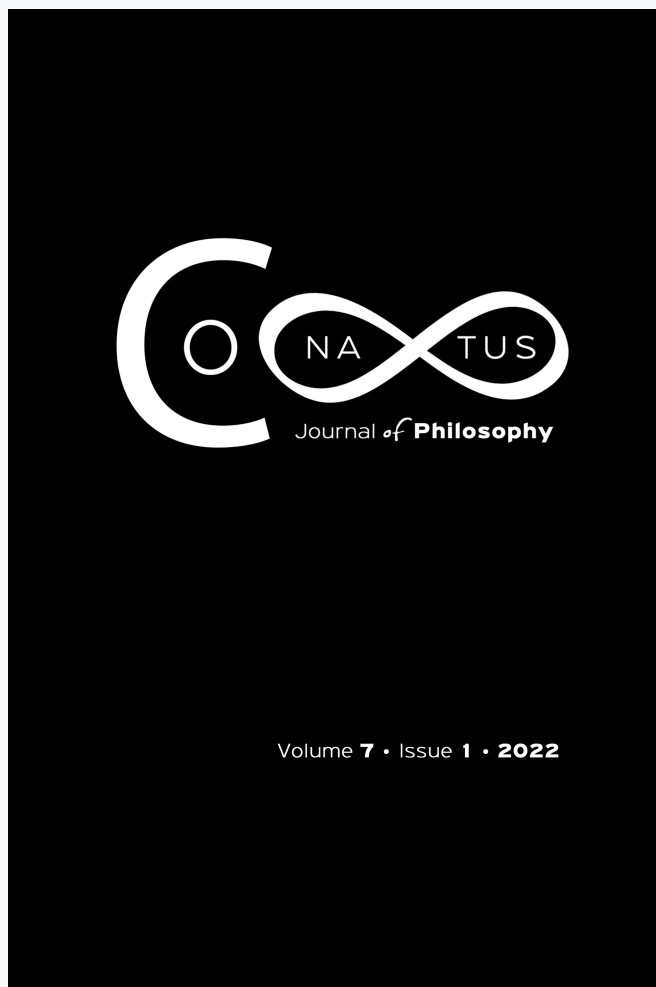


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# Physicians' Role in Helping to Die

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## Abstract

*Euthanasia and the duty to die have both been thoroughly discussed in the field of bioethics as morally justifiable practices within medical healthcare contexts. The existence of a narrow connection between both could also be established, for people having a duty to die should be allowed to actively hasten their death by the active means offered by euthanasia. Choosing the right time to end one's own life is a decisive factor to retain autonomy at the end of our lives. However, there is no definitive consensus on why physicians should be the ones performing the medical procedure to end a person's life. The moral problems arising from such assertion are not to be taken lightly, for medical tradition has long regarded the duty not to kill, not to actively end a patient's life, as the core moral obligation that gives meaning to the medical profession. Our concern is to question the moral justifiability of the arguments offered by physicians not to actively help patients die.*

**Keywords:** *euthanasia; physician's duties; palliative care; conscientious objection; medicalisation of death; bioethics*

## I. Introduction

Euthanasia and the duty to die have both been thoroughly discussed in the field of bioethics as morally justifiable practices within medical healthcare contexts.<sup>1</sup> The existence of a narrow connection between

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<sup>1</sup> See John Hardwig, "Dying at the Right Time: Reflections on (Un)Assisted Suicide," in *Ethics in Practice: An Anthology*, ed. H. LaFollete, 3<sup>rd</sup> ed. (Oxford: Oxford University Press, 1997), 101-112; John Hardwig, "Is There a Duty to Die?" *The Hastings Center Report* 27, no. 2 (1997): 34-42; Margaret Pabst Battin, *Ending Life: Ethics and the Way We Die* (Oxford: Oxford University Press, 2005); Margaret Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford: Oxford University Press, 1994); Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (London: Simon & Schuster, 1993); Allen Buchanan, "The Right to a

both could also be established, for people having a duty to die should be allowed to actively hasten their death by the active means offered by euthanasia. Choosing the right time to end one's own life is a decisive factor to retain autonomy at the end of our lives. However, there is no definitive consensus on why physicians should be the ones performing the medical procedure to end a person's life. The moral problems arising from such assertion are not to be taken lightly, for medical tradition has long regarded the duty not to kill, not to actively end a patient's life, as the core moral obligation that gives meaning to the medical profession. Our concern is to question the moral justifiability of the arguments offered by physicians not to actively help patients die.

This paper reflects on physicians' duties towards patients at the end of their lives. First, the traditional approach to medicine and physicians' obligations will be carefully examined to comprehend the reasons behind doctors' refusal to provide active euthanasia grounded in their alleged duty not to kill. Second, the just-mentioned argumentation to defend such a traditional approach to medicine will be questioned. Different counterarguments and objections will unveil the internal inconsistencies of the arguments and the lack of a connection with other current practices physicians perform. As a result, physicians' duties will need to be redefined and new arguments will become necessary to explain the paradigm shift and the justifiability of the novel medical practice. Finally, the focus will be put on the specific duties of healthcare professionals at the end of patients' life.

## II. Traditional approach

Mainstream medicine has traditionally defended, at least until recent times, the existence of an intrinsic set of ethics in the medical profession under which certain duties and restraints are inviolable. Above all, the duty not to harm a patient founded on the Hippocratic Oath: *primum non nocere* (first, do no harm). Kass<sup>2</sup> defended medicine as an inherently ethical activity pursuing an overarching good: the naturally given end of health understood as the wholeness and well-working of the body. But how is this abstract idea of *human wholeness* to be understood? It presupposes an underlying natural and universal subject, an *Anthropos* where body and person are self-identical, thus the correct functioning of the body becomes a sufficient and necessary

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Decent Minimum of Health Care," *Philosophy & Public Affairs* 13, no. 1 (1984): 55-78; Robert E. Ehman, "The Duty to Die: A Contractarian Approach," in *Is There a Duty to Die?*, eds. James M. Humber, and Robert F. Almeder (New Jersey: Humana Press, 2000), 61-77.

<sup>2</sup> Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (1989): 25-46.

condition to guarantee the person's characteristic development. Another closely related reason, on the same arguing foundations, understands the body as the living ground for the higher, characteristically and defining, human functions. So, the annihilation of the body would unavoidably imply the extinction of the person. As a result, since medicine pursues health understood as body wholeness, killing, i.e., the destruction of the body, is contrary to medicine's objectives; for, "to bring nothingness is incompatible with serving wholeness."<sup>3</sup>

According to the previous reasoning, the duty not to kill appears as one of the unyielding obligations that physicians must comply with to maintain the medical profession intact. The limits of medicine are fixed, firm, and non-negotiable under this perspective, so the dispensation of deadly drugs is utterly forbidden. Although we might think that some extreme medical circumstances would render such prohibition inhumane due to the caused suffering, either physical or mental, i.e., cases where euthanasia could be advocated for, the traditional approach would reject any alternatives. When the body's wholeness cannot be restored, doctors need to focus all their efforts to ease pain and suffering, checking the patient's comfort and providing support, and lastly avoiding any futile treatment that would unnecessarily extend the agony. Similarly, the traditional view goes on, courage to face the evil of death and ability to stand against the fear it creates in us is praiseworthy. This final macabre twist implies an ideological imposition on people, for there is only one accepted manner to cope with pain and suffering, so any other alternative is morally condemned as wrong. Consequently, liberty and autonomy at the end of life are significantly reduced directly harming people based on their previous life choices and their understanding of existence.

A more recent defence of physicians' duty not to kill has been offered by Garcia.<sup>4</sup> His argument rests on a previous understanding of human nature, which assumes that patients, like any other human animal, have an inherent interest in being alive. For, it is the precondition to enjoying all other possible goods and benefits that life might bring upon a person. Under this approach, there are no conditions whatsoever that render life value deprived. Instances of suffering, either physical or emotional, could never overcome that instinctive willingness to survive at all costs. Garcia goes even further to assert that life itself retains value even when it no longer produces satisfaction.<sup>5</sup> No attention is given to the fact that patients willing to actively hasten their death by euthanasia are autonomously deciding so after competence is

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<sup>3</sup> Ibid., 41.

<sup>4</sup> J. L. A. Garcia, "Health versus Harm: Euthanasia and Physicians' Duties," *Journal of Medicine and Philosophy* 32, no. 1 (2007): 7-24.

<sup>5</sup> Ibid., 10.

confirmed, and informed consent is provided. This lack of regard is due to the assumption that certain rights are not waivable, autonomy among them. Hence, the underlying human-animal *instinct* to continue being alive is conceived as the natural limit to our moral and intellectual capacity to decide how much suffering we are willing to endure, as well as how, when, and why we would want to put an end to our existence.

Since every human animal has that irrevocable interest in being alive, a doctors' defining duty is to maintain or restore health. For, keeping the body alive fulfils such necessary condition. Conceiving this as their main obligation, all other physicians' duties need to be consistent, compatible, and coherent with it and will keep it as the base of their justifications. Cases of active euthanasia and/or physician aid in dying become instances that wreck the internal coherency of doctors' obligations. Mercy killing is contrary to maintaining and restoring health because it halts suffering by ending the patient's life, whereas pain and suffering relief are among a physician's prominent duties because their aim is to keep the person alive even while avoiding the harm caused by physical and emotional distress. But what if the alleviation of suffering requires a high dose of drugs that would foreseeably end the patient's life? The traditional approach embraces here the doctrine of double effect, in an intention-sensitive understanding of morals. Providing drugs that knowingly terminate the patient's life is morally justifiable when, first and foremost, a physician's intention is to alleviate the suffering experienced by the patient. In such cases, death, although foreseen, is considered the unavoidable and unintended collateral effect of drug supply. As a result, terminal sedation is deemed coherent with the doctor's duties to avoid suffering and thus morally and professionally permitted.

Similarly, Pellegrino<sup>6</sup> presents an argument against physicians' help in dying grounded on the unnecessariness of active euthanasia and physician-assisted suicide due to the available methods of pain relief and palliative care. In other words, technological advances in the medical field regarding the alleviation of suffering at the final stages of life are deemed sufficient to render any other alternative, such as active euthanasia, as unnecessary. However, what about emotional and/or mental distress? Can it be equally properly addressed and removed? If so, would it not imply the loss of the patient's consciousness due to the high drug dose needed? Life would be void, meaningless in such a state where experience, both physical and intellectual, have been rendered impossible for the patient.<sup>7</sup> Furthermore, legalisation

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<sup>6</sup> Edmund D. Pellegrino, "Physician-Assisted Suicide and Euthanasia: Rebuttals of Rebuttals - The Moral Prohibition Remains," *The Journal of Medicine and Philosophy* 26, no. 1 (2001): 93-100.

<sup>7</sup> Compatibility between palliative care at the end of life and physician-assisted dying will be furtherly discussed in section IV.a.

and wide moral acceptance of physician-assisted dying within the medical community could significantly erode the physician-patient relationship. Patients' fears that their doctors could suggest euthanasia as an available option would be exacerbated. Therefore, patients' trust in physicians would diminish, for it could be thought that not all treatment options are being considered and physicians are not doing everything they can to help them. If patients believe that physicians are not trustworthy, they could withhold relevant medical information; for, when doctors are perceived as potential life-ending agents, sensitive medical issues could be hidden from them if patients feel their life is at risk. As a result, doctors could not completely rely on the patients' provided information regarding their condition, which would significantly impede the appropriate development of their work. For example, patients suffering from a terminal condition who are experiencing considerable physical pain could avoid talking to their physician about it due to their fear that she might consider such suffering unbearable and thus ending the patient's life if necessary. On the other side, a lack of information would inevitably lead physicians to treat patients in an inadequate manner further increasing the potential suffering and pain experienced.

### III. Objections to the traditional approach

The above depicted understanding of medicine is regarded as teleological essentialism,<sup>8</sup> that is, medicine is essentially devoted to healing the sick and preserving and extending life, thus helping a patient die is not permitted. This section will offer objections to the arguments presented to defend such a traditional approach to medicine.

First, attention will be given to Hippocratic Fundamentalism, the idea that medicine is committed to healing and the conservation of life, thus physician-assisted dying is not permissible. It is difficult to comprehend how defenders of this type of arguments are keen to also sustain doctors' obligation to prevent futile treatment to avoid extending agony unnecessarily. As defended by Rachels, when debunking the distinction between passive and active euthanasia, there seems to be only one identical underlying moral reason to justify both instances of either letting a patient die or actively hastening the process.<sup>9</sup> That is, what truly matters from a moral standpoint is the patient's regard for her life and her autonomous decision that it has come to an end.

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<sup>8</sup> Gary Seay, "Do Physicians Have an Inviolable Duty Not to Kill?" *Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 26, no. 1 (2001): 75-91.

<sup>9</sup> James Rachels, "Euthanasia, Killing, and Letting Die," in *Ethical Issues Relating to Life and Death*, ed. John Ladd (New York: Oxford University Press, 1979), 146-163; James Rachels, *The End of Life* (Oxford: Oxford University Press, 1986).

Doctors implicitly agree, and rightly do so, with such argumentation when rejecting further futile treatment; their acceptance of the patient's death seems obvious, so all that is at stake are the means that will be employed to avoid suffering. If rejection of futile treatment is an exception, morally justifiable, to the conservation of life at the core of doctors' duties, on what grounds could the inappropriateness of aiding to die not be considered another exception? Especially when autonomous patients competently decide so, but even more when palliative care is incapable of alleviating all pain and suffering. In those instances, would physicians not be neglecting their duty not to harm patients by refusing to provide active euthanasia, for it is the only alternative that puts an end to that agony? This kind of situation exemplifies that there are times when alleviating pain can be more important and overriding to physicians' duty not to end a patient's life. Hence, doctors' non-maleficence duty needs to be properly understood. Every alternative needs to be weighed and special attention to be given to those described cases where ending life is the sole option to end pain and suffering.

Evidently, opponents of physician aid in dying argue that terminal sedation would still be an available option to provide adequate care for the patient and is not contrary to the Hippocratic Oath. In cases where patients require such a high dose of morphine, or similar, to alleviate their pain that will irremediably also end their lives, it is sustained that hastening the patient's death is not intended but merely accepted as an unavoidable consequence of treatment. However, it is difficult to defend an intention-sensitive approach to morality in scenarios like the one just depicted. Even though there might be instances where our moral actions can be justified by merely considering our good intentions, especially when among its consequences some were not foreseen, it seems we would be sidestepping doctors' moral responsibilities by defending terminal sedation as one of those cases. As stated before, the patient's death is not the unforeseen consequence of the chosen treatment to ease her suffering and pain; quite the opposite, the selected drug is supplied in a dose high enough to also cause the patient's heart to stop, which implies her death. It appears that the doctrine of double effect proponents would be hiding behind this faulty reasoning to avoid accepting the true moral reasoning justifying their intervention. It could be that using the label of "foreseen but unintentional consequence" is easier than abandoning their previous medicine paradigm to embrace a new, redefined one.

By no means, a devaluation of the duty not to actively and intentionally help a patient die is intended with the objections presented. The duty not to harm is reflected in one of the prominent bioethical principles, non-maleficence, but needs to be regarded as a *prima facie* obligation, that is, it needs to be weighed against other physician-specific duties, which might

render it infeasible. Respect for patient's autonomy and the relief of suffering are also professional duties doctors have grounded on the principles of autonomy and non-maleficence,<sup>10</sup> respectively. When a patient autonomously requests hastening her own death due to the unbearable suffering experienced, the physician's duty to fulfil this right prevails over their obligation not to help a patient die.<sup>11</sup>

The other main cluster of arguments defended by the teleological understanding of medicine is concerned with the loss of trust that patients could feel towards their doctors.<sup>12</sup> As a result, it is thought that the risk of abuse might considerably increase or, at least, the possibility of its appearance is higher. However, recent research shows the opposite.<sup>13</sup> It is not the case that erosion of trust in the patient-physician relationship occurred in any of the countries where physician-assisted dying is legal. Findings of the study show that palliative care was furthered as the result of physician-assisted dying in those countries,<sup>14</sup> so the fear that abuse might happen is ungrounded. If anything, it seems that patients' trust in their physicians could improve when they foresee that their dying choices will be respected and multiple means to exit life are available. Going back to the example at the end of the previous section, a terminal patient would be confident enough to inform physicians about her suffering and her decision regarding the chosen means to put an end to her life. Knowing that her doctor respects her decision and will do what she can to help the patient increases patients' trust and contributes to strengthening the patient-physician relationship.

There is still a second, complementary, objection that can be offered against the loss of trust between patient and doctor. It concerns patients' expectations from healthcare systems and professionals. It is unrealistic to expect limitless treatment to be provided to only one person or small group of people, even less realistic at the end of life. That is not to say that the elderly be neglected regarding their treatment options, for adequate care should be provided at every stage of life. However, there are other morally binding imperatives that healthcare professionals must comply with to

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<sup>10</sup> Cf. Tom L. Beauchamp, and James F. Childress, *Principles of Biomedical Ethics*, 7<sup>th</sup> ed., 101-201 (New York; Oxford: Oxford University Press, 2013).

<sup>11</sup> For a more detailed explanation between correlative and noncorrelative doctors' duties, see Gary Seay, "Euthanasia and Physicians' Moral Duties," *Journal of Medicine and Philosophy* 30, no. 5 (2005): 517-533, who sustains that doctors' duty not to end a patient's life cannot be unconditional.

<sup>12</sup> See also in Pellegrino, and Kass.

<sup>13</sup> See Kenneth Chambaere, and Jan L. Bernheim, "Does Legal Physician-Assisted Dying Impede Development of Palliative Care? The Belgian and Benelux Experience," *Journal of Medical Ethics* 41, no. 8 (2015): 657-660.

<sup>14</sup> The Netherlands, Belgium, and Luxemburg.



guarantee everyone in society their fair share of healthcare resources. This just allocation of resources rests on the recognition that we are all equal from a moral standpoint, thus we all deserve to have the same opportunities in life, which are, at least to a significant extent, determined by our health condition. Age rationing, where allocation of scarce healthcare resources corresponds to earlier stages in life, ensures a just distribution of them, which allows every person to enjoy a higher life expectancy and quality of life for most.<sup>15</sup>

#### IV. A novel approach to medicine and doctors' duties

Identification of medicine goals and physicians' duties is fundamental to providing high-quality and adequate health care to society. So far, the traditional approach to medicine, which ultimate maxim was to avoid harm and promote health, has been questioned by different arguments which debunk the inviolability of doctors' duty not to end a patient's life. However, our notion of common-sense changes rapidly in medical ethics with all the scientific and technological advances, which result in new challenges to our thinking patterns about life and death.<sup>16</sup> What counts as a legitimate part of medicine has changed over time. Consider, for example, cosmetic surgery as a commonly accepted medical practice nowadays, which would not have had a place within the definition of medicine a few centuries ago.

The proposal for a new medical practice, to the extent of the possibilities within this paper, is to defend that aid in dying should be included within physicians' duties. It is, as Jonsen<sup>17</sup> puts it, the inauguration of a new social practice, where medical support to help patients end their lives in the chosen way becomes a procedure integral to the practice of medicine. That is not to utterly reject the principle "do no harm," but to understand that it needs nuancing, and it has exceptions. Respect for the patient's autonomy, as she decides when and how to end her life, becomes the pivotal bioethical principle to support our claim. However, there is still a further underlying objective: the humanization of medicine in a healthcare environment where scientific and technological medical improvements prolong and extend life to the limits of the morally defensible. That intention to keep a person alive until

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<sup>15</sup> Cf. Buchanan; Battin, *Ending Life*, 280-300; Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008).

<sup>16</sup> Cf. Gary Seay, "Euthanasia and Common Sense: A Reply to Garcia," *Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 36, no. 3 (2011): 321-327.

<sup>17</sup> Albert R. Jonsen, "Criteria That Makes Intentional Killing Unjustified," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp (Upper Saddle River, NJ: Prentice-Hall, 1996), 50-52.

the moment treatment becomes futile<sup>18</sup> rests on, and is morally supported by, the assumption that life has intrinsic value, and is further defended as the core medical principle of “first, do no harm.” Thus, the promotion of health, as well as the relief of pain and suffering, must be understood in a broader sense. Suffering and pain relief is a physician’s duty equally fundamental to their duty to conserve life,<sup>19</sup> and many situations will require them to hasten death grounded on the patient’s autonomous request not to endure any more suffering.

Reflecting on the objectives of medicine, Hardwig<sup>20</sup> argues against medical vitalism, that is the idea that being alive is itself valuable despite further medical or moral considerations, thus prolonging life is the highest value within medical practice. There are more important goals for healthcare than endlessly fighting death, e.g., the fair allocation and distribution of resources to treat everyone justly. We should also consider, as Hardwig suggests, the impact on families that medical vitalism has; for, families are reduced to mere “patient-support” systems and the impact on the lives of others is not to be left unconsidered. Longer life, the simple fact of remaining biologically alive for a lengthier period, is not valuable by itself. What matters is what we do with the time left, how we autonomously decide to spend it based on personal values and life trajectory. The traditional medical account, which rejects physicians’ aid in dying, fails to respect autonomous decisions by patients who opt for the earlier termination of their lives, choosing assisted death as the appropriate and meaningful personal way to end their lives.

Varelius<sup>21</sup> offers further criticism regarding the goals of medicine. For him, there are two main approaches to defining the goals of medicine: subjective and objective. Among the latter, we find considerations closely related to the preservation of life, such as the promotion of health and the patients’ wellbeing, together with the avoidance of harm. Those are the ones traditionally defended and incorporated by medical practice as exceptionless. However, further reflection will lead us to question such assumptions. For example, what is the role of the quality of life in the traditional approach? Should it matter at all what we consider as harm or benefit for the patients? It is not difficult to imagine situations where the same treatment might be beneficial for a person, based on her personal beliefs, and harmful for another. End-of-life process is exemplary in this regard: prolongation of life for a further two weeks might be regarded as necessary for a patient who is waiting for a

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<sup>18</sup> This is the idea of technological brinkmanship defended by Callahan, 23-56.

<sup>19</sup> Seay, “Do Physicians Have an Inviolable Duty Not to Kill?”

<sup>20</sup> John Hardwig, *Is There a Duty to Die?* (London: Routledge, 2000), 165-184.

<sup>21</sup> Jukka Varelius, “Voluntary Euthanasia, Physician-Assisted Suicide, and the Goals of Medicine,” *Journal of Medicine and Philosophy* 31, no. 2 (2006): 121-137.

loved one to arrive and say goodbye, and the same amount of time can easily become a nightmare for another patient who has made peace with her death and does not want it to be delayed any longer. Similarly, end-of-life choices demonstrate that the promotion of health is not self-evident regardless of the patient's personal circumstances. These considerations should make us consider the subjective approach to the ends and goals of medicine, which should be determined by the autonomous decisions of patients.

It seems evident that some of the questions posed before to challenge the objective perspective are easier to answer from a subjective patient's approach. There are two main reasons for valuing autonomy. First, it is an instrument for promoting the patients' well-being. Patients must be adequately informed about their condition, prognosis, and treatment options, so they can be in a position to independently decide what is best for them, considering their own life values and trajectories. Second, it is intrinsically valuable, independent of its role in promoting the patient's well-being. In other words, autonomous decisions that could not contribute to the patient's good retain value when the consent is informed and given freely.<sup>22</sup>

Overall, it seems obvious that medicine should not concern itself with promoting whatever enhances the patient's well-being regardless of the patient's autonomous considerations and decisions. Despite its origins, medicine has developed as a profession committed to the alleviation of pain and suffering, and not simply dedicated to healing and conserving life. This shift makes physicians' duty to alleviate suffering override, on some occasions, their duty not to end life.<sup>23</sup>

#### a. Compatibility between palliative care and euthanasia

One of the greatest challenges when discussing physician-aided dying is its apparent incompatibility with palliative care. Especially, active euthanasia, the objection goes, seems contrary to the goals and main objectives of the medical care provided at the end of life. Furthermore, the legalisation of diverse types of physician-assisted death would negatively affect palliative care for two main reasons. First, patients would feel that having the possibility to choose their own death makes them vulnerable to not receiving appropriate end-of-life care. In other words, having active euthanasia, for example, as a medical option at the end of life could make patients think that their physicians

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<sup>22</sup> Further discussion on whether there is such an intrinsic value on autonomy cannot be offered here. Cf. *Ibid.*, 123-125; R. Gillon, "Ethics Needs Principles - Four Can Encompass the Rest - and Respect for Autonomy Should Be 'First among Equals,'" *Journal of Medical Ethics* 29, no. 5 (2003): 307-312.

<sup>23</sup> Seay, "Do Physicians Have an Inviolable Duty Not to Kill?"; Seay, "Euthanasia and Physicians' Moral Duties."

would encourage them to elect this path instead of the expensive treatments necessary in palliative care. Second, the purposefulness of palliative care would significantly diminish, for considerations of more active procedures to end the patient's life would make it the chosen and preferable option in many cases. And, if death is deemed as an acceptable alternative, the importance of end-of-life care could be rendered less practical and appropriate. As a consequence of both, palliative care would presumably suffer from a lack of resources, both material and in personnel making alternative decisions at the end of life available to patients.

However, it is far from evident that the offered concerns regarding palliative care truly arise from the moral and legal acceptance of different physician-assisted dying procedures. I will try to show how palliative care and physician-assisted dying can be compatible, and in fact, are compatible in countries where these procedures are legal. As part of doing so, the main common assumptions of the incompatibility between palliative care and euthanasia will be debunked.

Palliative care and euthanasia are related and compatible. They are treatment alternatives, procedures that do not exclude each other, which can also be mutually beneficial and complementary. My claim here does not pretend to establish a reciprocal necessity and close relation between palliative care and active euthanasia; it is sufficient for the purpose of the argument to show how the relations between both is a two-way street where the procedures support each other in certain cases.

Death in contemporary western societies is more likely to happen after a prolonged period of deterioration and suffering.<sup>24</sup> This fact is paramount for understanding that palliative care is, in many cases, the best alternative, the adequate medical procedure before euthanasia can become acceptable. In the process of dying, physicians' duties of not harming and being beneficial to patients necessarily convey their obligation to provide the best care available before death occurs. Moreover, it might perfectly happen that for many dying people palliative care does effectively prevent the need for euthanasia by the aforementioned alleviation of pain and suffering. However,

this does not mean that all requests for and cases of euthanasia or PAS can be prevented; neither can it be claimed that such requests and cases are indications of a lack (or of a low quality) of palliative care.<sup>25</sup>

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<sup>24</sup> Callahan, 156-160; John Hardwig, "Medicalization and Death," *APA Newsletters on Philosophy and Medicine* 6, no. 1 (2006): 5-6.

<sup>25</sup> Guy Widdershoven, Margreet Stolper, and Bert Molewijk, "Dealing with Dilemmas around Patients' Wishes to Die: Moral Case Deliberation in a Dutch Hospice," in *The Patient's Wish*

Even when the best palliative care is provided, patients might still opt for a more active means of dying because they autonomously decide that waiting for any longer is needless. Although some of the main principles and goals of palliative care are irreconcilable with euthanasia, i.e., the acceleration of death is not an aim of palliative care, they share other objectives, i.e., the recognition that dying is an intrinsic part of life and that palliative care is designed to make patients as autonomous and active as possible.<sup>26</sup>

Research by Michael Gill<sup>27</sup> also supports the thesis of the compatibility between physician-assisted dying and palliative care. Even though the research undertaken by Gill focuses only on debunking common assumptions regarding the incompatibility of physician-assisted suicide, and good palliative care, I see no reasons to think that significant differences would appear in cases of active euthanasia, for what truly matters is the underlying moral ground to support the justifiability of physician-assisted death, regardless of the employed means to perform the procedure.

The first common assumption is concerned with suffering, more specifically, with the complete elimination of pain when palliative care is provided. It is commonly argued that appropriate palliative care would render physician-assisted dying unnecessary; for, if suffering is the prominent feature that determines a patient's wish to die, its effective alleviation would make people reconsider and lastly reject their willingness to end their lives. However, the ability to control pain does not make instances of physician-assisted dying illegitimate. First, it is not always possible to completely eliminate physical pain. Some people suffering from terminal conditions continue experiencing extreme pain even when the best palliative care is provided. Furthermore, 12% to 20% of patients receiving excellent end-of-life care keep their desire to hasten their deaths, which indicates that better palliative care does not totally eliminate physician-assisted death requests. Second, other physical conditions, such as nausea, extreme fatigue, and weakness, or diarrhea, can be an obstacle that impedes patients from having a comfortable and good death. Third, and last, people hold different attitudes and beliefs towards death, as well as have different pain and suffering thresholds. That implies that the exact same medical situation and its associated conditions, if it comparing different cases were at all possible, could be tolerable for one person and palliative care would suffice to ease her last days, but it could be

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*to Die: Research, Ethics, and Palliative Care*, eds. Christoph Rehmann-Sutter, Heike Gudat, and Kathrin Ohnsorge (Oxford: Oxford University Press, 2015), 152.

<sup>26</sup> *Ibid.*

<sup>27</sup> Michael B. Gill, "Is the Legalization of Physician-Assisted Suicide Compatible with Good End-of-Life Care?" *Journal of Applied Philosophy* 26, no. 1 (2009): 27-45.

unbearable for another patient who cannot endure that suffering and would prefer to end it by taking more active steps, i.e., requesting active euthanasia. Once again, justifications offered to defend why physical or psychological suffering are good reasons to provide help in dying are the truly important moral features to consider and discuss.

Another related and frequent assumption points to the incompatibility of hospice care and physician-assisted dying. Hospices have always been places where people went to receive adequate care throughout the final stage of their lives. Respect for life is the paramount principle guiding hospice practice, which seems contrary to helping someone die. However, the principle not to abandon patients at the end of their lives and respect their wishes conflicts with another hospice principle, that is, the one against postponing or hastening death. It seems obvious that in instances of a patient requesting her death to be hastened, hospice caregivers face a conflict of obligations, for they must respect the patient's wish and not abandon them in their suffering but providing help in dying is forbidden. We advocate for an inclusive understanding of both principles that makes help in dying, thus respecting the patients' autonomous wishes, compatible with providing the best care available, so people are not abandoned to their suffering. The end of a person's life must be understood as a continuum where respecting their death wishes can be compatible with providing the best care until just before the time comes. In addition to that, hospice personnel has the expertise to deal with death requests and physician-assisted dying procedures. Different studies show how hospice caregivers have not experienced any greater difficulty combining both.<sup>28</sup>

Now we shall address a final assumption. Physician-assisted dying requests, where the hopelessness of prospective life is presented as an argument to hasten death, are thought to be possibly erased by providing adequate end-of-life care. The type of care provided is viewed as sufficient to give suffering patients hope for the remaining days of their lives. Whereas different justifications could be offered from patients as to which extent their regarded hopelessness for life is due to bleak prospects in the expected end-of-life care, we believe that the determinant features that trigger such feelings have more to do with the patient's awareness of her factual medical condition. For example, in patients with a terminal condition, hopelessness is more likely to be associated with the imminence of death and its unavoidability. Thus, better end-of-life care could not change their previous decision and offered reasons for their wish to die due to their hopeless condition and future. Adequate palliative care could indeed make the remaining time bearable and will surely ease pain and suffering, but it cannot alter the features that make the patients' lives hopeless.

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<sup>28</sup> Gill.

In short, both palliative and end-of-life care are compatible with physician-aid in dying requests, for they must be understood as distinct stages within the same process. Respect for patients' autonomy is the prominent aspect to consider and accommodate in healthcare settings or hospices. Doctors, nurses, and hospice caregivers must accompany patients during their final time alive providing the best care possible until death comes, regardless of whether the time to die is natural, as it is commonly described in traditional literature, or chosen by the patient by a request to actively hasten their death.

#### b. Conscientious objection

One major issue to carefully consider when including physician-aid in dying as customary practice in healthcare settings is the impact conscientious objection might have on the effective implementation of such procedures. Medical professionals might appeal to their scruples to avoid performing assistance in dying, thus patients' autonomy might be seriously compromised and even disrespected on various occasions. Is conscientious objection a sufficiently robust moral appeal to avoid performing euthanasia or other dying procedures that need the help of a physician/nurse? Are there any exceptions? Traditional medical ethics have long regarded the appeal to scruples as a legitimate excuse to not perform specific procedures that were legally and morally demanded from patients, such as in cases of abortion or euthanasia. The justification offered in defence of conscientious objection was the right to freedom of conscience, protected by the United Nations Universal Declaration of Human Rights, which reads: "Everyone has the right to freedom of thought, conscience and religion" (art. 18). However, there could be limits to this right within specific contexts, such as healthcare, where professional duties rest on other citizens' rights establishing limits to physicians' right to conscientious objection. That will be the thesis we will advocate for in the following. Especially enlightening are Savulescu's words in that regard:

A doctors' conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's goods and the patient's informed desires.<sup>29</sup>

These words might appear to many as contrary to the predominant understanding of medical goals. However, we have advocated for a change of paradigm that is more adequate to present challenges within current

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<sup>29</sup> Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332, no. 7536 (2006): 294.

modern societies. Healthcare is a service provided to citizens by society, where the main objective of healthcare systems is to protect the health of their recipients. The focus when addressing conscientious objection must shift from healthcare practitioners (doctors, nurses, and pharmacists) to the rights patients are entitled to. Therefore, if a healthcare practitioner presents a conscientious objection not to do a specific procedure, and such objection compromises the quality, efficiency, or equitable delivery of a service, there are no reasons to tolerate it.<sup>30</sup> It may be thought that a possible solution would be to refer the patient to another doctor willing to perform whatever procedure objected to by the first physician. But there are several objections to this alternative, both philosophical and practical, that question the tolerability of conscientious objection in healthcare settings.

The previous discussion relates to our first objection: the commitments of healthcare practitioners. The latter are required to deliver healthcare services based on what is legal, beneficial, and desired by patients, and part of a just healthcare system. “Doctors are first and foremost providers of healthcare services. Society has every right to determine what kinds of services they ought to deliver.”<sup>31</sup> Healthcare professionals are not different from others who perform fundamental societal services. It might be difficult to fully grasp the implications of such assertion, for physicians have long retained a deontological moral code upon which their practices are substantiated. But why should such medical values override their obligations as a certain type of professionals within society? To be a doctor has implications based on what society requires from the profession grounded on their expertise and skills. Those requirements cannot be personally adopted by practitioners at will regardless of their fellow citizens’ rights.<sup>32</sup> We shall try to clarify the point with an example from another profession where the goals are established by society: teachers within a public educational setting. The knowledge and skills that teachers must provide to their pupils are established by society and enforced by governmental educational laws. Teachers cannot select specific parts within the national curriculum of their subject to impart and others to avoid based on their personal, either moral or religious, beliefs. A biology teacher cannot skip the Darwinist theory of evolution on grounds of her personal religious belief in the creation of the world by God. Then, why should we allow doctors to choose whether or not to perform euthanasia,

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<sup>30</sup> Ibid.

<sup>31</sup> Udo Schuklenk, “Conscientious Objection in Medicine: Private Ideological Convictions Must Not Supercede Public Service Obligations,” *Bioethics* 29, no. 5 (2015): iii.

<sup>32</sup> Alberto Giubilini, “The Paradox of Conscientious Objection and the Anemic Concept of ‘Conscience’: Downplaying the Role of Moral Integrity in Health Care,” *Kennedy Institute of Ethics Journal* 24, no. 2 (2014): 173-174.



where it is legal and citizens are entitled to receive such healthcare service, based on their beliefs and convictions?

The second objection points to the consequences of permitting conscientious objection, for it may lead to an inefficient waste of resources in cases where patients are unable to find an appropriate practitioner to deliver the service.<sup>33</sup> Similarly, it is not difficult to imagine patients who are not connoisseurs, or are simply less informed, of their right to the specific service their regular practitioner is conscientiously objecting to. As a result, they will fail to receive the service they are entitled to, which generates a morally and legally unjustifiable situation of inequity. Following Schuklenk,<sup>34</sup> patients are entitled to receive a uniform healthcare service from practitioners, not subjected to today's lottery of conscientious objectors. Furthermore, even in scenarios where we could accept conscientious objection on grounds that there would be sufficient professionals to help patients, healthcare practitioners who fail to state initially their principal-based unwillingness to perform a specific medical procedure acquire positive obligations towards their patients.<sup>35</sup> This is especially relevant in physician-assisted dying. A doctor who knows her patient and is fully aware of her willingness to hasten death when she decides so cannot wait just until the last days before the procedure will be performed to present her conscientious objection. The patient-doctor relationship is fundamental in medical procedures such as euthanasia and a strong relationship facilitates the patient's readiness and eases their psychological suffering at the end of life, for they know that a familiar caring person will be assisting and fulfilling their wish.

A third argument points to the inconsistency of permitting healthcare practitioners to object to performing and delivering specific services based on their moral and/or religious beliefs. If society does not, rightly, accept other forms of objection on self-preservation or self-interest grounds,<sup>36</sup> it would be inconsistent to accept other types of objections.<sup>37</sup> It might be initially believed that moral or religious claims are somehow more solid or consistent, but it is easy to show how we would never permit practices that would be plainly discriminatory just because they would have moral or

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<sup>33</sup> That is the situation faced by many women in the South of Italy, where a majority of doctors conscientiously object to abortion, seriously compromising the women's reproductive rights. Cf. Francesca Minerva, "Conscientious Objection in Italy," *Journal of Medical Ethics* 41, no. 2 (2015): 170-173.

<sup>34</sup> Schuklenk.

<sup>35</sup> Cf. Battin, *Ending Life*, 88-107.

<sup>36</sup> For example, physicians reject the provision of a service in a public healthcare setting because she could benefit more from that same procedure if conducted in her private surgery.

<sup>37</sup> Savulescu.

religious grounding. Giubilini<sup>38</sup> brilliantly exemplifies the case stating that we would not, and should not, permit healthcare practitioners to reject treating a patient based on her gender just because her religion prohibits so. The underlying reason is the existence of a moral justification to argue that a person's healthcare rights and entitlements have nothing to do with her gender. Similarly, in cases of physician-aid in dying, healthcare practitioners cannot avoid fulfilling their obligations as professionals by sidestepping them and presenting a conscientious objection. There are solid moral grounds for defending the justifiability to grant plenty of requests – depending on whether they meet the established criteria – for a hastened death in countries where the procedure is legal, thus doctors' duties involve the delivery of the service safely. Furthermore, an increase in the risk of abuse is not to be taken lightly. Healthcare professionals could appeal to their right to conscientiously object in situations where the true reason is different. How could we know that theirs are genuine moral objections and not mere inconveniences?<sup>39</sup>

The above offered arguments provide support against the permissibility of conscientious objection in healthcare settings, grounded in an understanding of healthcare practitioners as professionals within society from whom the delivery of specific services is expected. However, we are aware of the practical difficulties in attempting to implement such a huge change in societies where physician-assisted dying is not yet legal or has been recently legalised. It can surely be too much for society to fully comprehend and rationally accept. We thus believe that intermediate steps might be necessary to ease the transition and a thorough understanding of euthanasia and assisted suicide as morally justifiable healthcare services. It might be possible then for physicians, nurses, and pharmacists to initially object to these practices on moral grounds, even though some objections would remain in scenarios where the patients' rights would be compromised. For example, the conscientious objection would only be permissible when there are enough doctors willing to take over their colleagues' responsibilities guaranteeing an equitable and efficient service provision.<sup>40</sup>

### c. Why doctors?

Having discussed how to redefine doctors' duties and the goals of medicine, always giving special attention to the impact both have on physician-assisted dying, it is now necessary to explain why doctors must be the ones among other healthcare practitioners to perform euthanasia, and be present, having

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<sup>38</sup> Giubilini.

<sup>39</sup> Schuklenk; Giubilini.

<sup>40</sup> Battin, *Ending Life..*

previously prepared all that is needed, in assisted suicide. Advocates of a traditional approach to medicine, where ending a life is regarded as contrary to doctors' main duty not to harm, could argue that even where assisted death could be legalised and morally defensible, physicians should not be the ones performing it.<sup>41</sup> Our thesis here is that doctors must oversee assisted dying because they are the best professionally qualified to do so.

As previously stated, respect for the patients' autonomy and the relief of pain and suffering are two fundamental duties of doctors, which might sometimes collide with their duty not to harm, not to end a life.<sup>42</sup> We have proven that the first two together might override the latter, especially when we also consider physicians' duties as established by their professional expertise within society. Thus, doctors' duty to help patients die will arise, in this new scenario, from the expectations patients have regarding standard care.<sup>43</sup> Besides these morally grounded arguments presented from a new understanding of healthcare practitioners' duties, there are other reasons to defend our thesis.

First of all, physicians are currently using their professional knowledge to serve other interests far from strictly medical issues, or where the restoration of health and preservation of life is not the main goal of their work.<sup>44</sup> There are, in those countries where it is still legal, physicians providing lethal injections for inmates in the death row, only because they have the knowledge to do so. This example by no means defends the moral permissibility of the death penalty, but it only focuses on the non-traditionally understood role of physicians. Another example is cosmetic surgery, where physicians use their expertise and knowledge about human bodies to modify them attending to purely aesthetic intentions dictated by capitalist societies. There are, indeed, cases where cosmetic surgery is necessary to restore mental and societal health, facilitating the patients' return to their normal life, i.e., cases where doctors perform breast reconstruction surgery due to cancer. Therefore, if doctors can use their knowledge in those situations, why should they not employ it to help people die when there are strong moral reasons that justify their requests?

Secondly, the main reason to defend our thesis is that physicians are the most appropriately qualified, possess the best knowledge of the patient, and

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<sup>41</sup> Confront with the idea of self-euthanasia proposed by Ton Vink, "Self-Euthanasia, the Dutch Experience: In Search for the Meaning of a Good Death or *Eu Thanatos*," *Bioethics* 30, no. 9 (2016): 681-688.

<sup>42</sup> Seay, "Euthanasia and Physicians' Moral Duties."

<sup>43</sup> Seay, "Do Physicians Have an Inviolable Duty Not to Kill?"

<sup>44</sup> Richard Huxtable, and Maaïke Möller, "'Setting a Principled Boundary'? Euthanasia as a Response to 'Life Fatigue,'" *Bioethics* 21, no. 3 (2007): 117-126.

have control of the medication employed in assisted-dying.<sup>45</sup> Delegating the responsibility to less qualified professionals would most likely inflict harm or would unnecessarily put patients in a dangerous position. Good medical practice at the end of life requires that the dying person leaves in a state of maximum physical and mental comfort,<sup>46</sup> and the only professionals within society to guarantee that are healthcare practitioners. Moreover, due to the medicalization of death, which main consequence has been a significant shift from people dying at home to people spending their last weeks or months in healthcare facilities, “only healthcare professionals today develop sufficient experience and familiarity with death and dying.”<sup>47</sup> Furthermore, these practices should be restricted to physicians because of the inevitable involvement with safeguards, specific healthcare guidelines, the discharge of medical information that justify the procedure, and so forth. Societies that acknowledge and approve aid-in-dying medical procedures would require their healthcare professionals to include help in dying as a good medical practice, for it honours the autonomous decisions of patients<sup>48</sup> and guarantees their right to healthcare within which euthanasia is offered as a fundamental service.

Finally, as a way of summarising what has been so far discussed in this paper, physicians’ role could be understood under a different lens. Veatch<sup>49</sup> proposes regarding physicians as patients’ helpers, assistants, thus shifting the medical focus from doctors’ duties to patients’ rights. This perspective could help rebuild and strengthen the patient-doctor relationship, where dialogue becomes a secure place for mutual understanding, and make possible that patients discover their best interest from a comprehension of their practitioners’ knowledge. It can be seen as an educational process where patients learn how to proceed with specific illnesses, giving them an increase in informed autonomy to reach their own conclusions and decide which is their preferable treatment or procedure. This proposal emerges from the recognition that patients are the only ones who know what benefits them holistically speaking, whereas doctors are only concerned about their medical well-being. Moreover, doctors must accept that protecting patients’ rights is more important than seeking their benefit; in other words, patients have the right to choose a treatment that is

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<sup>45</sup> Ibid.; Seay, “Do Physicians Have an Inviolable Duty Not to Kill?”

<sup>46</sup> Geoffrey Scarre, “Can There Be a Good Death?” *Journal of Evaluation in Clinical Practice* 18, no. 5 (2012): 1082-1086.

<sup>47</sup> Ezekiel J. Emanuel, and Linda L. Emanuel, “The Promise of a Good Death,” *Lancet* 351, no. SUPPL.2 (1998): S11-21.

<sup>48</sup> Cf. Dan W. Brock, “Voluntary Active Euthanasia,” *The Hastings Center Report* 22, no. 2 (1992): 10-22.

<sup>49</sup> Robert M. Veatch, “Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients,” *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 25, no. 6 (2000): 701-721.

less likely to benefit them than other available alternatives. In the same way, the core duty of healthcare practitioners would be respect for the patient's autonomy and the recognition of their right to decline a beneficial treatment even when they could be mistaken. Consequently, two other duties become significantly relevant: their duty to tell the truth, that is, patients must be well informed and in an optimal position to decide what is best for them, and their duty to keep promises, that is, the information shared between patients and physicians would remain confidential.

## V. Conclusions

The present paper provides arguments to defend the implementation of physician-aid in dying among the duties that healthcare practitioners must perform. Healthcare should be understood as a cluster of services to which the whole citizenship is entitled to. The suitability of the procedures offered as part of the healthcare agenda depends on the justification we can present to defend their aptness to be considered fundamental services. Our reasons should be grounded on the core bioethical and medical principles: respect for autonomy, avoidance of harm, beneficence, and justice. Within such a theoretical-practical framework, we have questioned the traditional medical rejection to end a patient's life due to doctors' ultimate duty not to kill. Our main argument against the traditional view of physicians' duties points to a paradigm shift where there are other obligations that doctors must fulfil, which emerge from the patient's right to have her autonomous decision respected and her suffering and/or pain ended.

At this point, we have clarified why and how end-of-life and palliative care are compatible with euthanasia or other help-in-dying medical procedures. For, the total alleviation of suffering is not always possible, patients may have different suffering and pain thresholds, and end-of-life care must also always be present until the performance of euthanasia or physician-aid in dying. Additionally, the possible conscientious objection refusals to perform euthanasia have been addressed, analysing the inconsistencies of those objections and the practical negative implications they might have. However, more cautiously, we have accepted some instances where it could be possible to assume them as a transitional stage towards a new understanding of physicians' duties and responsibilities. Finally, healthcare practitioners' suitability, and further obligation, to be the ones responsible to perform end-of-life practices has been defended. For they are the ones best qualified and have the necessary knowledge to perform hastening death procedures, and they are already familiar with death and dying in medical settings.

Healthcare practitioners must perform end-of-life practices as part of their job in a new understanding of them as professionals from whom society requires specific services grounded on people's rights to healthcare.

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