Assisted Suicide; The Moral Permissibility of Hastening Death

Thesis

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By

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Abstract

The issues of physician assisted suicide and euthanasia have been widely debated for over 3000 years. These topics have been debated in courtrooms and in the media. The four principles of bioethics are often used in order to help resolve ethical dilemmas, however, in some cases the ethical guidance the four principles give can be deceiving. This analysis provides foundational, societal, and professional contexts as it relates to the topics of physician assisted suicide and euthanasia. The main argument is against physician assisted suicide and euthanasia in all cases, and is for the right of patients to forgo medical technology at the end of life in some cases.

Dedication

This work is dedicated to my family.

To my dad, William DiFilippo, MD, thank you for your unwavering support of all of my endeavors. You have been my source of inspiration and have always been there to give me strength and provide guidance. I am so grateful to have you as my dad and I hope to have made you proud to have me as your daughter.

To my brother and sister, Bill and Nikki, the limited time we've gotten to spend together over breaks has made all the difference in motivating me to finish this project

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Chapter 1. Introduction

The topics of physician assisted death and euthanasia are closely connected because if we were to allow people who are at the end of life to obtain assistance in dying from their physician, then the question of whether or not it is morally permissible to also allow euthanasia in end of life situations will often also arise. Physician assisted death is a form of active euthanasia. However, the difference lies in who performs the final act that ultimately ends the patient's life. With physician assisted death the physician prescribes medication for the patient to take on their own, and the patient is the one who does the final act in ending their life. With euthanasia, the physician is the one who does the final act in ending the patient's life, this can be from administering medication or removing a life sustaining machine with or without the patient's consent. As a student in bioethics, and as a family member of someone who recently died from an unusual neurologic condition called Crutzfeldt-Jakob disease, the distinction between killing and letting die is extremely important. To apply learning in bioethics the most conventional approach is to apply the four principles.

Principles of Bioethics

In modern medicine and bioethics, what has become popular is the four principles approach. Beauchamp and Childress introduced this standard approach to biomedical ethics. With their publication of Principles of Biomedical Ethics they presented a bioethics, using the four principles, that was easier for people to understand. The four principles include; Autonomy, Beneficence, Non-Maleficence, and Justice. The four principles are not self-evident. The definitions of these terms are fairly easy to understand, however, their definitions and limits are not always universally agreed upon. These principles are essential to bioethics decision making in a majority of cases. It is necessary to consider all four principles in order to resolve ethical issues.

The term autonomy is derived from the Greek words, “autos” which means self and “nomos” which means rule. The principle of autonomy was originally referred to as self-rule.

> “At minimum, personal autonomy encompasses self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding. In contrast, a person of diminished autonomy is in some material respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans” (Beauchamp & Childress, 2016).

In order to respect a person’s autonomy, we must acknowledge their ability to make their own choices and hold their own views based on their personal beliefs and values. There are limitations to the principle of autonomy. There is a prima facie standing to respect for autonomy, so it is possible for other moral considerations to sometimes override this principle.

The term beneficence, “connotes acts of mercy, kindness, friendship, charity, and the like. (Beauchamp & Childress, 2016)” There are two main principles of beneficence discussed by Beauchamp and Childress: positive beneficence and utility. Positive beneficence, “requires agents to provide benefits to others. (Beauchamp & Childress, 2016)” Utility, “requires that agents balance benefits, risks, and costs to produce the best overall results. (Beauchamp & Childress, 2016)” There is an array of prima facie rules of obligation in which the principle of positive beneficence supports: “(1) Protect and defend the rights of others. (2) Prevent harm from occurring to others. (3) Remove conditions that will cause harm to others. (4) Help persons with disabilities. (5) Rescue persons in danger” (Beauchamp & Childress, 2016).

The term non-maleficence obligates persons to avoid causing harm to others. In medical ethics the principle of non-maleficence is treated as being equal to “*primum non nocere*” which means, “Above all [or first] do no harm” (Beauchamp & Childress, 2016). The principle of non-maleficence follows the rule, “One ought not to inflict harm or evil” (Beauchamp & Childress, 2016).

Sometimes the principle of beneficence and the principle of non-maleficence are lumped together. However, the principles of beneficence seem to be more demanding than the principles of non-maleficence. This is due to the fact that when following the principle of beneficence persons must not only refrain from harmful acts, but they must also take positive steps in order to help others. Non-maleficence only requires persons to intentionally avoid actions which will cause harm. Beneficence requires helping by taking action, by doing things such as, “preventing harm, removing harm, and promoting good" (Beauchamp & Childress, 2016). The rules of non-maleficence, "(1) are negative prohibitions of action, (2) must be followed impartially, and (3) provide moral reasons for legal prohibitions of certain forms of conduct" (Beauchamp & Childress, 2016). The rules of beneficence, by contrast, "(1) present positive requirements of action, (2) need not always be followed impartially, (3) generally do not provide reasons for legal punishment when agents fail to abide by them" (Beauchamp & Childress, 2016). We are morally obligated to follow the rules of non-maleficence at all times towards all persons. However, we are not obligated follow the rules of beneficence at all times towards all persons, meaning we are not obligated to help or benefit those with whom we do not have a special relationship, we are only obligated to follow some rules of beneficence such as, "rescuing a stranger when the rescue efforts pose little risk" (Beauchamp & Childress, 2016). The principle of non-maleficence may override the principle of beneficence, "even if the best utilitarian outcome would be obtained by acting beneficently" (Beauchamp & Childress, 2016).

The fourth principle is the principle of justice. Philosophers have used the terms, "fairness, desert (what is deserved) and entitlement" (Beauchamp & Childress, 2016), in order to analyze the term justice. In the medical ethics world, the term justice can be interpreted as what is fair, or appropriate treatment considering what is owed to persons. There is a minimal requirement to justice, which has been traditionally accredited to Aristotle, this is, "Equals must be treated equally, and unequal's must be treated unequally" (Beauchamp & Childress, 2016).

As a student studying bioethics it is easy understand how these four principles have an impact in ethical decision making. However, in my family struggle with how to decide, the question I found myself asking is whether or not the four principles actually give guidance. I believe the ethical guidance that the four principles do give is illusive to what exactly would be right or wrong.

Definitions

Physician Aid in Dying can be defined as, “intentionally helping a person commit suicide by providing drugs for self-administration, at that person’s voluntary and competent request” (Nordqvist, 2018)” There is no constitutional right of individuals to Physician Aid in Dying. However, there is a difference between refusing treatment that may be considered life-saving and asking a physician to assist in ending a patient’s life. A patient can, for example, refuse treatment of chemotherapy or radiation which without it they may die. In states where Physician Aid in Dying is legal, the law specifies that, “only patients with less than six months to live may request Aid in Dying.”(2016). The physician writes a prescription for the drug, the patient picks it up, and is free to take it at any point. The physician does not need to be present for the patient to take the drug. Death occurs, in Physician Aid in Dying, as a direct result of ingesting the medication prescribed to the patient by the physician.

Euthanasia, sometimes referred to as mercy killing, is, “the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma” (Nordqvist, 2018). Euthanasia occurs when the life of a person is terminated by another person for “compassionate reasons” (P&M, #67, pg. 13). This term is derived from the

Greek words "*Eu*" and "*Thanatos*" which translates to mean, "Good death" (P&M, #67, pg. 13). For euthanasia, death occurs as a direct result of a physician administering an intravenous drug or lethal injection.

There are two subcategories of euthanasia: active and passive. There is a difference between passive and active euthanasia, "defenders of euthanasia distinguish active euthanasia from passive euthanasia" (Nordqvist, 2018). Active euthanasia, is more controversial than passive euthanasia, as it is, "when someone uses lethal substances or forces to end a patient's life, whether by the patient or somebody else" (Nordqvist, 2018). One of the most well-known physician advocates for Euthanasia was Dr. Jack Kevorkian in the early 1990's. Active euthanasia is illegal in the United States.

Passive euthanasia is fairly simply defined as, "allowing someone to die." Passive euthanasia occurs when "someone withdraws life-sustaining decides for the purpose of ending a patient's life" (2016). Life support termination can take many forms. One is withdrawing respiratory assistance, or removing a breathing tube, death can occur immediately or take several days to occur. Another is withdrawing nutrition and hydration, by this death occurs as a result of the disease. The termination of life support, or withdrawing care, is a common practice is the United States. Two very well-known historical cases involving passive euthanasia are the cases of Karen Quinlan and Nancy Cruzan. The term passive euthanasia is a term that bioethicists are straying away from. Unless the act of life support termination comes with mal-intent, it seems problematic to conflate forgoing medical technology with the term euthanasia.

Minimally conscious state means that a patient has minimal interaction with their environment, but it is not meaningful. Persistent vegetative states means that a patient has no meaningful interaction with their environment. Brain death in the United States is considered to be legally dead, and is clinically accepted as that. Unless the patient is going towards organ procurement, we should not continue anyone on medical technologies if they are deemed brain dead.

Palliative Sedation can be defined as, "the use of medication to induce decreased or absent awareness in order to relieve otherwise intractable suffering at the end of life" (Olsen, et al. 2010). Palliative sedation involves intentional sedation to or near unconsciousness, until the patient dies. However, when and if possible, sedation should be lifted. The position statement of The American Academy of Hospice and Palliative medicine states, "If palliative sedation is used for truly refractory existential suffering, as for its use for physical symptoms, it should not shorten survival" (American Academy of Hospice). Meaning that palliative sedation should only be used in order to minimize suffering, never to hasten death.

Important Considerations

An Advance Directive is a legal document which describes the way in which a person wishes decisions to be determined on their behalf when they are unable to make decisions for themselves. "In an increasing popular procedure rooted as much in respect for autonomy as in obligations of non-maleficence, a person, while competent, either writes a directive for health care professionals or selects a surrogate to make decisions about life-sustaining treatments during periods of incompetence" (Beauchamp &

Childress, 2016). There are two main forms of Advance Directives which aim to govern future decisions. These include; living will and durable power of attorney (DPA). Living wills are, “substantive or instructional directives regarding medical procedures in specific circumstances” (Beauchamp & Childress, 2016). A durable power of attorney is for proxy or health care directives. It is a legal document, “in which a person’s assigns another person authority to perform specified actions on behalf of the signer. (Beauchamp & Childress, 2016)” What makes the power durable is the fact that this power becomes effective when the signer become incompetent.

These documents are extremely important when being faced with an ethical decision. However, they can introduce moral problems. There are many reasons why these documents can pose moral problems, these include: (1) Not many people complete these documents, however, when they do they do not leave “sufficiently explicit instructions.” (2) The person chosen as the decision maker may not be available, or many themselves be incompetent when needed. They might also develop a conflict of interest. (3) When changing their treatment preferences, some patients fail to change this to be reflected in their directives, or protest against the decisions made by their appointed surrogate. (4) Advanced directives are often restricted by laws. For example, in some locations, advanced directives only go into effect legally, “if and only if the patient is terminally ill and death is imminent. Decisions must be made, however, in some cases in which death is not imminent or the patient does not have a medical condition appropriately described as a terminal illness” (Beauchamp & Childress, 2016).

> (5) “Living wills provide no basis for health professionals to overturn a patients instructions; yet prior decisions by the patient could turn out not to be in the patients best medical interest. Patients while competent often could not have reasonably anticipated the precise circumstances they actually encountered. Surrogate decision makers also sometimes make decisions with which physicians sharply disagree, in some cases asking the physician to act against his or her conscience. Even when the patient has a living will and has designated a surrogate, he or she may have failed to indicate which has priority in case of conflict” (Beauchamp & Childress, 2016).

There is a best interest standard which is the ethical decision making standard where, “a surrogate decision maker must then determine the highest probable net benefit among the available options, assigning different weights to interest the patient has in each option balanced against their inherent risks, burdens, or costs” (Beauchamp & Childress, 2016). The best interest standard is an undeniable, “quality-of-life criterion” (Beauchamp & Childress, 2016). The surrogate has an obligation to act beneficently by, “maximizing benefit through a comparative assessment that locates the highest probably net benefit” (Beauchamp & Childress, 2016). This best interest standard is important because it protects the interests of incompetent persons, “by requiring surrogates to assess the risks and probably benefits of various treatments and alternatives to treatment” (Beauchamp & Childress, 2016). This best interest standard can potentially override advanced directives completed by, “formerly autonomous patients, as well as consents or refusals by minors and by their incompetent patients” (Beauchamp & Childress, 2016).

When a patient does not have any legal documents appointing someone else to make their medical decisions, but they are unable to do so themselves, there is an order of decision making to be followed. This varies by state, as some states have statutory requirements, which, if followed, protects the physician and hospital from civil or criminal prosecution. There are some states which provide an order of preference, and other states do not. However, in many hospital policies there are guidelines. There are requirements in choosing a person to make medical decisions for the patient. In general, this person must know the patient, have a vested interest, be willing to provide guidance, and most importantly, have the patient's best interest at heart. For an adult, if there are no legal documents, or no patient appointed proxy, then the spouse is usually turned to first, followed by adult children, parents, siblings, next of kin, and then next of kith.

Chapter 2. History

Philosophy

The topics of euthanasia and physician assisted suicide are extremely controversial. Modern societies are very much divided on whether or not it is morally permissible to allow physician assisted suicide. However, this is not just a modern day issue, euthanasia has been a subject of controversy for over three thousand years, and these debates are as old as civilized society (Papadimitriou, et al, 2007). Active euthanasia and suicide were subjects of concern in antiquity. "Active euthanasia was rejected by the majority of philosophers because it was considered to be a violation of the autonomy of the individual and an action against the will of God" (Papadimitriou, et al, 2007). Passive euthanasia, on the other hand, seemed to be more acceptable. Many philosophers dealt indirectly with euthanasia, these philosophers include, but are not limited to; Plato, Aristotle, Epicurus, Hippocrates, and the Stoics" (Papadimitriou, et al, 2007).

Early philosophers, such as Plato and Aristotle, have historically offered "principled objections to suicide of killing even for merciful reasons" (P&M, #67, pg.1). Plato was born in c. 427 BC and died in 347 BC. It has been argued that Plato is one of the greatest philosophers to ever exist. He was against what is known today as active euthanasia, as he believed in the harmony of life. He was opposed to suicide as it is, "against the will of the Gods and thus not allowed" (Papadimitriou, et al, 2007). Written in *The Republic*, Plato states that, "doctors should be punished by death, if by administering any sort of drug they contribute to the termination of life" (Republic II 406e). However, Plato recognized the fact that there are people who suffer from insurmountable pain, and that there is a right for these people to commit suicide when they are, "faced with unavoidable misfortune due to having led a less than good life" (Papadimitriou, et al, 2007). Aristotle was born in c. 384 BC and died in 323 BC. Aristotle studied under Plato. In his book, *Nichomachean Ethics V,* Aristotle writes, "But to seek death in order to escape from poverty, or the pangs of love or from pain or sorrow is not the act of courageous man, but rather of a coward" (Papadimitriou, et al, 2007). He believed that committing suicide is doing an injustice to oneself.

Hippocrates, known as the father of medicine, was very clearly against active euthanasia, and in favor of passive euthanasia in cases of patients who are deathly ill. He argued that in situations where patients have incurable diseases, that physicians should not treat these patients, as medicine is powerless. According to Hippocrates, it is reasonable to withhold treatment in these situations where medicine cannot help.

On the other hand, philosophers, like the Stoics and Epicurus, defend the rationality of suicide or killing even for merciful reasons in some cases.

Epicurus was born in c. 341 BC and died in 270 BC, he believed that suicide was unreasonable. He believed some potential reasons why people may result to suicide are, "one is tired of life or one is afraid of dying," in these circumstances he believes one must try to overcome this, rather than committing suicide. He argued that, "each of us is free to put an end to our life if we are suffering from unbearable pain, provided this misfortune is neither brief nor intermittent" (Papadimitriou, et al, 2007).

The Stoics took an open door approach to suicide. The open door approach is explained by another well-known Stoic philosopher Epictetus, "The choice is up to you, if you truly think the situation is unbearable, the door is open. But if you stay, you accept the responsibility of doing whatever it takes to live a life worth living" (Cleary, 2018). There are a few examples by the Stoics which they believe justify suicide. "Zeno let himself die of starvation because he was too old, fragile, and dependent on other to be able to contribute any more to society" (Cleary, 2018). Cato, the archenemy of Julius Caesar, "committed suicide in order to not be used as a political pawn by the tyrant." (Cleary, 2018). Finally, an unnamed slave, committed suicide because they decided that, "death was preferable to slavery" (Cleary, 2018). The Stoics believed that the meaning of ones live is constructed by each individual as a moral agent. They believed that we should be living every moment to the fullest, as we do not know when our time will be up. Finally, they believed that the choice with what we do with our lives, including the decision to commit suicide, is entirely up to us.

A well-known philosopher, by the name of Immanuel Kant, believed that suicide is never morally justified. Kant believed that, "humans have a duty to respect life in ourselves and others due to the inherent value of human life" (Taylor, 1987). Kantians believe that the destruction of a human life is wrong, even if death would lead to more happiness or improve someone else's life (Johnson & Cureton, 2016). Kant argued, “Suicide violates our moral duty to honor and value rational creatures, which encompasses nearly all human lives, no matter the life’s value to others or the person living it” (Cholbi).

Religion

Many religions prohibit taking one’s own life and are opposed to physician assisted suicide and euthanasia. These include, but are not limited to; The Assemblies of God, Roman Catholicism, Buddhism, Islam, Mormon, and Judaism. Our family faith has been extremely important, we come from a non-denominational Christian background. Our religious text affirms that physician assisted suicide is wrong, however, that when treatment is futile it is morally appropriate to withdraw life sustaining technology and allow a natural death to occur. How we can articulate faith and beliefs outside of faith, such as applying it to bioethics, is very important. I will discuss many different religious views on end of life issues and discuss how they are related to one another. The right-to-die and physician-assisted suicide, “divide the public among religious and political lines” (Hamil-Luker & Smith, 1998).

The largest Pentecostal denomination in the Unit States is the Assemblies of God. The Assemblies of God are opposed to both suicide and euthanasia. In their teachings, they state that, “life is a sacred gift and only God should determine when life ends” (Religious Groups, 2019). They argue, God gives life, so it is not our prerogative to end life. The Assemblies of God, however, allows people to reject life support, stating, “that life need not be sustained at all costs when there is no hope for recovery” (Religious Groups, 2019).

The Roman Catholic Church also strongly opposes physician assisted suicide and euthanasia. Their view aligns with the view of the Assemblies of God that, “life should not be prematurely shortened because it is a gift from God, (Religious Groups, 2019)” and “we don’t have the authority to take into our hands when life will end” (Religious Groups, 2019). The Church believes that a person at the end of life, “has the moral option to refuse extraordinary treatments that only minimally prolong life” (Religious Groups, 2019). There is a belief among Catholic thinkers that there are a few conditions that lead to a patient wishing to take their own life. These include; “poor pain management, despair and loneliness, or the feeling of being a burden on family and others” (Religious Groups, 2019). John Di Camillo, a Catholic ethicist, believes that if we were able to provide better care to patients in the areas of psychological and palliative care, then these issues can be better addressed.

According to the teachings of Buddhism, “it is morally wrong to destroy human life, including one’s own, even if the intention is to end suffering” (Religious Groups, 2019). Buddhists believe that basic care should be provided to patients who are terminally ill, however, they are permitted to refuse treatment, “that might prove to be futile or unduly burdensome” (Religious Groups, 2019). The belief is that if there is no moral problem as long as there is no intention to take someone’s life.

The opposition of physician assisted suicide and euthanasia are also part of the teachings of the Islamic faith. The belief among Muslims is that, “life is sacred and comes from God; therefore it is a sin to take life” (Religious Groups, 2019).Their teachings include that, “God alone decides how long someone will live and when they will die" (Religious Groups, 2019). The Islamic faith takes a different approach to why they are opposed, their approach is that "you do not always know what is good for you" (Religious Groups, 2019). They believe that it may be possible one must, "go through some kind of difficulty to test you faith, in the Islamic tradition, end-of-life suffering is seen as a way to purify previous sins so that by the time you meet God, you do so in a more pure state" (Religious Groups, 2019). There is a difference between making the decision to end a life, and life ending by itself. They are "opposed to hastening death, but believe that the terminally ill need not employ extraordinary means and technologies to delay dying" (Religious Groups, 2019).

The Church of Jesus Christ of Latter-day Saints, also known as the Mormon Church, is also opposed to physician assisted suicide and euthanasia. The belief is that, "taking one's own life or the life of another violates God's commandments and his plan for each person" (Religious Groups, 2019). The Mormon Church acknowledges that many people do suffer, however, they believe, "in the sanctity of human life and its role in God's plan" (Religious Groups, 2019). When someone is dying, it is taught by the Mormon Church that, "it is acceptable to forgo excessive or extraordinary therapies" (Religious Groups, 2019).

The last religion that I will discuss that is opposed to both physician anssisted suicide and euthanasia is Judaism. There are three major Jewish movements, "Orthodox, Conservative, and Reform," all of which "prohibit suicide and assisted suicide, even in cases of painful terminal illnesses" (Religious Groups, 2019). According to the teachings of Judaism, "life is a precious gift from God, a person's life belongs to God, therefore, deciding when it ends should be left to God" (Religious Groups, 2019). It is a united belief among Jewish thinkers that a person at the end of life has the right to stop treatment. Judaism also teaches that physicians and caregivers, "should not do anything to hasten death and generally must work to keep people alive as long as possible" (Religious Groups, 2019). However, there is agreement that in the case of a patient at the end of life in a coma or vegetative state, life-prolonging treatment may be discontinued.

There are a few religions that teach and support the right of terminally ill patients to make their own decisions regarding what they wish to do with the end of their lives. The United Church of Christ is one of those religions. The UCC, "stresses the importance of respecting individual conscience and choice" (Religious Groups, 2019). They believe that even if the decision includes hastening death, it is the right of the patient to make that decision for themselves. The church believes that, "each of us approaches God on our own terms, and this includes at the end of our lives" (Religious Groups, 2019). The church also argues that the decision to discontinue treatment is a decision of conscience. The UCC supports, "the right of families to discontinue treatment for incapacitated loved ones who are near death" (Religious Groups, 2019).

Another religion that supports the right of terminally ill patients to make their own decisions regarding what they wish to do with the end of their lives is the Unitarian Universalist Association. In 1988, they passed a resolution which advocated for, "The right to self-determination in dying" (Religious Groups, 2019). This church supports the laws of states such as Oregon and Vermont, which, "enable terminally ill patients, under carefully defined circumstances, to seek physician assistance in hastening their own death" (Religious Groups, 2019). The teachings of the UUA follow that, "the ultimate questions of life and death belong with the person most intimately affected, not with the church, a legislative committee, or a bureaucratic panel" (Religious Groups, 2019). The UUA teaches on the individual, and those teachings form the position they take on end of life issues. Their faith, "honors the sanctity and integrity of the individual conscience" (Religious Groups, 2019).

In the Hindu religion, there is no formal teaching on physician assisted suicide or euthanasia. The Hindu religion focuses on karma. Hindu's believe in reincarnation, so, "the concept of karma centers around the belief that good and bad occurrences in one's life are caused by actions taken in past lives" (Religious Groups, 2019). There is a concern in the Hindu religion that, "prematurely ending a person's life could negatively impact their karma" (Religious Groups, 2019). Hindu's believe that when a person experiences suffering, it is, "because of something you did in the past, so if you circumvent karma by taking some action to stop suffering, you will pay for it later" (Religious Groups, 2019).

All religions deal with death in their own way. There is an important place for death and dying in all religions, and while all religions differ in their beliefs, beliefs on end-of-life issues often correlate in some way. For many, religion may help to provide comfort or understanding for those who are facing death, or after a loved one has died. From a religious standpoint, death is a way to prepare for whatever afterlife one believes in. Religion can help to give an explanation of death and dying to patients at the end of their lives.

Cases

The history of the law in important right-to-refuse and right-to-die cases have helped to shape societal opinions on the issues of physician assisted suicide and euthanasia. The cases of Karen Ann Quinlan and Nancy Cruzan are widely known to be right-to-die cases, however, they are cases regarding a patient, or their family's right-to-refuse treatment. The case of Elizabeth Bouvia was also a right-to-refuse case, as she wished to end her life by refusing to eat and drink. The cases of Dr. Jack Kevorkian and Brittney Maynard are both right-to-die, and right to assisted suicide and euthanasia cases, and are two of the most well-known cases in history.

Karen Ann Quinlan

The right-to-die issue began to gain substantial media attention in 1976 from the case of Karen Quinlan. This case was the first and is one of the most well-known right-to-refuse legal cases in the United States. At the age of 21 Karen Quinlan fell into a coma after consuming a combination of alcohol and sedatives. After five months in a coma the doctors diagnosed her as being in a persistent vegetative state. A major problem in this case was determining whether or not Karen Quinlan should be regarded as alive or dead. In court, her parents requested that she be disconnected from the ventilator that was sustaining her, as they believed there was no chance of her returning to consciousness and wanted to end her suffering. The physicians and the hospital argued that Quinlan was medically and legally alive and that disconnecting the respirator would likely result in her death, which they believed was considered to be killing/euthanasia. The initial ruling, by Judge Robert Muir, maintained the physicians and the hospitals argument that there was an obligation to continue life saving measures. However, on appeal, an unprecedented standard was set by the New Jersey Supreme Court which stated that, “people have a constitutionally protected right to die and that this right can be exercised for them in situations where the patient can no longer make decisions” (Urofsky, 2000, p. 38). Mechanical ventilation was removed in favor of her parents’ wishes, however, in this particular case, Karen Quinlan was being sustained by her feeding tube. She continued to live another 10 years after the mechanical ventilation was removed.

Nancy Cruzan

The first right-to-refuse legal case to reach the Supreme Court of the United States was the case of Nancy Cruzan. In 1983 the right-to-die issue was again ignited when Nancy Cruzan was in a terrible car accident at the age of 25. She was resuscitated at the scene and was brought to the hospital where she was placed on life support, which included artificial feeding through a tube and hydration. After approximately one month in a coma, the doctors diagnosed her as being in a persistent vegetative state. In 1988, since she was unable to speak for herself, her family and friends stated that they knew her wishes and that she would not wish to exist in a vegetative state, so they requested she be removed from life support. At this point, she had been in this state for four years, with no change in her condition. To their request, the doctors refused, as she was only being given basic needs; food and water. They argued that removing the artificial nutrition and hydration would be illegal and immoral as it would kill her through starvation and dehydration. This case was brought to court and the state trial court ruled that her life support may be terminated. This ruling was overturned by the Missouri state Supreme

Court which ruled that she may not be removed from life support as there was no documentation or, "clear and convincing evidence," stating that Cruzan would not wish to exist in this state. In 1990, the Supreme Court ruled that they could not prevent the State of Missouri from requiring, "clear and convincing evidence", and the State of Missouri withdrew from the case. The family of Nancy Cruzan gathered sufficient evidence to show Nancy would not have wanted to live this way and a court order to remove her artificial nutrition and hydration was issued. The Supreme Court ruled that, "constitutional liberty included the right to refuse medical attention even when it could prolong or preserve one's life" (Nancy Cruzan's Accomplishment, 1990). She passed away approximately 12 days later.

Elizabeth Bouvia

The case of Elizabeth Bouvia was a California Supreme Court case in 1983. Elizabeth Bouvia did not have a terminal illness. She was a 26-year-old with cerebral palsy, which rendered her physically incapacitated. She checked herself into the hospital, wanting sedating medications for symptom control, and did not wish to eat. She wanted to starve to death. The California Supreme Court said that Bouvia had a "right to refuse all medical intervention and that the hospital cannot force feed her" (Steinbrook). Since artificially administered nutrition and hydration is considered medical treatment, it can be refused. Since Bouvia won the case she went to the hospital to have to be given medications to control her symptoms while she starved herself, and the hospital refused. In this case, there is no right to demand for this patient, and the California Supreme Court did not say that the hospital had to participate. The hospital and the physicians said that this patient could decide to starve herself if she wishes, but they are not going to be the ones taking care of her. Bouvia then goes to Tiajuana, Mexico and approximately seven months later she decided that she wanted to change her decision, and she renounced her wish to die and ate solid food. Elizabeth Bouvia is still alive today.

Dr. Jack Kevorkian

One of the most well-known physician advocates for euthanasia was Dr. Jack Kevorkian. He first gained media attention when he completed an interview with the New York Times in 1990" (Belkin, 1990). He became infamous for the euthanasia of 54 year-old Janet Adkins. Adkins was an advocate for voluntary euthanasia and a member of the Hemlock Society. She suffered from Alzheimer's, and was in search of a way to end her life. "Kevorkian agreed to assist her in a public park, inside his Volkswagen van. Kevorkian attached the IV, and Adkins administered her own painkiller and then the poison" (Jack Kevorkian 2015). He referred to this as his, "suicide machine" (Jack Kevorkian, 2015). Kevorkian continued to assist, reportedly over 100, individuals with their deaths until he ultimately ended up in prison for 8 years due to the assisted death of Thomas Youk, who was suffering from Lou Gehrig disease. Youk and Kevorkian discussed the options of euthanasia versus assisted-death and determined that due to Youks disease and limited muscular ability that "active euthanasia would be the better route" (Jack Kevorkian 2015). Kevorkian videotaped himself injecting lethal medications to Youk, which resulted in his death. While he assisted in these patient's deaths, he was convicted of second-degree murder because he was the one who actually administered the lethal injection rather than letting the patient do it himself.

Brittney Maynard

A recent “Right to Die” case involving physician assisted suicide, is the case of Brittney Maynard. In 2014, Maynard was diagnosed with a terminal brain cancer known as glioblastoma, which has a prognosis of approximately six months to live. At the time of her diagnosis, she lived in California, however Brittney relocated to Oregon as she believed that the best option for her and her family would be to take advantage of the Death with Dignity laws that exist there. Brittney Maynard planned to end her life with prescription drugs given to her by her doctor. At the time, only three states had Death with Dignity laws, however, as of the summer of 2019 there are seven states that have Death with Dignity statutes. Maynard was a relentless advocate for a patient’s right to die with dignity. She was interviewed on many occasions and even wrote a piece for CNN titled, “My Right to Die with Dignity at 29” (Oregon Health Authority). The planned death of Brittney Maynard put the spotlight back on the legality of death with dignity laws.

Supreme Court Cases

The case of Nancy Cruzan was the first right-to-die case to reach the Supreme Court of the United States. However, there are two Supreme Court cases which truly stand out when discussing physician assisted-suicide. These two cases are: Washington v. Glucksberg (1997) and Vacco v. Quill (1997). The rulings of these two cases have, “altered the debate of Physician Assisted-Suicide. (P&M, #67, pg.2)” These cases were decided together in June of 1997. In both cases, “the Supreme court unanimously reversed two circuit course decision and upheld the constitutionality of state laws that prohibit assisted suicide and therefore physician assisted suicide” (P&M. #67, pg.2).

Vacco v. Quill

The case Vacco v. Quill is famous for the landmark decision regarding the right-to-die made by the Supreme Court of the United States. Dr. Timothy Quill was a spokesperson for the right-to-die movement. The state of New York had enacted a prohibition against physician-assisted suicide, meaning it was a crime for a physician to administer lethal medication or to otherwise knowingly, and intentionally end the life of a patient, even with patient consent. In 1990, Quill revealed in a New England Journal of Medicine article that he had prescribed a patient with leukemia a lethal dose of medication intended for suicide (*Vacco v. Quill*). In this case, Quill among other physicians, filed a lawsuit against the State of New York's Attorney General for the ban on physician-assisted suicide. In a unanimous decision, on June 26, 1997, the Supreme Court concluded that, "there is a legal distinction between letting a patient die and making that patient die" (*Vacco v. Quill).* They argued that the New York law did not infringe upon a fundamental right. The court also concluded further that, "the opinion specifically cited prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia" (*Vacco v. Quill*).

Washington v. Glucksberg

The case Washington v. Glucksberg was another landmark case, in 1997, where the United States Supreme Court determined that the right to assisted suicide was not protected by the Due Process Clause. A statute was enacted in 1854 in Washington State which criminalized assisted suicide, including physician assisted suicide. This statute was enacted because the State of Washington was concerned that physician-assisted suicide would, “cause more deaths, erode public trust in the medical community, and create opportunities for coercion, error, and abuse when treating terminally ill patients” (*Washington v. Glucksberg*). In 1994, Dr. Harold Glucksberg, a physician in the state of Washington, argued that, “the liberty interest protected by the due process clause of the 14th amendment, included a fundamental right to assisted suicide.” He basically argued that humans have a “right to die.” Glucksberg won his case against the district court, as well as the court of appeals, they agreed that the statute was unconstitutional. The question was, “whether the liberty interest, protected by the due process clause of the 14th amendment included a fundamental right to assisted suicide.” The court believed that the, “right to die,” was too broad. The Supreme Court of the United States viewed the right, as the “right to assisted suicide.” The Supreme Court of the United States referred back to a previous United States Supreme Court Case, Cruzan v. Missouri Department of Health, to clarify the scope of the fundamental right recognized in this case. In this case, the Supreme Court of the United States recognized that, “a person in a persistent vegetative state has a right to be taken off life support.” However, the Supreme Court of the United States argued that in the case of Nancy Cruzan, the fundamental right recognized was not the right to die, but rather, the right to refuse life-saving medical treatment. The United States Supreme Court concluded that the ban on physician-assisted suicide did not violate the due process clause, and they reversed the court of appeals decision. Since there is no constitutional right to suicide, then there is no need to even consider whether or not there is a constitutional right to physician-assisted suicide, since it is a much narrower question. It was clarified by Justice O'Connor that even though physician-assisted suicide was not legal in the state of Washington, the law still permits patients who are terminally ill to receive palliative care, which may increase the speed of death. The decision of this United States Supreme Court case drew a hard line between refusing life-saving treatment, and accepting life ending treatment.

Chapter 3. Analysis

Arguments against Physician Assisted Suicide

Many philosophers believe that euthanasia is wrong no matter what reason is provided. Reasons for this include the belief that any form of euthanasia is killing, even if the main intention was to provide comfort care and ease the pain of a person with a terminal illness. There is this fear of a slippery slope where the level of care patients who are terminally ill receive will decrease if euthanasia were permitted. Legalizing physician assisted suicide will lead to an increased incentives to cut corners and patients who might not have otherwise been steered towards a cessation of treatment might be led to do so. Physician assisted suicide hastens death. By prescribing medication to end a person's life, the physician would be hastening death, or causing death sooner than it would have come without that medication. Physician assisted suicide is not a completely autonomous act as it requires the assistance of a physician. While the final act of ending their life is carried out by the patient taking a lethal dose of medication, this would not be possible if the medication had not been prescribed to them by a physician. In modern medicine, there is improved access to palliative and hospice care to alleviate persistent and untreatable suffering. Finally, Physician assisted suicide violates the Hippocratic Oath by going against the basic principle of non-maleficence, "do no harm," as the act of prescribing the medication results in ending a life. The Hippocratic Oath states, "To please no one will I prescribe a deadly drug nor give advice which may cause his death" (Miles, 2004).

Arguments for Physician Assisted Suicide

There is an opposing side to every argument. Here I will discuss common reasons argued for in support of physician assisted suicide. First, there is a belief that palliative medicine and hospice care may not always be sufficient in treating severe suffering. While palliative and hospice case can help ease the majority of symptoms for many diseases, there are some rare diseases which may be considered too unbearable, that no amount of medication can help. Another argument for why physician assisted suicide should be permitted is due to conscientious objection. Meaning that physicians have the ability to decline providing assistance on the basis of moral or personal beliefs, so they are not being forced to do anything they do not believe is ethical. If the patient is able to make their decision to wish to end their life, and if a physician agrees and has no moral or personal beliefs against assisting, then it should be permitted as it would be a completely voluntary decision. The final argument I will present for the legalization of physician assisted death is the opinion that the Hippocratic Oath is open to interpretation. The Hippocratic Oath says that physicians are supposed to do no harm, and to help others, but some argue that helping others includes helping them to die. By doing so, they are following the scope of medical practice, which is to care for patients and to meet their needs and desires in all stages of life.

From the 1970s to present day there have been multiple societies established both in favor of and in opposition of right-to-die issues. Those advocating for the right-to-die included; Concern for Dying, Hemlock Society, which is now referred to as Compassion and Choices, Death with Dignity, and Final Exit Network. Those advocating against the right-to-die included; the National Right to life society and American Life League.

Death with Dignity

As of summer 2019, seven states who have adopted Death with Dignity laws. These states include; California, Colorado, District of Columbia, Hawaii, Oregon, Vermont, and Washington. Of these, Oregon is the most notorious, as they were the first state to enact the Death with Dignity Act. On October 27, 1997, Oregon enacted the Death with Dignity Act which allows terminally-ill patients in Oregon to, "end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose" (Oregon Health Advocacy). This is a form of physician-assisted death, where a licensed physician who meets certain criteria can prescribe a lethal dose of medication for a patient to take in order to end their own life.

The challenge is that if Death with Dignity Statutes are being adopted in many states, and continue to be, then it becomes difficult to differentiate whether or not the act of ending the life of a terminally ill patient can be placed on the physician who is prescribing the lethal dose of medication, or on the patient/family member who is administering the medication themselves or to the patient.

There are three countries in which both euthanasia and physician assisted suicide are legal. These include; the Netherlands, Belgium, and Luxembourg. In 2002, in the Netherlands, both euthanasia and physician assisted suicide were legalized by the

“Termination of Life on Request and Assisted Suicide Act,” for citizens over 12 years of age. This act states, “Physicians who perform the procedures will be exempt from criminal liability and set forth criteria for physicians to legally euthanize or assist in the suicide of a patient” (Euthanasia & PAS).

It was also in 2002 when Belgium legalized euthanasia and physician assisted suicide with the “Belgian Act on Euthanasia.” The patients do not have to be suffering from terminal illnesses. This act states that euthanasia and physician assisted suicide are legal to “competent" adults and emancipated minors suffering from constant and unbearable physical or mental suffering that cannot be alleviated” (Euthanasia & PAS). This act originally only applied to adults and emancipated minors, and in 2014 was extended to include all minors.

In 2009, Luxembourg became the third country in Europe to legalize euthanasia and Physician assisted suicide. This law protects doctors from sanctions and lawsuits for, “performing euthanasia or physician-assisted suicide if a patient with a grave and incurable condition has asked repeatedly for the procedure” (Euthanasia & PAS).

There are many countries where physician assisted suicide is legal, but euthanasia is illegal. These include: “Canada, Finland, Germany, and Switzerland” (Euthanasia & PAS). Colombia is the only country in the world where euthanasia is legal, but physician assisted suicide illegal.

Forgoing Medical Technology

When there is little hope of survival despite all care, and quality of life may be extremely poor, “it is believed that withdrawal of care should be considered.” (Campbell, 1994, 313). This decision, despite the physicians view of what they think is best, is ultimately up to the patient or the appointed surrogate decision maker. If the patient decides that they would like to continue care or treatment, whether the physician agrees or not, all treatment should be continued. When the decision is made to forgo life support, the patient is often given analgesics and sedatives to keep them comfortable; although this is turn also shortens the patient’s life. There are ethical issues that arise with this, as some may say that not extending the patient’s life by removing medical technology is killing them. However, I argue that it would be unethical to allow the patient to suffer for the last moments of their life if there is a way to alleviate their suffering, even if that way may potentially speed up the dying process.

Palliative care is essential to relieve the pain or distress of a patient when life-supporting treatment is withdrawn. Sedatives and analgesics may be given although they often shorten life. Feeds and fluids may also be withheld, as they would prolong the dying process and cause suffering. When treatment that directly supports life is discontinued, such as a ventilator or oxygen, the patient often dies within minutes to hours. The ethical issues come when the patient is aware or in pain. The symptoms that come from forgoing care in patients often cause distress or suffering until they lose consciousness. They can be given higher doses of pain medication, such as morphine, to relieve the distress. Without these types of drugs, there is potential for the patient to live for hours after removal of treatment. While this practice can help relieve suffering, there is concern that this may produce a slippery-slope. The arguments to say, "as far as your interests are concerned it would be morally best if we induced a quick and painless death. But if we do, it will launch the rest of us down a slippery slope. So put up with your distress, and save us all from slippery slopes" (Campbell, 1994, 313). There are cases in which the patient will endure extreme suffering and there may be cause to administer a higher dose of pain medication instead of prolonging the patients suffering. However, if the patient is unaware and is not suffering, then there is no reason to speed up the dying process in this way. It is understandable that the family may not want to deal with the prolonged dying process, but inducing death should never be an option. There may be extenuating circumstances where the patient would suffer unbearable pain, but again, permitting this could potentially lead to more "extenuating circumstances" in the future.

The pressing question is whether or not forgoing or withholding treatment hastens death? It is true that a patient may die after medical technology is removed, it is also true that they may have lived longer if it had not been removed, but I do not believe that is hastening death. I do believe, however, that this does change the timing of death, which I argue is ethically permissible. When death is hastened the end goal of the action is to end the patient's life. It is morally wrong to perform an action in which the intention is to end a life. However, it is not morally wrong to perform an action that will change the timing of death. Forgoing treatment or removing a ventilator is not morally wrong, as it only changes the timing of death, it does not cause death.

Killing and Letting Die

Drawing a sharp distinction between killing and letting die using conventional definitions is very difficult. Killing is, “a causal action that brings about death.” Letting die is, “an intentional avoidance of causal intervention so that disease, system failure, or injury causes death” (Beauchamp & Childress, 2016). However, there are many acts of what seems to be simply letting die which still count as killing, defeating the purpose of the distinction between the two terms. The meaning of the two terms are questionable, vague, and any attempt to clarify the meanings will lead to debate without resolution. Even when used correctly, the terms killing and letting die do not establish that one is better, worse, or more or less morally justified than the other.

In both voluntary euthanasia and physician assisted suicide both the patient and the physician work together in order to end the patient’s life. In a situation where an autonomous patient makes the decision to end their life, does it truly make a difference who performs the final act? Either way, the patient and the physician are working together in order to produce death, so why is killing illegal and letting die is not? Is there truly a difference between these two acts?

It is true that it is a basic human right to do with one’s life, self, and body what they wish. One of the four basic bioethical principles discussed above is autonomy, which applies to medicine in the above cases and can be defined as; a person’s ability to make their own decisions regarding their care without undue influence of another person. When a terminally ill patient has a wish to end their life and turns to their physician to help them end their life, their suffering, it is not something that is taken lightly. The patient who is making the request must be competent, meaning able to make and communicate their own decisions. Any physician who participates in a Death with Dignity Act does so voluntarily, just as the patient has the right to choose to participate, so does the physician.

In the cases discussed earlier, Karen Quinlan and Nancy Cruzan, the physicians viewed removing life-support as killing. However, it was ruled by the courts that this was not the case. In these cases, determining who had authority to make the decision to remove life-support on behalf of the patients was difficult because there were no legal documents in place stating that someone else had the authority to make decisions on these two women's behalf. The families in both cases argued that they knew that neither woman would like to live through a machine. In the Cruzan case, the court "supported the idea that patients have a fundamental right to refuse life-sustaining treatments but added that states may regulate the circumstances under which life-sustaining treatments may be withdrawn when the patient cannot speak on his or her own behalf" (Fine, 2005).

There is one main difference between physician assisted suicide and euthanasia. In euthanasia, there are underlying pressures for the patient to go through with taking the drug when it is being administered to them by the physician. This is because other people are involved in the process of ending their life. Physician assisted suicide, on the other hand, does not have the same underlying pressure. When a physician prescribes a patient a lethal dose of medication, the patient gets the prescription and can decide to take the drug to end their lives whenever they determine the time is right, but having the drug does not mean that they are required to end their lives.

Under the Death with Dignity Act, a physician can prescribe the patient the lethal dose of medication. This allows them the means to end their own lives, however, it is ultimately up to the patient if and when they decide to take action and actually end their lives. The Death with Dignity Act is in place so that the patient is given, “the freedom and empowerment to set their own timeframe” (Oregon Health Authority). This makes the decision wholly theirs. However, prescribing the lethal dose of medication to a patient goes against the basic principle of non-maleficence, “do no harm,” as the act of prescribing the medication results in ending a life.

Chapter 4. Discussion

I am going to give my position based on foundational, professional, and societal implications. I stand strong in my position that physician assisted suicide is never morally permissible. Due to the inherent value of a person's life, suicide or assisting in suicide, is immoral. We cannot take life, therefore we cannot choose when a life will be taken. If we were able to choose when we wished to end our lives, that would then imply that it is morally permissible to end a life. Taking the life of another human, sometimes referred to as, "playing God" is another reason why I argue physician assisted suicide is never morally permissible. From a non-denominational Christian standpoint, God is the only one who has the power to take a life. There is a plan for every single person's life, and when we interfere and decide when and how we want to end life, some may suggest this is "playing God." Going off of this religious approach, the sixth of the Ten Commandments states, "thou shalt not kill." This is a principle of many religious cultures. The gift of life has been given to us by God, and ending a life before death naturally occurs degrades the value of human life. My view is that at least when killing is not necessary that it is not morally permissible. However, in situations where killing may be necessary, such as war, it may be morally permissible.

Another reason I argue against physician assisted suicide is that it would be too difficult to actually regulate. Another ethical concern related to physician assisted suicide is what happens to the drugs when the patient decides that they do not wish to end their lives? 64% of patients who received drugs for physician assisted suicide died from taking them, meaning that 36% of patients who get drugs for physician assisted suicide do not take them (Engdahl, 2009, p. 116). There is a potential of the unused 36% of drugs to be used improperly, or by someone who is not the patient for other purposes. The most common method for assisted suicide is ingestion. While the methods of assisted suicide do vary, there is an increasing concern over controlled substances being out there and available.

A physician's main purpose and goal should be to promote health and to treat diseases to ultimately achieve a cure, and if a cure is not possible, then it is the role of the physician to assist in making the symptoms more tolerable. This does not include giving a patient the means to end their lives. Physicians are supposed to be healers, not killers. Even if individuals do have a right to die, there is no duty on the part of any physician to assist them. Physicians should not participate directly nor indirectly in suicide.

It is posited that the decision to end one's life should be a completely autonomous decision. This decision should never be influenced by anyone or anything else. Since this decision often comes at a time in a person's life that can be very frightening, they are not capable of making the true autonomous decision to end their life. This decision is also not completely autonomous because it is not something they can carry out on their own. It is necessary to have a physician support the decision in order for them to prescribe the medication for them to take.

A popular argument, that I will unpack, is the slippery slope argument. This basically says that if Physician Aid in Dying were to be made legal in all states, then it would inevitably lead to the legalization or acceptance of euthanasia. In order to ensure that we do not come any closer to legalizing euthanasia, we must also not allow physician assisted suicide. As of summer 2019, physician assisted suicide is legal in seven states, to terminally ill patients. Eventually, there is a fear that since it is legal for terminally ill patients, the limits will be stretched to allow patients who have chronic or life-debilitating illnesses to be able to utilize the physician assisted suicide resources, as has happened in the Netherlands. For the slippery slope argument, if physician assisted suicide were to be legalized, there is a fear that the quality of end of life care will decrease. If physician assisted suicide were legalized, insurance companies may not wish to continue to pay for the higher quality care for patients at the end of life since this option exists. Also, patients who cannot afford end of life care, or whose insurance companies will not cover it, may feel pressured to choose physician assisted suicide. This would be a violation of the principle of justice, as those who are impoverished will have an unfair disadvantage. Per the principle of justice, people should have equal opportunities presented and available to them. If end of life care becomes too expensive for patients to afford, then there's a chance that more patients may turn to physician assisted suicide in order to avoid the expenses not covered by their insurance companies. Finally, if physician assisted suicide were legalized it may lead society to have a more negative view on patients who are terminally ill at the end of life, thinking that their lives are not worth living and that they should opt to take advantage of being able to end their lives on their own.

There is a clear distinction between allowing to die and killing a patient. Allowing a patient to die can be equated with withdrawing care. So removing life support measures, such as a ventilator, or artificial nutrition and hydration, with the patient's request and consent, would be allowing them to die. Killing the patient, or euthanasia, would be the case of the physician deciding the patient has been on the ventilator or has been given artificial nutrition and hydration for long enough and they determine that it is time for them to be taken off, with or without the patient's consent.

The moral argument for Euthanasia is essentially equivalent to the moral argument for physician assisted suicide. Voluntary active euthanasia is illegal in all states. In the case of voluntary active euthanasia, where a physician or someone on their team has the patient's consent and is the one who administers the last dose of the medication which ends the patient's life, the failure rate of this is very low. The only difference between physician assisted suicide and voluntary active euthanasia is who takes the final act leading to the patient's death. However, the physician is just as morally culpable in the case of physician assisted suicide as they are in the case of Voluntary Active Euthanasia, as they are either providing the means or assisting in ending the patient's life. Euthanasia is never morally permissible in any case.

One could make an argument against physician assisted suicide and euthanasia using the four principles of bioethics but one can also construct a compelling counter narrative. For our personal situation, the way that the four principles conflict with one another did not help to guide us in making decision for my cousin.

There are cases in which forgoing or withdrawing medical technology is morally permissible. I will discuss a few examples of cases in which it is permissible to withhold or withdraw care. I argue that it is morally permissible to forgo or withdraw care on a patient when treatment is futile. In Webster's dictionary, the term futile is defined as, "having no result or effect" (Merriam-Webster's dictionary). When referring to futility in medicine, it is defined as treatment which has no benefit to the patient. In cases of futility, where no matter what treatment the patient is given, there is no hope for a cure or to improve their condition, it is morally permissible for the patient to decide that they do not wish to pursue further treatment or continue current treatment. If a patient has a terminal illness, and they have exhausted all treatment options, they are morally permitted to make the decision to let their disease take its natural course.

I argue that it is morally permissible to forgo or withhold further treatment in cases of severe, irreversible handicap or suffering. This can refer to many conditions, but one in particular I will mention is Creutzfeldt-Jakob Disease. This disease is extremely rare, "fewer than 1000 (Sikorska, 2012)" patients are diagnosed per year. Cruetzfeldt-Jakob Disease, often referred to as CJD, is a degenerative brain disorder. CJD is a fatal disease that progresses very rapidly. There is no known prevention for this disease. Patients with CJD lose the ability to care for themselves, as well as the ability to recognize their friends and family. There is currently no treatment or cure for CJD. The only current available treatment is strictly palliative, the aim is to make the person as comfortable as possible and try to alleviate their symptoms. Towards the end of this disease progression many patients end up needing artificial nutrition and hydration. Patients with CJD ultimately end up needing constant, around the clock, care, including artificial nutrition and hydration.

After watching my cousin die from Crutzfeldt-Jakob disease our family struggled with questions regarding what a good death is, and what are the limits of medical technology. Questions that came to my mind included questions about assisted suicide and the difference between allowing to die and causing death. Since I watched the process of allowing to die, in this case, I know that there is a difference. In a case such as CJD I argue that it is morally permissible to forgo medical technology, such as artificial nutrition and hydration that will further sustain the patient, while continuing symptom management, to allow them to die.

Many ethical questions revolving around forgoing medical treatment involve deciding if and when life support should be discontinued. A question to consider is; "what degree of risk of severe handicap should suffice for decision making? Only certainty? 50 percent? (Campbell, 1994, 305)" It is possible that while removing a patient off of a ventilator, they may still be receiving artificial nutrition and hydration. The ethical dilemma is if the artificial nutrition and hydration should continue and whether or not the artificial nutrition and hydration is "life-supporting in the same way as a mechanical ventilator (Campbell, 1994, 305). If the patient is predicted to suffer from a severe handicap, and would likely require around the clock care, then I believe it is morally permissible to discontinue all life support measures. If the only thing keeping the patient alive is the artificial nutrition and hydration, but there is no brain function or chance of the patient to ever walk or talk again, then I also believe it is morally permissible to discontinue the artificial nutrition and hydration. I argue this because I do not think it is fair to keep a patient alive who will have a poor quality of life by suffering from permanent and severe intellectual and physical handicaps. However, if there is a chance that the patient could walk and talk and function in everyday life again, maybe not

100% on its own but with assistance, then I believe the patient has the right to a chance at life.

Due to advances in medical technology it is now possible to maintain life for long periods without any hope of recovery. With advances in knowledge and technology physicians can take over the function of most vital organs when they fail, for days or even weeks. In most cases machines can take over until a donor becomes available. Patients have a right to refuse any and all treatment. Right of refusal means that patients have the right to refuse medical treatment. The cases discussed previously, Quinlan, and Cruzan confirm that a patient is not required to accept medical treatment. The Quinlan case also shows that treatment can be refused after it has been started. Forced medical treatment is a form of common law battery, which is why the right to refuse medical treatment is so important. It is deeply rooted in the history of the United States.

In the cases of medical futility or cases of severe, irreversible handicap or suffering, I believe it is morally permissible for patients, or their surrogate decision makers, to seek palliative and hospice care to help with symptom control and management, however, it is not morally permissible for them to take ending their lives into their own hands.

Palliative sedation is used in order to help relieve suffering. I believe in the cases I have just discussed, palliative sedation is very appropriate and important to help maintain little to no suffering in patients at the end of life. Palliative sedation is used in order to, "induce decreased or absent awareness in order to relieve otherwise intractable suffering at the end of life" (Olsen). It is important to reiterate that palliative sedation is not hastening death. The practice of palliative sedation calls upon the principles of beneficence and non-maleficence. The principle of beneficence applies because it is the physicians duty to alleviate suffering, and the principle of non-maleficence applies because it is also the physicians duty to prevent or avoid harm. Palliative sedation is different than physician assisted suicide and euthanasia due to the intent of the action. The intent of physician assisted suicide and euthanasia is ultimately death for the patient, which is the end goal. The intent of palliative sedation is strictly for the, “relief of unremitting and intractable suffering achieved by sedation. (Olsen)” In palliative sedation, the cause of the patient’s death is the underlying disease or illness, it is not due to the medications the patient is being given to sedate them. The end goal is to make the process of dying naturally due to disease or illness more comfortable for the patient.

Having gone through an initial review of what bioethics has to address regarding the issues of physician assisted suicide and euthanasia, I have the following conclusion based on my foundational belief, based on the impact on the profession, and the impact on society. Though much more can be said creating a moral argument, these are the conclusions I have come up with thus far.

Death Today

Medical treatment is constantly developing. Despite great medical advances, people do still die. However, both Dowbiggin (2003) and Lavi (2005) discuss medical treatment, its progress, and it’s shift of focus from good palliative care to treatment, which has impacted the way that death is interpreted in today’s society. The focus seems to be more on the quantity of life, rather than the quality of life. Modern society seems to focus more now on curative care regardless of whether the quality of life is favorable or not, rather than focusing on dying well. “The challenge for bioethics is to create a framework for teaching an aging population to prepare for death and to support one another through the dying process. (Dugdale, 2010)”

Every single day, in hospitals all across the United States there are patients dying surrounded by ventilators, feeding pumps, and numerous tubes rather than dying comfortably in their own homes surrounded by the ones that they love. (DeSpelder & Strickland, 2009) The argument against dying this type of death began with the case of Karen Ann Quinlan, and still continues today (Dowbiggin, 2003).

Chapter 5. Conclusion

The topics of both physician-assisted death and euthanasia have been widely debated issues since before the United States even existed. These debates date back to as early as 500 BC. These debates really began to receive public attention in the 1970s-1990s through the media due to the medical cases mentioned above. It was only after these cases that the focus shifted to the issue of surrogate decision making and shined the light on patient's right to die. In recent years, we have seen major developments in law and policy in relation to physician assisted death. Despite the major developments in modern medicine related to the topic of physician assisted death and euthanasia, the right to die continues to be an issue today. As with any major ethical debate, it is difficult to arrive at a common agreement. While we all have a vested interest in seeing that ethical issues are solved, many people are not willing to bend on their moral and religious beliefs in order to do so. While many patients wish to have live pain free and with dignity at the end of their life, physician assisted death and euthanasia are not the answer.

Bibliography

American Academy of Hospice. (n.d.). Statement on Palliative Sedation. Retrieved from http://aahpm.org/positions/palliative-sedation

Beauchamp, T. L., & Childress, J. F. (2016). *Principles of biomedical ethics*. New York: Oxford University Press.

Belkin, L. (1990, June 6). Doctor tells of first death using his suicide device: A victim of Alzheimer's pressed a button and died, inventor says doctor tells of first death by means of suicide. New York Times (1923), pp. A1-B6

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, 1986 Cal. App. LEXIS 1467 (Cal. App. 2d Dist. Apr. 16, 1986)

Campbell, Neil. "When Care Cannot Cure: Medical Problems in Seriously Ill Babies." The Beginning of Human Life (1994): 303--332.

Cholbi, Michael, "Suicide", *The Stanford Encyclopedia of Philosophy* (Fall 2017 Edition), Edward N. Zalta (ed.), <https://plato.stanford.edu/archives/fall2017/entries/suicide/>.

Cleary, S. C. (2018, March 13). Should I Kill Myself or Have a Cup of Coffee? The Stoics and Existentialists Agree On The Answer. Retrieved from https://dailystoic.com/stoics-existentialists/

Cureton, Adam (2016). Kant on Cultivating a Good and Stable Will. In Iskra Fileva (Ed.) _Questions of Character_. Oxford: Oxford University Press. Pp. 63-77.

DeSpelder, L.A., & Strickland, A.L. (2009). The last dance: Encountering death and dying (8th ed.). New York, NY: McGraw-Hill.

Dowbiggin, I. (2003). A merciful end: The euthanasia movement in modern America. New York: NY: Oxford University Press.

Dugdale, Lydia (2010, November 01). The Art of Dying Well. *The Hastings Center Report, 40,* 6, 22-24.

Engdahl, S. (2009). Assisted suicide. Detroit, MI: Greenhaven Press.

(n.d.). Futile. Retrieved from https://www.merriam-webster.com/dictionary/futile

Fine R. L. (2005). From Quinlan to Schiavo: medical, ethical, and legal issues in severe brain injury. *Proceedings (Baylor University. Medical Center)*, *18*(4), 303–310. doi:10.1080/08998280.2005.11928086

Hamil-Luker, J., & Smith, C. (1998). Religious Authority and Public Opinion on the Right to Die. *Sociology of Religion,59*(4), 373. doi:10.2307/3712123

Jack Kevorkian. (2015, December 03). Retrieved from https://www.biography.com/people/jack-kevorkian-9364141

Jenifer Hamil-Luker, Christian Smith, Religious Authority and Public Opinion on the Right to Die, *Sociology of Religion*, Volume 59, Issue 4, Winter 1998, Pages 373–391, https://doi.org/10.2307/3712123

Lavi, S. J. (2005). The modern art of dying: a history of euthanasia in the United States. Princeton: NJ: Princeton University Press.

Melton, J. G. 1991. The churches speak on euthanasia. Detroit, MI:Gale Research.

Miles, Steven H. (2004). The Hippocratic Oath and the ethics of medicine. Oxford ; New York :Oxford University Press,

Nancy Cruzan's accomplishment. (1990, Dec 27). New York Times, pp. A18.

Nordqvist, C. (2018, December 17). Euthanasia and assisted suicide: What are they and what do they mean? Retrieved from https://www.medicalnewstoday.com/articles/182951.php

Olsen, M. L., Swetz, K. M., & Mueller, P. S. (2010). Ethical decision making with end-of-life care: palliative sedation and withholding or withdrawing life-sustaining treatments. *Mayo Clinic proceedings*, *85*(10), 949–954. doi:10.4065/mcp.2010.0201

Oregon Health Authority-FAQs. (n.d.). Retrieved from https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx

Papadimitriou, J. D., Skiadas, P., Mavrantonis, C. S., Polimeropoulos, V., Papadimitriou, D. J., & Papacostas, K. J. (2007). Euthanasia and suicide in antiquity: viewpoint of the dramatists and philosophers. *Journal of the Royal Society of Medicine*, *100*(1), 25–28. doi:10.1177/014107680710000111

Plato. Republic II. The Greeks. Od Hatzopoulos, ed. Athens: Kaktos Publishers, 1992: 90-7; lines 406e-407e

(2019, January 16). Religious Groups' Views on End-of-Life Issues. Retrieved from https://www.pewforum.org/2013/11/21/religious-groups-views-on-end-of-life-issues/

Sacred Congregation for the Doctrine of the Faith (SCDF). 1982. Declaration on euthanasia (5 May 1980). Vatican Council II 2:510-6.

Sikorska B., Knight R., Ironside J.W., Liberski P.P. (2012) Creutzfeldt-Jakob Disease. In: Ahmad S.I. (eds) Neurodegenerative Diseases. Advances in Experimental Medicine and Biology, vol 724. Springer, New York, NY

Taylor, P. (1987). INHERENT VALUE AND MORAL RIGHTS. *The Monist, 70*(1), 15-30. Retrieved from http://www.jstor.org/stable/27903011

Urofsky, M.i. (2000). Lethal judgments: Assisted suicide & American law. Lawrence: KS: University Press of Kansas.

Vacco v. Quill, 521 U.S. 793, 117 S. Ct. 2293, 138 L. Ed. 2d 834, 1997 U.S. LEXIS 4038, 65 U.S.L.W. 4695, 97 Cal. Daily Op. Service 5027, 97 Daily Journal DAR 8122, 11 Fla. L. Weekly Fed. S 174 (U.S. June 26, 1997)

Washington v. Glucksberg, 521 U.S. 702,117 S. Ct. 2258,117 S. Ct. 2302; 138 L. Ed. 2d 772,