55,000 per year (Hanes, 2012).

Perhaps the most well-known individual to suffer from this disease was former president Ronald Reagan. Many have said Ronald Reagan's early stages of Alzheimer's was evident toward the end of his presidency. Once considered to be "The Great Communicator," he began losing his eloquence. In November of 1994, five years after leaving office, he was diagnosed with Alzheimer's disease (Weller, 2015). His health

deteriorated significantly from the time of his diagnosis to the time of his death due to the disease. On June 5, 2004, the 40th President of The United States died of pneumonia.

The next type of disease or condition is terminal cancers. The word cancer is derived from the Latin word for crab. This is because cancers are often very irregularly shaped, and as a crab does, cancer tends to grab onto an individual and does not let go. The term cancer refers specifically to a new growth that has the ability to invade surrounding tissues, spread to other organs, and could eventually lead to death if not treated (John Hopkins University, 2015). The terms tumor and cancer are used interchangeably however; this is not entirely correct. A tumor can be either cancerous/malignant or non-cancerous/benign. Cancer is considered to be another word for a malignant tumor. Cancers are diagnosed according to the stage they are in. There are 5 stages of cancer and determining the correct stage the cancer is, it essential for determining how to treat it (Cancer Institute NSW, 2016). According to the Cancer Institute NSW (2016), the stages are as followed:

- stage 0 is *in situ* cancer and in the position where it started;
- stage 1 is localized cancer however, invades neighboring tissue;
- stage 2 usually includes spread to the nearest lymph nodes;
- stage 3 usually indicates more extensive lymph node involvement;
- stage 4 always indicates distant spread.

Cancers found in their early stages typically do not result in the patient's death therefore, a huge focus goes into early detection of cancer. Also important is the type of cancer and which parts of the body it has affected (Cancer Research UK, 2014). As

shown below, cancer was the second leading cause of death in the United States in 2013.

Number of deaths for leading causes of death:

- Heart disease: 611,105
- Cancer: 584,881
- Chronic lower respiratory diseases: 149,205
- Accidents (unintentional injuries): 130,557
- Stroke (cerebrovascular diseases): 128,978
- Alzheimer's disease: 84,767
- Diabetes: 75,578
- Influenza and Pneumonia: 56,979
- Nephritis, nephrotic syndrome, and nephrosis: 47,112
- Intentional self-harm (suicide): 41,149

Source: [Health, United States, 2014, Table 20](#) (Data are for 2013)

Table 1: Number of Deaths for the Leading Causes of Death for 2013 (via Health, United States, 2014, Table 20).

According to Cancer Research UK (2016), there are more than 200 different types of cancer belonging to the 5 main cancer groups which are; Carcinomas, Lymphomas, Leukaemias, Brain Tumors, and Sarcomas. The most common places for cancer to develop are the skin, lungs, breasts, prostate, colon and rectum and cancer usually develops in the cells. According to the MacMillian Cancer Support (2016), there are three main types of cell where cancer develops:

- **Epithelial cells.** Called carcinomas, these cancers develop in this type of cell and make up about 80-90% of the cancers diagnosed today.
- **Cells of the blood and lymphatic system.** Leukaemias and lymphomas are the types of cancers that develop in this type of cell. They account for about 7% of cancers diagnosed today.

- **Connective tissue cells.** Sarcomas are the types of cancers that develop in this type of. This accounts for about 1% of cancers that are diagnosed today.

However, depending on the cancer, some are more dangerous for men and women than others. The five most dangerous cancers in males are lung/bronchus, prostate, colon/rectum, pancreas, and liver **cancer** while, the five most dangerous cancers in women are lung/bronchus, breast, colon/rectum, pancreas, and ovary (UnityPoint Health, 2014).

In 2013, 72,220 women and 87,260 men, died from lung/bronchus cancer. Lung/bronchial cancer causes more deaths in both men and women in the United States than any other type of cancer (UnityPoint Health, 2014). Symptoms involved with this type of cancer includes difficulties breathing, coughing, wheezing, chest pain, shortness of breath, and coughing up blood. If this type of cancer spreads to the individual's bones, it would cause excruciating pain in the affected areas. Furthermore, if it has spread to the individual's brain, they can experience Neurological symptoms including headaches, seizures, blurry vision, or even stroke like symptoms (Disabled World, 2016). Although survival rates have increased over the years, many individuals still die from this type of cancer. The one-year survival rate for lung cancer is around 50%, while the five-year survival rate is only 16% (UnityPoint Health, 2014).

Prostate cancer was responsible for the death of 29,720 men in 2013 and is the second-leading cause of cancer-related deaths in men. Approximately, 1 in 6 men in the United States will be diagnosed with prostate cancer during their lifetime. Survival rates are directly associated with early detection, so men are advised to get screened every

year. Males who are diagnosed early have a 98 percent survival rate (UnityPoint Health, 2014).

39,620 women died from breast cancer in 2013. Though breast cancer is now the second-leading cause of women's death in the United States, it is still the leading cancer-killer in women worldwide. Awareness for breast cancer screenings and encouraging self-examination has improved early detection and survival rates over the past several decades, making today's five-year survival rate 90 percent (UnityPoint Health, 2014).

26,300 men and 24,530 women died in 2013 of colon cancer. The third most common cancer begin as clumps of benign cells, called polyps. These cells become cancerous over time therefore, screening is recommended for men and women over the age of 50 (UnityPoint Health, 2014). Patients who are suffer from colon cancer may cause symptoms such as a change in bowel habits, rectal bleeding, blood in the stool, cramping or abdominal pain, weakness, fatigue, and unintended weight loss (American Cancer Society, 2016).

According to UnityPoint Health (2014), pancreatic cancer killed 19,480 men and 18,980 women in 2013. Due to how quickly this cancer progresses, and no way of early detection, it is currently one of the most dangerous types of cancer. The likelihood of someone being diagnosed with pancreatic cancer surviving one year is 25 percent, while the likelihood for five years, is only 6 percent. It also develops very quickly, with few symptoms which makes it one of the deadliest forms of cancer. Furthermore, pancreatic cancer has shown resistance to chemotherapy and the cause of pancreatic cancer is still

unknown. Many have suggested, obesity and tobacco to increase the risk of an individual developing pancreatic cancer (UnityPoint Health, 2014).

Liver cancer was responsible for the death of 14,890 men in 2013 and occurs more often in men than women (UnityPoint Health, 2014). According to the American Cancer Society (2016), some of the most common symptoms of liver cancer are significant weight loss, loss of appetite, Nausea or vomiting, pain in the abdomen or near the right shoulder blade, swelling or fluid build-up in the abdomen, yellowing of the skin and eyes (jaundice). Symptoms do not appear until the cancer is in later stages therefore, making this cancer very dangerous. Furthermore, early detection of liver cancer is difficult (UnityPoint Health, 2014).

Lastly, ovary cancer claimed the lives of 14,030 women in 2013. An estimated 20,000 new cases of ovarian cancer occur in the United States every year. Early detection is difficult due to ovarian cancer not usually causing symptoms. Ovarian cancer is most common in older women. Close to 50% of the women diagnosed with ovarian cancer are 63 years old or older (UnityPoint Health, 2014). According to the American Cancer Society (2016), an estimated 1,685,210 people in the United States will be diagnosed with cancer. This does not include basal cell or squamous cell skin cancer and in situ carcinomas except for those found in urinary bladder.

One of the hardest parts of a cancer diagnosis is surviving the treatment. The main types of cancer treatment include surgery, radiation therapy, chemotherapy, immunotherapy, targeted therapy, hormone therapy, stem cell transplant, and precision medicine. Though chemotherapy is supposed to be able to “destroy” the cancer, it does not deal with the root cause of the cancer and it does not offer a favorable chance for

recovery. Many doctors have stated they would not receive agree to receiving conventional cancer treatment, meaning chemotherapy and radiation, if they had cancer. It is suggested that their decision to refuse conventional cancer treatments has to do with cancer drugs being found to **actually make cancer worse and kill patients more quickly (Evans, 2012)**. A questionnaire put together by scientists based at McGill Cancer Centre was sent to 118 lung cancer doctors to evaluate what degree of faith these practicing physicians had in the treatments they recommended to their patients (Ransom, 2015). As part of the questionnaire, the doctors were to imagine they had cancer and were asked which of six current trials they would choose to participate in. Of the 79 doctors that responded, 64 or 81% stated they would not consent to be in any trial containing Cisplatin, which is one of the common chemotherapy drugs they were trailing and at that time, accounted for \$110,000,000 a year of sales worldwide. Even more surprising, 58 of the 79 or 73% of the physicians, concluded all of the trials in question were unacceptable due to the ineffectiveness of chemotherapy and its unacceptably high degree of toxicity (Ransom, 2015). Yet these are the very treatments these doctors were prescribing to their patients. However, though some people with cancer will only have one treatment, most will more than likely have to have a combination of treatments, such as surgery with chemotherapy and/or radiation therapy (National Cancer Institute, 2015). This means opportunities to suffer from more side effects.

According to the American Cancer Society (2016), patients struggle most with the physical side effects of cancer treatment. Though the intention of chemotherapy drugs is to cure or for a palliative option, these are very powerful drugs with extensive

side effects, which explains people's great fear of the adverse effects of chemotherapy. Anti-cancer drugs not only attack cancer cells however, also the healthy cells that divide quickly. These include blood-producing cells, hair cells, and the cells of the mucous membranes of the mouth and throat area and of the digestive system. These are responsible for causing the majority of side effects patients experience while going through chemotherapy which includes: fatigue, mouth or throat sores, nausea, vomiting, appetite loss, hair loss, blood disorders, cognitive changes often referred to chemo brain and diarrhea or constipation.

In 2012, a patient named Hazel was diagnosed with breast cancer. She described her chemotherapy as the following (Ransom, 2015):

“This highly toxic fluid was being injected into my veins. The nurse administering it was wearing protective gloves because it would burn her skin if just a tiny drip came into contact with it. I couldn't help asking myself “If such precautions are needed to be taken on the outside, what is it doing to me on the inside?” From 7 pm that evening, I vomited solidly for two and a half days. During my treatment, I lost my hair by the handful, I lost my appetite, my skin color, my zest for life. I was death on legs.”

Perhaps, the worst side effect experienced by chemo patients is pain. Pain is most often caused by the cancer itself. The amount of pain a patient experiences depends on the type of cancer, the stage the cancer is in, and the patient's pain threshold. Pain can also be caused by cancer-related treatment or tests. Approximately, 30% to 50% of people undergoing treatment for cancer experience pain while, 70% to 90% of people with advanced cancer experience pain (American Cancer Society, 2016).

However, what must be addressed is, is the pain and suffering all worth receiving the treatment?

A study performed that focused on the contribution of curative and adjuvant cytotoxic chemotherapy to 5-year survival in adults, demonstrated its honestly not. In the study, the authors studied 154,971 Americans and Australians with cancer (Morgan, Ward, & Barton, 2004). The participants of the study, age 20 and older, were treated with conventional treatments, including chemotherapy. The study revealed that only 3,306 survived 5 years of the chemotherapy treatment, yet the study did not specify if the patients were cancer free. Furthermore, the overall contribution of curative and adjuvant cytotoxic chemotherapy to 5-year survival in adults was estimated to be 2.3% in Australia and 2.1% in the United States (Morgan, Ward, & Barton, 2004).

Radiation therapy can also cause side effects (American Cancer Society, 2016). Pain from external radiation depends on the part of the body that's treated. In addition to pain, common side effects include fatigue, hair loss, digestive issues, low blood count, and skin issues. Since radiation can damage normal and healthy cells, sometimes this damage can have long-term effects (American Cancer Society, 2016). This is commonly seen in individuals who received radiation at a very young age.

Another long-term problem caused by chemotherapy and radiation treatment is the increased risk of the patient getting a second cancer years later. This is caused by the damage chemotherapy and radiation causes to normal, healthy tissues surrounding the cancer (American Cancer Society, 2016). According to the American Cancer Society (2014), the risk of developing a solid tumor after radiation treatment increases as the dose of radiation increases. Some cancers require larger doses of radiation than

others, while certain treatment techniques use more radiation than other. The area treated is important, since second cancers tend to develop in or near the area that was previously treated with radiation. Certain organs, such as the breast and thyroid, seem more likely to develop cancers after radiation than others (American Cancer Society, 2014).

Additionally, most kinds of leukemia, such as acute myelogenous leukemia (AML), chronic myelogenous leukemia (CML), and acute lymphoblastic leukemia (ALL) can be caused by exposure from past radiation. Myelodysplastic syndrome (MDS), a bone marrow cancer that frequently becomes acute leukemia, has also been linked to past exposure to radiation (American Cancer Society, 2014).

Alkylating agents are the first class of chemotherapy agents used in treating cancer. These drugs modify the bases of DNA, interfering with DNA replication, transcription, and leading to mutations (Emory University, 2016). According to the American Cancer Society (2014), these drugs can cause Acute Myeloid Leukemia (AML) and Myelodysplastic Syndrome (MDS). Often MDS develops first, and progresses to AML. Alkylating agents known to cause leukemia include:

- Mechlorethamine
- Chlorambucil
- Cyclophosphamide (Cytosan®)
- Melphalan
- Lomustine (CCNU)
- Carmustine (BCNU)
- Busulfan

This risk increases as the doses of drugs increase, with those who had a longer length of treatment time, and with more drug given over a shorter period of time. Studies have shown that leukemia risk begins to rise 2 years after treatment with alkylating agents, becomes even more likely to occur after 5 to 10 years, and then slowly declines. Unfortunately, if a patient develops MDS and leukemia following treatment with alkylating agents, treatment tends to be harder and usually has a poor outcome (American Cancer Society, 2014).

The effects of cancers though are more than just physical; cancer also has an impact on the patient's mental health. According to the Mesothelioma Group (2015), many patients experience depression from receiving a potentially fatal diagnosis and learning to live with limitations. Some patients may lose the ability to be independent due to the cancer itself or the treatment. Others suffer from loss of energy levels therefore, making the activities they once enjoyed, no longer possible. Another article, also explains that psychological conditions experienced by cancer patients generally present as adjustment disorder, depressed mood, anxiety, impoverished life satisfaction, or loss of self-esteem (Roy-Byrne, 2016).

Additionally, patients also experience a process similar to grieving after a diagnosis and during palliative treatment or even during end-of-life. This grief process is made up of denial, anger, bargaining, depression, and acceptance. Additionally, evidence found supports that cancer survivors and cancer patients also suffer from PTSD. This has been linked directly to the traumatic experiences associated with the disease, the treatments, and due to fear of a fatal prognosis (Mesothelioma Group, 2015).

The treatments for cancer can also cause depression and anxiety. A side effect of chemotherapy known as chemo brain can cause depression, mental fog, and other forms of cognitive impairment. An article published by the American Cancer Society, shows the link between depression and chemo brain, and identifies that both should be considered. Radiation can also lead to depression. According to the Mesothelioma Group (2015), a study that focused on the prevalence of mental health conditions diagnosed in cancer patients of working age found that nearly 30% of the patients that participated in the study were diagnosed with a condition prior to the concluding of the study.

Stress is something also experienced by those diagnosed and/or treated by cancer. According to the National Cancer Institute (2012), people who have cancer may find the physical, emotional, and social effects of the disease and treatment to be stressful. Additionally, patients who attempted to manage the stress they experience with behaviors such as smoking or drinking alcohol or those who become more sedentary following their diagnosis, have a poorer quality of life after their treatment. Even more so, there is no evidence that successful management of psychological stress improves cancer survival.

However, evidence gathered from experimental studies suggests that psychological stress can affect a tumor's ability to grow and spread (National Cancer Institute, 2012). For example, studies performed showed that when mice with human tumors were kept in conditions that increase stress, their tumors were more likely to grow and spread. In other experiments, tumors that had been transplanted into the mammary fat pads of mice, had a much higher rate of spreading to the lungs and lymph

nodes when the mice were stressed in comparison to if the mice were not stressed. Additionally, studies in mice and in human cancer cells grown in the laboratory, found that the hormone norepinephrine, also known as the stress hormone, may promote angiogenesis, the growth of new capillary blood vessels in the body, and metastasis, the spread of cancer (National Cancer Institute, 2012).

Although no strong evidence exists to support that stress directly affects the outcome of cancer, some data gathered does suggest that some patients develop a sense of helplessness or hopelessness once the stress they experience from their cancer diagnosis and/or treatment becomes overwhelming. A higher rate of death has been associated with patient who experience this sense, although the mechanisms are unclear (National Cancer Institute, 2012).

The stress and depression have additional significant impact on those who experience it due to their diagnosed of cancer. According to a study examining the suicide rate of patients diagnosed with cancer and suicide, patients were almost 13 times more likely to commit suicide in the first week after learning they had cancer than they were prior to the diagnosis (Fang et al, 2012). Additionally, twelve weeks after they received the diagnosis, patients were still nearly 5 times more likely to commit suicide than they had been prior to the diagnosis. Though the risk declined after that, the study found that in the year following the diagnosis, patients were still 3 times more likely to commit suicide compared to people who had never experienced a cancer diagnosis. Of all the individuals involved in the study, there were 786 suicides among the patients diagnosed with cancer, including 29 people who killed themselves in the first week after learning of their diagnosis. Furthermore, the study found that the risk of

death from heart attack or stroke increased to 5 times after a cancer diagnosis (Fang et al, 2012). This has been linked to the direct stress a cancer diagnosis has on the patient. Of all the individuals involved in the study, there were 48,991 deaths due to heart attack or stroke among patients who received a cancer diagnosis. The risk was highest the first week after diagnosis.

Another type of disease type is muscular dystrophy, which is a group of diseases that cause progressive weakness and loss of muscle mass (Mayo Clinic, 2016).

According to researchers at the University of Washington's Rehabilitation Research and Training Center (2016), chronic pain is something a majority of people with muscular dystrophy (MD), suffer from every day and it often interferes with activities considered important. There are 9 major kinds of muscular dystrophy with the two most common being Myotonic (MMD) and Duchenne (DMD) (WebMD, 2016). Myotonic is a progressive muscle degeneration that causes weakness and shrinkage of the muscle tissue. There are two kinds of MMD and the disease tends to also affect the central nervous system, heart, gastrointestinal tract, eyes, and hormone-producing glands (WebMD, 2016). Individuals diagnosed with MMD have a significantly decreased life-expectancy. Duchenne is progressive muscle degeneration that primarily affects males. Individuals who are diagnosed with DMD experience a lot of difficulties at a very young age. Specifically, their arms, legs, and spine become deformed over time and they experience cognitive impairment. Furthermore, they experience severe breathing and heart problems in later phases of the disease. Those who are diagnosed with DMD usually die before their late 20s (WebMD, 2016). There are currently no cures for muscular dystrophy. Though there have been some advancements made in treating

muscular dystrophy, those who are diagnosed with these types of diseases are guaranteed to live a life of struggles and suffering.

Another disease that doesn't have a cure is Amyotrophic Lateral Sclerosis (ALS). According to The ALS Association (2016), ALS is a progressive neurodegenerative disease that has a significant impact on the person's quality of life. This disease affects the nerve cells in the brain and spinal cord.

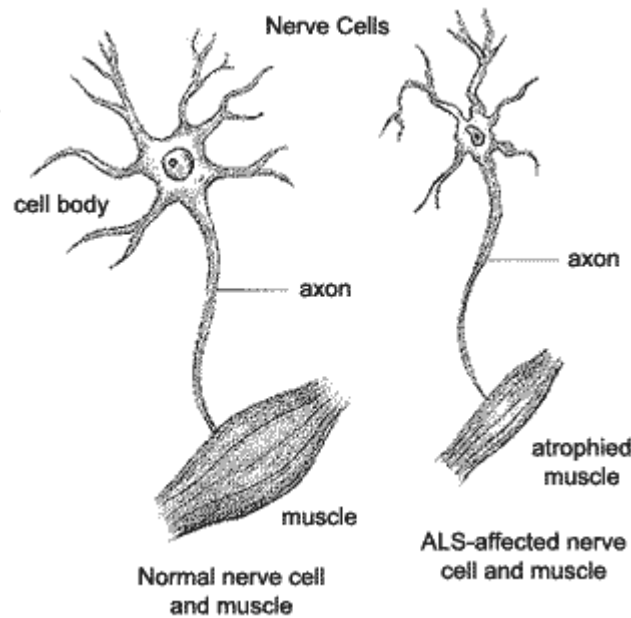


Illustration 2: The Affects Amyotrophic Lateral Sclerosis has on a Nerve Cell (via The ALS Association).

When motor neurons degenerate, the brain's ability to initiate and control muscle movement. People who suffer from this disease often lose the ability to speak, eat, move, and even breathe. Furthermore, The ALS Association (2016) estimates that 6,400 people in the U.S. are diagnosed with ALS every year. A majority of people who develop ALS are between the ages of 40 and 70, and it is more common in men than women. Once a diagnosis is made, the disease takes its toll on the patient rather quickly.

The life expectancy of a person with ALS averages about two to five years from the time of diagnosis (The ALS Association, 2016). Those who are diagnosed with ALS are guaranteed to become paralyzed due to the disease. Riluzole was the first treatment to alter the course of ALS. This drug was approved by the FDA in late 1995 and can prolong the life of persons with ALS however, by only a few months (The ALS Association, 2016).

The costs for medical care, equipment and home health caregiving significantly increases as the symptoms of DMD, MMD, and ALS progresses.

In a study published in the journal *Muscle & Nerve*, the author estimated the annual cost of ALS as well as Duchenne MD (DMD) and Myotonic MD (MMD or DM) based on information gathered. They examined the following categories (Larkindale et al, 2014):

- 1) Direct medical costs such as expenditures for inpatient and outpatient medical expenses, medications and equipment, including both out-of-pocket and reimbursed costs;
- 2) Nonmedical costs such as expenditures for housing, vehicles, paid care at home, dietary supplements and travel related; and lastly
- 3) Indirect costs such as the estimated loss of income related to the illness of at least one family member with ALS, DMD or MMD.

What they found was, the per-patient annual costs for ALS, DMD and MMD were significant, exceeding more than \$32,000 for each disease.

Disease	Medical Costs	Nonmedical Costs	Lost Income	Total
ALS (amyotrophic lateral sclerosis)	\$31,121	\$17,889	\$14,682	\$63,692
Duchenne MD (DMD)	\$22,533	\$12,939	\$15,481	\$50,953
Myotonic MD (MMD, or DM)	\$17,451	\$5,157	\$9,628	\$32,236

Table 2: The Cost for All Three Neuromuscular Disorders (via Larkindale et al).

Additionally, they estimated, which later admitted estimations were conservative, the annual costs for the entire United States. These costs exceeded \$250 million a year.

Disease	Total National Cost
ALS	\$256-\$433 million
DMD	\$362-\$488 million
MMD (DM)	\$448 million

Table 3: The Annual Costs for ALS, DMD and MMD in the United States (via Larkindale et al).

The total estimated cost of ALS, DMD and MMD combined is between \$1.07 to \$1.37 billion annually. The author also concluded that their findings indicate that costs for ALS, DMD and MMD mirror those for other chronic disabling diseases, such as Parkinson's disease and multiple sclerosis, in the U.S. (Larkindale et al, 2014).

Perhaps the most well-known individual diagnosed with ALS is Stephen Hawking, a famous physicist and cosmologist. In an interview with BBC (2013), Hawking explained his view of a patient’s right to die. He said, *“I think those who have a terminal illness and are in great pain should have the right to choose to end their*

lives and those that help them should be free from prosecution. We don't let animals suffer, so why humans?" Though he lives a very active life, Hawking understands that the longevity he has experienced with this disease, is extremely rare. As explained previously, once diagnosed, the disease takes its toll on the patient rather quickly. The life expectancy of a person with ALS averages about two to five years from the time of diagnosis (The ALS Association, 2016). Due to his understanding, he believes the decision to end one's life, belongs to the one suffering from a disease. During on time in his life, Hawking became very ill and was put on life-support. His wife at the time had a decision to make of whether to keep him on life-support. She decided to leave him on because, Hawking had not completed his advanced directives therefore, she was not sure of his wishes regarding his death. However, even if he had completed his advanced directives, there could have still been some limitations.

Chapter 7: The Limitations and The Problems With.

The Limitation of Advanced Directives

Nearly all states allow for adult individuals to execute an advance directive. Though the arrival of advanced directives was considered a win for those who advocate for rights of the terminally ill, there are still some limitations that exist with advanced directives. An advanced directive is a legal document that provides the patient an opportunity to make specific instructions for healthcare decisions in the event of something traumatic occurring leaving the patient on life-support. The difficulties involved in deciphering a patient's intended meaning, greatly limits the usefulness of advance directives. Strictly following an advance directive may not completely reflect the patient's autonomous choice. Patients are often experience some misunderstandings about the medical interventions they are choosing or rejecting. Furthermore, they might even have some reservations because of the implications of needing advance directives (Lawrence & Brauner, 2009).

Interpretation of the advance directions by the physicians might not yield the correct information therefore, resulting in the incorrect treatment of the patient. This is primarily, due to how advance directives are written. Too often, advance directives are either too general or too specific to provide any direction on which and when certain decisions need to be made. For the most part, the best directives are those that designate a medical power of attorney however, even the effectiveness they provide can be subject to question (Lawrence & Brauner, 2009). Studies have shown that close family members sometimes fail to have a good understanding of what a patient really wants. Additionally, advance directives do not always resolve questions involving the best care

for patients specifically for those that can no longer make competent decision regarding their own health. Furthermore, change in treatment preferences over time could occur therefore, presenting a potential negative impact. A person may change their mind or preferences regarding end of life treatment based on new information, new technology, or even new personal experience (Fagerlin, Ditto, Schneider, & Smucker, 2002). However, if these changes are not reflected in the patient's advanced directives or are unknown by the patient's family, this could result in the incorrect decision being made.

The Problem with the Ethical Argument: Non-maleficence, Beneficence, and Autonomy

The exercise of autonomy must also be balanced against other fundamental values embraced by society, such as the respect for human life. This is something especially true in medicine and physicians are at the forefront of this topic. Perhaps the most noteworthy argument against the "Right to Die" or "Dying with Dignity" legislative is the notion that there is an unethical aspect to it. As mentioned previously, much research has been done addressing a physician's involvement in aiding in their patient's death. Most of the research aims to answer the following question: If physicians are to participate in these types of acts, how can they honor the conflicting requirements of non-maleficence, beneficence, and autonomy at the same time? When considering the question above, it is necessary to return to the four principles of medical ethics, provided by Beauchamp and Childress (Pugh, 2012). According to Beauchamp and Childress, there are four principles of medical ethics: the principle of beneficence, the principle of non-maleficence, the principle of justice, and the principle of respect for autonomy (Pugh, 2012). These principles are to be understood as *prima facie* duties,

which are duties that are bound to each other equally, unless it is overridden or trumped by another duty or duties. This can sometimes cause some difficulties, since these principles are often in conflict. The topic of physician aiding in their patient's death is one where these principles are said to conflict.

The principle of non-maleficence may be regarded as conflicting with respecting the autonomy of the patient who wants to end their own life (Pugh, 2012). However, the principle of non-maleficence which, prevents a physician from intentionally harming their patients, should not be considered as conflicting with a physician aiding their patient in suicide. Instead, what should be realized is that, physician-assisted suicide is not about a doctor's decision to intentionally end the suffering of a terminally ill person, but rather about the decision by a terminally ill person to intentionally end their own life under the supervision of a trusted medical profession. When we realize this, we realize the physician is respecting autonomy which requires that physicians allow their patients to act in accordance with their fully informed choices (Pugh, 2012).

The principle of beneficence is the duty to contribute positively to the patient's welfare (Ersek, 2004). When a physician assists a suffering patient to die after aggressive attempts to manage the patient's psychological and physical symptoms fail, it is a compassionate response to medical failure therefore, contributing positively to the patient's welfare and respecting the patient's autonomy.

The Problem with the Ethical Argument: The Hippocratic Oath

Another popular argument made against physician assisted suicides is that if physicians are to assist with the death of their patients, it would go against the Hippocratic Oath taken by all physicians upon completion of Medical School. Despite

popular belief, this is an act that is supported by the very oath taken by doctors upon graduation of medical school.

The classical version (Edelstein, 1943) of the Hippocratic Oath states the following:

“I swear by Apollo Physician and Asclepius and Hygieia and Panaceaia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant”:

“To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.”

“I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.”

“I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy.

In purity and holiness I will guard my life and my art.”

“I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.”

“Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with

both female and male persons, be they free or slaves.”

“What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about. If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.”

When examining the classical version, one can see it says the physician should not give deadly drugs to those who ask for them. It also however, specifically forbids doctors to perform abortion and any kind of surgery. Additionally, it states a doctor should not get paid for teaching another to be a physician. Due to advancements in medicine, surgery has become a common practice of physicians, abortion is legal and therefore commonly performed by doctors, and doctors are those who are responsible for teaching future doctors. Therefore, some specifics in the classical version of the oath have changed with the times.

The modern-day version of the Hippocratic Oath was written in 1964 by Louis Lasagna, the Academic Dean of the School of Medicine at Tufts University (John Hopkins University, 2016). This is how the modern-day version reads:

“I swear to fulfill, to the best of my ability and judgment, this covenant”:

“I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.”

“I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.”

“I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.”

“I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.”

“I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.”

“I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.”

“I will prevent disease whenever I can, for prevention is preferable to cure.”

“I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.”

“If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.”

In this version, the statement previously made regarding surgery and abortion is no longer there and neither is the phrase forbidding a provider to not give deadly drugs. Instead, it states that a physician must “tread with care in matters of life and death”, and that the power to take life is an “awesome responsibility” that should be faced with

“great humbleness”. One should believe that a provider’s involvement in assisting in suicide is consistent with this new oath specifying life and death.

Furthermore, the original version mentions the provider has a duty to keep patients “from harm and injustice”. The modern version does not even mention anything about harm. The oath adequately explains a physician’s responsibility to their patient. A physician is to apply “all measures that are required” to benefit those who are sick. If “a surgeon’s knife or a chemist’s drug” cannot help the patient, then the physician should feel obligated to assist the patient in their decision to die with dignity. Even more so, doctors have an obligation to their patients to show them warmth, sympathy, and understanding. This only further solidifies the necessity of the physician to support the decisions made by their patient as well as understand their role in assisting with the decisions their patients make.

In the original version of the Hippocratic Oath, the following section can be found:

“I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.”

Since the Hippocratic Oath says physicians are not to provide a “deadly drug”, some have concluded that physicians, by their training and moral commitment, are to refuse assisting or aiding their patients in their death (Lindsay, Beauchamp, & Dick, 2006). However, the statement in the Hippocratic Oath that “prohibits” physicians from providing a deadly drug to their patients, did not reflect accepted medical practice in ancient Greek. Instead, a physician could provide a lethal drug for a suffering patient upon request. To a certain extent, physicians who provide assistance in hastening death

today, are adhering to a longstanding understanding of the scope of medical practice. This means, these physicians are caring for and meeting the needs of their patients in all stages of the patient's life (Lindsay, Beauchamp, & Dick, 2006).

Furthermore, the statement above is consistently used by those against euthanasia however, the history of the euthanasia debate and descriptions of how a dying person was cared for in ancient Greece, make it unlikely that the statement above refers to anything like the modern-day concepts of physician-assisted suicide, voluntary or non-voluntary euthanasia, or discontinuing life-sustaining treatment (Miles, 2005).

Additionally, the Greek-derived word euthanasia, which -literally means good death, was not coined until 280 BCE. This was about a century after the Oath had already been written by Hippocrates. Therefore, it is not possible that this new word referred to assisting death, instead it referred to a suffer-less, natural death (Miles, 2005).

The Problem with the Ethical Argument: First, Do No Harm

Another common argument made is that if doctors are to participate in physician assisted suicides, they would be going against the Oath which protects their welfare by making doctors honor-bound to always "First, Do No Harm", however, this is not in the Hippocratic Oath (Shmerling, 2015). Instead, it can be found in another one of Hippocrates' works called *Of the Epidemics*. Though there is similar verbiage utilized in both pieces, *no priority is given at either point*. For example, the following is from a translation of the Hippocratic Oath:

"I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them."

Though the commitment is to avoid harm, there is nothing that requires it be the top priority of the physician. On the other hand, *Of the Epidemics* states:

“The physician must be able to tell the antecedents, know the present, and foretell the future — must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm.”

Once again, there is no clear priority given to the avoidance of harm over the goal of providing help. However, we must ask if “first, do no harm” is even realistically possible for physicians to achieve?

The idea that doctors should treat their patients without causing any harm at the same time is not sensible and not in any way possible. Medicine is not made up of predictable and/or preventable harm (Shmerling, 2015). If physicians took “first, do no harm” literally, it would not be possible for them to practice medicine. No one would be able to have their blood drawn, due to the possibility of the needle stick hurting them. Nor would anyone be allowed to receive lifesaving surgery due to the possible complications and pain involved in the healing process, or even receive an x-ray due to the potential harm caused by the radiation. Furthermore, it would be necessary to stop ordering mammograms, because they could potentially lead to a biopsy for a non-cancerous lump furthermore, it would once again expose the patient to radiation which carries its own risks. Medical personnel would even have to stop performing cardiopulmonary resuscitation (CPR) because there is a possibility of cracking the sternum during chest compressions. Providers would also have to stop prescribing medication due to the possibility of side effects the patient might experience from taking the medication. However, how realistic is this? Not very since these are all things

doctors do and things doctors recommend. Furthermore, these actions are all considered to be within the bounds of ethical practice and good medicine. Perhaps it is due to the modern interpretation of “first, do no harm” which is that doctors should do what is necessary to help their patients. This includes recommending tests or treatments for which the potential benefits outweigh the risks of harm. This should include assisting their patient’s in dying with dignity.

Now the above argument can seem a bit abrupt however, there is truth in the information. What needs to be examined is what does the term “harm” exactly mean. If we examine the word “harm”, we will find that the involvement of a physician in physician assisted suicide and euthanasia does not fall into the parameters of any conception of harm. This is supported by Mill’s work in *On Liberty*. Mill does not directly address this particular issue however, he provides multiple examples in *On Liberty* demonstrating his favoritism of physician-assisted suicide. Thus, if one believes in the liberal tradition of John Stuart Mill, then one should be in favor of allowing the option of physician-assisted suicide.

If a physician is going to design how he or she practices medicine by “doing no harm” then allowing a patient to live their life suffering from something incurable or untreatable, goes against that. This is a practice long thought to be appropriate. Plato suggested that medical treatment should not be provided to severely ill and disabled patients. The argument that physician who aid with the death of their patients go against the ethics involved in practicing “good” medicine could not be more wrong. Relieving the suffering of others is very much recognized as a basic moral value and a goal of medicine. James Rachels (1975) argued that if an individual agrees to withhold

treatment, it could take the patient longer to die therefore, they might suffer more than they would if a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong their agony has been made, active euthanasia is preferable to passive euthanasia, rather than the reverse.

Despite advances in palliative medicine and hospice care, many patients continue to suffer from severe pain and other physical symptoms that available therapies cannot reduce to a “tolerable” level (State of New York, 2011). Therefore, practicing “good” medicine involves not only relieving of suffering experienced by all however, it also involves finding alternative solution when the suffering cannot be relieved. Sometimes, the alternative solution involves the physician assisting in the patient dying with dignity. Furthermore, Plato argued that no treatment should be provided to prolong the life of severely ill or disabled individuals, because they represent a burden to themselves and others (State of New York, 2011). This is something mentioned in the modern-day Oath taken by soon-to-be physicians. Physicians must understand it is possible that the sickness might not only affects the patient however, it might also affect the patient’s family and economic stability.

Chapter 8 The Other Impacts

The Impact Caring for the Dying or Terminally Ill

The decisions that are made during the end-of-life process are some of the most difficult to decisions to ever be made. They can impact the patient's family and their friends for many years, both financially and emotionally. A quote found in the Archives of Internal Medicine reads: "Managed care and managed death are less expensive than fee-for-service care and extended survival" (WordPress.com, 2009). Multiple studies examining the costs of medical care have shown that we spend an incredibly high amount of our health care resources on patients who are terminally ill (Scitovsky, 2005). The options for end-of-life care include hospitals, nursing homes, a patient's own home and hospice facilities (Debt.org., 2016).

Hospitals offer medical care every day, all year long from qualified doctors and nurses. Furthermore, they offer a full range of treatment choices, modern medical equipment, teams of specialists, and the ability to receive tests and life-saving procedures. However, due to the around-the-clock medical care, the cost of keeping people alive in the hospital can grow exponentially. According to the National Hospice and Palliative Care Organization (2011), Medicare paid \$50 billion for doctor and hospital bills during the last two months of patient's lives in 2008. Between 20% to 30% of these expenditures may have had no impact on improving the quality or extending the patient's life (NHPCO, 2011). The very next year, Medicare paid \$55 billion for doctor and hospital bills incurred during the last two months of patients' lives (National Hospice and Palliative Care Organization, 2011). These amounts are astronomical, and a true depiction of the over-treatment that occurs in U.S. hospitals

daily. This is something explained by Dr. Diane Meier, a geriatric specialist at Mount Sinai Hospital in New York. She explains that there is a certain expectation doctors have developed. If a patient has cancer, they require chemotherapy, if they have heart failure, they require a procedure, if they have a fracture, they require a surgical repair (Mogul, 2014). This ultimately results in more people dying in hospitals, often in an intensive care unit while on either, a ventilator or feeding tube. Furthermore, it means more visits from different doctors and specialists, which lead to additional tests, treatments and, drug prescriptions. This means even more money being spent by the government, private insurers and by the patients and their family (Mogul, 2014). Realistically, it is all an unnecessary expense for many when considering the terminal diagnosis.

Chronically ill patients in New York and New Jersey spend more time in the hospital during their last six months of life than their counterparts in the rest of the country — an average of 14.4 and 12.9 days, respectively. The national average is 9.8 days.

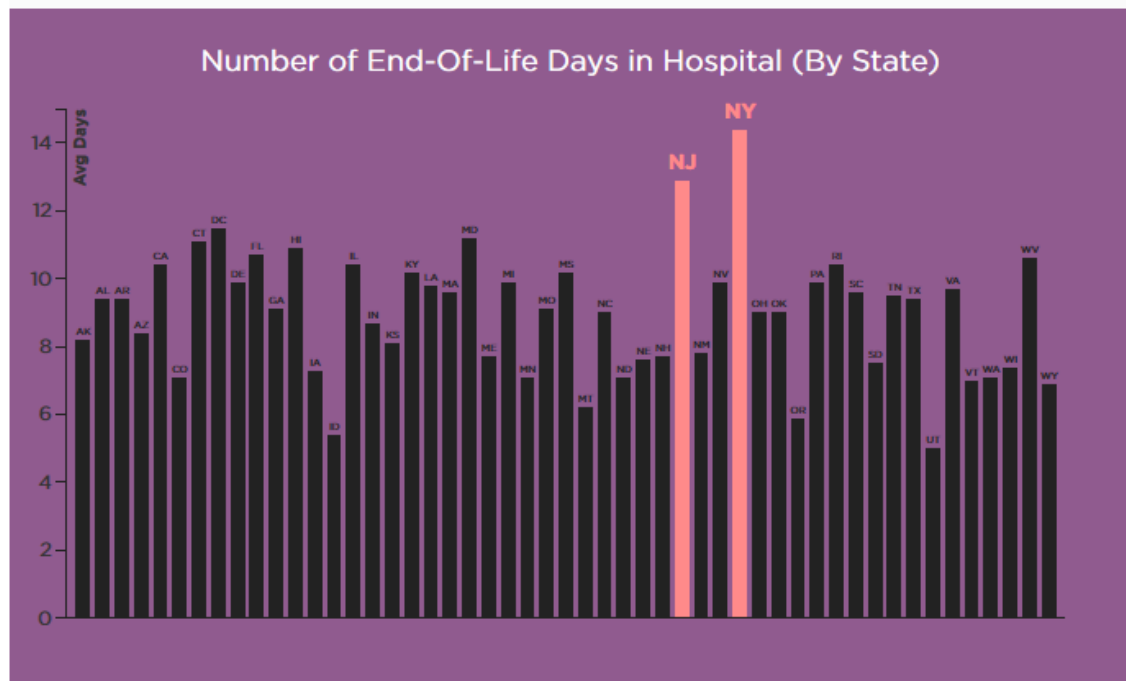


Illustration 3: The Average Number of Days Chronically Ill Patients Spend in the Hospital During the Last Six Months of Their Life (via Mogul).

In 2009, hospital inpatient charges exceed \$6,200 per day, and costs to maintain someone in an ICU could reach up to \$10,000 per day (Debt.org., 2016). If we were to do the math using the national average of 9.8 days and the two reimbursement rates above, the total reimbursement would be \$60,760 for one person to be kept in a hospital and \$98,000 for one person to stay in ICU. If the patient was to live in New York or New Jersey, the total reimbursement would be \$89,280 and \$79,980 respectively for one person to be kept in a hospital while for one person to stay in ICU, the total reimbursement would be, \$144,000 and \$129,000 respectively.

Furthermore, skilled nursing facilities were reimbursed at a rate of approximately \$622 per day in 2009 (Debt.org., 2016). In a study performed that focused on the length a patient remains in a nursing home at the end of their life, the authors found some striking results. They determined that of the 8,433 subjects of the study that died between 1992 and 2006, 27.3% of resided in a nursing home prior to their death while 70% died in the facility without being transferred to a hospital (Kelly et al., 2010). In regards to the length of stay, the median length of stay in a nursing home before death was 5 months. Additionally, 65% died within 1 year of nursing home admission while, 53% died within 6 months of nursing home admission. If we were to do the math using the 5 months' median at \$622 a day, the total reimbursement would be between \$93,922 to \$95,166 per person.

Hospice is another option for a terminally ill patient to decide to participate in (WordPress.com, 2009). Hospice offers pain management and palliative care for

patients who are terminally ill. It is not tied to a particular place therefore, is offered at home or in an assisted living facility nursing home, hospital or hospice center. Although hospice is provided at a much lower cost, it's still a cost that, depending on the length of time a person remains alive can cost a significant amount of money. Of the approximately 2.5 million Americans who died in 2009, an estimated 42% were under the care of hospice at the time of their deaths (NHPCO, 2011). Total hospice spending for Medicare in 2010 was \$13 billion, with an average cost of approximately \$10,700 per patient (Debt.org, 2016). The cost of hospice provided as a resident at the hospice facility averages \$700 a day, while the cost of hospice care in the home setting averages \$160 a day. If a terminally ill patient resides at the hospice for 6 months, with the average cost of \$700 a day, the bill would be \$126,000. If a terminally ill patient were to live for 6 months and receive treatment at home, they would have a bill for \$28,800. However, this requires for their family and/or friends to become their caregivers.

This of course, does not account for the patient's financial responsibility. Medicare Part B, which covers services such as skilled nursing facilities and inpatient services, only covers 80% of the total charges occurred by the patient after they met their deductible. This means, the patient is left responsible for the remaining 20% (Center for Medicare Advocacy, 2016). If we were to do the math to figure what the patient's responsibility would be using the national average of 9.8 days in a hospital, the patient would be responsible for \$15,190 for their stay in hospital and \$24,500 for their stay in the ICU. In regards to the patient's responsibility for their stay in a nursing home or a skilled nursing facility, their total responsibility would be between \$23,480 to \$23,791. This does not include the amount the family would have to pay for funeral

services, which typically range from \$7,000 to \$10,000 (Parting, 2015). Additionally, an article from the New England Journal of Medicine published a quote stating that, 30-40% of the medical care expenditures incurred are compiled in the last month of life (WordPress.com, 2009).

However, for individuals suffering from a terminally ill cancer, the costs could be much higher. As explained previously, cancer is the second leading cause of deaths in the United States. Recent data taken from Medicare revealed that the average cost of a terminally ill cancer patients who die after conventional treatment was around \$30,397. Approximately 33% of those costs were incurred during the last month of life. The cost of cancer has increased significantly just as the likelihood of someone being diagnosed with cancer has. According to the MacMillian Cancer Support (2016), an estimated one in three people will develop cancer at some point in their lifetime. Though cancers can occur at any age, the risk of developing cancer increases as we age. Approximately, 36% of all cancers are diagnosed in people aged 75 or over while, 53% of all cancers occur in people aged 50-74. However, even with the diagnosis occurring later in the individual's life, the cost to treat an individual with cancer can be significant.

Furthermore, the cost of cancer prescription drugs continues to grow. According to Lacie Glover of the U.S. News and World Report Health (2015), the significant increase in prescription drug spending in 2014 was caused by the price of cancer drugs. In 2014, Americans spent approximately \$374 billion on prescriptions. Nearly 9 percent of that amount was spent on oncology drugs. An addition \$11.1 billion was spent on supportive care treatments, to assist the patient help with the side effects

of strong chemotherapy drugs (Glover, 2015). Cancer drugs that have recently been approved by the FDA cost an average of \$10,000 per month, with some exceeding \$30,000 per month. Approximately 10 years ago, the average cost per month of newly approved drug averaged \$4,500. Patients are typically responsible for 20 to 30 percent of the costs therefore, the cost of a year's worth of these new drugs would cost anywhere from \$24,000 to \$36,000 in addition to what is already covered by the patient's health insurance (Glover, 2015).

With the cost of cancer treatment soaring and caring for the terminally ill on the rise, the family is usually left with a heavy debt to pay following the death of their loved one. A survey published in the New York Business Wire showed that 1/3 of the families surveyed, were financially burdened anywhere from 5 to 7 years after their loved one's death as a result of medical care expenditures (WordPress.com, 2009). This truly demonstrates the significance of the financial impact caring for the terminally ill has on the family. This is a struggle that unfortunately many people will have to experience due to as demonstrated in the table below, cancer was the second leading cause of deaths in 2013.

The cost of caring for a terminally ill family member has more than just a financial aspect to it. There is also a cost created by a psychological, emotional, and physical aspects for those who become caregivers. Observations made in a clinical setting and early empirical research has demonstrated that assuming a caregiving role of a terminally ill individual can be very stressful. Caregiving encompasses all the characteristics seen of a chronic stress experience. It promotes a physical and psychological strain over an extended period of time. Furthermore, it is accompanied by

high levels of unpredictability and uncontrollability and has the capacity to create secondary stress in multiple life domains such as work and family relationships. Additionally, it frequently requires high levels of vigilance and concern (Schulz and Sherwood, 2008). As a result of these stressors, the caregiver may experience effects such as psychological distress, impaired health habits, physiologic responses, psychiatric illness, physical illness, and even death. Another study, which examined the stress and anxiety experienced by caregivers, found that 55% of male caregivers and 36% of female caregivers showed moderate or severe anxiety while 36% of male caregivers compared to 14% of female caregivers had moderate or severe depression (Oechsle, Goerth, Bokemeyer, and Mehnert, 2013). The evidence on the health effects of caregiving gathered over the last two decades is so significant, it has helped convince policymakers that caregiving is a major public health issue (Schulz and Sherwood, 2008).

Neglecting to recognize the unavoidable financial and psychological burden placed on the surviving family by the providers caring for the terminally ill, is clearly a demonstration of practicing irresponsible medicine. In the current era of controlling cost, it is necessary to question whether the high cost of dying is the example of resources being wasted on the dying (Schulz and Sherwood, 2008). Should these resources be allocated in a more productive fashion to other patients, or even to other aspects in the community such as education or housing? I absolutely believe so.

Chapter 9: What Needs to Change and Conclusion

Holland's Euthanasia Law and What Needs to Change

On April 10, 2001, the law permitting both euthanasia and assisted suicide was approved in the Netherlands. It went in to effect on April 1, 2002 and is currently known as Holland's Euthanasia Law (Patients Right Council, 2013). According to the Patients Right Council (2013), the Dutch define "euthanasia" in a specific way that is not consistent with how others define it. The Dutch's definition is as follows:

*"Euthanasia is understood to be an action which aims at taking the life of another **at the latter's expressed request**. It concerns an action of which death is the purpose and the result."* It only applies to **voluntary** euthanasia. This particular treatment is often times referred to as the "life-terminating treatment and is **not solely for residents**. Instead, **the prospect of "euthanasia tourism" does exist with this law even though**, public relations statements made about the law have asserted that only Dutch residents are able to receive euthanasia or assisted suicide (Patients Right Council, 2013).

Physicians in the Netherlands who participate in their patient's death or assist their patients kill themselves are not prosecuted as long a certain set of guidelines are adhered to. The guidelines that must be followed by the providers were established in 1981 in the Rotterdam court and read as followed:

1. The patient must be experiencing unbearable pain.
2. The patient must be conscious.
3. The death request must be voluntary.
4. The patient must have been given alternatives to euthanasia and time to consider these alternatives.
5. There must be no other reasonable solutions to the problem.
6. The patient's death cannot inflict unnecessary suffering on others.
7. There must be more than one person involved in the euthanasia decision.
8. Only a doctor can euthanize a patient.
9. Great care must be taken in actually making the death decision.

Once the provider participates in a euthanasia or assisted-suicide death, they are required to report it to the Regional Review Committee for Termination of Life on Request and Assisted Suicide and must be able to show the patient's death request was carefully considered and requested multiple times (Patients Right Council, 2013). The regional committees are made up of at least 1 legal specialist, 1 physician and 1 expert on ethical or philosophical issues. An estimated 200,000 Dutch individuals carry the necessary documentation explaining how they wish to die if they are to develop a physical or mental illness which prevents them from having a normal life (Richburg, 2000). In 2010, there was a total of 136,058 deaths recorded in the Netherlands. Of those, 78,727 occurred with end-of-life decisions (Statistics Netherlands, 2016). This law has allowed patients to have control over how and when they die. Even more so, it has allowed for those who are suffering, to find true relief.

Personal Testimony and Stories

I have had my own experience with a terminally ill family member and it was honestly one of the worst experiences of my life. I didn't even recognize him when I entered the room. My once 210 pound, strong-willed grandfather now only weighed about 85 pounds. Two years prior, he had been diagnosed with Alzheimer's, a type of dementia that effects the person's memory, thinking, as well as their behavior (Alzheimer's Association, 2016). When patients are diagnosed with Alzheimer's, a majority of them put together a plan that explains how they want to be cared for as the disease progresses. These are known as Advanced Directives and can be accompanied by a living will. My grandfather's advanced directives consisted of a do not resuscitate (DNR), do not intubate (DNI), while his living will, consisted of a request for no

feeding tube. He knew this disease would cost him his life and he was ready to let it go. However, what we didn't realize is how much it would cost his family and friends. During the beginning of his onset of the disease, he would forget our names and then who we were. Eventually, he forgot how to talk and even how to get himself dressed. Toward the end of his fight, he forgot how to walk and finally, how to eat. I remember seeing the anguish my grandmother would go through and it's not like she didn't have her own health issues to deal with however, that had to be put on the back burner so that she could care for my grandfather. My grandfather eventually died from what doctors claimed "complications from Alzheimer's" however, my family and I are fully aware it was from the malnutrition caused by him not eating or drinking anything. He had lost so much weight; he was unrecognizable as he laid in his coffin. The family was finally at peace however, the effects of watching my grandfather die that way and the financial responsibilities left as a result of the care he received, still remain a burden. What I would like to know is, how is this morally or ethically acceptable?

A similar situation happened earlier this year with my husband's uncle. We learned he had been diagnosed with lung, stomach, and liver cancer. The doctors told us, due to how advanced his cancer was, his treatment would be very aggressive and he would likely die from it. My husband's uncle begged the doctors to let him die because the pain he was in and the sickness he felt was unbearable. Instead, he spent the last days of his life doped up on pain pills or as the doctors put it, in what should be considered a "tolerable" level of pain. My husband's uncle was ready to go after he learned his diagnosis and the unfortunate prognosis it came with however; no physician would grant him his wish. Once again, I watched my grandmother go through the

depression as she had to care for him just as she cared for my grandfather. Once again, I must ask, how is this morally or ethically acceptable?

Though this next story does not carry any personal involvement, as I read it (Milton, 1993), I couldn't help but realize the necessity of a right to die law in The United States. Jennifer Cowart was a 32-year-old mother who decided to enjoy a day at the beach with her younger brother. On their way back home they saw a go-kart track and decided to stop for a while. Jennifer secured herself in her go-kart and began to make her way around the track when she was bumped into one of the guardrails. This caused her go-kart to flip to its side and soon, it was engulfed in flames with Jennifer strapped in. She could not free herself from the go-kart and even attempts to aid her from her brother failed due to the intensity of the flames. Jennifer was stuck in the burning go-kart for an estimated 2 minutes before the fire burned through the safety-belt. She fell to the ground and her brother pulled her away from the fire. She was still alive however, suffered 3rd and 4th degree burns over 95% of her body. Jennifer begged the medical personnel aiding her to let her die. However, no one granted her, her wish. Instead, she was transferred to a burn center, where she remained for a year until infection took over her body and she finally died. The doctors and staff members at the burn center described Jennifer as being in the most agonizing physical pain they had ever witnessed. The medical staff providing her treatment could not alleviate her pain effectively without sedating her permanently since, this would have likely resulted in her death. She was so badly burned; her two children were not allowed to see her the entire duration of her hospitalization. Even if Jennifer would have been able to leave the hospital, she was fully aware that she would never live a normal life again. She had lost

her ears, nose, fingers, toes, and had limited use of her arms and legs. Additionally, she would have health issues with her kidneys, liver, lungs, and other organs as a result of the injuries she sustained. When she finally succumbed to her injuries, her medical bills exceeded 3 million dollars. After reading this, the first question that came to mind was what gave those doctors the right to keep her alive for so long even after she begged for death? How was any part of the Hippocratic Oath upheld by the providers involved in that situation? All she did as a result of trying to enjoy an afternoon with her brother was suffer. She suffered the burns on 95% of her body, she suffered from agonizing pain because the amount of medication necessary to relieve her pain, or to even help get it to a tolerable level, would have killed her. She suffered by not being able to see her children because she was so badly burned. She suffered from the astronomical amount of financial burden keeping her hospitalized put on her family and finally, she suffered from an infection that finally cost her, her life. This is not what medicine is supposed to do or what it is supposed to stand for.

Conclusion

Medicine gives those who can receive it, the ability to improve their health and overall life. However, for those who are suffering from a terminal illness or incurable disease, it can only offer them a degree of comfort. Nowhere in the Hippocratic Oath does it say, physicians should aim to achieve comfort for the terminally ill. Instead, a physician is to apply “all measures that are required” to benefit those who are sick. With today’s medicine focused solely on curing diseases, it is a tragic reality that when a cure is not possible, many patients are left to suffer horribly as they live out their last days with little or no relief. Why should the patient be forced to endure such anguish when it

is not necessary? If a dying patient has no rights regarding the timing nor the means for terminating their life, does this mean they must die slowly? Painfully? Without any dignity? Financially impoverished? If so, medicine is failing them in more than one way.

Patients who are terminally ill or suffer from a disease which inhibits their ability to live a productive life and cannot be cured, should have the right to determine when to end their life and physicians should be allowed to aid in their request. This paper has focused and supported the need for the United States to adapt a law such as the Holland's Euthanasia Law. It achieved this by discussing some of the history of the debate about right to die, explaining how the "right" to die does in fact exist, discussing Holland's Euthanasia Law, explaining some of the diseases patient who would desire to participate in euthanasia or physician assisted suicide might be experiencing, explaining the limitations that exist with advance directives, addressing the problem with the ethical arguments made against the right to die, by discussing the impact caring for a dying or terminally ill individual has on their family and friends, and finally by providing some personal testimonies and stories. The very first "Right to Die" legislative was drafted in 1906 in Ohio. Though it was not successful, it marked the beginning of a very two-sided movement (Bio., 2015). Currently, five states have decided it is legal to aid patients suffering with dying with dignity still, this movement continues to grow as it should. The United States should follow in Holland's footsteps and should therefore, adapt an assisted suicide and/or euthanasia law.

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