HCM 540 WK 4 NOTES

Hello.

Welcome to Week 4.

This week topic is "Ethical Issues of Death and Dying".

We are going to discuss the ethical issues presented by the use of fluids and nutrition in the dying patient; present the ethical arguments for and against physician-assisted death; examine the role of the family in the dying process and the ethical issues posed by their involvement; examine the ethics of physician assisted suicide.

The discussion question is about physician assisted-suicide.

The CT Written Assignment 4 is about the following topic:

Explain how an individual's personal sense of justice can sometimes conflict with legal or ethical standards.

You may relate personal experiences with this issue.

The Midterm Examination is ready for you to take. Please be sure to follow directions and manage your time accordingly.

Have a productive week.

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[**Module 4 Discussion**](https://saintleo.brightspace.com/d2l/lms/discussions/messageLists/frame.d2l?ou=36835&tId=122101&fId=0&threadId=0&postId=0&groupFilterOption=0)

What principles of ethics will you consider when responding to a patient’s request for assisted-suicide?

What principles of ethics should be considered by a provider when responding to a patient’s request for assisted-suicide?

Explain how an individual's personal sense of justice can sometimes conflict with legal or ethical standards.

You may relate personal experiences with this issue.

Ethical theories have a common use of guiding moral behavior Morrison & Furlong (2014) says our primary focus in healthcare is to follow four principles of **respect for *autonomy******, beneficence, nonmaleficence, and justice* (pp. 49-59).** P. Kurtz & R.L. Burr (2009) point out that thesetheories are involved with the rights of people in a society as well as the responsibilities of others in that civilization. A recently developed theory referred to as *ethic of caring* has another stance. That is to say, “that relationships and responsibilities are more [crucial] than rights and obligations or outcomes. This means that the nurse is concerned with all aspects of the patient’s wellbeing, not merely the disease process” (Butts & Rich, p. 261). Care is meant to meet all domains of needs such as physiologically, psychologically, sociologically, and spiritually understanding that each impacts the totality of health (Butts et al., 2009, p.261).

“Justice- Derived from the work of John Rawls, this principle refers to an equal and fair distribution of resources, based on analysis of benefits and burdens of decision. Justice implies that all citizens have an equal right to the goods distributed, regardless of what they have contributed or who they are” (p.257) (Butts & Rich, 2008).

Butts, J. B., & Rich, K. L. (2008). *Nursing Ethics Across the Curriculum and into Practice*, Sunbury, MA: Jones and Bartlett, ISBN: 978-0-763-74898-2, Retrieved from, <http://www.jblearning.com/samples/076371786X/1786X_CH11_248_269.pdf>

“The Hippocratic Oath proclaims: “I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”[[1]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn1) This is an essential precept for a flourishing civil society. No one, especially a doctor, should be permitted to kill intentionally, or assist in killing intentionally, an innocent neighbor.

Human life need not be extended by every medical means possible, but a person should never be intentionally killed. Doctors may help their patients to die a dignified death from natural causes, but they should not kill their patients or help them to kill themselves. This is the reality that such euphemisms as “death with dignity” and “aid in dying” seek to conceal.

In 2015, at least 18 state legislatures and the District of Columbia are considering whether to allow physician-assisted suicide (PAS).[[2]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn2) Legalizing physician-assisted suicide, however, would be a grave mistake because it would:

* Endanger the weak and vulnerable,
* Corrupt the practice of medicine and the doctor–patient relationship,
* Compromise the family and intergenerational commitments, and
* Betray human dignity and equality before the law.
* First, PAS endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time. People who deserve society’s assistance are instead offered accelerated death.
* Second, PAS changes the culture in which medicine is practiced. It corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing. By the same token, PAS threatens to fundamentally distort the doctor–patient relationship because it reduces patients’ trust of doctors and doctors’ undivided commitment to the life and health of their patients. Moreover, the option of PAS would provide perverse incentives for insurance providers and the public and private financing of health care. Physician-assisted suicide offers a cheap, quick fix in a world of increasingly scarce health care resources.
* Third, PAS would harm our entire culture, especially our family and intergenerational obligations. The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for those family members to internalize this attitude and view themselves as burdens. Physician-assisted suicide undermines social solidarity and true compassion.
* Fourth, PAS’s most profound injustice is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation’s commitment to equality before the law—showing profound disrespect for and callousness to those who will be judged to have lives no longer “worth living,” not least the frail elderly, the demented, and the disabled. No natural right to PAS exists, and arguments for such a right are incoherent: A legal system that allows assisted suicide abandons the natural right to life of all its citizens.

Instead of embracing PAS, we should respond to suffering with true compassion and solidarity. People seeking PAS typically suffer from depression or other mental illnesses, as well as simply from loneliness. Instead of helping them to kill themselves, we should offer them appropriate medical care and human presence. For those in physical pain, pain management and other palliative medicine can manage their symptoms effectively. For those for whom death is imminent, hospice care and fellowship can accompany them in their last days. Anything less falls short of what human dignity requires. The real challenge facing society is to make quality end-of-life care available to all.

Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill. They properly seek to alleviate suffering, and it is reasonable to withhold or withdraw medical interventions that are not worthwhile. However, to judge that a patient’s life is not worthwhile and deliberately hasten his or her end is another thing altogether.

Citizens and policymakers need to resist the push by pressure groups, academic elites, and the media to sanction PAS. Recent experience with PAS both in the United States and in Europe suggests how problematic it is.

**Endangering the Weak and Marginalized**

To understand how PAS endangers the weak and marginalized, one must understand what PAS entails and where it leads. With PAS, a doctor prescribes the deadly drug, but the patient self-administers it. While most activists in the United States publicly call only for PAS, they have historically advocated not only PAS, but also euthanasia: the intentional killing of the patient by a doctor.

This is not surprising: The arguments for PAS are equally arguments for euthanasia. Neil Gorsuch, currently a federal judge, points out that some contemporary activists fault the movement for not being honest about where its arguments lead. He notes that legal theorist and New York University School of Law Professor Richard Epstein “has charged his fellow assisted suicide advocates who fail to endorse the legalization of euthanasia openly and explicitly with a ‘certain lack of courage.’”[[3]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn3)

The logic of assisted suicide leads to euthanasia because if “compassion” demands that some patients be helped to kill themselves, it makes little sense to claim that only those who are capable of self-administering the deadly drugs be given this option. Should not those who are too disabled to kill themselves have their suffering ended by a lethal injection?

And what of those who are too disabled to request that their suffering be ended, such as infants or the demented? Why should they be denied the “benefit” of a hastened death? Does not “compassion” provide an even more compelling reason for a doctor to provide this release from suffering and indignity?[[4]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn4) As Professor John Keown points out:

If compassion justified us in giving a lethal prescription to a terminally ill patient on request to end their suffering, it would equally justify us in giving them a lethal injection, particularly if they were physically unable to commit suicide. It would also justify us in giving a lethal injection to a terminally ill patient who was incapable of making a request.[[5]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn5)

Judge Gorsuch notes that for the Dutch, “it is the *physician’s* assessment of the patient’s *quality of life* as ‘degrading’ or ‘deteriorating’ or ‘hopeless’ that stands as the ultimate justification for killing.”[[6]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn6)

Although the Supreme Court of the United States has ruled in two unanimous decisions that there is no constitutional right to PAS, three states permit it by statute: Oregon, Washington, and Vermont.[[7]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn7) Physician-assisted suicide and euthanasia are allowed in three European countries—the Netherlands, Belgium, and Luxembourg—and Switzerland allows assisted suicide.[[8]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn8)

The evidence from these jurisdictions, particularly the Netherlands, which has over 30 years of experience, suggests that safeguards to ensure effective control have proved inadequate. In the Netherlands, several official, government-sponsored surveys have disclosed both that in thousands of cases, doctors have intentionally administered lethal injections to patients without a request and that in thousands of cases, they have failed to report cases to the authorities.[[9]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn9)

**Physician-Assisted Suicide Will Most Threaten the Weak and Marginalized***.*

Physician-assisted suicide will most threaten the weak and marginalized because of the cultural pressures and economic incentives that will drive it.[[10]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn10) The New York State Task Force on Life and the Law, established by Governor Mario Cuomo, explained in its report:

Dr. Paul McHugh, University Distinguished Service Professor of Psychiatry at Johns Hopkins University School of Medicine and Psychiatrist-in-Chief at Johns Hopkins Hospital from 1975 to 2001, highlights that “with physician-assisted suicide, many people—some not terminally ill, but instead demoralized, depressed and bewildered—die before their time.”[[12]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn12) This sad reality led Dr. Leon Kass—a medical doctor, philosopher, and former chairman of the President’s Council on Bioethics—to explain that physician-assisted suicide “is, in fact, the state’s abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, and the poor.”[[13]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn13)

The people most likely to be assisted by a physician in their suicide are suffering not simply from terminal illness, but also from depression, mental illness, loneliness, and despair. “Researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death,” write Dr. Herbert Hendin, Professor of Psychiatry and Behavioral Science at New York Medical College and Chief Executive Officer and Medical Director of Suicide Prevention Initiatives, and Dr. Kathleen Foley, Professor of Neurology at Cornell University’s medical school and attending neurologist, pain and palliative care services, at Sloan–Kettering Cancer Center.[[14]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn14) As Dr. Hendin reports:

The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients.…

… The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.…

… The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases.[[11]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn11)

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Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated. This is particularly true of those over fifty, who are more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to treatment.[[15]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn15)

From their decades of professional medical practice, Drs. Hendin and Foley report that when patients who ask for a physician’s assistance in suicide “are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.”[[16]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn16) They conclude: “Patients requesting suicide need psychiatric evaluation to determine whether they are seriously depressed, mentally incompetent, or for whatever reason do not meet the criteria for assisted suicide.”[[17]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn17)

Yet only five of the 178 Oregon patients who died under the Oregon assisted suicide laws in 2013 and 2014 were referred for any psychiatric or psychological evaluation. Remarkably, patients were referred for psychiatric evaluation in less than 5.5 percent of the 859 cases of assisted suicide reported in Oregon since its law went into effect in 1997.[[18]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn18) “This constitutes medical negligence,” writes Dr. Aaron Kheriaty, Associate Professor of Psychiatry at U.C. Irvine School of Medicine. Dr. Kheriaty concludes, “To abandon suicidal individuals in the midst of a crisis—under the guise of respecting their autonomy—is socially irresponsible: It undermines sound medical ethics and erodes social solidarity.”[[19]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn19)

Regrettably, even in jurisdictions that require a doctor to mention palliative care and hospice alternatives before proceeding with assisted suicide, the doctors need not be experts. Drs. Hendin and Foley point out:

They are not required, however, to be knowledgeable about how to relieve physical or emotional suffering in terminally ill patients. Without such knowledge, which most physicians do not have, they cannot present or make feasible alternatives available. Nor in the absence of such knowledge are they required to refer the patient to a physician with expertise in palliative care.[[20]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn20)

**The Legal Protections in Physician-Assisted Suicide Are Ineffective.**

Even if one were to accept an argument for PAS on the basis of autonomy and compassion, one would be forced to conclude that neither value is sufficiently protected in laws that have been enacted in several states and in current bills that would authorize it in additional jurisdictions. One of the greatest concerns is that autonomy will be violated and people pressured or coerced into killing themselves.

The District of Columbia’s Death With Dignity Act of 2015 would authorize physicians to prescribe deadly drugs to patients.[[21]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn21) This act is substantially similar to the laws passed in Oregon, Washington, and Vermont and others pending in various jurisdictions.[[22]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn22) None of the purported protections offered in the bill are sufficient; the experience with PAS to date shows that all will prove ineffective. Professor Alexander Capron, a leading health lawyer, has concluded that the Oregon safeguards are “largely illusory.”[[23]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn23) So, too, are those in the D.C. proposal.

The D.C. bill states that to receive a physician’s assistance in suicide, the patient must make two oral requests, separated by 15 days, to a physician of the patient’s choice. Before the second request, the patient must also make a written request, no less than 48 hours before the lethal drugs are prescribed or provided. This written request must be witnessed by two individuals, neither of whom may be the physician and only one of whom may be related to the patient, stand to inherit upon the patient’s death, or be an owner or employee of a health care facility where the patient is residing. The witnesses must attest that the patient is capable and acting voluntarily.

Likewise, the chosen physician must judge the patient to be capable and acting voluntarily and that the patient will likely die within six months. Then the physician refers the patient to a consulting physician who must verify these judgments.

Despite the purported safeguards, this system is ripe for abuse. One of the witnesses may be a family member with a financial or emotional incentive to see the patient die, and the other may simply be a friend willing to affirm that judgment. Patients or their more powerful guardians could shop around for a doctor who is willing to make the judgment that they are capable, acting freely, and likely to die within six months.

Moreover, the bill does not specify whether death need be likely *with* medical treatment or *without*. As a team of physicians has noted, “Deciding who should be counted as ‘terminally ill’ will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide.”[[24]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn24)

Of course, there is no reason to assume that all doctors will seek to make a serious diagnosis, because a patient can shop around for a compliant physician. Richard Doerflinger notes that Compassion and Choices (C&C), formerly known as the Hemlock Society and one of the advocacy groups pushing for assisted suicide laws nationwide, keeps a list of “friendly” doctors:

The doctors who declare patients qualified for assisted suicide are not randomly selected. C&C has boasted of its direct involvement in the vast majority of such cases in Oregon, as it has its own list of doctors who are willing and able to get patients around any pesky “safeguards.” If the patient’s own physician, or the next physician, discovers a disorder such as depression, the patient can simply shop around to find one who won’t care (or just call C&C in the first place).[[25]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn25)

Such shopping around for doctors claimed the life of Helen, a woman in Oregon. Judge Gorsuch recounts:

Helen was a breast cancer patient in her mid-eighties when the Oregon law went into effect. Helen’s regular physician refused to assist in her suicide; a second doctor was consulted but also refused, on the stated ground that Helen was depressed. At that point, Helen’s husband called Compassion in Dying. The medical director of the group spoke with Helen and later explained that Helen was “frustrated and crying because she felt powerless.” Helen was not, however, bedridden or in great pain…. The Compassion in Dying employee recommended a physician to Helen. That physician, in turn, referred Helen to a specialist (whose specialty is unknown), as well as to a psychiatrist who met Helen only once. A lethal prescription was then supplied.[[26]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn26)

Remarkably, the D.C. bill provides explicit protections for doctors to engage in such judgments by providing immunity from liabilities: “No person shall be subject to civil or criminal liability or professional disciplinary action for: (A) Participating in good faith compliance with this act.” Doerflinger explains:

“Good faith” is the loosest of legal standards, much weaker than the negligence standard physicians are generally held to. Instead of meeting the objective standards for what doctors *should* know, a doctor need only say that he sincerely didn’t know that he failed to live up to them.[[27]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn27)

The political left is ordinarily quite opposed to tort reform or medical malpractice limitations, yet here they explicitly support them. Doerflinger concludes:

So, in a matter of literal life and death, standards are much lower than anywhere else in law or medicine. You’re likely to be seen as terminal (hence a candidate for assisted suicide) if the doctor feels that you are, or thinks that you could become so without treatment. If you take the lethal drugs in a few weeks based on that prediction, there is, of course, no chance to prove him wrong.[[28]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn28)

J Judge Gorsuch echoes this concern:

[I]t is also rather remarkable that, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, the Oregon assisted suicide statute creates an entirely different regime when it comes to administering this “treatment,” specifically and uniquely immunizing doctors from criminal prosecution, civil liability, or even professional discipline for any actions they take in assisting a suicide, as long as they act in “good faith.” Thus, while a doctor may be found liable for mere negligence in any other operation or procedure, there is no recourse for family members when a doctor kills a patient even on the basis of gross negligence by misdiagnosing the patient as terminal or by misassessing the patient as competent.[[29]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn29)

The disability-rights group Not Dead Yet agrees:

[I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.[[30]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn30)

Moreover, there are no protections relating to the time when the lethal drugs are taken. Once the requirements are met, a doctor may prescribe the deadly drugs and send the patient home to self-administer them. The D.C. bill, like the state bills, provides no safeguards to ensure that the patient is mentally competent when he or she takes the drugs and is not being pressured to do so. The lack of any legal protections ensuring autonomy at the time the lethal choice is made led Judge Gorsuch to ask: “How does it serve the putative goal of autonomous patient decision making to set up a regime that allows people to commit suicide without considering whether they are, in fact, acting freely, competently, and autonomously at the time of suicide?”[[31]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn31)

In sum, a family member or friend who might benefit financially from the death of a patient may act as a witness that the patient is voluntarily requesting the lethal prescription, and doctors who support the ideology of death and have never before met the patient (or the patient’s family) can judge the patient to be “qualified” under the law. Finally, at the time of administering the deadly drug, there are no safeguards to ensure voluntariness or competence or to guard against coercion. Such a measure woefully fails to protect autonomy.[[32]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn32)

**The World’s Experience with Physician-Assisted Suicide Laws Confirms the Lethal Logic.**

While many assisted suicide laws attempt to limit PAS eligibility to the terminally ill, and while many laws attempt to provide protections ensuring autonomous consent, the experience of countries with PAS and euthanasia suggests that safeguards fail to ensure effective control.

In 1989, while teaching law and medical ethics at the University of Cambridge, Professor John Keown began to investigate PAS and euthanasia in the Netherlands. He found that key Dutch guidelines, such as requiring an explicit request from the patient, have long been widely violated with virtual impunity.[[33]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn33)He pointed out that the first of several official surveys conducted by the Dutch found that in 1990, “the total number of life-shortening acts and omissions where the doctor’s *primary* intention … was to kill, and which are therefore indubitably euthanasiast, is 10,558.”[[34]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn34)

Shockingly, the majority of these cases were nonvoluntary. Oxford legal scholar John Finnis, commenting on the Dutch data, remarks: “[W]ell over half … were without any explicit request. In the United States that would be over 235,000 unrequested medically accelerated deaths per annum.”[[35]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn35) In 2013, 1.7 percent (1,807 patients) of all deaths in Belgium were due to euthanasia and physician-assisted suicide.[[36]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn36) A 2010 study discovered that 66 of 208 identified deaths in Belgium were administered *without* an explicit patient request.[[37]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn37)

Keown confirms that “the *undisputed* empirical evidence from the Netherlands and Belgium shows widespread breach of the safeguards, not least the sizeable incidence of non-voluntary euthanasia and of non-reporting.”[[38]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn38) In October of 2013, three judges of the High Court of Ireland voiced the same concern: “[T]he incidence of legally assisted death without explicit request in the Netherlands, Belgium and Switzerland is strikingly high.”[[39]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn39) And the numbers of those assisted in committed suicide keep growing.[[40]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn40)

Part of the reason for these troubling statistics is that any purported legal safeguards can be and have been abused, and over time the logic of a “right to die” is extended to ever-wider groups of patients, including the incompetent. Keown describes the logic of PAS as based on judging some lives as unworthy of life:

Once a doctor is prepared to make such a judgment in the case of [a] patient capable of requesting death, the judgment can, logically, equally be made in the case of a patient incapable of requesting death.… If a doctor thinks death would benefit the patient, why should the doctor deny the patient that benefit merely because the patient is incapable of asking for it?… The logical “slippery slope” argument is unanswerable.[[41]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn41)

Dr. Ezekiel Emanuel, writing in the *Atlantic Monthly*, affirms that this is the lesson to take from the Netherlands and that proposed American PAS laws cannot avoid the same outcome:

The Netherlands studies fail to demonstrate that permitting physician-assisted suicide and euthanasia will not lead to the nonvoluntary euthanasia of children, the demented, the mentally ill, the old, and others. Indeed, the persistence of abuse and the violation of safeguards, despite publicity and condemnation, suggest that *the feared consequences of legalization are exactly its inherent consequences*.[[42]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn42)

In 1996, two doctors prosecuted in the Netherlands for the nonvoluntary euthanasia of disabled infants were acquitted when they argued medical necessity.[[43]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn43) The Dutch courts simply followed the inexorable logic that drives the case for PAS and voluntary euthanasia to a new extent. If necessity justifies ending the life of a suffering patient who requests it, it equally justifies ending the life of a suffering patient who cannot request it. Dutch pediatricians have now devised a protocol for infanticide.[[44]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn44)

A 2005 study in the *New England Journal of Medicine* recorded that in the previous seven years, 22 cases of infant euthanasia were reported in the Netherlands.[[45]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn45) A 2013 Netherlands commission on euthanasia argued that as many as 650 infants per year should be eligible for euthanasia on the basis of the children’s diagnosis as “babies who in spite of very intensive treatment are certain to die in the short term, babies with a poor prognosis and very poor expected quality of life, or babies who are not dependent on intensive treatment but who face a life of severe suffering with no prospect of improvement.”[[46]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn46) The U.N. Human Rights Committee formally condemned this Dutch infanticide: “The Committee is gravely concerned at reports that new-born handicapped infants have had their lives ended by medical personnel.”[[47]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn47)

In March 2014, Belgium became the first country to legislatively allow doctors to euthanize “consenting” minors, despite the objections of 160 physicians.[[48]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn48) In an open letter, these doctors argued that legalization without age restriction was unnecessary, as palliative care is sufficient, and the bill would create excessive pressure on both children and parents to choose premature death.[[49]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn49)Nevertheless, Belgium went forward and removed the age restrictions.

Diagnoses of disability are now considered sufficient grounds for death. In December 2012, Marc and Eddy Verbessem, 45-year-old deaf twins, were euthanized in a Belgian hospital after they discovered they were going blind.[[50]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn50)Nancy Verhelst, a 44-year-old transsexual Belgian whose doctors made mistakes in three sex change operations, was left feeling as though she was a “monster.” She then requested—and was granted—euthanasia by lethal injection.[[51]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn51)

In the Netherlands, the euthanized include Ann G., a 44-year-old woman whose only ailment was chronic anorexia.[[52]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn52) In the beginning of 2013, Dutch doctors administered a lethal injection to a 70-year-old blind woman because she said the loss of sight constituted “unbearable suffering.”[[53]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn53) In early 2015, a 47-year-old divorced mother of two suffering from tinnitus, a loud ringing in the ears, was granted physician-assisted suicide in the Netherlands.[[54]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn54) She left behind a 13-year-old son and a 15-year-old daughter.[[55]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn55) Gerty Casteelen was a 54-year-old psychiatric patient with molysomophobia, a fear of dirt or contamination. Her doctors decided that she would not be able to control her fear and agreed to administer a lethal injection.[[56]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn56)

**Corrupting the Practice of Medicine**

Physician-assisted suicide threatens to:

* Corrupt the culture in which medicine is practiced;
* Corrupt the profession of medicine by permitting the tools of healing to be used as a technique for killing;
* Fundamentally distort the doctor–patient relationship, greatly reducing patients’ trust of doctors and doctors’ undivided commitment to the healing of their patients; and
* Create perverse incentives for insurance providers and the financing of health care.

**Physician-Assisted Suicide Corrupts the Profession of Medicine.**

The heart of medicine is healing. Doctors cannot heal by assisting patients to kill themselves or by killing them. They rightly seek to eliminate disease and alleviate pain and suffering. They may not, however, seek to eliminate the patient. Allowing doctors to assist in killing threatens to fundamentally corrupt the defining goal of the profession of medicine.

In testimony before the U.S. House of Representatives, Dr. Kass elaborated on this point:

The legalization of physician-assisted suicide will pervert the medical profession by transforming the healer of human beings into a technical dispenser of death. For over two millennia the medical ethic, mindful that power to cure is also power to kill, has held as an inviolable rule, “Doctors must not kill.”[[57]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn57)

Dr. Paul McHugh agrees that this inviolable rule is essential to the practice of medicine:

Since ancient Greece physicians have been tempted to help desperate patients kill themselves, and many of those Greek doctors must have done so. But even then the best rejected such actions as unworthy and, as the Hippocratic Oath insists, contrary to the physician’s purpose of “benefiting the sick.”[[58]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn58)

For this reason, the American Medical Association (AMA) code of ethics rejects physician-assisted suicide. The AMA states: “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer.”[[59]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn59) As law professor O. Carter Snead notes,[[60]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn60) dozens of professional associations and groups representing vulnerable persons oppose physician-assisted suicide, including the:

* American Medical Association,
* World Health Organization,
* American Nurses Association,
* American Association of Critical-Care Nurses,
* Hospice Nurses Association,
* Oncology Nurses Society,
* American Osteopathic Association,
* American Psychiatric Association,
* American Academy of Hospice and Palliative Medicine,
* American Academy of Pain Management,
* American Academy of Pain Medicine,
* American Academy of Orthopaedic Surgeons,
* American Academy of Physical Medicine,
* Society of Critical Care Medicine,
* American Academy of Neurology,
* American Neurological Association,
* American Society of Anesthesiologists,
* American Society of Clinical Pathologists,
* College of American Pathologists,
* American Society of Abdominal Surgeons,
* American Association of Clinical Endocrinologists,
* Society of Medical Consultants to the Armed Forces,
* American Institute of Life Threatening Illness and Loss,
* Massachusetts Medical Society,
* Disability Rights Education and Defense Fund,
* American Disabled for Attendant Programs Today,
* American Association of People with Disabilities,
* Association of Programs for Rural Independent Living,
* Justice for All,
* National Council on Disability,
* National Council on Independent Living,
* National Spinal Cord Injury Association,
* Not Dead Yet,
* TASH,
* World Association of Persons with Disabilities, and
* World Institute on Disability.

Practicing medicine is a not a morally neutral act of mere technical skill. Physicians do not practice medicine simply to fulfil the desires of consumer-patients, whatever those desires may be. Rather, medicine is a profession governed by its core commitment to healing patients. Dr. Kass explains that professionals profess their devotion to the purposes they serve and the ideals to which they look. Teachers are devoted to learning, lawyers to justice, clergy to things divine, and “the physician devotes himself to healing the sick, looking up to health and wholeness.” Dr. Kass adds: “Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business.”[[61]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn61)

Killing is incompatible with caring. Dr. Kass explains: “Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead?… ‘Better off dead’ is logical nonsense.” Indeed, “to bring nothingness is incompatible with serving wholeness: one cannot heal—or comfort—by making nil. The healer cannot annihilate if he is truly to heal. The boundary condition, ‘No deadly drugs,’ flows directly from the center, ‘Make whole.’”[[62]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn62)

Dr. McHugh illustrates what happens when this boundary is crossed: “Once doctors agree to assist a person’s suicide, ultimately they find it difficult to reject anyone who seeks their services. The killing of patients by doctors spreads to encompass many treatable but mentally troubled individuals, as seen today in the Netherlands, Belgium and Switzerland.”[[63]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn63) Disability groups note that “numerous studies have demonstrated that physicians underestimate the quality of life of people with disabilities compared to our own assessments.”[[64]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn64)

**Physician-Assisted Suicide Distorts the Doctor–Patient Relationship.**

Physician-assisted suicide will not only corrupt the professionals who practice medicine, but also affect the patients because it threatens to fundamentally distort the doctor–patient relationship, greatly reducing patients’ trust of doctors and doctors’ undivided commitment to the healing of their patients.

Our laws shape our culture, and our culture shapes our beliefs, which in turn shape our behaviors. The laws governing medical treatments will shape the way that doctors behave and thus shape the doctor–patient relationship. Legal philosopher John Finnis explains how a change in the law will lead to a change of heart on the part of doctors:

Now change the law and the professional ethic. Killing with intent becomes a routine management option. Oh yes, there are restrictions, guidelines, paperwork. Well meant. Not utterly irrelevant. But as nothing compared with our doctors’ change in heart, professional formation, and conscience.[[65]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn65)

On this point, Dr. Kass agrees:

Won’t it be tempting to think that death is the best treatment for the little old lady “dumped” again on the emergency room by the nearby nursing home? Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses, if he is to care fully for those who entrust themselves to him. A physician friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: “Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.”[[66]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn66)

Dr. Kass asks us to consider the new normal that PAS would bring to patients:

Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.[[67]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn67)

Finnis dramatizes this new normal, highlighting how the change in law leads to a change in patients’ behavior:

A new zone of silence. Can I safely speak to my physician about the full extent of my sufferings, about my fears, about my occasional or regular wish to be free from my burdens? Will my words be heard as a plea to be killed? As a tacit permission? And why does my physician need my permission, my request?[[68]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn68)

The trust that patients place in their doctors will be seriously breached if patients fear that their doctors may encourage—and actively facilitate—their death.

**Physician-Assisted Suicide Creates Perverse Incentives for Insurance Providers.**

Physician-assisted suicide will create perverse incentives for insurance providers and the financing of health care. Assisting in suicide will often be a more “cost-effective” measure from the perspective of the bottom line than is actually caring for patients. In fact, some advocates of PAS and euthanasia make the case on the basis of saving money.

Baroness Mary Warnock, a leading ethicist in the United Kingdom, has argued, “If you’re demented, you’re wasting people’s lives—your family’s lives—and you’re wasting the resources of the National Health Service.” Warnock went on to suggest that such people have a “duty to die.”[[69]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn69)

Derek Humphry, founder of the Hemlock Society, also points to the role of money, noting that “the pressures of cost containment provide impetus, whether openly acknowledged or not, for the practicalities of an assisted death.” He goes on to add that “the connections between the right-to-die and the cost, value, and allocation of health care resources are part of the political debate, albeit frequently unspoken.” Humphry, however, was one advocate willing to speak about that cost: “It is impossible to predict exactly how much money could be saved.… Conservative estimates, however, place the dollar amount in the tens of billions.”[[70]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn70)

Physician-assisted suicide has affected the financing of health care in the United States as well. Dr. McHugh notes:

When a “right to die” becomes settled law, soon the right translates into a duty. That was the message sent by Oregon, which legalized assisted suicide in 1994, when the state-sponsored health plan in 2008 denied recommended but costly cancer treatments and offered instead to pay for less-expensive suicide drugs.[[71]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn71)

Richard Doerflinger adds:

Last year, over half the patients who committed assisted suicide in Oregon relied on the government for their health coverage or had no coverage at all. Over three-quarters of those dying under Washington’s assisted suicide law were partly or completely dependent on Medicare or Medicaid.[[72]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn72)

This sets the stage for a perverse alignment of public financing and patient death, just as the New York Task Force predicted in its 1994 report:

Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians’ decisions at the bedside.… Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process.…

Physicians who determine that a patient is a suitable candidate for assisted suicide or euthanasia may be far less inclined to present treatment alternatives, especially if the treatment requires intensive efforts by health care professionals.[[73]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn73)

These perverse financial incentives will exercise a subtle but profound pressure on patients as the advice from their physicians and the procedures covered by their insurance increasingly point toward PAS. Given the increasing number of elderly patients in modern societies, their increasing longevity, and the increasing cost of treating their chronic illnesses, PAS will increasingly be seen as a cost-effective option and one that the elderly should be encouraged to consider.

**Compromising the Family and Intergenerational Obligations**

Physician-assisted suicide will also negatively affect our culture, especially the family and our intergenerational obligations. The temptation to view elderly or disabled family members as burdens will surely rise. The temptation for elderly and disabled family members to view themselves as burdens will also surely rise. Instead of the solidarity of civil society and true compassion, PAS threatens to create cheap solutions by eliminating those who are perceived as socially and economically burdensome.

**The Family Has Responsibility for Disabled and Elderly Relatives.**

There is a natural cycle to human life. Human beings enter the world as entirely needy, totally dependent newborns. Many people exit life dependent on others as well. Along the way, there will undoubtedly be periods of trial and tribulation when people need the assistance of others. Traditionally, the family has been a central social institution for weathering life’s storms. Mothers and fathers take care of children at the dawn of life*,* and then children take care of their aging parents at the twilight.

Family life is meant to include shouldering one another’s burdens and assisting those in need. In his provocatively titled essay “I Want to Burden My Loved Ones,” ethicist Gilbert Meilaender explains why he refuses to accept the logic of atomistic individualism:

Is this not in large measure what it means to belong to a family: to burden each other—and to find, almost miraculously, that others are willing, even happy, to carry such burdens? Families would not have the significance they do for us if they did not, in fact, give us a claim upon each other. At least in this sphere of life we do not come together as autonomous individuals freely contracting with each other. We simply find ourselves thrown together and asked to share the burdens of life while learning to care for each other.[[74]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn74)

While the family is the primary institution tasked with intergenerational care, no family is an island. As Dr. Kass and Eric Cohen point out, families are situated within a larger culture—and the law shapes this culture:

Even if the burdens of aging and death are always borne most fully by individuals and families, how we age and die are not only private matters. Our communal practices and social policies shape the environments in which aging and caregiving take place—not only in moments of crisis, when life-or-death decisions need to be made, but in the long days of struggle and everyday attendance. Faith-based institutions and community groups support families in meeting those needs they cannot meet alone. Programs like Medicaid assist those who are old and impoverished, in need of nursing that they cannot themselves afford.[[75]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn75)

**Physician-Assisted Suicide Creates****Heightened Pressures on Disabled and Elderly Family Members.**

The introduction of PAS would undermine familial relationships and promote the view that disabled and elderly relatives are not people to be loved but burdens to be managed. Physician-assisted suicide would alter how people in general view the disabled and elderly and how the disabled and elderly view themselves. On the interaction between the two groups, Professor Finnis describes a dramatic scene:

Another zone of fearful silence. Outside the door are the relatives. What will they be telling the doctor about my condition and my wishes? What is prudent to tell them about my suffering, my depression, my wishes? Are they interpreting my state of mind just as I would wish? Are their interests in line with mine?[[76]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn76)

Physician-assisted suicide creates a temptation for relatives and thus undermines trust. Because of its potential to corrupt these intergenerational ties, Finnis concludes that in a world with PAS, “[m]any people will find that their nearest and dearest are less and less near, and less and less dear.”[[77]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn77)

Victoria Reggie Kennedy, widow of the late Senator Edward Kennedy (D–MA), campaigned against a bill that would have legalized PAS in Massachusetts on precisely these grounds. Kennedy noted that “the proposed law is not about bringing family together to make end of life decisions; it’s intended to exclude family members from the actual decision-making process to guard against patients’ being pressured to end their lives prematurely.”[[78]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn78) She went on to explain how her husband was able to die a true death with dignity by avoiding the pressures of assisted suicide:

When my husband was first diagnosed with cancer, he was told that he had only two to four months to live, that he’d never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die.

But that prognosis was wrong. Teddy lived 15 more productive months.… Because that first dire prediction of life expectancy was wrong, I have 15 months of cherished memories—memories of family dinners and songfests with our children and grandchildren; memories of laughter and, yes, tears; memories of life that neither I nor my husband would have traded for anything in the world.

When the end finally did come—natural death with dignity—my husband was home, attended by his doctor, surrounded by family and our priest.[[79]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn79)

Mrs. Kennedy concluded that most people wish for a good death “surrounded by loved ones, perhaps with a doctor and/or clergyman at our bedside.” But with PAS, “what you get instead is a prescription for up to 100 capsules, dispensed by a pharmacist, taken without medical supervision, followed by death, perhaps alone. That seems harsh and extreme to me.”[[80]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn80) Indeed it is.

Even if legal protections against pressure and coercion could somehow be made effective, how could they prevent the corruption of culture? In a society with PAS, legal safeguards will not mute the clear moral message transmitted by laws allowing PAS: that some lives are “not worth living” and that some people have a duty to end their lives.

These cultural pressures are not merely the suppositions of cultural philosophy. They play out in real life. Dr. Hendin has documented many such stories, such as this one:

A wife who no longer wished to care for her sick, elderly husband gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to have his life ended; the doctor, although aware of the coercion, ended the man’s life.[[81]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn81)

These stories are not isolated incidents. Dr. Hendin reports that a study of Dutch hospitals found that “doctors and nurses reported that more requests for euthanasia came from families than from patients themselves. The investigator concluded that the families, the doctors, and the nurses were involved in pressuring patients to request euthanasia.”[[82]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn82) The same pressure is evident in the limited places where physician-assisted suicide is legal in the United States. Oregon Health Authority research found that 40 percent of those who were assisted with suicide cited being a burden on family or friends and caregivers as their motivation to end their lives.[[83]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn83)

These considerations are particularly disturbing because suicide is a phenomenon that can spread throughout a society, based on imitation. Social scientists, Dr. Kheriaty notes, “know that there is a ‘social contagion’ aspect to suicide.”[[84]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn84) In its guide to preventing suicide, the World Health Organization notes the scholarly research on the imitative nature of suicide:

Over 50 investigations into imitative suicides have been conducted. Systematic reviews of these studies have consistently drawn the same conclusion: media reporting of suicide can lead to imitative suicidal behaviours.… Particular subgroups in the population (e.g., young people, people suffering from depression) may be especially vulnerable to engaging in imitative suicidal behaviours. Finally, and probably most importantly, overt description of suicide by a particular method may lead to increases in suicidal behaviour employing that method.[[85]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn85)

Commenting on Brittany Maynard’s suicide, Dr. Kheriaty argues that “given what we know about suicide’s social effects, and given the media portrayal around her death, we can anticipate that her decision will influence other vulnerable individuals.”[[86]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn86) Dr. Kheriaty concludes that PAS will send a signal to legitimize such suicidal desires:

Refusing to legitimate suicide helps those in need. The practice of physician-assisted suicide … sends a message that some lives are not worth living. The law is a teacher: If assisted suicide is legalized, this message will be heard by everyone who is afflicted by suicidal thoughts or tendencies.[[87]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn87)

In doing so, PAS undermines our entire culture.

**Betraying Human Dignity and Equality Before the Law**

Perhaps the most profound injustice of PAS is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and worth. For our legal system to be coherent and just, the law must respect this dignity by taking all reasonable steps to prevent the taking of innocent lives. Classifying a subgroup of people as legally eligible to be killed violates our nation’s commitment to equality before the law and shows profound disrespect for the elderly and disabled.

No natural right to physician-assisted suicide exists, and arguments for such a right are indeed incoherent. A legal system that permits assisted suicide undermines the natural right to life for all of its citizens.

**Every Human Being Has Intrinsic Human Dignity and Worth.**

The American Creed, best articulated in the Declaration of Independence, holds it to be a self-evident truth “that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.” Philosophers Patrick Lee and Robert P. George explain that “every human being, of whatever age, size, or degree of development, has inherent and equal fundamental dignity and basic rights.”[[88]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn88)

This dignity does not depend on subjective evaluations of worth, even of self-worth, or on the ability to “contribute” to society. Rather, the dignity is *intrinsic*. Human dignity is not based on an instrumental account of what a person *can do*, but on recognition of what a human being *is*: a person made for reason, freedom, and love. Lee and George explain that “a human being is valuable as a subject of rights in virtue of what he or she is…. And so a human being remains a subject of rights, someone who has a right not to be intentionally killed, for as long as he or she exists.”[[89]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn89)

Of course, a belief in human dignity is not unique to the United States. The Universal Declaration of Human Rights begins by noting that the “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.”[[90]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn90)The European Convention on Human Rights also emphasizes the inalienable right to life: “Everyone’s right to life shall be protected by law. This right is one of the most important of the Convention since without the right to life it is impossible to enjoy the other rights.”[[91]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn91)

**The Law Must Respect Human Dignity and Equality Before the Law.**

The deepest injustice of PAS, then, is that it treats some human lives as lacking dignity or worth—and therefore unworthy of the law’s protection. Lee and George conclude that “the choice to kill an innocent human life, whether one’s own or another’s, even for the sake of avoiding terrible suffering, is intrinsically immoral. Euthanasia and suicide are contrary to the intrinsic dignity of human persons.”[[92]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn92)

Obviously, this does not require that every medical procedure to extend life must be accepted. As the Supreme Court held in a unanimous decision upholding New York’s prohibition on PAS, there is a significant difference between allowing someone to die of natural causes and killing him.[[93]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn93)

The D.C. assisted suicide bill, like most, attempts to define which lives are unworthy of legal protection and thus eligible for physician assistance in killing. That definition is unavoidably a statement of who is unworthy of legal protection. There is no way around it. While the evidence discussed in the first section of this paper indicates that its proposed safeguards would fail to ensure effective control, even the attempt to define which lives are eligible for suicide is a grave injustice: It violates human dignity and equality before the law. It declares that some lives matter less than others.

Disability-rights groups are particularly concerned about the ways in which assisted suicide deprives disabled people of the law’s equal protection. In 2009, for example, Not Dead Yet, ADAPT, the Disability Rights Education and Defense Fund, the National Council on Independent Living, and the National Spinal Cord Injury Association filed a joint amicus brief in the Montana court system in a case reviewing Montana’s law on assisted suicide.

Diane Coleman, president of Not Dead Yet, summarized these arguments in an article for the *Disability and Health Journal*.[[94]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn94) Coleman explains that the push for assisted suicide undermines the value of the lives of people with disabilities:

The primary underlying practical basis for the physician’s determination that the individual is eligible for assisted suicide is the individual’s disabilities and physical dependence on others for everyday needs, which is viewed as depriving them of what nondisabled people often associate with “autonomy” and “dignity,” and may also lead them to feel like a “burden.” This establishes grounds for physicians to treat these individuals completely differently than they would treat a physically able-bodied suicidal person.[[95]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn95)

In addition to denying the intrinsic human dignity of the disabled, PAS laws violate the equal protection of the law. The law and government officials would treat suicidal disabled citizens differently from able-bodied citizens:

Not Dead Yet’s central argument is that legalized assisted suicide sets up a double standard for how health care providers, government authorities, and others respond to an individual’s stated wish to die. Some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual.[[96]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn96)

As the joint amicus brief notes, “Assisted suicide singles out some people with disabilities, those labeled ‘terminal’ or very severely impaired, for different treatment than other suicidal people receive.”[[97]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn97) Government policy should seek to respect the innate dignity of the disabled by eliminating every form of unjust discrimination against them, not by expressly approving the worst form of discrimination of all.

**A “Right” to Physician-Assisted Suicide Is Incoherent, Grounded in Neither Nature Nor Reason.**Not only does PAS violate human dignity and equality, but any supposed right to assisted suicide is incoherent, grounded neither in nature nor in reason.

Dr. Kass highlights the absurdity of a “right to die”: “As the ultimate new right, grounded neither in nature nor in reason, it demonstrates the nihilistic implication of the new (‘postliberal’) doctrine of rights, rooted in the self-creating will.” He later adds: “If we start at the beginning, with the great philosophical teachers of natural rights, the very notion of a right to die is nonsensical.” This is partly because “the right to life is a matter of nature, not will.”[[98]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn98) Dr. Kass notes that:

We Americans hold as a self-evident truth that governments exist to secure inalienable rights, first of all, the right to self-preservation; now we are being encouraged to use government to secure a putative right of self-destruction. A “right to die” is surely strange and unprecedented, and hardly innocent.[[99]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn99)

If there is a right to the pursuit of happiness, how could one argue that the pursuit of happiness could entail the elimination of the person with that right?[[100]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn100)

The American Founders would agree with Professors Kass, Lee, and George. They distinguished liberty from license. Liberty, they rightly understood, is self-directed action in accord with the moral law; license is self-destructive action that debases one’s community. The Founders would have little patience for an argument based on “autonomy” (what they would view as license) to commit PAS, especially as the legal allowance of such a practice would threaten other people’s right to life. Dr. Kass highlights the absurdity in terms of the philosophy of Kant:

For Kant, autonomy, which literally means “self-legislation,” requires acting in accordance with one’s true self—that is, with one’s rational will determined by a universalizable, that is, rational maxim. Being autonomous means not being a slave to instinct, impulse or whim, but rather doing as one ought, as a rational being. But “autonomy” has now come to mean “doing as you please,” compatible no less with self-indulgence than with self-control.[[101]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn101)

Any purported right to assisted suicide is both incoherent and impossible to specify. To highlight this incoherence and lack of specificity, John Finnis reflected on the phrase “right to die”:

Where is the proposition specifying *who* has the right, to *what* acts, by *which* persons? Is it the right of terminally ill patients? (And what is terminal illness?) Or only of those who are suffering? (And what sort and degree of sufferings?) Or of all who are suffering whether or not their illness is terminal? Is it a right only to be assisted in killing oneself…? Or also that others be permitted (or perhaps under a duty) to kill me? (When I cannot do so myself? Or also when I choose?)[[102]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn102)

In truth, the entire concept of a right to assisted suicide will be applied only to certain people whom government officials have classified as “eligible.” Finnis explains:

Even when you fall seriously ill, or become clinically depressed, you will find (if the reformers [i.e., those proposing bills to allow assisted suicide] are to be believed) that your right to autonomy does not give you the right to be assisted in suicide unless you are ill *enough* or suffering *enough*, or depressed severally and incurably *enough*—in each case “enough” in the view of somebody else, *other people*.[[103]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn103)

Rather than allow the government to decide whose life is unworthy of life, it is much better to have the government respect the intrinsic dignity of every human life and thus provide for the equal protection in law of all human beings. The alternative, as Finnis presents it, requires that we “allow some people to sit in judgment on the life of another human person, to judge that person’s life worthless, and so to authorize themselves or others to carry out that person’s request for death.”[[104]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn104)

If we empower such people to judge other people’s lives as worthless, how long will it be until the choice for death under certain circumstances becomesan obligation—perhaps enforced by other people. Thus, an incoherent “right” to assisted suicide might very well result in a duty to have oneself euthanized.

**The Legal System as a Whole Must Protect Rights.**Physician-assisted suicide would transform our nation’s legal system. A society that creates a right to assisted suicide will seriously compromise the natural right not to be killed. As Finnis has argued, “A whole new breed of lawyers and law teachers and judges will rapidly come into existence to give effect to the new régime.”[[105]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn105) With this new set of legal officials interpreting and enforcing new laws, society can expect to see more people have their right not to be killed violated.

Given the various ways in which PAS will change the practice of medicine, law, and the culture, Finnis asks “which legal framework will*take … rights most seriously*.” He answers:

[T]he secular, highly experienced, and sophisticated members of the Walton Committee [House of Lords Select Committee on Medical Ethics, chaired by Lord Walton] and the New York Task Force judge that if euthanasia were legalized at all, the right *not*to be killed would be catastrophically nullified for very many more people than the few whose supposed right to die is compromised by present law.[[106]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn106)

The right not to be killed cannot be protected effectively in a nation that allows physician-assisted suicide.

**The Alternative: Respecting Human Dignity and Equality and Offering True Compassion**

Physicians are always to care, never to kill. They are to eliminate illness and disease but never eliminate their patients. Not every medical means must be used. Patients can refuse or doctors can withhold particular treatments that are useless or causing more harm than good.[[107]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn107) But in deciding that a treatment is useless, we must not decide that a patient is worthless. Doctors should not kill.

**Mental Health and Palliative Care: True Compassionate Treatment.**Instead of embracing PAS, we should respond to suffering with true compassion. Most people seeking PAS suffer from depression or other mental illnesses, physical illness, or simply loneliness. Dr. Kheriaty notes:

Suicidal individuals typically do not want to die; they want to escape what they perceive as intolerable suffering. When comfort or relief is offered, in the form of more-adequate treatment for depression, better pain management, or more-comprehensive palliative care, the desire for suicide wanes.[[108]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn108)

Rather than helping suicidal people to kill themselves, we should offer them treatment and support. For those in physical pain, palliative care and other pain management can manage their symptoms effectively. For those for whom death is imminent, hospice care and fellowship to accompanying them in their last days is what a true death with dignity looks like. Victoria Reggie Kennedy has said it best:

My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. [PAS] turns his vision of health care for all on its head by asking us to endorse patient suicide—not patient care—as our public policy for dealing with pain and the financial burdens of care at the end of life. We’re better than that. We should expand palliative care, pain management, nursing care and hospice, not trade the dignity and life of a human being for the bottom line.[[109]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn109)

Palliative care focuses on improving a patient’s quality of life by alleviating pain and other distressing symptoms of a serious illness. Palliative care is an option for people of any age at any stage in illness, whether that illness is curable, chronic, or life threatening.

When a patient receives a terminal or life-altering diagnosis, the subsequent life changes are not limited to the medical challenges. Patients encounter the physical trauma of the medical diagnosis while also experiencing psychological difficulties, social changes, and even existential concerns. In Oregon Health Authority research, 91 percent of those who were assisted with suicide cited loss of autonomy as their motivation to end their lives, and 71 percent cited loss of dignity as their motivation. Only 31 percent cited inadequate pain control.[[110]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn110) These needs require different forms of care. Palliative care seeks to take into consideration every facet of the patient’s situation—with professionals who can attend to all aspects of the patient’s needs.

The most common structure in which patients receive palliative care is in hospice. Hospice care can be provided in patients’ homes, hospice centers, hospitals, long-term care facilities, or wherever a patient resides. By rejecting PAS and committing to palliative care and hospice care, we can better people’s lives at the end of life. As Dr. Kass notes:

We must care for the dying, not make them dead. By accepting mortality yet knowing that we will not kill, doctors can focus on enhancing the lives of those who are dying, with relief of pain and discomfort, moral and social support, and, when appropriate, the removal of technical interventions that are merely useless or degrading additions to the burdens of dying.[[111]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn111)

Regrettably, palliative care is not as widely available as it should be. The United States has only one palliative care physician for every 1,200 persons living with a serious or life-threatening illness. Even with the aging population, only 63 percent of hospitals report a palliative care program.[[112]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn112)

In order to increase the availability and understanding of palliative care, medical schools should ensure that students are trained in managing pain and other common distressing symptoms and that they learn how to talk to patients about palliative options at the end of life. As Drs. Hendin and Foley note, when there is a lack of comprehensive support for patients with terminal or life-altering diagnosis, “the focus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements for assisted suicide.”[[113]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak" \l "_ftn113)This we must resist.

**Always to Care, Never to Kill**

Doctors should help their patients die a dignified natural death, but doctors should not assist in killing or self-killing. Physicians are always to care, never to kill.

Physician-assisted suicide endangers the weak and marginalized in society. Where PAS has been allowed, safeguards that were put in place to minimize this risk have proved inadequate and over time have been weakened or eliminated altogether.

Introducing PAS changes the culture in which medicine is practiced. It corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing. It also distorts the doctor–patient relationship by reducing patients’ trust of doctors and doctors’ undivided commitment to the healing of their patients. Physician-assisted suicide also creates perverse incentives for insurance providers and the financing of health care.

Worse yet, PAS negatively affects our entire culture. The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for elderly and disabled family members to view themselves as burdens. Instead of solidarity through civil society and true compassion, PAS creates quick-fix, discriminatory, and lethal solutions.

The most profound injustice of PAS is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and is the subject of immeasurable worth. No natural right to PAS exists, and arguments for such a right are incoherent. A legal system that sought to vindicate a right to assisted suicide would jeopardize the real natural right to life for all of its citizens.

For all of these reasons, citizens and policymakers need to resist the push for physician-assisted suicide”.

**KEY TAKEAWAYS**

1. “Physician-Assisted Suicide endangers the weak and vulnerable and corrupts the practice of medicine and the doctor–patient relationship.
2. Physician-assisted suicide will create perverse incentives for insurance providers and the financing of health care.
3. The most profound injustice of PAS is that it violates human dignity and denies equality before the law” (Anderson, 2015).

**SUMMARY**

*“Allowing physician-assisted suicide would be a grave mistake for four reasons. First, it would endanger the weak and vulnerable. Second, it would corrupt the practice of medicine and the doctor–patient relationship. Third, it would compromise the family and intergenerational commitments. And fourth, it would betray human dignity and equality before the law. Instead of helping people to kill themselves, we should offer them appropriate medical care and human presence. We should respond to suffering with true compassion and solidarity. Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill”* (Anderson, 2015).

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[[2]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref2) State legislation as of March 20, 2015: Alaska, HB 99; California, SB 128; Colorado, HB 15-1135; Connecticut, SB 668; Iowa, HF 65; Kansas, HB 2150; Maryland, HB 1021; Massachusetts, HD 1674; Minnesota, SF 1880; Missouri, HB 307; Montana, SB 202; Nevada, SB 336; New Jersey, AB 2270; New York, AB 02129; Oklahoma, HB1673; Utah, HB 391; Wisconsin, AB 67/SB 28; Wyoming, HB 119; and the District of Columbia, B21-0031. In the courts, a New Mexico appeals court will review a lower court’s decision claiming to find a right to assisted suicide in the state constitution.

[[3]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref3) Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton, NJ: Princeton University Press, 2006), p. 7.

[[4]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref4) Leon Kass elaborates on this point: “Physician-assisted suicide, once legal, will not stay confined to the terminally ill and mentally competent who freely and knowingly elect it for themselves. Requests will be engineered and choices manipulated by those who control the information, and, manipulation aside, many elderly and incurable people will experience a right to choose death *as their duty* to do so. Moreover, the vast majority of those who are said to ‘merit’ ‘a humane and dignified death’ do not fall in this category and cannot request it for themselves. *Persons with mental illness or Alzheimer’s disease, deformed infants, and retarded or dying children would thus be denied our new humane ‘aid-in-dying.’ But not to worry. The lawyers, encouraged by the cost-containers, will sue to rectify this inequity.*Why, they will argue, should the comatose or the demented be denied a right to assisted suicide just because they cannot claim it for themselves? With court-appointed proxy consentors, we will quickly erase the distinction between the right to choose one’s own death and the right to request someone else’s.” Leon R. Kass, “Dehumanization Triumphant,” *First Things*, August 1996, <http://www.firstthings.com/article/1996/08/002-dehumanization-triumphant> (accessed January 28, 2015) (emphasis added).

[[5]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref5) See Emily Jackson and John Keown, *Debating Euthanasia* (Oxford: Hart Publishing, 2012), p. 102.

[[6]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref6) Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 111 (emphasis in original).

[[7]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref7) See *Glucksberg*and *Quill*: *Glucksberg* *v. Washington*, 521 U.S. 702 (1997) (holding that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause”), and *Vacco* *v.* *Quill*, 521 U.S. 793 (1997) (holding that because refusing treatment is logically distinct from assisting suicide, New York State’s prohibition on PAS treated all patients the same and so did not violate the Equal Protection Clause). For a helpful discussion of these cases and precedents, see Gorsuch, *The Future of Assisted Suicide and Euthanasia*, pp. 8–18. Oregonians legalized PAS through Ballot Measure 16, the Death with Dignity Act in 1994; see O.R.S. § 127.800-995 (1994), which took legal effect late in 1997. Washingtonians approved Initiative 1000, the Death with Dignity Act, in 2008; see R.C.W § 70.245 (2008). In 2013, the Vermont Legislature passed the Patient Choice and Control at End of Life Act; see 18 V.S.A. § 5289 (2013). In 2009, a Montana Supreme Court decision gave physicians the ability to raise the defense of consent to a charge of violating the state’s assisted suicide law;see *Baxter* *v. Montana*,WL 5155363 (2009). New Mexico, meanwhile, is in the middle of court proceedings over physician-assisted suicide, with a lower court having ruled in its favor, but that ruling is being appealed. Eric Eckholm, “New Mexico Judge Affirms Right to ‘Aid in Dying,’” *The New York Times*, January 13, 2014, <http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html>(accessed January 28, 2015).

[[8]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref8) Jose Pereira, “Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls,” *Current Oncology*,Vol. 18, No. 2 (April 2011), [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/:/)(accessed February 4, 2015).

[[9]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref9) See also John Keown’s discussion of the Netherlands in Jackson and Keown, *Debating Euthanasia*, pp. 118–128.

[[10]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref10) Public opinion demonstrates that levels of support for PAS differ substantially along socioeconomic and ethnic lines. Those who support PAS tend to be white, affluent, and able-bodied, and those who are most worried about being killed in the name of compassion are in poorer and minority communities or are disabled. For example, a 1997 study that reviewed previous studies found that support for PAS is generally about 20 percent higher among white respondents than among black respondents. Patients who end their lives with doctor-assisted suicide are more likely to be white and college-educated. This gap may also be rooted in a disparity of palliative and hospice care available to minority groups. For instance, dementia patients in the poorest quartile for socioeconomic status are less likely to receive hospice services. Low-income black women receiving fee-for-service Medicare are also less likely than white women to receive hospice care. See Kathleen M. Fairfield et al., “Disparities in Hospice Care Among Older Women Dying with Ovarian Cancer,” *Journal of Gynecologic Oncology*, Vol. 125, No. 1 (April 2012), pp. 14–18; Preethy Nayar et al., “Disparities in End of Life Care for Elderly Lung Cancer Patients,”*Journal of Community Health*, Vol. 39, No. 5 (October 2014), pp 1012–1019; Melissa Lopresti, Fritz Dement, and Heather T. Gold, “End-of-Life Care for People with Cancer from Ethnic Minority Groups: A Systematic Review,” *American Journal of Hospice and Palliative Care*, December 29, 2014; Ezekiel Emanuel, Diane L. Fairclough, and Linda Emanuel, “Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers,” *JAMA*,Vol. 284, No. 19 (November 15, 2000), pp. 2460–2468, http://jama.jamanetwork.com/article.aspx?articleid=193281 (accessed March 4, 2015); Lilian Liou Cohen, “Racial/Ethnic Disparities in Hospice Care: A Systematic Review,” *Journal of Palliative Medicine*, Vol. 11, No. 5 (June 2008), pp. 763–768; and Amanda Connolly, Elizabeth Sampson, and Nitin Purandare, “End-of-Life Care for People with Dementia from Ethnic Minority Groups: A Systematic Review,” *Journal of American Geriatric Society*,Vol. 60, No. 2 (February 2012), pp. 351–360, <http://www.ncbi.nlm.nih.gov/pubmed/22332675> (accessed February 23, 2015).

[[11]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref11) New York Department of Health, Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*,May 1994, <https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm> (accessed January 28, 2015). The report continued: “We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine … to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. *They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group.*The risks of legalizing assisted suicide and euthanasia for these individuals … are likely to be extraordinary.” Ibid. (emphasis added).

[[12]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref12) Paul McHugh, “Dr. Death Makes a Comeback,” *The* *Wall Street Journal*,January 22, 2015, <http://www.wsj.com/articles/paul-mchugh-dr-death-makes-a-comeback-1421970736> (accessed January 28, 2015).

[[13]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref13) Kass, “Dehumanization Triumphant.”

[[14]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref14) Herbert Hendin and Kathleen Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective,” *Michigan Law Review*,Vol. 106, No. 8 (June 2008), p. 1622. In a study of 200 terminally ill cancer patients, the prevalence of depressive syndromes among patients who expressed a desire for death was 59 percent. Among those who did not desire death, only 8 percent demonstrated depressive syndromes. See H. M. Chochinov et al., “Desire for Death in the Terminally Ill,” *The American Journal of Psychiatry*, Vol. 152, No. 8 (August 1995), pp. 1185–1191.

[[15]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref15) Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton, 1998), pp. 34–35.

[[16]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref16) Hendin and Foley, “Physician-Assisted Suicide in Oregon,” pp. 1625–1626.

[[17]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref17) Ibid., p. 1622.

[[18]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref18) Oregon Public Health Division, “Oregon’s Death with Dignity Act—2014,” <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf> (accessed February 24, 2015).

[[19]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref19) Aaron Kheriaty, “Apostolate of Death,” *First Things*, April 2015, p. 19.

[[20]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref20) Hendin and Foley, “Physician-Assisted Suicide in Oregon,” p. 1616.

[[21]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref21) Death with Dignity Act of 2015, B21-0038, Leg. Sess. 20, <http://lims.dccouncil.us/Legislation/B21-0038> (accessed January 28, 2015).

[[22]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref22) Oregon, O.R.S. § 127.800-995 (1994); Washington, R.C.W § 70.245 (2008); and Vermont, 18 V.S.A. § 5289 (2013).

[[23]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref23) Alexander M. Capron, “Legalizing Physician-Aided Death,” *Cambridge Quarterly of Healthcare Ethics*, Vol. 5, No. 1 (Winter 1996), p. 14.

[[24]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref24) Joanne Lynn et al., “Defining the ‘Terminally Ill’: Insights from SUPPORT,” *Duquesne Law Review*, Vol. 35, No. 1 (Fall, 1996), p. 334.

[[25]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref25) Richard M. Doerflinger, “Flirting with Death,” *Public Discourse*,January 5, 2015, <http://www.thepublicdiscourse.com/2015/01/14217/> (accessed February 4, 2015).

[[26]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref26) Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 124.

[[27]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref27) Doerflinger, “Flirting with Death” (emphasis in original).

[[28]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref28) Ibid.

[[29]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref29) Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 119.

[[30]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref30) Diane Coleman, “Assisted Suicide Laws Create Discriminatory Double Standard for Who Gets Suicide Prevention and Who Gets Suicide Assistance: Not Dead Yet Responds to Autonomy, Inc.,” *Disability and Health Journal*,Vol. 3, No. 1 (January 2010), p. 48, [http://www.disabilityandhealthjnl.com/article/S1936-6574(09)00089-2/fulltext](http://http/www.disabilityandhealthjnl.com/article/S1936-6574(09)00089-2/fulltext) (accessed March 5, 2015).

[[31]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref31) Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 180.

[[32]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref32) In some of the newly introduced bills, these problems are actually far worse, not better. For example, the California bill introduced in 2015 is modeled on Oregon’s law but greatly weakens its provision on psychological counseling, dropping the requirement that, once referred for counseling, a patient must be found competent before the assisted suicide can proceed. The bill introduced in Maryland removes the language stating that an illness must be considered irreversible and incurable in order to be considered terminal and says a doctor need only find that it is “more likely than not” that the patient will die of the illness in six months.

[[33]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref33) See John Keown, “Euthanasia in the Netherlands: Sliding down the Slippery Slope?” *Notre Dame Journal of Law, Ethics & Public Policy*,Vol. 9, No. 2 (1995), <http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1427&context=ndjlepp> (accessed March 5, 2015).

[[34]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref34) Ibid., p. 423 (emphasis in original).

[[35]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref35) John Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good* (Oxford: Oxford University Press, 2011), p. 255.

[[36]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref36) Government of Belgium, Commission Fédérale de Contrôle, *Et D’évaluation de L’euthanasie*, 2014, p. 7, <http://www.health.belgium.be/filestore/19097638/Rapport_Euthanasie12-13_FR.pdf> (accessed March 5, 2015). Commenting on the report, the European Institute for Bioethics noted, “The deaths caused today represent 1.7% of all deaths in Belgium.” European Institute of Bioethics, “Belgian Euthanasia Increases by 89% in Four Years,” September 15, 2014, <http://www.ieb-eib.org/en/document/belgian-euthanasia-increases-by-89-in-four-years-382.html> (accessed March 11, 2015).

[[37]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref37) Kenneth Chambaere et al., “Physician-Assisted Deaths Under the Euthanasia Law in Belgium: A Population-Based Survey,” *CMAJ*, Vol. 182, No. 9 (June 15, 2010), p. 896, <http://www.cmaj.ca/content/182/9/895.full> (accessed March 5, 2015).

[[38]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref38) John Keown, “A Right to Voluntary Euthanasia? Confusion in Canada in Carter,” *Notre Dame Journal of Law, Ethics & Public Policy*, Vol. 28, No. 1 (2014), p. 30, <http://scholarship.law.nd.edu/ndjlepp/vol28/iss1/1/> (accessed March 5, 2015) (emphasis in original).

[[39]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref39) *Fleming v. Ireland & Ors*, IEHC 2 (2013), para. 102, <http://www.bailii.org/ie/cases/IEHC/2013/H2.htm>(accessed March 5, 2015).

[[40]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref40) The number of official euthanasia cases grows year by year in both the Netherlands and Belgium, the first European countries to legalize PAS. In 2013, according to the Netherlands official report, the total number of doctor-administered deaths was 4,829—a 15 percent increase from the previous year. See Netherlands Regionale Toetsingscommissies, *Euthanasie: Jaarverslag 2013* (Euthanasia: Annual report 2013), <http://www.euthanasiecommissie.nl/Images/Jaarverslag2013_NL_tcm52-40686.pdf> (accessed January 28, 2015). There were 1,807 reported cases of euthanasia in Belgium in 2013—a 27 percent increase over 2012, which was a 25 percent increase above 2011. See Leo Cendrowicz, “Euthanasia and Assisted Suicide Laws Around the World,” *The Guardian*,July 17, 2014, <http://www.theguardian.com/society/2014/jul/17/euthanasia-assisted-suicide-laws-world> (accessed January 28, 2015).

[[41]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref41) Keown, “A Right to Voluntary Euthanasia?” p. 23.

[[42]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref42) Ezekiel J. Emanuel, “Whose Right to Die?” *The Atlantic*, March 1, 1997, <http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/> (accessed January 28, 2015) (emphasis added).

[[43]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref43) *Arrest Gerechtshof te Leeuwarden*d.d.4 April 1996, in the Case Against K, 20.5 *Tijdschrift Voor Gezondheidsrecht* 284, 19 (1996).

[[44]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref44) Eduard Verhagen and Pieter J. J. Sauer, “The Groningen Protocol—Euthanasia in Severely Ill Newborns,” *The New England Journal of Medicine*, Vol. 352, No. 10 (March 10, 2005), pp. 960–961, <http://www.nejm.org/doi/full/10.1056/NEJMp058026#t=article> (accessed February 9, 2015).

[[45]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref45) Ibid.

[[46]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref46) Press release, “Clear Criteria for Medical End-of-Life Decisions in Neonates with Very Serious Defects,” Royal Dutch Medical Association, June 12, 2013, <http://knmg.artsennet.nl/web/file?uuid=4406e682-5e7b-4a5b-9fca-a0454ef124e0&owner=a8a9ce0e-f42b-47a5-960e-be08025b7b04&contentid=134424> (accessed January 28, 2015). The pro-euthanasia mindset has been long established in the country, and the legal barrier is often ignored. As early as 1997, a study examined the causes of all infant mortalities in the country and discovered that “57% of all deaths had been preceded by a decision to forgo life-sustaining treatment; this decision was accompanied by the administration of potentially life-shortening drugs to alleviate pain or other symptoms in 23%, and *by the administration of drugs with the explicit aim of hastening death in 8%.*” Agnes van der Heide et al., “Medical End-of-Life Decisions Made for Neonates and Infants in the Netherlands,” *The Lancet*,Vol. 350 (July 26, 1997), p. 251, <http://dare.uva.nl/document/2/2127> (accessed January 29, 2015) (emphasis added).

[[47]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref47) U.N. Human Rights Committee, “Concluding Observations of the Human Rights Committee, The Netherlands,” U.N. doc CCPR/CO/72/NET, July 19 and 23, 2001, <http://www1.umn.edu/humanrts/hrcommittee/netherlands2001.html> (accessed February 16, 2015).

[[48]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref48) Derek Blyth, “Federal Parliament Passes Euthanasia Law for Minors,” *Flanders Today*,February 14, 2014, <http://www.flanderstoday.eu/politics/federal-parliament-passes-euthanasia-law-minors> (accessed January 29, 2015).

[[49]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref49) Open Letter, “Fin de vie des enfants : une loi inutile et précipitée” (End of life of children: unnecessary and hasty legislation), *La Libre* (Brussels)¸ January 29, 2014, <http://www.lalibre.be/debats/opinions/fin-de-vie-des-enfants-une-loi-inutile-et-precipitee-52e93c5b3570e5b8eeea1a00> (accessed January 29, 2015).

[[50]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref50) Naftali Bendavid, “For Belgium’s Tormented Souls, Euthanasia-Made-Easy Beckons,” *The Wall Street Journal*,June 14, 2013, <http://www.wsj.com/articles/SB10001424127887323463704578495102975991248>(accessed January 28, 2015).

[[51]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref51) Editorial, “Belgian Helped to Die After Three Sex Change Operations,” BBC News, October 2, 2013, <http://www.bbc.com/news/world-europe-24373107> (accessed January 28, 2015).

[[52]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref52) Graeme Hamilton, “Death by Doctor: Controversial Physician Has Made His Name Delivering Euthanasia When No One Else Will,” *National Post*,November 22, 2013, <http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/> (accessed January 29, 2015).

[[53]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref53) DutchNews.nl, “Woman, 70, Is Given Euthanasia After Going Blind,” October 7, 2013, <http://www.dutchnews.nl/news/archives/2013/10/women_70_gets_euthanasia_after/> (accessed January 28, 2015).

[[54]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref54) DutchNews.nl, “Euthanasia Clinic Criticized for Helping Woman with Severe Tinnitus to Die,”January 19, 2015, <http://www.dutchnews.nl/news/archives/2015/01/euthanasia-clinic-criticised-for-helping-woman-with-severe-tinnitus-to-die.php/> (accessed January 28, 2015).

[[55]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref55) Sue Reid, “The Country Where Death Is Now Just a Lifestyle Choice: A Mum with Ringing Ears. Babies Whose Parents Don’t Want Them to Suffer. They’ve All Been Allowed to Die by Assisted Suicide in Holland,” *Daily Mail*, January 1, 2015, <http://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html> (accessed March 11, 2015).

[[56]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref56) Joke Mat, “In the Netherlands, Nine Psychiatric Patients Received Euthanasia,” *NRC Handelsblad*(Amsterdam), January 2, 2014, <http://www.nrc.nl/nieuws/2014/01/02/in-the-netherlands-nine-psychiatric-patients-received-euthanasia/> (accessed January 28, 2015).

[[57]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref57) Kass, “Dehumanization Triumphant.”

[[58]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref58) McHugh, “Dr. Death Makes a Comeback.”

[[59]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref59) American Medical Association, “Opinion 2.211—Physician-Assisted Suicide,” June 1996, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page> (accessed January 28, 2015).

[[60]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref60) O. Carter Snead, “Physician Assisted Suicide: Objection in Principle and Prudence,” *Notre Dame Law School Faculty Lectures and Presentation*,Paper 26, 2014, <http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1023&context=law_faculty_lectures> (accessed January 28, 2015).

[[61]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref61) Leon R. Kass, “Neither for Love nor Money: Why Doctors Must Not Kill,” *Public Interest*, Vol. 94 (Winter 1989), pp. 29 and 39.

[[62]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref62) Ibid., pp. 40 and 41.

[[63]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref63) McHugh, “Dr. Death Makes a Comeback.” McHugh continues: “The fundamental premise of medicine is the vocational commitment of doctors to care for all people without doubting whether any individual is worth the effort. That means doctors will not hold back their ingenuity and energies in treating anyone, rich or poor, young or old, prominent or socially insignificant—or curable or incurable. This is the heart and soul of medical practice. The confidence with which patients turn to their physicians depends on it, and it is what spurs doctors to find innovative ways of helping the sick.” Ibid.

[[64]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref64) Coleman, “Assisted Suicide Laws Create Discriminatory Double Standard,” p. 46.

[[65]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref65) Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 260. Finnis explains how a change in the law regarding physician-assisted suicide will change the mindset and dispositions of professionals who are operating within the new culture: “So do not think of the euthanasia law being administered by today’s medical practitioners and nurses and hospital administrators, whose codes of ethics exclude killing as a treatment and management option.… [T]he ethics of all those professions and classes would—and would be bound to—change.” Ibid., p. 260.

[[66]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref66) Kass, “Neither for Love nor Money,” p. 35. Elsewhere, Kass adds: “Even conscientious physicians will have trouble caring wholeheartedly for patients once death becomes a ‘therapeutic option.’ The prohibition against killing patients, medicine’s first principle of ethical self-restraint, recognizes that no physician devoted to the benefit of the sick can serve the patient by making him dead. The physician-suicide-assistant or physician-euthanizer is a deadly self-contradiction.” Kass, “Dehumanization Triumphant.”

[[67]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref67) Kass, “Neither for Love nor Money,” p. 35.

[[68]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref68) Finnis, *The Collected Essays of John Finnis*, Vol. 3,*Human Rights and Common Good*, p. 260.

[[69]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref69) Martin Beckford, “Baroness Warnock: Dementia Sufferers May Have a ‘Duty to Die,’” *The Telegraph*, September 18, 2008, <http://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html> (accessed January 28, 2015).

[[70]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref70) Derek Humphry and Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement*(New York: St. Martins, 2000), pp. 339, 340, and 353.

[[71]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref71) McHugh, “Dr. Death Makes a Comeback.”

[[72]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref72) Doerflinger, “Flirting with Death.”

[[73]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref73) New York Department of Health, Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, chap. 6, quoted in Finnis, *The Collected Essays of John Finnis*, Vol. 3,*Human Rights and Common Good*, p. 265.

[[74]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref74) Gilbert Meilaender, “I Want to Burden My Loved Ones,” *First Things*,October 1991, <http://www.firstthings.com/article/1991/10/003-i-want-to-burden-my-loved-ones> (accessed January 28, 2015).

[[75]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref75) Leon R. Kass and Eric Cohen, “Cast Me Not Off in Old Age,” *Commentary*,January 1, 2006, http://www.aei.org/publication/cast-me-not-off-in-old-age/ (accessed January 28, 2015). Dr. Kass and Cohen conclude: “In the end, there is no ‘solution’ to the problems of old age, at least no solution that any civilized society could tolerate. But there are better and worse ways to see our aging condition. The better way begins in thinking of ourselves less as wholly autonomous individuals than as members of families; in relinquishing our mistaken belief that medicine can miraculously liberate our loved ones or ourselves from debility and decline, and instead taking up our role as caregivers; and in abjuring the fantasy that we can control the manner and the hour of our dying, learning instead to accept death in its proper season as mortal beings replaced and renewed by the generations that follow.” Ibid.

[[76]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref76) Finnis, *The Collected Essays of John Finnis*, Vol. 3,*Human Rights and Common Good*, p. 261.

[[77]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref77) Ibid. Finnis continues: “[What] could remove or even appreciably diminish the patient’s subjection to the pressure of the thought that my being killed is what my relatives expect of me and is in any case the decent thing to do, even though I utterly fear it and perhaps perceive it as the uttermost and ultimate indignity, an odious, devastating subjection to the needs and will of others? And likewise with the other sources of tyranny, the new power, opportunity, and ethic of doctors, and the real and novel power of the relatives.” Ibid., p. 262.

[[78]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref78) Victoria Reggie Kennedy, “Question 2 Insults Kennedy’s Memory,” *Cape Cod Times*, November 3, 2012, <http://www.capecodtimes.com/article/20121027/OPINION/210270347> (accessed March 5, 2015).

[[79]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref79) Ibid.

[[80]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref80) Ibid.

[[81]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref81) Herbert Hendin, “The Dutch Experience,” in Kathleen Foley and Herbert Hendin, eds., *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins University Press, 2002), p. 109.

[[82]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref82) Ibid. Hendin and Foley write: “One can readily see how in the best of circumstances frail, elderly patients can feel coerced to die. Caregiver burden has been identified as a serious issue, particularly for women … who are asked to shoulder the work and responsibility of providing twenty-four-hour care to a parent.” Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in Foley and Hendin, *The Case Against Assisted Suicide*, p. 157.

[[83]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref83) Oregon Public Health Division, “Oregon’s Death with Dignity Act—2014.”

[[84]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref84) Kheriaty, “Apostolate of Death,” p. 19.

[[85]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref85) World Health Organization, Department of Mental Health and Substance Abuse, “Preventing Suicide: A Resource for Media Professionals,” 2008, <http://www.who.int/mental_health/prevention/suicide/resource_media.pdf> (accessed March 5, 2015).

[[86]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref86) Kheriaty, “Apostolate of Death,” p. 20.

[[87]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref87) Ibid., p. 20.

[[88]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref88) Patrick Lee and Robert P. George, *Body-Self Dualism in Contemporary Ethics and Politics*(Cambridge, U.K.: Cambridge University Press, 2008), p. 93.

[[89]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref89) Ibid., p. 155.

[[90]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref90) The Universal Declaration of Human Rights,<http://www.un.org/en/documents/udhr/> (accessed February 24, 2015).

[[91]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref91) Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms and Protocol, <http://www.echr.coe.int/Documents/Collection_Convention_1950_ENG.pdf> (accessed February 27, 2015).

[[92]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref92) Lee and George, *Body-Self Dualism in Contemporary Ethics and Politics*,p. 156.

[[93]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref93) *Vacco* *v. Quill*. The Supreme Court overturned a ruling of the 2nd Circuit Court that, among other things, argued that because patients could deny care resulting in their death, they should be able to have assistance in killing.

[[94]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref94) Coleman, “Assisted Suicide Laws Create Discriminatory Double Standard,” pp. 40 and 48.

[[95]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref95) Ibid., p. 41.

[[96]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref96) Ibid., p. 43.

[[97]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref97) Ibid. The brief continues: “Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one’s life; rather, surrounding barriers and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living.” Ibid., p. 44.

[[98]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref98) Leon R. Kass, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics*(San Francisco: Encounter Books, 2002), pp. 203, 212, and 214.

[[99]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref99) Ibid., p. 203.

[[100]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref100) Lee and George argue that “it makes no sense to hold that the fulfillment of entity is intrinsically valuable, and yet the entity itself is not.” Lee and George, *Body-Self Dualism in Contemporary Ethics and Politics*, pp. 160–161.

[[101]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref101) Kass, *Life, Liberty and the Defense of Dignity*,p. 216.

[[102]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref102) Finnis, *The Collected Essays of John Finnis*, Vol. 3,*Human Rights and Common Good*,p. 257 (emphasis in original).

[[103]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref103) Ibid., p. 258 (emphasis in original).

[[104]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref104) Ibid., p. 259. Finnis later explains how assisted suicide laws threaten the very justice of a political community: “A just society cannot be maintained, and people cannot be treated with the equal concern and respect to which they are all entitled, unless we hold fast to the truth … that none of us is entitled to act on the opinion that the life of another is not worth living. To trash this truth … is to discard the very foundations of just and *equal respect* for persons in their liberty, their pursuit of happiness, and their life.” Ibid., p. 270 (emphasis in original).

[[105]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref105) Ibid., p. 259.

[[106]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref106) Ibid., pp. 262 and 264 (emphasis in original).

[[107]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref107) Dr. Kass explains: “Ceasing medical intervention, allowing nature to take its course, differs fundamentally from mercy killing. For one thing, death does not necessarily follow the discontinuance of treatment…. Not the physician, but the underlying fatal illness becomes the true cause of death. More important morally, in ceasing treatment the physician need not intend the death of the patient, even when the death follows as a result of his omission. His intention should be to avoid useless and degrading medical additions to the already sad end of a life. In contrast, in active, direct mercy killing the physician must, necessarily and indubitably, intend primarily that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death.” Kass, “Neither for Love nor Money,” pp. 43–44.

[[108]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref108) Kheriaty, “Apostolate of Death,” p. 19.

[[109]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref109) Kennedy, “Question 2 Insults Kennedy’s Memory.”

[[110]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref110) Oregon Public Health Division, “Oregon’s Death with Dignity Act—2014.”

[[111]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref111) Kass, “Dehumanization Triumphant.” Elsewhere, Kass adds that “death with dignity, understood as living dignifiedly in the face of death, is not a matter of pulling plugs or taking poison.” Kass, *Life, Liberty and the Defense of Dignity*, p. 249.

[[112]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref112) R. Sean Morrison and Diane E. Meier, “America’s Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals,” Center to Advance Palliative Care and the National Palliative Care Research Center, May 2011, p. 9, <http://reportcard.capc.org/pdf/state-by-state-report-card.pdf> (accessed January 30, 2015).

[[113]](http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak#_ftnref113) Hendin and Foley, “Physician Assisted Suicide in Oregon,” p. 1616.

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<http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak>

**“What is physician aid-in-dying?**

Physician aid-in-dying (PAD) refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life. (For related discussion, see also [End of Life Issues](http://depts.washington.edu/bioethx/topics/eol.html).)

**What role does language play in discussions of aid-in-dying?**

A variety of terms have historically been used to describe when a terminally ill patient uses a lethal dose of medication for the purpose of ending his or her life (or having control over the timing of death). Prior to the passage of the Oregon Death with Dignity Act in 1996, the term most often used was “physician-assisted suicide” (PAS). Those who use this term feel that it is an accurate reflection of the relationship between doctor and patient and refer to the etymological roots of suicide as “auto-killing” or “self-killing.” The use of this term ties the role of the physician to one that aids the patient in killing him or herself. However, implicit in the understanding of the word suicide is the notion of a premature death that is being hastened out of despair, therefore when mental illness impairs judgment, intervention to stop a suicide is ethically warranted because the person seeking suicide has lost his ability to carefully weigh the benefits and burdens of continued life. Generally speaking, persons who are suicidal are treated as though their decision-making capacity is compromised and health care providers often intervene and provide life-sustaining treatments (including involuntary psychiatric treatment) over the objections of the patient. Therefore, some people, including several national professional organizations\*, object to the term suicide for the choice of a terminally ill patient to hasten death, because of the associations between suicide and mental illness. They argue that, unlike the patients with impaired judgment who request suicide, terminally ill patients who request medication under the Act have the capacity to make a rational, autonomous decision to end their lives.

The term “physician aid-in-dying” is used to describe the practice authorized under the Washington, Oregon and Vermont Death with Dignity Acts and is meant to reflect the requirement that eligible persons must be decisionally competent and have a limited life expectancy of about 6 months or less. In this context, the term is meant to reflect that physicians provide assistance to patients who are otherwise going to die, and who seek help to control the timing and circumstances of their death in the face of end-of-life suffering they deem intolerable. While this term evades the mental health connotations associated with the word suicide, people who object to the use of “physician aid in dying” suggest that it could include other practices that are clearly outside the legal bounds of the three states’ Death with Dignity Acts, e.g. a patient who receives assistance in ingesting the medication, which would constitute euthanasia (see below). Here we use the term physician aid-in-dying to reflect the practice that is legal under the Washington Death with Dignity Act.

It is important to note that both terms, “physician assisted suicide” and “physician aid-in-dying” are value-laden and may reflect the speaker or writer’s political or ideological support for or objection to the practice. Recent research has detailed the need for open and honest discussion on end of life issues. This discussion should supersede any debate over the use of particular terms or language. Acknowledging the power of both historic and contemporary terminology, will help flesh out both sides of this sensitive and powerful debate.

\*The Oregon Department of Public Health, American Public Health Association, American Psychological Association, American Academy of Hospice and Palliative Care, American Medical Women’s Association, and the American Medical Student Association have adopted the term patient directed dying or physician aid-in-dying and have rejected the term physician-assisted suicide. Neither term is used in Oregon, Washington or Vermont Death with Dignity laws.

**Is physician aid-in-dying (PAD) the same as euthanasia?**

No. While both physician aid-in-dying and euthanasia involve the use of lethal medications to deliberately end a patient's life, the key difference is in who acts to administer the medications that will end the patient’s life. In physician aid-in-dying, the patient must self-administer the medications; the "aid-in-dying" refers to a physician providing the medications, but the patient decides whether and when to ingest the lethal medication. Euthanasia occurs when a third party administers medication or acts directly to end the patient’s life. Euthanasia is illegal in every state, including Washington.

Some other practices that should be distinguished from physician aid-in-dying include:

* **Withholding/withdrawing life-sustaining treatments:** When a competent adult patient makes an informed decision to refuse life-sustaining treatment, their wishes are generally respected. The right of a competent adult patient to refuse life-sustaining treatments is supported by law.
* **Pain medication that may hasten death:** Often a terminally ill, suffering patient may require dosages of pain medication that have side effects that may hasten death, such as impairing respiration. Using the ethical principle of double effect as the foundational argument, it is generally held by most professional societies, and supported in court decisions, that this action is justifiable. Since the primary goal and intention of administering these medications is to relieve suffering, the secondary outcome of potentially hastening death is recognized as an expected and acceptable side-effect in a terminally ill patient.
* **Palliative sedation:** This term refers to the practice of sedating a terminally ill patient to the point of unconsciousness, due to intractable pain and suffering that has been refractory to traditional medical management. Such patients are imminently dying, usually hours or days from death. Often other life-sustaining interventions continue to be withheld (CPR, respirator, antibiotics, artificial nutrition and hydration, etc.) while the patient is sedated. Palliative sedation may occur for a short period (respite from intractable pain) or the patient may be sedated until s/he dies. In the rare instances when pain and suffering is refractory to treatment even with expert clinical management by pain and palliative care professionals, palliative sedation may legally be employed.

**Is physician aid-in-dying (PAD) ethically permissible?**

The ethics of physician aid-in-dying continue to be debated. Some argue that PAD is ethically permissible (see [arguments in favor](https://depts.washington.edu/bioethx/topics/pad.html#favor)). Often this position is argued on the grounds that PAD may be a rational choice for a dying person who is choosing to escape unbearable suffering at the end of life. Furthermore, the physician's duty to alleviate suffering may, at times, justify providing aid-in-dying. These arguments rely on respect for individual autonomy, recognizing the right of competent people to choose the timing and manner of death in the face of a terminal illness.

Others have argued that PAD is not ethically permissible because PAD runs directly counter to the traditional duty of the physician to preserve life and to do no harm (see [arguments against](https://depts.washington.edu/bioethx/topics/pad.html#against)). Furthermore, many argue if PAD were legal, abuses would take place, as the social forces that condone the practice are a slippery slope that could lead to euthanasia. For instance, the disabled, poor or elderly might be covertly pressured to choose PAD over more complex and expensive palliative care options.

For more information on the debate around PAD please see [Euthanasia Pros and Cons](http://euthanasia.procon.org/).  
**What are the arguments in favor of physician aid-in-dying (PAD)?**

Those who argue that PAD is ethically justifiable offer the following arguments:

1. **Respect for autonomy:** Decisions about time and circumstances of death are personal. Competent people should have right to choose the timing and manner of death.
2. **Justice:** Justice requires that we "treat like cases alike." Competent, terminally ill patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering but who are not dependent on life support, such as respirators or dialysis, refusing treatment will not suffice to hasten death. Thus, to treat these patients equitably, we should allow assisted death as it is their only option to hasten death.
3. **Compassion:** Suffering means more than pain; there are other physical, existential, social and psychological burdens such as the loss of independence, loss of sense of self, and functional capacities that some patients feel jeopardize their dignity. It is not always possible to relieve suffering. Thus PAD may be a compassionate response to unremitting suffering.
4. **Individual liberty vs. state interest**: Though society has strong interest in preserving life, that interest lessens when a person is terminally ill and has strong desire to end life. A complete prohibition against PAD excessively limits personal liberty. Therefore PAD should be allowed in certain cases.
5. **Honesty & transparency:** Some acknowledge that assisted death already occurs, albeit in secret. The fact that PAD is illegal in most states prevents open discussion between patients and physicians and in public discourse. Legalization of PAD would promote open discussion and may promote better end-of-life care as patients and physicians could more directly address concerns and options.

**What are the arguments against physician aid-in-dying (PAD)?**

Those who argue that PAD is ethically impermissible often offer arguments such as these:

1. **Sanctity of life:** Religious and secular traditions upholding the sanctity of human life have historically prohibited suicide or assistance in dying. PAD is morally wrong because it is viewed as diminishing the sanctity of life.
2. **Passive vs. Active distinction:** There is an important difference between passively "letting die" and actively "killing." Treatment refusal or withholding treatment equates to letting die (passive) and is justifiable, whereas PAD equates to killing (active) and is not justifiable.
3. **Potential for abuse:** Vulnerable populations, lacking access to quality care and support, may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage loved ones to opt for assisted death and the protections in legislation can never catch all instances of such coercion or exploitation. To protect against these abuses, PAD should remain illegal.
4. **Professional integrity:** Historical ethical traditions in medicine are strongly opposed to taking life. For instance, the Hippocratic oath states, "I will not administer poison to anyone where asked," and I will "be of benefit, or at least do no harm." Furthermore, some major professional groups such as the American Medical Association and the American Geriatrics Society oppose assisted death. The overall concern is that linking PAD to the practice of medicine could harm both the integrity and the public's image of the profession.
5. **Fallibility of the profession:** The concern here is that physicians will make mistakes. For instance there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus the State has an obligation to protect lives from these inevitable mistakes and to improve the quality of pain and symptom management at the end of life.

**Is physician aid-in-dying (PAD) illegal?**

Physician aid-in-dying is legal in Oregon, Washington, and Vermont, where voter-approved initiatives or legislative action have legalized aid-in-dying under very specific circumstances. A Montana lower court has also determined that physician aid-in-dying is permitted under Montana's State Constitution; this decision was upheld by the Montana State Supreme Court in December 2009.   
   
In other states, without specific legislative authority or a court decision, physician aid-in-dying would most likely be considered illegal, and in many states is explicitly illegal.  
The citizens of Oregon passed Measure 16, the Oregon Death with Dignity Act, on November 16, 1994 by a margin of 51.3% to 48.7%. Opponents immediately challenged the law and it was not enacted. In response, the Oregon Legislature referred Measure 51 (a law to repeal Measure 16) for a public vote. That measure was defeated by 60% of the votes in 1997. Thus, physician-assisted dying has been legal in the state of Oregon since 1997. In November 2008, the citizens of Washington state passed I-1000, The Washington State Death with Dignity Act (DwDA) by a margin of 57.8% to 42.2%, and it went into effect on March 5th, 2009. On May 20, 2013, PAD was legalized in Vermont when the governor signed a bill that was passed by the state legislature. Similar legislation was been introduced in 2013 and 2014 in Connecticut, Hawaii, Kansas, Massachusetts, New Hampshire, New Jersey and Pennsylvania; none of these states has yet to approve these bills.

The laws in all three states have strict patient eligibility criteria, limiting access to competent, legal residents of the state over age 18, with a terminal illness (defined as an estimated life expectancy of 6 months or less) that is confirmed by two independent physicians. There is a requirement for two oral requests with a 15-day waiting period in between, as well as a written request that must be witnessed. Prescriptions may be written no less than 48 hours after the receipt of the written request. Patients must be able to self-administer the medications (i.e., have the mental and physical capacity to take the medications on their own). Providers may decline to prescribe medication under the Act.

Several major court decisions have been made regarding this issue. In the case of [Washington v. Glucksberg](http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=96-110), the plaintiffs argued that prohibitions against suicide impinged on an individual’s right to liberty, as stated in the due process clause of the 14th Amendment. The Ninth US Circuit Court of Appeals upheld this argument, but this decision was later overturned by the United States Supreme Court. In another case, [Vacco v. Quill](http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=95-1858), the Second Circuit Court found a New York law prohibiting assisted suicide was in conflict with the equal protections clause of the 14th amendment, which says that no state shall "deny to any person within its jurisdiction the equal protection of the laws." The Court held that competent patients were being treated differently than incompetent patients. The US Supreme Court declined to find a federal constitutional right to “assisted suicide”, and made a legal distinction between refusal of treatment and PAS. The Court also left the decision of whether to legalize PAS up to each individual state.

There have been high-profile cases related to specific incidents of aid-in-dying. One involved Dr. Timothy Quill (of Vacco v. Quill) who was investigated but not indicted for his participation in the suicide of a patient after he published his account of the incident. Another involved Dr. Jack Kevorkian who claimed to have assisted over 100 patients in death, and was acquitted on murder charges on multiple occasions. In November 1998, he and his patient, 52 year-old Thomas Youk, who suffered from Amyotrophic Lateral Sclerosis (ALS-otherwise known as Lou Gehrig's Disease) appeared on the TV show 60 Minutes where Dr. Kevorkian administered a lethal injection. As a result of the show, Kevorkian was tried for first degree murder in Oakland County, Michigan. Prosecutors argued that, in administering a lethal injection to Youk, his actions constituted euthanasia rather than PAD. Kevorkian was convicted of second degree murder in 1998, sentenced to a 15-25 year term of which he served 8 years, and was released in 2007.

**What does the medical profession think of physician aid-in-dying (PAD)?**

Surveys of individual physicians show that half believe that PAD is ethically justifiable in certain cases (Cohen et al., 1994). However, professional organizations such as the American Medical Association have generally argued against PAD on the grounds that it undermines the integrity of the profession.

Surveys of physicians in practice show that about 1 in 5 will receive a request for PAD sometime in their career (Back et al., 1996; Meier et al., 1998). Qualitative research has shown that requests for PAD bring up sensitive issues and emotions. Physicians stated that the discussion around these issues was lengthy and included patient and physician concerns about depression, pain and symptom management, issues of control, and exploration of the fear of abandonment (Back et al., 2002; Dobscha et al., 2004; Ganzini et al., 2000, 2001).

**What should I do if a patient asks me for physician aid-in-dying (PAD)?**

One of the most important aspects of responding to a request for PAD is to be respectful and caring. Virtually every request represents a profound event for the patient, who may have agonized over his situation. The patient's request should be explored, to better understand its origin and to determine if there are other interventions that may help ameliorate the concerns that motivated the request. In most cases, there are alternatives in palliative and hospice care that likely will address most of the patient’s concerns. Palliative care physicians recommend the following process for evaluating and responding to requests (Emanuel, 1998; Quill & Arnold, 2008a, 2008b).

1. Wait to directly respond to the request until you have explored the reasons for the patient’s request.  Discuss various ways of addressing the patient’s pain, suffering, hopes, and fears.  If time permits, tell the patient that you would like to talk more about this at a subsequent appointment. That gives both you and the patient time to prepare for a fuller exploration of PAD as well as other palliative treatments, hospice, etc.
2. Evaluate for depression or other psychiatric conditions and treat appropriately.
3. Assess the patient’s decision-making competence.
4. Engage in discussion surrounding the patient’s diagnosis, prognosis, and goals for care. Make sure to assess patient understanding.
5. Evaluate patient’s physical, mental, social, and spiritual suffering. Be sure to take into account the patient’s support system as well as personal and professional pressures and stressors.
6. Discuss all alternative options, such as palliative care and hospice.
7. Consult with professional colleagues regarding the patient’s situation. Where appropriate, ask for help from a palliative care specialist to assure that all options have been explored.
8. Help the patient complete advance directives, DNR orders and POLST forms, as appropriate and ensure that preferences are followed.

**What if the request for physician aid-in-dying persists?**

If a patient's request for aid-in-dying persists, each individual clinician must decide his or her own position and choose a course of action that is ethically justifiable and legally permissible. It is useful to carefully reflect on and think through where you stand on the issue and be prepared to openly discuss your position with the patient, acknowledging and respecting difference of opinion when it occurs. Patients who ask for PAD-in states where it is legal or illegal-understand that physicians will have different opinions about what they can and should do. The most important thing is to be clear and transparent about your position. Even in states where it is illegal, some physicians will decide to help their patients, particularly when patients are enduring unbearable suffering. While we cannot condone this practice, we must recognize its occurrence and the reasoning behind it. No physician, however, should feel forced to provide assistance if he or she is morally opposed to PAD.

**What are the attending physician’s duties and responsibilities under the Washington Death with Dignity Act?**

1. Confirm the following eligibility criteria:
   * Washington State resident
   * Age 18 and older
   * Competent (able to make and communicate an informed decision to health care providers)
   * Terminally ill (incurable, irreversible disease expected to cause death within six months, as determined by the attending physician and a consulting physician)
   * Able to voluntarily express his or her wish to die
2. Assure that it is an informed decision, which means the patient has an appreciation of the relevant facts, after being fully informed about the following:
   * Medical diagnosis
   * Prognosis
   * Potential risks associated with taking the prescribed medication
   * Probable result of taking the prescribed medication
   * Feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
3. Evaluate the patient's request:
   * Assess reasons,
   * Explore and recommend alternatives (palliative care, hospice, pain/symptom management, psychosocial and/or spiritual counseling, palliative sedation).
4. Counsel patient about the following:
   * Opportunities to rescind request at any time.
   * Recommend notifying next of kin.
   * Importance of having another person present and not taking medications in a public place.
5. Refer to a consulting physician, who reviews the medical record and interviews the patient to confirm the diagnosis, and confirm that the patient is competent and is making a voluntary request.
6. Refer to a counselor if concerned about a psychiatric or psychological disorder or depression causing impaired judgment.
7. Work with pharmacists to prescribe/get medications.
8. Document all steps in the medical record.
9. Sign the death certificate.
   * List the underlying terminal disease as the cause of death.
10. Send a copy of the dispensing record to DOH within 30 days” (Starks, Dudzinski, & White, 2013).

Starks, H., Dudzinski, D., White, N. (2013). Ethics in Medicine: Physician aid-in-dying, University of Washington, Retrieved from, <https://depts.washington.edu/bioethx/topics/pad.html>

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Patient assisted suicide refers to when a patient intentionally and willfully ends his or her own life with the assistance of a third party. What I found interesting the text stated this assistance may encompass different levels of involvement, for merely providing information about how to commit suicide to providing the means to commit suicide, such as a lethal quantity of pills (Morrison E. &., 2014). Another term tossed around in health care is physician aid-in-dying (PAD) refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life.

As with many of the topics we have discussed, there are principles of ethics involved. One principles of ethics to consider when responding to a patient’s request for assisted-suicide is the principle of autonomy, which is the ability to decide for oneself. In essence, this ethical principle is an extension of the ethical principle of beneficence because a person who is independent usually prefers to have control over his life experiences in order to obtain the lifestyle that he enjoys (Rainbow, 2015). Heath care workers are faced with patients requesting assisted-suicide and it is important to understand how these situations should be handled.

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**COURSE HERO**

**“Abstract**

Does the process of dying have to be slow, painful, and undignified? Proponents for assisted suicide argue that suffering in dying is a plight that many doctors and nurses force on their unwilling patients. How should health professionals respond when a patient dying of an incurable disease begs for a quick and easy death? The nurse’s role in assisted suicide is an issue that should concern all nurses. The author examines the background of the arguments for and against assisted suicide. By putting these components into perspective and examining relevant issues, possible resolutions are proposed.

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**Introduction**

A slow, painful, undignified death is a fate that most of us would not wish on our worst enemies. Proponents for assisted suicide argue that suffering in dying is a plight that many doctors and nurses force on their unwilling patients. When a patient dying of an incurable disease begs for a quick and easy death, how should health professionals respond? The question of assisted suicide, and in particular the nurse’s role in assisted suicide, is a topic that concerns all nurses. A look at the background, the arguments for, and the arguments against assisted suicide may suggest answers.

By definition, assisted suicide is a type of *euthanasia* or "good death," a term associated with ending a patient’s suffering by causing death (Webster, 1995). Euthanasia is categorized as either active or passive. *Active euthanasia* or "mercy killing" refers to actions taken with the intention of ending a patient’s life (Potter, 1997). Active euthanasia is illegal in most settings, and some people consider it to be the same as murder. *Passive euthanasia* refers to allowing a patient to die, making no attempt to hasten or prolong the process even if the means are available (Potter, 1997). Allowing a patient to refuse life sustaining treatment and removing a feeding tube at the patient’s request are examples of passive euthanasia. The patient will die, but the cause will be a natural process.

It is called *suicide* when a person takes his or her own life, and *assisted suicide*when a person helps another to take his or her own life. Assisted suicide straddles the line between active and passive euthanasia. The caregiver generally provides the means of death, but the patient takes the action. The term *assisted* has many shades of meaning; some examples of how it moves from passive to active may help to explore the ethical controversy. Example one: A physician assists by writing a prescription for a lethal drug, knowing that the patient plans to kill himself. Example two: A nurse assists by leaving the prescribed lethal drug at the patient’s bedside. Example three: A patient is very weak and has difficulty with purposeful movement. The nurse assists the patient by placing the medication in the patient’s hand, helping the patient place the medication in the mouth, and holding a straw to the patient’s lips to allow drinking fluid and swallowing the lethal medication.

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**The Case for Assisted Suicide**

A basis question that must be asked is why do patients request assistance in suicide? In an editorial in the New England Journal of Medicine, Scanlon (1996) writes, "It represents not only the ultimate claim to self-determination, but also a response to the egregious inadequacies and inhumanity that often characterize the care of the dying and critically ill" (p. 1401). The ANA (1994) position paper on assisted suicide states that "requests for assisted suicide can be related to numerous factors including unrelieved pain and other symptoms, depression, feelings of loss of control, fear of isolation, concern for family and a sense of hopelessness" (p. 3). The American Society of Clinical Oncology Task Force on Cancer Care at the End of Life states that "patients fear a lonely, painful, inhumane, technological attempt to delay or counter forces of nature that cannot be altered, and that the process of their dying will be out of their control" (Schnipper, 1998, p. 1987). Therefore, it seems clear that patients request, even beg for assistance in dying, not because they desire death, but because the alternative is so repugnant.

"The central argument supporting assisted suicide is based on respect for patients’ autonomy" (Haddad, 1997, p. 18). The United States judicial system has consistently confirmed the patient’s right to decide his or her life’s course and the patient’s right to die. With the 1976 Quinlan case and the 1990 Cruzan case the right to refuse treatment became law. The Patient Self-Determination Act of 1991 required hospitals to inform patients of their right to refuse treatment, order ongoing treatment halted, and refuse future treatment even if these refusals will result in death. Assisted suicide may be seen as a logical extension of the patient’s right to self-determination.

Additional ethical arguments involve the principles of beneficence and nonmaleficence. With modern medicine focused on curing disease it is an unfortunate reality that when a cure is no longer possible, many patients are left to suffer horribly as they live out their last days with little or no relief. The patient, the family, and the nurse caring for the patients are all affected. Healthcare professionals often avoid dealing with these patients, and physicians worried about legal issue are reluctant to prescribe sufficient amounts of pain medication (Alspach, 1997). Why should the patient be forced to endure such agony when it is not necessary? "If dying patients have no rights in relation to the timing and means for terminating their life, does this imply that they have the obligation to die slowly? To die painfully? To die devoid of dignity: To die financially impoverished?" (Alspach, 1997, p. 16). The ANA (1994) recognizes the problem even as it disagrees with assisted suicide:

Nurses witness firsthand the devastating effects of debilitating and life-threatening disease and are often confronted with the despair and exhaustion of patients and families. At times, it may be difficult to find a balance between the preservation of life and the facilitation of a dignified death. Nurses need to recognize their own feelings of sadness, fear, discouragement and helplessness and realize the influence of these feelings on clinical decision making. These agonizing tensions may cause a nurse to consider intentionally hastening a patient’s death as a humane and compassionate response, yet the traditional goals and values of the profession militate against it (p. 2).

Supporters of assisted suicide argue that it is a violation of the principal of nonmaleficence, that it is doing harm, to allow a patient to remain in pain when death is requested and the means is available (Kaveny, 1997).

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**Case Against Assisted Suicide**

The participation of health care workers in patient suicide is troubling for many reasons. Among these reasons are a fear of escalating use, a belief that patients would not choose death if better palliative care were available, and the moral-ethical unwillingness of most nurses to participate in patient suicide (Wlody, 1997). Churchill and King (1997) noted the following in the British Medical Journal:

The most widely feared abuse associated with the legalization of physician assistance in death is the gradual extension of such practices to include those not terminally ill, and the expansion of physician activity beyond assisted suicide to active euthanasia, both non-voluntary [when patients are unable to request or consent] and involuntary [when patients are competent but do not request or consent]. (p. 138)

This concern is known as the "slippery slope." At this time only patients in the terminal stages of incurable illness are considered candidates for assisted suicide. Once the prohibition against taking a life is lifted, once death becomes a choice, what is the stop this choice from being offered to others? Kavney (1997) asks the questions, "First, by what rationale may this liberty interest be limited to the terminally ill? Is not the interest equally if not more important to those afflicted with severely debilitating chronic diseases, since they fact a longer period of suffering?" (p. 129). Factors such as caregiver convenience and economic priority could intrude into the decision-making process. Persons with durable powers of attorney would be able to decide that their patient with Alzheimer’s disease or on a ventilator would not want to live further. "Studies have shown that most health-care costs can be traced to expenses incurred in the last months of life. Employers and insurance companies could achieve great financial savings by encouraging patients to choose assisted suicide at the ‘appropriate’ time" (Kavney, 1997), p. 130). This slope is indeed slippery.

The practice of medicine with its emphasis on cure can often come in conflict with the practice of caring. When a cure is no longer possible, the cure vs. care controversy becomes crucial. Offering a patient an early death may be an acceptable medical alternative, but is it an acceptable nursing alternative? Can nurses fit assisted suicide into their moral and ethical foundation? Assisted suicide may lessen suffering, but can it be considered caring or healing?

Nurses are consistently oriented to the provision of care that promotes well being in the people served (ANA, 1995). In 1980, the American Nurses Association (ANA) defined *nursing* as "the diagnosis and treatment of human responses to actual or potential health problems" (Potter & Perry, 1997, p. 216.) In 1995, the ANA expanded the definition of nursing to include:

"…attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation; integration of objective data with knowledge gained from an understanding of the patient or group’s subjective experience; application of scientific knowledge to the process of diagnosis and treatment; and provision of a caring relationship that facilitates health and healing" (p. 6).

The preamble to the *ANA Code for Nurses: With Interpretive Statements* tells us that nursing judgement is based on universal moral principles such as autonomy [self-determination], beneficence [doing good], nonmaleficence [avoiding harm], and justice [treating people fairly]. "The most fundamental of these principles is respect for persons" (ANA, 1985, p. 1). The ethical dilemma for nurses lies in the tug-of-war between the ethical principles of autonomy and beneficence/nonmaleficence.

Despite the arguments that patients have the right to suicide based on self-determination, that right does not extend to nurse assistance in suicide. An editorial in the *National Catholic Reporter* declared, "It is emblematic of a cultural extreme in which individualism and individual autonomy is the good, outweighing any connection to community – even family – or any obligation to the larger society" (Anonymous, 1997, p. 28). Patients do not desire death for its own sake. Rather, they see death as the better alternative to pain and loss of control. This response to a health problem can be treated in other ways. "Nurses may provide interventions to relieve symptoms in the dying client even when the interventions entail substantial risks of hastening death" (ANA, 1985, p. 4). The widely accepted doctrine of "double effect" generally states that treatments often have both desired or good effects and undesired or bad effects. As long as the purpose of the treatment is the good effect – to minimize pain or enhance quality of life – it is acceptable, even if it speeds the process of death. The key is intent. A lethal dose of morphine given to stop a patient’s pain is permissible, while the same dose given to cause death is not. The line has been drawn. Actions that allow death to happen in due course are acceptable. Actions taken to deliberately cause the death of a patient cross the line and are not ethically, morally, or legally acceptable.

The moral-ethical reluctance that nurses feel about assisted suicide is related to who they are and what they stand for. How can an ethical nurse, dedicated to healing, participate in an act that purposely ends a patient’s life? (Volker, 1998) writes, "a request for [assisted suicide] is a potential response to illness. Whether assisting a dying patient to end his or her life constitutes healing is debatable, and opinions in this regard may vary depending on the perspectives and values of individual nurses and patients" (p. 43). Assisting in a patient’s suicide does not have to be an acceptable nursing intervention. "Furthermore," Kaveny (1997) says, "there is a reason to question whether the availability of assisted death will give physicians, as well as members of the broader medical community [including nurses] an excuse for not remedying profound inadequacies in the way the U.S. health-care system currently manages end-of-life issues" (p. 131).

The legal issue may no longer impede nurses from participating in assisted suicide, and the ethical-moral issues will be come all the more important. The Supreme Court recently ruled in Vacco v. Quill (1997) to uphold a New York State law banning assisted suicide. The court found that there is no fundamental right to assisted suicide. However, the court also seems to have left it up to the states to decide whether assisted suicide should be legal. The Oregon Death with Dignity Act allowing assisted suicide became state law in 1994. Other states are considering similar legislation, and some may follow Oregon’s lead. Morally and ethically, most nurses do not agree with assisted suicide. Wlody (1997) examined several international studies and found that "common threads include the compassion nurses feel for patients’ suffering and the finding that most nurses state that they do not and would not participate in assisted suicide (or euthanasia)" "p. 75). Even if an action is legal, it is not necessarily moral or ethical.

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**Summary**

The question of assisted suicide presents a dilemma for doctors, patients, and nurses alike. The ethical dilemma of assisted suicide revolves around the conflict between the patient’s right to autonomy and the nurse’s ethical duty to the principles of beneficence and nonmaleficence. Assisted suicide does not have to become the only option to terminal illness. Rather than focusing our energy on helping patients to die, nurses and doctors could aggressively pursue palliative care options that support an end of life with dignity. Unrelieved pain and loss of personal control are frequent reasons for requesting assisted suicide. If these can be mitigated, requests should be much rarer. The laws are changing and the slope is slippery, but the majority of nurses believe that they should not participate in assisted suicide. The position of the ANA (1994) is that "nurses are obliged to provide relief of suffering, comfort and, when possible, a death that is congruent with the values and desires of the dying person. Yet, nurses must uphold the ethical mandates of the profession and not participate in assisted suicide" (p. 5). The American Association of Critical-Care Nurses’ (1996) position is even more specific: "The profession’s position is that nurses should not participate in acts of assisted suicide and active euthanasia. Such acts are inconsistent with the ethical norms of the profession and undermine the integrity of individual practitioners and the care they render: (p. 2).

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**Recommendations**

Nurses can become active, aggressive patient advocates for better palliative care – even if the end result is a shorter life. Another option that deserves consideration is hospice, a philosophy of care that provides support for the patient while allowing death with dignity. Nurses must remain dedicated to caring for patients and dedicated to promoting maximum health, even in the midst of terminal illness”. (Dyer, n.d.).

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Dying With Dignity: Reasons to support choice.

“The majority of Australians believe that a person suffering from a terminal illness is entitled to effective treatment of symptoms and should be able to make key decisions about when and how they die.

This majority of about 85% - demonstrated by numerous polls over the last two decades - supports the enactment of legislative change to enable the right to choose the timing and circumstances of one’s death, and to ensure that members of the medical profession and other health carers are not at risk of criminal charges in providing end-of-life assistance.

Parliaments, both Federal and State, must move to enact legislative change to ensure access to and protection of this fundamental human right of choice.

| **Susie Byrne Convenor, SA Nurses Supporting Choices in Dying** |
| --- |
| https://www.dwdv.org.au/sb_cache/aboutus/id/108/f/SusieByrne.jpg  *''Our group, SA Nurses Supporting Choices in Dying was formed in South Australia in March 2010 to provide a forum for the nursing voice and perspective on the legislation of voluntary euthanasia and other patient choices in end of life care. We passionately support our patient's right to autonomy throughout every stage of life and most importantly the right to be able to choose the most appropriate when end of life approaches. We believe that voluntary euthanasia should also be included in these choices. We are honoured to be included as Ambassadors for Law Reform''.* |

| Phillip Adams Yvonne Allen Lynette Allison Prof Dennis Altman AM Valma Angliss AM Robyn Archer AO Bettina Arndt Brenda Aynsley OAM Rev Gordon Bannon Ron Barassi AM Greg Barns Prof Peter Baume AC Layne Beachley AO Emeritus Prof David Beanland AO Frances Bedford MP JP John Bell AO | Casey Bennetto Trevor Bensch Henry Bosch AO Dr Sandra Bradley Dr Edward Brentnall MBE OAM Bob Brown Julian Burnside AO QC Susie Byrne Dr Leslie Cannold Dr Nick Carr Prof Lyn Carson Moss Cass Tricia Caswell Joy Chambers-Grundy Prof Simon Chapman AO Hon Robin Chapple |
| --- | --- |

| **Prof Simon Chapman AO Public health researcher & advocate** |
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| https://www.dwdv.org.au/sb_cache/aboutus/id/110/f/SimonChapman.jpg*''My mother, Margaret, died in 1984 when her primary breast cancer metastasised into her lungs. She was just 64. Over about six weeks her breathing became progressively shallow, until over the last long days, she slowly suffocated to death. Oxygen was the only support available to her. She was not in pain, but no palliative care could be offered to relieve her growing panic and confusion. As has often been said, we help our pets to better deaths. I edited a book in 1995, The Last Right: Australians Take Sides on the Right to Die (available free here*[*http://ses.library.usyd.edu.au//bitstream/2123/10762/2/TheLastRight.pdf*](http://ses.library.usyd.edu.au/bitstream/2123/10762/2/TheLastRight.pdf)*) where over 60 Australians on different sides of the voluntary euthanasia debate wrote essays''.* |

| Hon Stephen Charles QC Emeritus Prof Alf Clark Greg Combet AM Everald Compton Peter Couchman Prof Nick Crofts Peter Cundall AM Rev Natasha Darke Kenneth Davidson Rev Dr Craig de Vos Catherine Deveny Hon John Dowd AO QC Prof Gary Dowsett Denise Drysdale | Prof the Hon Gareth Evans Hon Elizabeth Evatt AC Dr Ilsa Evans Dr June Factor Prof Ross Fitzgerald AM Tamara Fraser AO Patrick Galvin AM Max Gillies AM Brian Goldsmith Sandy Gore John Greenwell Dr Julian Hafner Prof George Hampel QC Peter Hardham |
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| **Iola Mathews OAM Author** |
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| https://www.dwdv.org.au/sb_cache/aboutus/id/128/f/Matthews_Iola.jpg  *''I support law reform because of the end-of-life experience of my parents, who were both members of DWDV (then VESV). At 85 my father had a massive brain stroke, but his wishes were ignored, until we sought the help of Rodney Syme (see chapter 10 of Rodney’s book A Good Death). My mother had a major stroke at 95 and a doctor ignored her wishes, with the result that she lived (unhappily) to nearly 100. I have told her story in my book: My mother, my writing and me: a memoir''.* |

| Robert Hewett Janet Holmes a Court AC David Hume and Maya Hume OAM Dr David Hunt Peter Isaacson AM Dr Warren Johnson AM Rosemary Jones Hon Sandra Kanck Prof David Kelly Stephen Kenny | Hon Steph Key MP Mary Kostakidis Assoc Prof Helga Kuhse Coral Levett MACN Hon Anne Levy Dr Murray Lloyd Amanda Lohrey Paul McDermott Lindsay McDougall Judith McGrath |
| --- | --- |

| **Prof George Williams Anthony Mason Professor of Law, Uni. of NSW** |
| --- |
| https://www.dwdv.org.au/sb_cache/aboutus/id/130/f/GeorgeWilliams.jpg  *''I believe that the law should allow each person the freedom to choose how they live their life. This must extend to how their life ends''.* |

| Prof Peter McIntyre AO Emeritus Prof Carmel McNaught Hilary McPhee AO Hon Rod Mackenzie OAM Dr Francis Macnab AM Hon Ian Macphee AO Prof Marion Maddox Eve Mahlab AO | Iola Mathews OAM Ron Merkel QC Gordon Moffatt AM Prof Rob Moodie AM Val Morgan Hon Jocelyn Newman Amy Orange |
| --- | --- |

| **Prof Emeritus John Willoughby** |
| --- |
| https://www.dwdv.org.au/sb_cache/aboutus/id/132/f/Willoughby_John.png  *''Two reasons motivate my willingness to be a DWDV Ambassador. Firstly, and obviously, voluntary assisted dying is powerfully justified by some of the rare exigencies of life, namely, pain or suffering without possible relief. I've observed such situations. The second is the important public expression of the fact that medical practitioners, like me, can be found who also see voluntary assisted dying as ethically valid and who support legislation of voluntary assisted dying. This view is contrary to the often-held view that medical professions are opposed to legalisation''.* |

| Prof Neville Pamment Emeritus Prof Malcolm Parker Hon Mark Parnell The Hon Tom Pauling AO QC Kirk Pengilly Frank Penhalluriack Marshall Perron Anne Phelan OAM | Prof Peter Pierce and Mrs Rae Pierce AM Adrian Price Chris Puplick AM Rev Kenneth Ralph Bill Richmond Robert Richter QC Rev Christopher Ridings Roland Rocchiccioli |
| --- | --- |

| **Ian Wood Co-founder Christians for VE Choice** |
| --- |
| https://www.dwdv.org.au/sb_cache/aboutus/id/120/f/IanWood.jpg*''I became publicly involved in lobbying for assisted dying in 2009 after seeing a photo of Chantal Sebire pleading for assistance to die. Chantal suffered from a rare form of nasal cancer, leaving her blind and her jaw disintegrating. I knew there had to be better ways of dying. I was also aware that opposition by some Christian hierarchy is a major reason why we do not have compassionate choice now. I therefore co-founded Christians Supporting Choice for Voluntary Euthanasia, together with Rev Trevor Bensch, to give a voice for the silent majority of Christians who do support this issue''.* |

| Prof Doreen Rosenthal AO Dr Harry Rundle Delys Sargeant AM Prof Rick Sarre Hon Chris Schacht Prof Peter Singer AC Dick Smith AO Jim Soorley Prof John Spicer Tracey Spicer Dr John Stanton | Anne Summers AO Dr Rodney Syme John Valder AO Lesley Vick Rev Dr Craig de Vos Prof Merrilyn Walton Dr Bruce Watson Prof Colin Wendell-Smith AO Prof George Williams Emeritus Prof John Willoughby Ian Wood |
| --- | --- |

**Peter Hardham  
Lawyer, Human Rights Advocate, former Ombudsman**

*The reason why I became an Ambassador for DWDV is that I believe that every individual should have the right, where possible, to choose their own dying process, and that this should be done with as much compassion and dignity as possible. It is also my belief that this process should be undertaken with the assistance and guidance of a suitably qualified and experienced member of the medical profession. I believe these views are consistent with the views of members of DWDV.*

(DWDV, 2017).

Dying with Dignity Victoria, (DWDV). (2017). Ambassadors lead the call for law reform, Retrieved from. <https://www.dwdv.org.au/about-us/ambassadors>

**What is PAD?**

* Assisted suicide is ending one’s life intentionally with the help of another person.
* Voluntary active euthanasia means that the patient freely chooses to have a lethal agent given by another person.
* Assisted death includes both assisted suicide and active euthanasia.

**Placing the Debate in Context**

* What is the physician’s professional obligation?
* Should physicians be helping people live life to its fullest potential?
* Should the quality of care at the end of life be improved?
* Should we provide a balance between what technology can do and a peaceful death?

**Ethical Argument: Autonomy**

* Supporters say that physician-assisted death honors integrity and allows the patient to define a “harm”.
* Opponents say that autonomy should be present in treatment, but it does not justify the decision to take a life.

**Ethical Argument: Compassion**

* Proponents feel that discussing assisted death often prevents suicide.
* Opponents remind us that suffering is unique to each person.
* To relieve suffering by ending the life of the sufferer is not acceptable.
* Physicians need to listen for the real reason for a request for assisted death.

**The Slippery Slope**

* Proponents support the need for guidelines to increase trust and the healing relationship.
* There is a need to consult with another physician on the matter.
* Documentation is essential.
* Opponents feel that the slippery slope is a real concern.
* Once the rules are relaxed, the vulnerable will not be protected against the physician.
* The guidelines and second opinions could actually be a hypocritical façade.

**Professional Integrity**

* Physicians are supposed to be healers.
* Assisting in suicide is opposed to that role and destroys moral integrity.
* The same could be said for other health care professionals.
* Those who support this option feel that the definition of integrity is too narrow.
* Professional integrity should also include relieving suffering and respect for a patient’s choices.
* Integrity could also include assisting patients to have a peaceful death.

**Substituted Judgment**

* What about patients who are no longer able to make decisions about end of life treatment?
* At present, physician-assisted death proposals exclude those who are not able to make their own decisions.
* Opponents worry that physician-assisted death could include even those who no longer can voice their preferences

**Steps for the Clinical Management of a Request for Assisted Death**

1. The provider should listen to the request for assisted death in an open and sympathetic manner and evaluate the issues underlying the request.
2. Providers should share their personal stance with patients in an open and professional manner, always assuring patients that they will be supported throughout this personal decision-making process.
3. All providers should take appropriate steps to process their personal emotional reactions to the patient’s request (e.g., hospice team meetings).
4. The provider should have a continuing dialogue with the patient and appropriate family members or support persons concerning the development and implementation of the therapeutic treatment plans, including a request for assisted death, in a manner that is consistent with the provider’s moral values and belief system.

**How Does One Manage This?**

* Listen and evaluate what you are hearing.
* What are the underlying issues?
* Be sincere and candid about your stance on this issue.
* Assure that there will be adequate comfort care.

Nelson, J.L. (2014). Theory of healthcare ethics. Morrison, E. & Furlong, B. (Eds). *Health care ethics:  Critical issues for the 21st century (pp. 185-194).* Burlington, MA: Jones & Bartlett Learning.

“First, what exactly do we mean by the term physician-assisted suicide?

Assisted suicide is the act of intentionally killing yourself with the aid of someone who provides the knowledge or the means to do so. Many people prefer the term [“physician aid-in-dying”](http://jama.jamanetwork.com/article.aspx?articleid=1861875) simply because the word suicide has negative connotations. (Suicide isn't illegal, but some people consider it immoral.) Physician aid-in-dying is distinct from euthanasia. In states that have approved physician aid-in-dying, doctors can provide patients with the medications that will end their lives, assuming they meet certain strict criteria, but physicians can’t administer the medication. A patient has to be able to take it on his or her own. Euthanasia is where a doctor, or another person, administers the medication. That’s illegal in the United States, although euthanasia is legal, with certain restrictions, in the Netherlands, Belgium, and Luxembourg.

In states that allow physician-assisted suicide, which patients qualify?

Patients have to be terminally ill, which by definition means their doctor believes they have six months or less to live. They have to be able to take the drug themselves. They must have the mental capacity to know what they are doing and what the consequences are. They have to make two verbal requests, 15 days apart, and one written request with two witnesses. And two doctors—an attending physician and a consulting physician—must verify that the patient meets all the criteria. There are a lot of hoops to jump through. It’s not an easy process. The rules are there to try to make sure patients aren’t coerced, and that they know what they are doing.

What are the main arguments for allowing doctors to hasten a patient’s death?

The basic question is one of autonomy. It’s my life. I should have the right to take my life when that seems like the proper and best thing to do. Suicide isn’t illegal. Doctors control the means—drugs that end life painlessly. Why should they be able to withhold them from me?

What about the arguments against assisted suicide?

Some people fear that it will become an ethical slippery slope. Once we allow physician-assisted suicide for competent people who are terminally ill and can take the medication on their own, it opens the way to offering it to people who are no longer mentally competent. And then to people who are in distress but not terminally ill, such as the [24-year-old depressed woman in Belgium.](http://www.msn.com/en-us/news/world/healthy-24-year-old-granted-right-to-die-in-belgium/ar-AAckxLg) Where does it stop? However, I’m not so concerned about the slippery slope. I think we can put safeguards in place, as we’ve done with the laws that have been passed.

The disabled community, through organizations like [Not Dead Yet](http://www.notdeadyet.org/), offers another argument. They insist that people should be given the right to live well before they are given the right to die with assistance. They worry that people may want to end their lives because they aren’t getting the help and support they need. That’s a legitimate concern that we should try to guard against. One way is to offer more and better support to people with disabilities so they may live life more fully. But there’s no evidence that people with disabilities are more likely than others to access physician aid-in-dying.

Another argument comes from people who work in [palliative care and hospice](http://aahpm.org/positions/pad). Many say that if good palliative care—controlling pain, shortness of breath, or nausea—were widely available and offered, patients wouldn’t choose physician-assisted suicide. And it’s true that palliative care medicine is very good at controlling these symptoms. But the experience in Oregon shows that nearly all of the people who received a prescription for aid-in-dying were in hospice at the time, and had access to palliative care. Most people who seek out aid-in-dying don’t do it because they are in pain or have other physical symptoms. They do it because they want to have control over how and when they die.

Lastly, there are religious arguments against suicide. The main idea here is the “sanctity of life”—the belief that life is precious and death should never be hastened. I can understand this point of view, but I think it should apply only to believers. Why should the rest of the population be held to this standard?

**ADVERTISEMENT**

Do the strict guidelines for physician aid-in-dying prevent some patients from getting the help they want at the end of life?

Absolutely. Consider the example of patients with ALS, commonly called [Lou Gehrig’s disease.](http://www.mda.org/disease/amyotrophic-lateral-sclerosis/medical-management/assistance-stages-of-als)Slowly but inevitably they lose all motor function, eventually including the ability to swallow or breathe. Along the way, they lose control of their arms. Physically, they can’t take a drug to end life. Someone would have to give it to them. That would be euthanasia, and that’s illegal. Or consider people with [Alzheimer’s disease.](http://www.berkeleywellness.com/healthy-mind/memory/article/should-you-be-tested-alzheimers) They may decide that they don’t want to live beyond a certain point—say when they can no longer recognize loved ones. But by the time they reach that point, they don’t have the mental capacity to make an informed decision to end life. Many people with a legitimate reason to want aid-in-dying can’t get it.

Does that pose an ethical dilemma?

There are all kinds of ethical questions to wrestle with. Why should someone who can move his or her arms be able to get physician aid-in-dying and someone who can’t be denied it? For that matter, why should someone have to be terminally ill? Why should someone who is suffering horribly, unremittingly, not have a right to physician aid-in-dying? Those are difficult questions to answer.

The legal issues are just as complicated. In the 1970s and 1980s, courts ruled that a patient (or his or her proper surrogate) has the right to say, “I don’t want this feeding tube or this ventilator” and those wishes have to be followed, even if it means the patient will die. We can make those wishes known in an [advance directive,](https://www.nlm.nih.gov/medlineplus/advancedirectives.html) and even at a time when we’re no longer able to speak or move, they still have authority. But refusing treatment, even treatment that will keep you alive, is different than taking a medication that will end your life. You can’t ask for physician aid-in-dying in an advance directive. Your spouse can’t say, “He wouldn’t have wanted to live like this” and ask a doctor to give you a medication to end life. Currently, that doesn’t fly.

We hear about some doctors prescribing pain medication that has the effect of hastening a patient’s death. How is that different?

Ethicists and theologians call that the [double effect](http://www83.homepage.villanova.edu/richard.jacobs/MPA%208300/theories/double%20effect.html). If a patient is suffering, a doctor can administer medication, in whatever doses are required to obtain relief. This might hasten that patient’s death, but the intention is to ease symptoms, not to kill someone. Ethically, giving good symptom relief is appropriate and right. If symptom relief leads to an early death, that’s an unfortunate second, unwanted effect; it wasn’t the intention. Among virtually all medical ethicists, including Catholic ones, that’s considered acceptable. And it is legal. But that’s distinct from giving a patient a medication specifically with the intention of ending life.

Oregon was the first state to legalize physician-assisted suicide. What have we learned from the experience there?

Under [Oregon’s Death with Dignity Act](https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx), 155 prescriptions were written for physician aid-in-dying in 2014. That’s the most ever, but it’s still not a lot. Typically, between 27 and 42 percent of the prescriptions are never taken. So a very small percentage of dying people in Oregon choose physician aid-in-dying—around 3 out of 1,000. Most are white, well-educated, and over 65. In 2014, 90 percent died at home. Ninety-three percent were on hospice care.

Why did they choose physician aid-in-dying? More than 91 percent said the reason was fear of losing autonomy. More than 86 percent said the reason was decreasing ability to participate in activities that make life enjoyable. More than 71 percent said they wanted to die with dignity. Significantly, pain and other symptoms do not top the list. Even less important are depression, financial issues, and lack of social support.

As a medical ethicist, what are your personal feelings about physician aid-in-dying?

I’m ambivalent. There are strong arguments on both sides. I voted for the first [California ballot measure for assisted suicide](https://ballotpedia.org/California_Proposition_161,_the_Aid-in-Dying_Act_(1992)) in 1992, but I definitely had misgivings. If we were to vote on it again, I probably would vote yes, with the same misgivings. I’m especially concerned about the arguments made by the disability community.

What do you say to people who fear being kept alive when they are terminally ill?

It’s become more and more clear that one way to hasten your own death is to [voluntarily stop eating and drinking](http://www.patientsrightscouncil.org/site/vsed-voluntarily-stopping-eating-drinking/). That’s the way we naturally die most of the time. If I were suffering and dying, and it was time to hasten the process, I would stop eating and drinking, assuming I had the mental capacity to make the decision. You don’t have to implicate a physician, or anyone else, in your death. And unlike taking a medication that kills you, you can change your mind, up to a certain point” (Jaret, 2016}.

Jaret, P. (2016, April 26). Is Physician-Assisted Suicide Ethical?*Berkley Wellness.*Retrieved from <http://www.berkeleywellness.com/healthy-community/health-care-policy/article/physician-assisted-suicide-ethical>

Perspective

End of life cases are often overlooked by many medical professionals because of their complexity and ethical challenges. It has been some time since the landmark decisions regarding Karen Ann Quinlan and Nancy Beth Cruzan were handed down, and since then, it has been reasonable to think that ethical issues central to these cases and others like them had been resolved. As medical professionals, we need to recognize that death is eminent and/or inevitable for many medical conditions despite aggressive treatments and interventions. It is because of this that end of life decisions and care begins with an honest discussion of disease progression and prognosis.

The prognosis of a patient with a life-limiting disease should be estimated according the best available medical data; as medical professionals, we should be honest and forthright in discussing this information with the patient and family. The prognosis of malignant diseases can usually be determined from the staging of the disease.

The prognosis of chronic nonmalignant diseases must be based on clinical progression as documented by serial medical assessments, or a nursing assessment of progression in homebound patients, and a recent decline in functional status as determined by clinical assessment, decreased performance test results, and a high dependence during the activities of daily living. Documented recent impairment of nutritional status related to the terminal process can also be utilized for assessment.**Objectives**

* Discuss the ethical issues presented by the use of fluids
* and nutrition in the dying patient.
* Present the ethical arguments for and against physician-assisted death.
* Examine the role of the family in the dying process and the ethical issues posed by their involvement.
* Examine the ethics of physician assisted suicide.

**Reading**

* Chapter 10: Ethical Issues in the Use of Fluids and Nutrition: When Can They Be Withdrawn?
* Chapter 11: Death, Medicine, and the Moral Significance of Family Decision Making
* Chapter 12: Ethical Issues Concerning Physician-Assisted Death

**Companion Site Activity**

For Module 4, you are required to complete at least two interactive exercises from the Navigate Companion website related to the assigned chapters within this module.

**In the News!**

For Module 4, watch the NBC Learn video: [“Talking About Death Can Bring End-of-Life Benefits.”](javascript:var%20newWnd=ObjLayerActionGoToNewWindow('%20https://archivesbb.nbclearn.com/portal/site/root/widget/8JehJhSz6wntIMu08VHkNsOgKn46kcOdVMPgl0G4vX6_PEyQABypX-RsSjMtgiL-dgwvKKfgys8YiaLTBaAm1tjpG0crIofGQtWN-s0MpEl9XjGl8n8dxTkmRUNmxAjZ5KSdM-CbxD3t-q23eVEoka1GzXXupBpK/62295','Trivantis_','width=1009,height=662,scrollbars=1,resizable=1,menubar=1,toolbar=1,location=1,status=1');)

After viewing the video, reflect on the questions below:

*Do you think that as a society, we are pushing terminally ill patients to make a quick decision regarding their care? Do you think this is ethically moral? What do you think the implications of these types of decisions are?*

*As a society, we are* *pushing terminally ill patients to make a quick decision regarding their care? Is this ethically moral?*

*What are the implications of pushing terminally ill patients to make a quick decision of these types of decisions?*

**“Background**    A patient’s request to a health care professional to help hasten death is not uncommon.  The motivation for this request is usually a combination of relentless physical symptoms, progressive debility, in combination with a loss of sense of self, loss of control, fear of the future, and fear of being a burden on others. Some physicians are frightened by these requests, feeling that they are being asked to cross unacceptable professional boundaries.  Others may be tempted to quickly accede, imagining that they would want the same thing in the patient’s shoes.  But requests for a hastened death may provide awareness into a patient’s experience of suffering, and may lead to opportunities for more effective treatment if fully evaluated.  In general, the clinician should clarify, explore, evaluate, intensify treatment, and support the patient to ensure a full understanding of the request and to ensure that all alternatives have been considered before responding. This Fast Fact provides guidance on how to evaluate and initially respond to a patient who raises the topic of a hastened death. Fast Fact #159 will explore how to respond when the request for a hastened death persists after a full evaluation and search for alternatives.

1. Clarify which question is being asked before responding.  Is the patient simply having thoughts about ending his life (very common), or is he exploring the possibility of a hastened death in the future if his condition deteriorates, or is he exploring your willingness to assist right now (1, 2)?
2. Support the patient, and reinforce your commitment to trying to find a mutually acceptable solution for the patient’s problem and to continue to work through the process.  This does not mean violating fundamental values, but it does mean searching in earnest with the patient and family to find a way to approach the dilemma (3).  Attend to your own support by discussing the patient with trusted colleagues and/or with your multidisciplinary team.
3. Evaluate the patient’s decision-making capacity.  Is she seeing her medical condition clearly?  Is the request proportionate to the level of unrelieved suffering?  Are there dominating aspects of anhedonia, worthlessness and guilt, or is the capacity for pleasure and joy preserved in some small ways? Is this request consistent with the patient’s past values?  Get help from an experienced psychiatrist or psychologist if you are unsure (4).
4. Explore the many potential dimensions that may contribute to the patient’s “unbearable” suffering to be sure you (and the patient) fully understand its underlying cause(s).  Sometimes in may be an unrelenting physical symptom, other times feelings of depression, or a family or spiritual crisis, or perhaps a combination of many factors (1, 2).
5. Respond to the associated emotions, which may be strong and conflicted.  Try to empathically imagine what the patient is going through and asking for.  Distinguish your own feelings and reactions from those of the patient.
6. Intensify treatment of any potentially reversible elements of the patient’s suffering.  Depending on the patient’s circumstances, offer to increase treatment of pain or other physical symptoms, consider biological or interpersonal treatment of depression; see if an appropriate and acceptable spiritual counselor is available.  Be creative and brainstorm potential solutions with your multidisciplinary team (1, 2).
7. Respond directly to the request for hastened death only after this multidimensional evaluation has been completed.  If the patient has full decision-making capacity and all alternative approaches to the patient’s unbearable suffering have been fully considered, then re-explore exactly what is being requested, and look for mutually acceptable ways to potentially respond – see Fast Fact #159 (5).  Note that many patients may be looking for the potential of an escape they will never use, but a smaller number will be looking for a way to hasten death in the present” (Quill, 2008).

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**“What is physician aid-in-dying?**

Physician aid-in-dying (PAD) refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life. (For related discussion, see also [End of Life Issues](http://depts.washington.edu/bioethx/topics/eol.html).)

**What role does language play in discussions of aid-in-dying?**

A variety of terms have historically been used to describe when a terminally ill patient uses a lethal dose of medication for the purpose of ending his or her life (or having control over the timing of death). Prior to the passage of the Oregon Death with Dignity Act in 1996, the term most often used was “physician-assisted suicide” (PAS). Those who use this term feel that it is an accurate reflection of the relationship between doctor and patient and refer to the etymological roots of suicide as “auto-killing” or “self-killing.” The use of this term ties the role of the physician to one that aids the patient in killing him or herself. However, implicit in the understanding of the word suicide is the notion of a premature death that is being hastened out of despair, therefore when mental illness impairs judgment, intervention to stop a suicide is ethically warranted because the person seeking suicide has lost his ability to carefully weigh the benefits and burdens of continued life. Generally speaking, persons who are suicidal are treated as though their decision-making capacity is compromised and health care providers often intervene and provide life-sustaining treatments (including involuntary psychiatric treatment) over the objections of the patient. Therefore, some people, including several national professional organizations\*, object to the term suicide for the choice of a terminally ill patient to hasten death, because of the associations between suicide and mental illness. They argue that, unlike the patients with impaired judgment who request suicide, terminally ill patients who request medication under the Act have the capacity to make a rational, autonomous decision to end their lives.

The term “physician aid-in-dying” is used to describe the practice authorized under the Washington, Oregon and Vermont Death with Dignity Acts and is meant to reflect the requirement that eligible persons must be decisionally competent and have a limited life expectancy of about 6 months or less. In this context, the term is meant to reflect that physicians provide assistance to patients who are otherwise going to die, and who seek help to control the timing and circumstances of their death in the face of end-of-life suffering they deem intolerable. While this term evades the mental health connotations associated with the word suicide, people who object to the use of “physician aid in dying” suggest that it could include other practices that are clearly outside the legal bounds of the three states’ Death with Dignity Acts, e.g. a patient who receives assistance in ingesting the medication, which would constitute euthanasia (see below). Here we use the term physician aid-in-dying to reflect the practice that is legal under the Washington Death with Dignity Act.

It is important to note that both terms, “physician assisted suicide” and “physician aid-in-dying” are value-laden and may reflect the speaker or writer’s political or ideological support for or objection to the practice. Recent research has detailed the need for open and honest discussion on end of life issues. This discussion should supersede any debate over the use of particular terms or language. Acknowledging the power of both historic and contemporary terminology, will help flesh out both sides of this sensitive and powerful debate.

\*The Oregon Department of Public Health, American Public Health Association, American Psychological Association, American Academy of Hospice and Palliative Care, American Medical Women’s Association, and the American Medical Student Association have adopted the term patient directed dying or physician aid-in-dying and have rejected the term physician-assisted suicide. Neither term is used in Oregon, Washington or Vermont Death with Dignity laws.

**Is physician aid-in-dying (PAD) the same as euthanasia?**

No. While both physician aid-in-dying and euthanasia involve the use of lethal medications to deliberately end a patient's life, the key difference is in who acts to administer the medications that will end the patient’s life. In physician aid-in-dying, the patient must self-administer the medications; the "aid-in-dying" refers to a physician providing the medications, but the patient decides whether and when to ingest the lethal medication. Euthanasia occurs when a third party administers medication or acts directly to end the patient’s life. Euthanasia is illegal in every state, including Washington.

Some other practices that should be distinguished from physician aid-in-dying include:

* **Withholding/withdrawing life-sustaining treatments:** When a competent adult patient makes an informed decision to refuse life-sustaining treatment, their wishes are generally respected. The right of a competent adult patient to refuse life-sustaining treatments is supported by law.
* **Pain medication that may hasten death:** Often a terminally ill, suffering patient may require dosages of pain medication that have side effects that may hasten death, such as impairing respiration. Using the ethical principle of double effect as the foundational argument, it is generally held by most professional societies, and supported in court decisions, that this action is justifiable. Since the primary goal and intention of administering these medications is to relieve suffering, the secondary outcome of potentially hastening death is recognized as an expected and acceptable side-effect in a terminally ill patient.
* **Palliative sedation:** This term refers to the practice of sedating a terminally ill patient to the point of unconsciousness, due to intractable pain and suffering that has been refractory to traditional medical management. Such patients are imminently dying, usually hours or days from death. Often other life-sustaining interventions continue to be withheld (CPR, respirator, antibiotics, artificial nutrition and hydration, etc.) while the patient is sedated. Palliative sedation may occur for a short period (respite from intractable pain) or the patient may be sedated until s/he dies. In the rare instances when pain and suffering is refractory to treatment even with expert clinical management by pain and palliative care professionals, palliative sedation may legally be employed.

**Is physician aid-in-dying (PAD) ethically permissible?**

The ethics of physician aid-in-dying continue to be debated. Some argue that PAD is ethically permissible (see [arguments in favor](https://depts.washington.edu/bioethx/topics/pad.html#favor)). Often this position is argued on the grounds that PAD may be a rational choice for a dying person who is choosing to escape unbearable suffering at the end of life. Furthermore, the physician's duty to alleviate suffering may, at times, justify providing aid-in-dying. These arguments rely on respect for individual autonomy, recognizing the right of competent people to choose the timing and manner of death in the face of a terminal illness.

Others have argued that PAD is not ethically permissible because PAD runs directly counter to the traditional duty of the physician to preserve life and to do no harm (see [arguments against](https://depts.washington.edu/bioethx/topics/pad.html#against)). Furthermore, many argue if PAD were legal, abuses would take place, as the social forces that condone the practice are a slippery slope that could lead to euthanasia. For instance, the disabled, poor or elderly might be covertly pressured to choose PAD over more complex and expensive palliative care options.

For more information on the debate around PAD please see [Euthanasia Pros and Cons](http://euthanasia.procon.org/).  
**What are the arguments in favor of physician aid-in-dying (PAD)?**

Those who argue that PAD is ethically justifiable offer the following arguments:

1. **Respect for autonomy:** Decisions about time and circumstances of death are personal. Competent people should have right to choose the timing and manner of death.
2. **Justice:** Justice requires that we "treat like cases alike." Competent, terminally ill patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering but who are not dependent on life support, such as respirators or dialysis, refusing treatment will not suffice to hasten death. Thus, to treat these patients equitably, we should allow assisted death as it is their only option to hasten death.
3. **Compassion:** Suffering means more than pain; there are other physical, existential, social and psychological burdens such as the loss of independence, loss of sense of self, and functional capacities that some patients feel jeopardize their dignity. It is not always possible to relieve suffering. Thus PAD may be a compassionate response to unremitting suffering.
4. **Individual liberty vs. state interest**: Though society has strong interest in preserving life, that interest lessens when a person is terminally ill and has strong desire to end life. A complete prohibition against PAD excessively limits personal liberty. Therefore PAD should be allowed in certain cases.
5. **Honesty & transparency:** Some acknowledge that assisted death already occurs, albeit in secret. The fact that PAD is illegal in most states prevents open discussion between patients and physicians and in public discourse. Legalization of PAD would promote open discussion and may promote better end-of-life care as patients and physicians could more directly address concerns and options.

**What are the arguments against physician aid-in-dying (PAD)?**

Those who argue that PAD is ethically impermissible often offer arguments such as these:

1. **Sanctity of life:** Religious and secular traditions upholding the sanctity of human life have historically prohibited suicide or assistance in dying. PAD is morally wrong because it is viewed as diminishing the sanctity of life.
2. **Passive vs. Active distinction:** There is an important difference between passively "letting die" and actively "killing." Treatment refusal or withholding treatment equates to letting die (passive) and is justifiable, whereas PAD equates to killing (active) and is not justifiable.
3. **Potential for abuse:** Vulnerable populations, lacking access to quality care and support, may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage loved ones to opt for assisted death and the protections in legislation can never catch all instances of such coercion or exploitation. To protect against these abuses, PAD should remain illegal.
4. **Professional integrity:** Historical ethical traditions in medicine are strongly opposed to taking life. For instance, the Hippocratic oath states, "I will not administer poison to anyone where asked," and I will "be of benefit, or at least do no harm." Furthermore, some major professional groups such as the American Medical Association and the American Geriatrics Society oppose assisted death. The overall concern is that linking PAD to the practice of medicine could harm both the integrity and the public's image of the profession.
5. **Fallibility of the profession:** The concern here is that physicians will make mistakes. For instance there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus the State has an obligation to protect lives from these inevitable mistakes and to improve the quality of pain and symptom management at the end of life.

**Is physician aid-in-dying (PAD) illegal?**

Physician aid-in-dying is legal in Oregon, Washington, and Vermont, where voter-approved initiatives or legislative action have legalized aid-in-dying under very specific circumstances. A Montana lower court has also determined that physician aid-in-dying is permitted under Montana's State Constitution; this decision was upheld by the Montana State Supreme Court in December 2009.   
   
In other states, without specific legislative authority or a court decision, physician aid-in-dying would most likely be considered illegal, and in many states is explicitly illegal.  
The citizens of Oregon passed Measure 16, the Oregon Death with Dignity Act, on November 16, 1994 by a margin of 51.3% to 48.7%. Opponents immediately challenged the law and it was not enacted. In response, the Oregon Legislature referred Measure 51 (a law to repeal Measure 16) for a public vote. That measure was defeated by 60% of the votes in 1997. Thus, physician-assisted dying has been legal in the state of Oregon since 1997. In November 2008, the citizens of Washington state passed I-1000, The Washington State Death with Dignity Act (DwDA) by a margin of 57.8% to 42.2%, and it went into effect on March 5th, 2009. On May 20, 2013, PAD was legalized in Vermont when the governor signed a bill that was passed by the state legislature. Similar legislation was been introduced in 2013 and 2014 in Connecticut, Hawaii, Kansas, Massachusetts, New Hampshire, New Jersey and Pennsylvania; none of these states has yet to approve these bills.

The laws in all three states have strict patient eligibility criteria, limiting access to competent, legal residents of the state over age 18, with a terminal illness (defined as an estimated life expectancy of 6 months or less) that is confirmed by two independent physicians. There is a requirement for two oral requests with a 15-day waiting period in between, as well as a written request that must be witnessed. Prescriptions may be written no less than 48 hours after the receipt of the written request. Patients must be able to self-administer the medications (i.e., have the mental and physical capacity to take the medications on their own). Providers may decline to prescribe medication under the Act.

Several major court decisions have been made regarding this issue. In the case of [Washington v. Glucksberg](http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=96-110), the plaintiffs argued that prohibitions against suicide impinged on an individual’s right to liberty, as stated in the due process clause of the 14th Amendment. The Ninth US Circuit Court of Appeals upheld this argument, but this decision was later overturned by the United States Supreme Court. In another case, [Vacco v. Quill](http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=95-1858), the Second Circuit Court found a New York law prohibiting assisted suicide was in conflict with the equal protections clause of the 14th amendment, which says that no state shall "deny to any person within its jurisdiction the equal protection of the laws." The Court held that competent patients were being treated differently than incompetent patients. The US Supreme Court declined to find a federal constitutional right to “assisted suicide”, and made a legal distinction between refusal of treatment and PAS. The Court also left the decision of whether to legalize PAS up to each individual state.

There have been high-profile cases related to specific incidents of aid-in-dying. One involved Dr. Timothy Quill (of Vacco v. Quill) who was investigated but not indicted for his participation in the suicide of a patient after he published his account of the incident. Another involved Dr. Jack Kevorkian who claimed to have assisted over 100 patients in death, and was acquitted on murder charges on multiple occasions. In November 1998, he and his patient, 52 year-old Thomas Youk, who suffered from Amyotrophic Lateral Sclerosis (ALS-otherwise known as Lou Gehrig's Disease) appeared on the TV show 60 Minutes where Dr. Kevorkian administered a lethal injection. As a result of the show, Kevorkian was tried for first degree murder in Oakland County, Michigan. Prosecutors argued that, in administering a lethal injection to Youk, his actions constituted euthanasia rather than PAD. Kevorkian was convicted of second degree murder in 1998, sentenced to a 15-25 year term of which he served 8 years, and was released in 2007.

**What does the medical profession think of physician aid-in-dying (PAD)?**

Surveys of individual physicians show that half believe that PAD is ethically justifiable in certain cases (Cohen et al., 1994). However, professional organizations such as the American Medical Association have generally argued against PAD on the grounds that it undermines the integrity of the profession.

Surveys of physicians in practice show that about 1 in 5 will receive a request for PAD sometime in their career (Back et al., 1996; Meier et al., 1998). Qualitative research has shown that requests for PAD bring up sensitive issues and emotions. Physicians stated that the discussion around these issues was lengthy and included patient and physician concerns about depression, pain and symptom management, issues of control, and exploration of the fear of abandonment (Back et al., 2002; Dobscha et al., 2004; Ganzini et al., 2000, 2001).

**What should I do if a patient asks me for physician aid-in-dying (PAD)?**

One of the most important aspects of responding to a request for PAD is to be respectful and caring. Virtually every request represents a profound event for the patient, who may have agonized over his situation. The patient's request should be explored, to better understand its origin and to determine if there are other interventions that may help ameliorate the concerns that motivated the request. In most cases, there are alternatives in palliative and hospice care that likely will address most of the patient’s concerns. Palliative care physicians recommend the following process for evaluating and responding to requests (Emanuel, 1998; Quill & Arnold, 2008a, 2008b).

1. Wait to directly respond to the request until you have explored the reasons for the patient’s request.  Discuss various ways of addressing the patient’s pain, suffering, hopes, and fears.  If time permits, tell the patient that you would like to talk more about this at a subsequent appointment. That gives both you and the patient time to prepare for a fuller exploration of PAD as well as other palliative treatments, hospice, etc.
2. Evaluate for depression or other psychiatric conditions and treat appropriately.
3. Assess the patient’s decision-making competence.
4. Engage in discussion surrounding the patient’s diagnosis, prognosis, and goals for care. Make sure to assess patient understanding.
5. Evaluate patient’s physical, mental, social, and spiritual suffering. Be sure to take into account the patient’s support system as well as personal and professional pressures and stressors.
6. Discuss all alternative options, such as palliative care and hospice.
7. Consult with professional colleagues regarding the patient’s situation. Where appropriate, ask for help from a palliative care specialist to assure that all options have been explored.
8. Help the patient complete advance directives, DNR orders and POLST forms, as appropriate and ensure that preferences are followed.

**What if the request for physician aid-in-dying persists?**

If a patient's request for aid-in-dying persists, each individual clinician must decide his or her own position and choose a course of action that is ethically justifiable and legally permissible. It is useful to carefully reflect on and think through where you stand on the issue and be prepared to openly discuss your position with the patient, acknowledging and respecting difference of opinion when it occurs. Patients who ask for PAD-in states where it is legal or illegal-understand that physicians will have different opinions about what they can and should do. The most important thing is to be clear and transparent about your position. Even in states where it is illegal, some physicians will decide to help their patients, particularly when patients are enduring unbearable suffering. While we cannot condone this practice, we must recognize its occurrence and the reasoning behind it. No physician, however, should feel forced to provide assistance if he or she is morally opposed to PAD.

**What are the attending physician’s duties and responsibilities under the Washington Death with Dignity Act?**

1. Confirm the following eligibility criteria:
   * Washington State resident
   * Age 18 and older
   * Competent (able to make and communicate an informed decision to health care providers)
   * Terminally ill (incurable, irreversible disease expected to cause death within six months, as determined by the attending physician and a consulting physician)
   * Able to voluntarily express his or her wish to die
2. Assure that it is an informed decision, which means the patient has an appreciation of the relevant facts, after being fully informed about the following:
   * Medical diagnosis
   * Prognosis
   * Potential risks associated with taking the prescribed medication
   * Probable result of taking the prescribed medication
   * Feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
3. Evaluate the patient's request:
   * Assess reasons,
   * Explore and recommend alternatives (palliative care, hospice, pain/symptom management, psychosocial and/or spiritual counseling, palliative sedation).
4. Counsel patient about the following:
   * Opportunities to rescind request at any time.
   * Recommend notifying next of kin.
   * Importance of having another person present and not taking medications in a public place.
5. Refer to a consulting physician, who reviews the medical record and interviews the patient to confirm the diagnosis, and confirm that the patient is competent and is making a voluntary request.
6. Refer to a counselor if concerned about a psychiatric or psychological disorder or depression causing impaired judgment.
7. Work with pharmacists to prescribe/get medications.
8. Document all steps in the medical record.
9. Sign the death certificate.
   * List the underlying terminal disease as the cause of death.
10. Send a copy of the dispensing record to DOH within 30 days” (Starks, Dudzinski, & White, 2013).

Starks, H., Dudzinski, D., White, N. (2013). Physician aid-in-dying: Ethics in medicine, University of Washington School of Medicine, Retrieved from, <https://depts.washington.edu/bioethx/topics/pad.html>

“The debate over physician-assisted suicide and voluntary euthanasia will soon reach its most important stage in this country. Last spring the Second and Ninth Circuit Courts of Appeals handed down momentous decisions striking down state laws in New York and Washington that forbid physician-assisted suicide. Although the [Second](http://www.tourolaw.edu/2ndcircuit/april96/95-7028.html) and [Ninth](http://www.law.vill.edu/Fed-Ct/Circuit/9th/opinions/9435534.htm) Circuit Court cases focus on physician-assisted suicide, and although there are important differences between physician-assisted suicide and [voluntary euthanasia](http://www.euthanasia.com/), the legal reasoning that would justify physician-assisted suicide would almost certainly extend to voluntary euthanasia. The intensity of the debate on both issues will grow during the wait for rulings this year by the Supreme Court, which has accepted the two circuit-court cases for review.

In physician-assisted suicide a doctor supplies a death-causing means, such as barbiturates, but the patient performs the act that brings about death. In voluntary euthanasia the physician performs the death-causing act after determining that the patient indeed wishes to end his or her life. Neither term applies to a patient's refusal of life-support technology, such as a respirator or artificial nutrition, or a patient's request that it be withdrawn; these have had ethical and constitutional sanction nationwide for years. And neither term applies to what is sometimes called indirect euthanasia, when the administration of drugs primarily for pain relief may have the secondary effect of causing death, as the physician is well aware. This practice, too, is ethically and legally sanctioned.

In formulating their decisions the circuit-court judges made a number of assumptions about the actual or likely circumstances surrounding cases of death by active intervention. Their judgments are based on misreadings of history, misinterpretations of survey data, mistaken reasoning, and simple misinformation.

**Myth No. 1**: It is primarily advances in biomedical technology—especially life-sustaining technology—that have created unprecedented public interest in physician-assisted suicide and voluntary euthanasia. "The emergent right to receive medical assistance in hastening one's death [is an] inevitable consequence of changes in the causes of death, advances in medical science, and the development of new technologies. Both the need and the capability to assist individuals [to] end their lives in peace and dignity have increased exponentially" (Ninth Circuit Court of Appeals).

Physician-assisted suicide and euthanasia have been profound ethical issues confronting doctors since the birth of Western medicine, more than [2,000 y ears ago](http://www.lcl.cmu.edu/phildept/ethicsintro/part3/Euthanasia.html). All the arguments made today to justify—or condemn—the two practices were articulated before any modern biomedical technology existed. The ancient[Hippocratic Oath](http://www3.medaccess.com/consumer/doctor/h_oath.htm) enjoins physicians to "neither give a deadly drug to anybody if asked for it, nor make a suggestion to this effect." The oath was written at a time when physicians commonly provided euthanasia and assisted suicide for ailments ranging from foot infections and gallstones to cancer and senility. Indeed, the Hippocratic Oath represented the *minority*view in a debate within the ancient Greek medical community over the ethics of euthanasia.

Even in America legalized euthanasia, rather than being a new issue, has been publicly debated and rejected—a fact the courts failed to mention. Modern interest in euthanasia in the United States began in 1870, when a commentator, Samuel Williams, proposed to the Birmingham Speculative Club that euthanasia be permitted "in all cases of hopeless and painful illness" to bring about "a quick and painless death." The word "painless" is important: the idea of euthanasia began gaining ground in modern times not because of new technologies for agonizingly prolonging life but because of the discovery of new drugs, such as morphine and various anesthetics for the relief of pain, that could also painlessly induce death. Over the next three decades Williams's proposal was reprinted in popular magazines and books, discussed in the pages of prominent literary and political journals, and debated at the meetings of American medical societies and nonmedical professional associations. The debate culminated in 1906, after the Ohio legislature took up "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons"—a bill to legalize euthanasia. The merits of the act were debated for months and were covered extensively in the pages of *The New York Times*, which vigorously opposed legalization, and in medical journals. The Ohio legislature overwhelmingly rejected the bill, effectively ending that chapter of the euthanasia debate.

Thus, decades before the discovery of penicillin (1928) and the development of mechanical respirators (1929), dialysis (1945), and other life-sustaining technologies, serious public discussions of physician-assisted suicide and euthanasia took place in the United States (and also in European countries). These discussions were couched in the same language we use today—"patients' rights," "the relief of pain and suffering," "the loss of dignity."

Indeed, rather than creating a perceived need for physician-assisted suicide and euthanasia, advances in life-sustaining technology should help to obviate them. Patients who are being kept alive by technology and want to end their lives already have a recognized constitutional right to stop any and all medical interventions, from respirators to antibiotics. They do not need physician-assisted suicide or euthanasia.

**Myth No. 2**: Legalizing physician-assisted suicide and euthanasia is widely endorsed. "There is unquestionably growing popular support for permitting doctors to provide assistance to terminally ill patients who wish to hasten their deaths" (Ninth Circuit Court of Appeals).

Yes, [polls](http://www.trinity.edu/~mkearl/death-5.html#eu) show that a majority of Americans support physician-assisted suicide and euthanasia—indeed, have supported legalizing them for almost twenty-five years. But the support is neither strong nor deep. Careful analysis of the polling data suggests that there is a "rule of thirds": a third of Americans support legalization under a wide variety of circumstances; a third oppose it under any circumstances; and a third support it in a few cases but oppose it in most circumstances.

Americans tend to endorse the use of physician-assisted suicide and euthanasia when the question is abstract and hypothetical. One formulation that has been used for almost fifty years and elicits widespread agreement is "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life if the patient and his or her family request it?" The question has several flaws, the most important one being that "to end the patient's life" is vague and specific neither to physician-assisted suicide nor to euthanasia. The phrase could mean simply stopping life-sustaining technologies that are keeping the patient alive, which is already legal.

Other, more carefully designed questions can elicit majority support for physician-assisted suicide and euthanasia, but only when patients are described as terminally ill *and*experiencing unremitting physical pain. Support dwindles when the public is asked about physician-assisted suicide and euthanasia in virtually any other situation. Two thirds of Americans oppose physician-assisted suicide or euthanasia when a terminally ill patient has no pain but wants to die because of concern about being a burden to his or her family, or because he or she finds a drawn-out dying process meaningless. The most accurate characterization of the survey data is that a significant majority of Americans oppose physician-assisted suicide and euthanasia *except*in the limited case of a terminally ill patient with uncontrollable pain.

**Myth No. 3:** It is terminally ill patients with uncontrollable pain who are most likely to be interested in physician-assisted suicide or euthanasia. "In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early" (Ninth Circuit Court of Appeals).

The empirical studies of physician-assisted suicide and [euthanasia in the Netherlands](http://www.iaetf.org/fctholl.htm) (where the practices have long been accepted), the United States, and elsewhere indicate that pain plays a minor role in motivating requests for the procedures. A 1996 update of the comprehensive and rigorous 1991 Remmelink Report on euthanasia practices in the Netherlands revealed that in only 32 percent of all cases did pain play any role in requests for euthanasia; indeed, pain was the sole reason for requesting euthanasia in no cases. A study of patients in nursing homes in the Netherlands revealed that pain was among the reasons for requesting physician-assisted suicide or euthanasia in only 29 percent of cases and was the main reason in only 11 percent. A [study of physicians in Washington State](http://ballingerr.xray.ufl.edu/euthanas/back1.htm) who admitted to having received requests for physician-assisted suicide or euthanasia revealed that severe pain played a role in only about a third of the requests. A study of HIV-infected patients in New York found that interest in physician-assisted suicide was not associated with patients' experiencing pain or with pain-related limitations on function. My own recent study of cancer patients, conducted in Boston, reveals that those with pain are more likely than others to oppose physician-assisted suicide and euthanasia. These patients are also more likely to say that they would ask to change doctors if their attending physician indicated that he or she had performed physician-assisted suicide or euthanasia. No study has ever shown that pain plays a major role in motivating patient requests for physician-assisted suicide or euthanasia.

What does motivate requests? According to studies, depression and general psychological distress. The Remmelink Report found that among Dutch patients the leading reason for requesting euthanasia was a perceived loss of dignity. The study of Washington State physicians found that the leading factors driving requests were fear of a loss of control or of dignity, of being a burden, and of being dependent. Among the New York HIV-infected patients the leading factors were depression, hopelessness, and having few—and poor-quality -- social supports. In my own study, patients who were depressed were most likely to discuss euthanasia seriously, to hoard drugs for suicide, and to have read [*Final Exit*](http://www.efn.org/~ergo/exit.shtml), [the Hemlock Society](http://www2.privatei.com/hemlock/index.html) suicide manual.

These studies highlight an important conflict between people's actual attitudes and likely medical practice. Many Americans say they would support physician-assisted suicide or euthanasia for patients in pain; they oppose the practices for patients who worry about being a burden, about life's being meaningless, about hopelessness. But patients with depression and psychological distress are most likely to request death; patients in pain are less likely to request it.

**Myth No. 4:** The experience with euthanasia in the Netherlands shows that permitting physician-assisted suicide and euthanasia will not eventually get out of hand. "There is no reason to believe that legalizing assisted suicide will lead to the horrific consequences its opponents suggest" (Ninth Circuit Court of Appeals).

The slippery slope feared by opponents and supporters alike is the route from physician-assisted suicide or euthanasia for terminally ill but competent adults to euthanasia for patients who cannot give consent: the unconscious, the demented, the mentally ill, and children. Because the Netherlands is the one developed democracy that has experience with sanctioned euthanasia, advocates and adversaries alike invoke it to defend their points of view. What does the Dutch experience actually show?

Contemporary Dutch policy regarding voluntary euthanasia had its origins in 1973, with the case of a physician, Geertruida Postma, who injected a deaf, partially paralyzed seventy-eight-year-old woman with morphine, ending her life. The patient happened to be Postma's mother. Postma was convicted of murder but given a suspended sentence of one week in jail and one year on probation, a sentence that effectively exonerated her. A subsequent case in 1981 resulted in an agreement between Dutch prosecutors and the Royal Dutch Medical Society, under the terms of which physicians who participated in physician-assisted suicide or euthanasia would not be prosecuted for murder if they adhered to certain guidelines. The main guidelines, parts of which have been incorporated into proposals for outright legalization in other countries, are that 1) the patient must make an informed, free, and explicit request for physician-assisted suicide or euthanasia, and the request must be repeated over time; 2) the patient must be experiencing unbearable suffering—physical or psychological—that cannot be relieved by any intervention except physician-assisted suicide or euthanasia; 3) the attending physician must have a consultation with a second, independent physician to confirm that the case is appropriate for physician-assisted suicide or euthanasia; and 4) the physician must report the facts of the case to the coroner, as part of a notification procedure developed to permit investigation and to ensure that the guidelines have been followed.

It is important to recognize that despite a widespread perception to the contrary, euthanasia has not been legalized under the Dutch penal code—it remains a crime, albeit one that will not be prosecuted if performed in accordance with the guidelines. Several recent efforts in the Netherlands to overtly legalize physician-assisted suicide and euthanasia have been defeated, primarily because of opposition from Dutch religious authorities. The Dutch rules differ from what U.S. proposals (such as those embodied in a [1994 Oregon measure](http://www.islandnet.com/%0A~deathnet/ergo_orlaw.html) on physician-assisted suicide, still in the courts) would require in the following respects: they do not stipulate that a patient must be terminally ill, and they do not require that a patient be experiencing *physical*pain or suffering—a patient can be experiencing psychological suffering only.

Not until 1990, a decade after the Dutch rules were promulgated, was the comprehensive and reliable empirical study done of physician-assisted suicide and euthanasia in the Netherlands which resulted in the Remmelink Report. The recent update of this report reveals that of about 9,700 requests for physician-assisted suicide or euthanasia made each year in the Netherlands, about 3,600 are acceded to, accounting for 2.7 percent of all deaths in the Netherlands (2.3 percent from euthanasia, 0.4 percent from physician-assisted suicide). Nearly 80 percent of patients who undergo physician-assisted suicide or euthanasia have cancer, with just four percent having neurological conditions such as Lou Gehrig's disease or multiple sclerosis. The report revealed that 53 percent of the Dutch physicians interviewed had participated in physician-assisted suicide or euthanasia at some point in their career; 29 percent had participated within the previous two years. Only 12 percent of the Dutch doctors categorically refused to participate in physician-assisted suicide or euthanasia, most likely for religious reasons.

The 1996 data show small increases in the numbers of requests for physician-assisted suicide and euthanasia since 1990, but the overall changes are undramatic. The new research does indicate, however, that problems identified by the Remmelink Report have by no means been eliminated.

First, the update found that beyond the roughly 3,600 cases of physician-assisted suicide and euthanasia reported in a given year, there are about 1,000 instances of nonvoluntary euthanasia. Most frequently, patients who were no longer competent were given euthanasia even though they could not have freely, explicitly, and repeatedly requested it. Before becoming unconscious or mentally incompetent about half these patients did discuss or express a wish for euthanasia; nevertheless, they were unable to reaffirm their wishes when the euthanasia was performed. Similarly, a study of nursing-home patients found that in only 41 percent of physician-assisted suicide and euthanasia cases did doctors adhere to all the guidelines. Although most of the violations were minor (usually deviations in the notification procedure), in 15 percent of cases the patient did not initiate the request for physician-assisted suicide or euthanasia; in 15 percent there was no consultation with a second physician; in seven percent no more than one day elapsed between the first request and the actual physician-assisted suicide or euthanasia, violating the guideline calling for repeated requests; and in nine percent interventions other than physician-assisted suicide or euthanasia could have been tried to relieve the patient's suffering.

Second, euthanasia of newborns has been acknowledged. The reported cases have involved babies suffering from well-recognized fatal or severely disabling defects, though the babies were not in fact dying. Precisely how many cases have occurred is not known. One estimate is that ten to fifteen such cases occur each year. Whether ethically justified or not, providing euthanasia to newborns (upon parental request) is not voluntary euthanasia and does constitute a kind of "mercy killing."

The Netherlands studies fail to demonstrate that permitting physician-assisted suicide and euthanasia will not lead to the nonvoluntary euthanasia of children, the demented, the mentally ill, the old, and others. Indeed, the persistence of abuse and the violation of safeguards, despite publicity and condemnation, suggest that the feared consequences of legalization are exactly its inherent consequences.

Third, the Boudewijn Chabot case raises a warning flag. Chabot, a psychiatrist, participated in the suicide of a depressed fifty-year-old woman in 1991. Her first son had committed suicide a few years earlier. Then her father had died. Under the stress her marriage dissolved. In May of 1991 her second son died of cancer, and less than three months later the woman reached Chabot through the Dutch Voluntary Euthanasia Society, seeking someone to help her end her life. She refused antidepressants and additional psychotherapy. She was never seen by another physician in consultation. When Chabot discussed the case with seven colleagues, at least two suggested that he not assist in the suicide. The Dutch Supreme Court ultimately opted not to penalize Chabot, reaffirming the permissibility of providing assisted suicide and euthanasia on grounds of mental suffering alone. The Amsterdam Medical Disciplinary College did reprimand him, however.

A statement by Else Borst-Eilers, the Dutch Minister of Health, raises concerns about how euthanasia will come to be viewed once it is routine: "There are situations in which the best way to heal the patient is to help him die peacefully, and the doctor who in such a situation grants the patient's request acts as the healer *par excellence*." The logic of understanding voluntary euthanasia as "healing" begins to justify using euthanasia for children, the incompetent, the mentally ill, and others who are suffering or who we imagine are suffering in some fashion. As we have seen, there is a very strong tendency among people who are healthy to extrapolate from the suffering of others in ways that those who are in fact suffering would not countenance.

Many in favor of legalization urge caution in applying the experience of the Netherlands to the United States, citing the many significant geographic, cultural, and political differences between the countries. The differences suggest, though, that the kinds of departures from agreed-upon procedures that have occurred in the Netherlands are likely to be even more commonplace in America. Whatever the emerging cultural, ethnic, and religious diversity of the Netherlands, it pales in comparison to the raucous diversity of the United States. And the Dutch have relative income equality, whereas income inequality in the United States is among the greatest in the developed world. Such diversity and inequality make it harder to share norms and to enforce them. The Dutch are also a law-abiding people who view government social supports, interventions, and regulations as legitimate. America is a land founded on opposition to government, where candidates for office campaign against government legitimacy. If the law-abiding Dutch violate their own euthanasia safeguards, what can we expect of Americans?

In the Netherlands physician-assisted suicide and euthanasia are provided in the context of universal and comprehensive health care. The United States has yet to provide such coverage, and leaves tens of millions effectively without health care. Paul van der Maas, the professor of public health who conducted the two Netherlands studies, has said that in the absence of health-care coverage he would be loath to permit euthanasia in the Netherlands, fearing that pressure might be brought to bear on patients and doctors to save money rather than to help patients.

What, then, should be U.S. policy regarding physician-assisted suicide and euthanasia? Magazine and television stories about patients who want to end their suffering by means of physician-assisted suicide or euthanasia help to reinforce the seemingly inherent link between pain and such interventions. As an oncologist I have often personally cared for patients who suffer despite all available treatment. Only the callous and insensitive would deny that in such cases physician-assisted suicide or euthanasia can offer obvious benefits -- can end a life that is worse than death.

But these cases distort the picture. The question is not about whether intervention is right for this or that particular patient. In any given case it may be the ethical thing to do, whatever the law says—and should be done. The question confronting the United States is one of policy: Should we broadly legalize physician-assisted suicide and euthanasia? We must not be swayed by a few—or even a few thousand—wrenching cases in which such intervention seems unequivocally right.

Most of the patients interested in physician-assisted suicide or euthanasia will not be suffering horrific pain. As noted, depression, hopelessness, and psychological distress are the primary factors motivating the great majority. Should their wishes be granted? Our usual approach to people who try to end their lives for reasons of depression and psychological distress is psychiatric intervention—not giving them a syringe and life-ending drugs.

Legalizing physician-assisted suicide and euthanasia, some argue, would not benefit only those who eventually made use of these procedures; it would also provide "psychological comfort" or "reassurance" to millions of other Americans, who would know that if they were dying and things got really bad, they could end their lives. However, the one study we have—the Boston study mentioned previously—shows that for every cancer patient who is likely to be reassured by a discussion of physician-assisted suicide or euthanasia, another patient finds that such a discussion would decrease his or her trust in the care being provided.

Whatever the benefits of legalized physician-assisted suicide and euthanasia, they must be measured against the dangers of legalization. In considering dangers we must consider more than potential violations of safeguards, although the Dutch experience indicates that the danger is real. (It is hardly surprising that, according to surveys, those who are most opposed to physician-assisted suicide and euthanasia include those most likely to experience abuse and coercion: the old, the less well off, and minorities.) For instance, how would legalization affect our society's already tenuous commitment to providing quality health care for the millions of people who die every year?

Providing the terminally ill with compassionate care and dignity is very hard work. It frequently requires monitoring and adjusting pain medications, the onerous and thankless task of cleaning people who cannot control their bladders and bowels, and feeding and dressing people when their every movement is painful or difficult. It may require agonizing talks with dying family members about their fears, their reflections on life and what comes after, their family loves and family antagonisms. Ending a patient's life by injection, with the added solace that it will be quick and painless, is much easier than this constant physical and emotional care. If there is a way to avoid all this hard work, it becomes difficult not to use it.

Broad legalization of physician-assisted suicide and euthanasia would have the paradoxical effect of making patients seem to be responsible for their own suffering. Rather than being seen primarily as the victims of pain and suffering caused by disease, patients would be seen as having the power to end their suffering by agreeing to an injection or taking some pills; refusing would mean that living through the pain was the patient's decision, the patient's responsibility. Placing the blame on the patient would reduce the motivation of caregivers to provide the extra care that might be required, and would ease guilt if the care fell short. Such an easy, thoughtless shift of responsibility is probably what makes most hospice workers so deeply opposed to physician-assisted suicide and euthanasia.

There is one final matter to consider: the possibility that euthanasia not only would be performed on incompetent patients in violation of the rules—as an abuse of the safeguards—but would become the rule in the context of demographic and budgetary pressures on Social Security and Medicare as the Baby Boom generation begins to retire, around 2010.

Once legalized, physician-assisted suicide and euthanasia would become routine. Over time doctors would become comfortable giving injections to end life and Americans would become comfortable having euthanasia as an option. Comfort would make us want to extend the option to others who, in society's view, are suffering and leading purposeless lives. The ethical arguments for physician-assisted suicide and euthanasia, advocates of euthanasia have maintained, do not apply to euthanasia only when it is voluntary; they can also be used to justify some kinds of nonvoluntary euthanasia of the incompetent. Euthanasia would come to be seen as "one end of a spectrum of caring for dying patients," as the philosopher and euthanasia defender [Dan Brock](http://www.cariboo.bc.ca/ae/php/phil/MCLAUGHL/students/phil433/brock1.htm) writes. "When viewed in this way," he goes on, "it will be difficult to deny euthanasia to a patient for whom it is seen as the best or most appropriate form of care simply because that patient is now incompetent and cannot request it."

Advocates of physician-assisted suicide and euthanasia urge legalization for reasons of compassion, but there is no guarantee that the reasons offered in 1997 would remain the justification even a few years ahead, under different social and economic circumstances. The confluence of ethical arguments, medical practice, demographic and budgetary pressures, and a social ethos that views the old and sick as burdens would seem capable of overwhelming any barriers against euthanasia for incompetent patients.

The proper policy, in my view, should be to affirm the status of physician-assisted suicide and euthanasia as *illegal*. In so doing we would affirm that as a society we condemn ending a patient's life and do not consider that to have one's life ended by a doctor is a right. This does not mean we deny that in exceptional cases interventions are appropriate, as acts of desperation when all other elements of treatment—all medications, surgical procedures, psychotherapy, spiritual care, and so on—have been tried. Physician-assisted suicide and euthanasia should not be performed simply because a patient is depressed, tired of life, worried about being a burden, or worried about being dependent. All these may be signs that not every effort has yet been made.

By establishing a social policy that keeps physician-assisted suicide and euthanasia illegal but recognizes exceptions, we would adopt the correct moral view: the onus of proving that everything had been tried and that the motivation and rationale were convincing would rest on those who wanted to end a life. Such a policy would recognize that ending a life by physician-assisted suicide or euthanasia is an extraordinary and grave event. To recognize a legal right to physician-assisted suicide or euthanasia transforms the practices into routine interventions that can be administered without the need for a publicly acceptable justification. Doctors who end patients' lives would no longer bear the burden of having to prove the appropriateness of their action, if called upon to do so, but could simply justify their action as a legally sanctioned procedure.

Advocates for legalization might find a policy that permits exceptions to embody a double standard. But crafting a social policy in this way would also embody what we know: not all cases are the same, and among the millions of Americans who die each year there are morally relevant differences that cannot be captured in an inflexible rule. We must ensure that moral judgments are made in individual cases, and that those who make them will be accountable before the law.

Emmanuel, E. J. (1997, March). Whose right to die? The Atlantic Monthly, Retrieved from, <https://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/>

“Absolute prohibitions of physician assistance in suicide have long been canonical in medical ethics, but a powerful reformation of views on euthanasia and physician-assisted suicide is now underway in several countries. The key moral issue that will drive discussion is the liberty to choose the means to one's death and the justification, if any, for limiting that liberty” (Beauchamp, 1999, p. 437).

**Killing and letting die**

“The influential distinction between killing and letting die is essential to the traditional view that killing (even at another's request) is prohibited and letting die permitted under specified conditions. However, the multi-purpose term "killing" does not entail a wrongful act or a crime, and there are several generally accepted justifications of killing, such as killing in self-defense and killing to rescue a person endangered by the immoral acts of other persons. Correctly to apply the label "killing" or the label "letting die" to a set of events will therefore not determine whether the set of events is morally acceptable or unacceptable. This is as true in medicine as elsewhere. Killing may typically be wrong and letting die rarely wrong, but this conclusion is contingent on the features of particular circumstances, not merely on whether the act is a killing or a letting die” (Beauchamp, 1999, p. 437).

“Forgoings that let a patient die can be both as intentional and as immoral as actions that involve direct interventions to bring about death (and both can be forms of killing).

Furthermore, the killing/letting-die distinction is largely irrelevant to today's mainstream issues about physician-assisted suicide, because the cases are not ones in which physicians are involved in either killing or of letting die. For example, a physician who prescribes a lethal medication at a patient's request does not thereby cause the patient's death and neither kills the patient nor lets the patient die, whether or not the patient voluntarily ingests the medication and dies. (Beauchamp, 1999, p. 437).

“A common thesis is that "letting die" occurs in medicine by "ceasing useless medical technologies", but "letting die" actually occurs in medicine under two circumstances: one is the cessation of medical technology because it is useless and the other is the cessation of medical technology (p.437) because it has been refused. Honouring a refusal of a useful treatment knowing of a fatal outcome is letting someone die, not killing the person. The type of action-a killing or a letting die-can thus depend entirely on whether a valid refusal justifies the forgoing of medical technology. If there is no valid refusal, the act is an unjustified killing; if the act is of an identical type but is underwritten by a valid refusal, it is a justified letting die” (Beauchamp, 1999, p. 438).

“The received account of letting die in both law and medicine relies on a doctrine about the causation of death. The thesis is that intentionally forgoing a medical technology qualifies as letting die, rather than killing, if and only if an underlying disease or injury causes death. Despite its venerability, this received view is unsatisfactory. To obtain a satisfactory position, it must be added that the forgoing of the medical technology is validly authorised and for this reason is justified.

In many cases of justified withdrawing or withholding of a medical treatment, death is not caused by an underlying condition of disease or injury. For example, an act of removing a nasogastric tube to abate hydration or nutrition leads to death from malnutrition, not death from an underlying condition of disease or injury. The disease or injury motivates and justifies the decision to forgo treatment, but does not cause death.

From both a legal and a moral point of view, one reason why physicians do not injure or maltreat patients when they withhold or withdraw medical technology (often with the intention of bringing about death) is that physicians are morally and legally obligated to recognise and act upon a valid refusal, irrespective of the causal outcome of doing so. Since a valid refusal of treatment obligates the physician to forgo treatment, it would be absurd to hold that these legal and moral duties require physicians to cause the deaths of their patients-in the legal and moral sense of "cause" and thereby to kill them.

The particular form or mode of causation of death is not therefore the material matter in the justification of assistance in dying by forgoing treatment. As long as a refusal of medical technology is valid, there exists no problem about responsibility for the death that ensues or about the justification of the action” (p. 438).

“Of course, refusal and request are not so alike that the physician must act on whatever the patient or family wishes. Whereas a health professional is obligated to honour a refusal, he or she is not obligated to honour a request. Valid refusals obligate a physician to do something (or forbear from doing something) that leads to death, whereas valid requests only make it permissible for a physician (or some other person) to lend aid in dying. A physician who in principle accepts the permissibility of assistance in bringing about death may still refuse to honour a particular request if there is good moral reason for doing so. Causing a person's death is morally wrong, when it is wrong, not merely because the death is caused by someone, but because an unauthorised and unjustified harm or loss to the person occurs. The death is bad for the person only if there is an unauthorised and unjustified deprivation of opportunities and goods that life would otherwise have afforded. If a person freely elects and authorises death and sees that event as a personal benefit, rather than a setback, then meeting the person's request involves no clear harm or moral wrong. If letting die based on valid refusals does not harm or wrong persons or violate their rights, how can assisted suicide or voluntary active euthanasia harm or wrong a person who dies? In each case, persons seek what for them in their bleak circumstances is the best means to the end of quitting life. Their judgment is that lingering in life is worse than death. The person in search of assisted suicide, the person who seeks active euthanasia, and the person who forgoes life-sustaining technology to end life may be identically situated. They simply select different means to the end of their lives” (p. 438).

**Looking to the future**

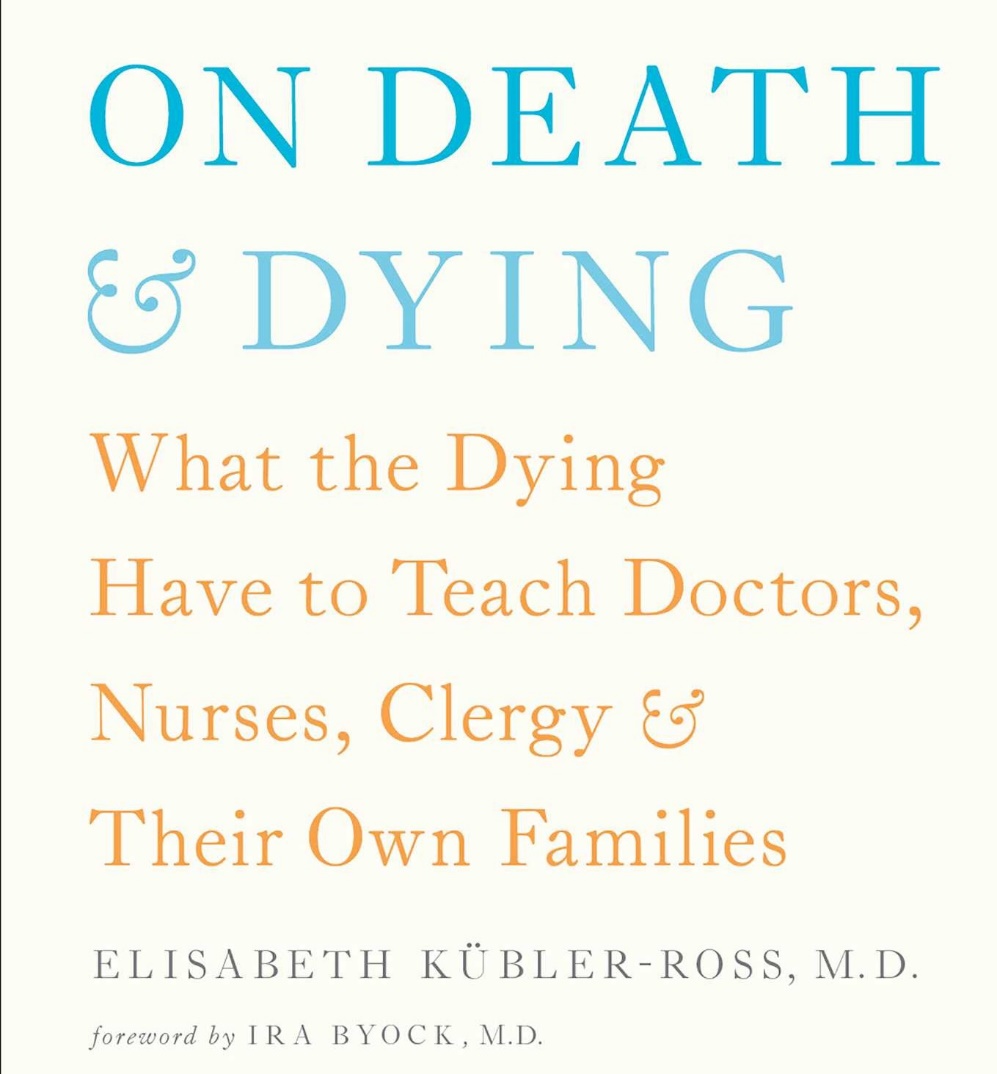
“In the twenty-first century we can expect the following to happen: the laws or precedents permitting physician-assistance in death will prove manageable and even be improved in the Netherlands, Oregon, Japan, and other locations. In the meanwhile, law, ethics, and medicine will struggle to find more conservative alternatives. (p. 438).

One option will be the cultivation of a wider array of circumstances under which competent patients are allowed to refuse nutrition and hydration in order to end their lives. The refusal of nutrition and hydration appears to encounter no legal or moral problems in many countries, despite the fact that there is no clear distinction between starving oneself to death and suicide or between a physician's starving a patient to death at the patient's request and physician-assisted suicide. The other option that is certain to come into increased favour is a dramatically improved style of palliative care. There is already a consensus that better end-of-life care, including palliative care, is needed, and we can expect to see more resources and training in support of this commendable goal.

No one of these three different options: (1) provision of fatal means to death, (2) planned forgoing of nutrition and hydration, and (3) improved palliative care will necessarily be best for each patient. The presentation of these options is also consistent with the larger argument I have presented, which is that these issues of euthanasia, physician-assisted suicide, and aid-in-dying are primarily about increased liberty, not about killing and letting die” (p. 439).

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**CT WRTTEN ASSIGNMENT**

Explain how an individual's personal sense of justice can sometimes conflict with legal or ethical standards.

You may relate personal experiences with this issue.

How could an individual's personal sense of justice in certain cases conflict with legal or ethical standards of healthcare delivery?

“Nurses are often involved in supporting parents when tragedy strikes at birth. They must be knowledgeable regarding the disease process and the appropriate nursing care in these situations and the support families need when ethical dilemmas arise. (p.37)

Many approaches can be used to solve ethical dilemmas. Although an approach does not guarantee a right decision, it provides a logical, systematic method for decision making. Because the nursing process is also a method of problem solving, nurses can use a similar approach when faced with ethical dilemmas (Box 3-2). (p.38)

BOX 3-2 **Applying the Nursing Process to Solve Ethical Dilemmas**

**Assessment**

Gather data to clearly identify the problem and the decisions necessary. Obtain viewpoints from all who will be affected by the decision and applicable legal, agency policy, and common practice standards.

Analysis

Decide whether an ethical dilemma exists. Analyze the situation using ethical theories and principles. Determine whether and how these conﬂict.

Planning

Identify as many options as possible, their advantages and disadvantages, and which are most realistic. Predict what is likely to happen if each option is followed. Include the option of doing nothing. Choose the solution.

Implementation

Carry out the solution. Determine who will implement the solution and how. Identify all interventions necessary and what support is needed.

Evaluation

Analyze the results. Determine whether further interventions are necessary. (p.38)

Many approaches can be used to solve ethical dilemmas. Although an approach does not guarantee a right decision, it provides a logical, systematic method for decision making. Because the nursing process is also a method of problem solving, nurses can use a similar approach when faced with ethical dilemmas.

Decision making in ethical dilemmas may seem straightforward, but it rarely results in answers agreeable to everyone. Many agencies therefore have bioethics committees to formulate policies for ethical situations, provide education, and help make decisions in specific cases. The committees include a variety of professionals such as nurses, physicians, social workers, ethicists, and clergy members. The family members most closely affected by the decision also participate if possible. A satisfactory solution to ethical dilemmas is more likely to occur when people work together”. (p.38)

“The legal foundation for the practice of nursing provides safeguards for clients and sets standards by which nurses can be evaluated. Nurses need to understand how the law applies speciﬁcally to them. When nurses do not meet the standards expected, they may be held legally accountable. (p.46)

Three categories of safeguards determine the law’s view of nursing practice: (1) nurse practice acts, (2) standards of care set by professional organizations, and (3) rules and policies set by the institution employing the nurse. Every state has a nurse practice act that determines the scope of practice of registered nurses in that state. Nurse practice acts deﬁne what the nurse is allowed to do when caring for clients. The acts also specify what the nurse is expected to do when providing care. Some parts of the law may be very speciﬁc. Others are stated broadly to allow ﬂexible interpretation of the role of nurses. Nurse practice acts vary among states, and nurses must understand these laws wherever they practice. Nurses should have a copy of the nurse practice act for their state and refer to it for questions about their scope of practice.

Laws relating to nursing practice also delineate methods, called standardized procedures, by which nurses may assume certain duties commonly considered part of medical practice. The procedures are written by committees of nurses, physicians, and administrators. They specify the nursing qualiﬁcations required for practicing the procedures, deﬁne the appropriate situations, and list the education required. Standardized procedures allow the role of the nurse to change to meet the needs of the community and expanding knowledge.

Each health care agency sets speciﬁc policies, procedures, and protocols that govern nursing care. All nurses should be familiar with those that apply in the agencies in which they work. Nurses are frequently involved in writing and revising nursing policies and procedures. In the event of a malpractice claim, the applicable policy, procedure, or protocol is likely to be used as evidence. The case of the professionals is strengthened if all agency policies were followed properly. These policies should be revised and updated regularly. (p. 46)

Negligence is the failure to perform as a reasonable, prudent person of similar background would act in a similar situation. Negligence may consist of doing something that should not be done or failing to do something that should be done. (p. 46)

Malpractice is negligence by professionals, such as nurses and physicians, in the performance of their duties. Nurses may be accused of malpractice if they do not perform according to established standards of care and in the manner of a reasonable, prudent nurse with similar education and experience in a similar situation. Four elements must be present to prove negligence: duty, breach of duty, damage, and proximate cause. (46)

**REFUSAL OF CARE**

“Sometimes clients decline treatment offered by health care workers. Clients refuse treatment when they believe that the beneﬁts of treatment are insufﬁcient to balance the burdens of the treatment or their quality of life after treatment. Clients have the right to refuse care, and they can withdraw agreement to treatment at any time. When a person makes this decision, a number of steps should be taken. (p.47)

First, the physician or nurse should establish that the client understands the treatment and consequences of refusal. If the physician is unaware of the client’s decision, the nurse should notify that physician accordingly. The nurse documents the refusal, explanations given to the client, and notiﬁcation of the physician on the chart. If the treatment is considered vital to the client’s well-being, the physician discusses the need with the client and documents the results. Opinions by other physicians may be offered to the client as well.

Clients may be asked to sign forms indicating that they understand the possible results of rejection of treatment. This measure is to defend against any subsequent lawsuit in which a client claims lack of knowledge of the possible results of a decision. If no ethical dilemma exists, the client’s decision stands.

In cases of an ethical dilemma a referral may be made to the hospital ethics committee. In rare situations the physician may seek a court ruling to force treatment. For example, if a woman refuses a cesarean birth, her decision may gravely harm the fetus. This situation is the only legal instance in which a person is forced to undergo surgery for the health of another. Indigent or minority women are more likely to have a court-ordered cesarean birth (Lindgren, 1996). However, court action is avoided if possible because it places the woman and her caregiver in adversarial positions. In addition, it invades the woman’s privacy and interferes with her autonomy and right to informed consent. If legally mandated surgery were to become widespread and cause women to avoid health care during pregnancy, the resulting harm would affect more women and infants than would be protected by the surgery.

Coercion is illegal and unethical in obtaining consent. Even though the nurse may strongly believe that the client should receive the treatment, the client should not feel forced to submit to unwanted procedures. Nurses must be sure that personal feelings do not adversely affect the quality of their care. Clients have the right to good nursing care, regardless of their decisions to accept or reject treatment.

Documentation is the best evidence that a standard of care has been maintained. It includes nurses’ notes, electronic data, ﬂow sheets, care paths, consent forms, and any other data recorded on the chart. In many instances notations in hospital records are the only proof that care has been given. Unfortunately, accurate and thorough documentation is the most common area lacking in malpractice cases (Simpson & Chez, 2001). When documentation is not present, juries often assume that care was not given.

Documentation must be speciﬁc and complete. This careful step is critical because of the long statute of limitations. Nurses are unlikely to remember situations that happened years in the past and, if sued, must rely on their documentation to explain their care. (p.47) [In addition,] “documentation must show that nurses assessed the client appropriately, continually monitored for problems, identiﬁed problems and instituted correct interventions, and reported changes in the client’s condition to the primary care provider. (p.47)

The nurse can also reduce malpractice liability by maintaining expertise. To ensure that nurses maintain their expertise in provision of safe care, most states require proof of continuing education for renewal of nursing licenses. Nursing knowledge grows and changes rapidly, and all nurses must keep current. New information from classes, conferences, and professional publications can help nurses perform as would a reasonably prudent peer. Nurses should analyze research articles to determine whether changes in client care are indicated by the research evidence. (p.48)

Employers often provide continuing education classes for their nurses through conferences, satellite television systems, computer networks, and other means. Membership in professional organizations, such as state branches of the American Nurses Association or specialty organizations like [the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN)], gives nurses access to new information through publications, nursing conferences, and other educational offerings. Continuing nursing education is also widely available on the Internet.

Expertise is a concern when nurses are “ﬂoated” or required to work with clients whose needs differ from those of the nurses’ usual clients. In these situations nurses need cross-training, which includes orientation and education to perform care safely in new areas. The employer must provide appropriate cross training for nurses who ﬂoat. Nurses who work outside their usual area of expertise must assess their own skills and avoid performing tasks or taking responsibilities in areas until they have been educated to be competent in those areas”. (p.48) (Murray & McKinney, 2009).

Murray, S., McKinney, E. (2009). *Foundations of Maternal-Newborn and Women's Health Nursing*, (5th ed.), Chapter 3, Ethical, social, and legal issues, Saunders,ISBN: 978-143-771553-8, Retrieved from, <https://www.elsevier.com/books/foundations-of-maternal-newborn-and-womens-health-nursing/murray/978-1-4377-0259-0>

Simpson, K.R., & Chez, B.F. (2001). Professional and legal issues. In K.R. Simpson & P.A. Creehan (Eds.), AWHONN’s perinatal nursing (2nd ed., 21-49). Philadelphia: Lippincott.

Epstein, E. (2008). End-of-life experiences of nurses and physicians in the newborn intensive care unit. Journal of Perinatology.771-778

End of life cases are often overlooked by many medical professionals because of their complexity and ethical challenges. As medical professionals, we need to recognize that death is eminent and/or inevitable for many medical conditions despite aggressive treatments and interventions. It is because of this that end of life decisions and care begins with an honest discussion of disease progression and prognosis.

The prognosis of a patient with a life-limiting disease should be estimated according the best available medical data; as medical professionals, we should be honest and forthright in discussing this information with the patient and family. The prognosis of malignant diseases can usually be determined from the staging of the disease.

The prognosis of chronic nonmalignant diseases must be based on clinical progression as documented by serial medical assessments, or a nursing assessment of progression in homebound patients, and a recent decline in functional status as determined by clinical assessment, decreased performance test results, and a high dependence during the activities of daily living. Documented recent impairment of nutritional status related to the terminal process can also be utilized for assessment.

Things to consider:

* The nature of hydration and nutrition.
* The patient’s bodily integrity and self-determination.
* The physician’s professional integrity.
* The standard approach: romanticizing death/demonizing families.
* Dying in intimacy.
* Assisted suicide.
* Voluntary active euthanasia.
* Assisted death.
* Physician-assisted death.
* The ethical arguments of physician-assisted death.
* The clinical management of requests for assisted death.
* The assisted death debate in context.

Questions to reflect on:

*Do you think that as a society, we are pushing terminally ill patients to make a quick decision regarding their care? Do you think this is ethically moral? What do you think the implications of these types of decisions are?*

“The principle of justice could be described as the moral obligation to act on the basis of fair adjudication between competing claims. As such, it is linked to fairness, entitlement and equality. In health care ethics, this can be subdivided into three categories: fair distribution of scarce resources (distributive justice), respect for people’s rights (rights based justice) and respect for morally acceptable laws (legal justice) (Gillon, 1994). Alperovitch et al. (2009) describe two elements of the principle of justice, namely equality and equity.

The right to be treated equally, and in some cases equal access to treatment, can be found in many constitutions, but in actual practice, a number of different factors may influence actual access to treatment e.g. age, place of residence, social status, ethnic background, culture, sexual preferences, disability, legal capacity, hospital budgets, insurance cover and prognosis. The Swiss Academy of Medical Sciences recently reported that doctors and other medical staff are increasingly refusing to administer potentially useful treatment for economic reasons (SAMS, 2008) and there has been considerable debate in the UK over the refusal of expensive treatment to patients who would benefit from it (need reference here).

With regard to equality in the provision of care, some people are not treated with the same degree of respect as that accorded to others e.g. with indifference, unfriendliness, lack of concern or rudeness. Such attitudes, prejudice and discrimination may, in some cases, be a reflection of the stigmatization of people belonging to groups identified and devalued on the basis of a particular attribute (of which [*dementia*](http://www.alzheimer-europe.org/Glossary/dementia) is one example). Inequality and discrimination may also be based on structural violence such as racism, sexism and poverty (Mahajan et al., 2008) which Kelly (2006) describes as a form of discrimination based on unequal power relations.

Gillon (1994) emphasises that justice is more than mere equality in that people can be treated unjustly even if they are treated equally. With reference to Aristotle, he argues that it is important to treat equals equally and unequals unequally in proportion to the morally relevant inequalities (the criterion for which is still being debated). Situations will always arise where decisions have to be taken and there are limited resources, different options and/or other conflicting moral concerns. Care must be taken to ensure that health care resources are used sensibly and fairly. People with dementia are potentially vulnerable in that they are likely at some stage to be unable to state their preferences and ensure that they are respected. Advance directives at least provide written evidence of their wishes, which should go some way towards ensuring that they are not placed at a disadvantage to others when it comes to making crucial decisions about their health and well-being. Health care proxies could also play a useful role in ensuring that such decisions are taken into account and as far as possible respected.

Nevertheless, it is possible that a high degree of incapacity and increased vulnerability, perhaps combined with failure by others to recognise their personhood, may result in a lack of distributive justice. Nerney (undated) argues:

*“Once individuals get reduced to a status where personal* [*autonomy*](http://www.alzheimer-europe.org/Glossary/autonomy) *or self-determination is not "possible", they may lose their moral claim on our resources. Contemporary ethicists (…/…) make this claim on the principle of distributive justice. Distributive justice underlies our progressive tax system, e.g., and simply calls for sharing resources in ways that approximate fairness. Distributive justice has been the cornerstone upon which we argued for resources for the most vulnerable. Contemporary ethical theory has now turned this principle on its head. Because we live in times of scarce resources, especially medical and long term care resources, those who can "benefit" the least (read those with significant disabilities) may end up having the lowest moral claim on these resources.” (*Alzheimer Europe, 2013).

Alzheimer Europe. (2013). Justice: The four common bioethical principles, Retrieved from, <http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/The-four-common-bioethical-principles/Justice>

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“Whether your role is that of a doctor or a health care administrator, working in the field of health care is both highly rewarding and challenging. Many medical procedures and treatments have both merits and downsides, and patients have their own input and circumstances to consider. The four principles of health care ethics developed by Tom Beauchamp and James Childress in the 1985 *Principles of Biomedical Ethics* provide medical practitioners with guidelines to make decisions when they inevitably face complicated situations involving patients. The four principles of health care ethics are autonomy, beneficence, non-maleficence, and justice.

The Four Principles of Health Care Ethics

The basic definitions of each of the four principles of health care ethics are commonly known and used often in the English language, but they take on special meaning when being utilized in a medical setting. All of these principles play a key role in ensuring optimal patient safety and care.

**1. Autonomy**: In medicine, autonomy refers to the right of the patient to retain control over his or her body. A health care professional can suggest or advise, but any actions that attempt to persuade or coerce the patient into making a choice are violations of this principle. In the end, the patient must be allowed to make his or her own decisions – whether or not the medical provider believes these choices are in that patient’s best interests – independently and according to his or her personal values and beliefs.

**2. Beneficence**: This principle states that health care providers must do all they can to benefit the patient in each situation. All procedures and treatments recommended must be with the intention to do the most good for the patient. To ensure beneficence, medical practitioners must develop and maintain a high level of skill and knowledge, make sure that they are trained in the most current and best medical practices, and must consider their patients’ individual circumstances; what is good for one patient will not necessary benefit another.

**3. Non-Maleficence**: Non-maleficence is probably the best known of the four principles. In short, it means, “to do no harm.” This principle is intended to be the end goal for all of a practitioner’s decisions, and means that medical providers must consider whether other people or society could be harmed by a decision made, even if it is made for the benefit of an individual patient.

**4. Justice**: The principle of justice states that there should be an element of fairness in all medical decisions: fairness in decisions that burden and benefit, as well as equal distribution of scarce resources and new treatments, and for medical practitioners to uphold applicable laws and legislation when making choices.

**A Closer Look: Case Study**

One [hypothetical case study](http://www.ukcen.net/index.php/ethical_issues/ethical_frameworks/the_four_principles_of_biomedical_ethics) involves a patient who has an ovarian cyst that, left untreated, will result in kidney failure. An operation to remove the cyst is the best treatment, but the patient is frightened of needles and is against the surgery that would require a needle to give her anesthesia. The doctor must work with the patient to respect the fact that she dislikes needles and doesn’t want the operation (her autonomy), and needs to find a solution that would prevent her from going into kidney failure, which is in her best interest (beneficence). Although the surgery is the best choice, forcing the patient to accept the needle would be harmful to her (non-maleficence). Finally, the doctor needs to consider the impact that the patient’s choices might have on others if she starts to go into preventable kidney failure, she’ll need dialysis, which affects other people who need the same treatment (justice). So before making the final decision the doctor must consider all four principles of health care ethics, which will help the physician make the choice that will have the best possible benefits for both the patient and society.

**The Role of a Health Care Administrator**

Health care administrators plan, organize, and oversee the functions of the health care facilities at which they work, as well as the other members of the staff who work there, including doctors and nurses. Thus, they play a vital role in ensuring that patients are receiving high quality and ethical treatment.

While health care administrators are required to have a bachelor’s degree to enter the field, a graduate degree will help set candidates apart and further advance in their career. A [Master’s in Health Administration](http://online.sju.edu/graduate/masters-health-administration?cmgfrm=https%3A%2F%2Fwww.bing.com%2F) increases the knowledge and skills of people who are already working in health care administration or who are interested in entering the field. Instructors from a variety of fields under the wide umbrella of health care contribute their knowledge on health care ethics to create a practice-based program that will meet the challenges of today’s medical system head on.

Although doctors and nurses directly oversee each patient’s health, health care administrators play an important role in facilitating decisions about patient care, particularly when the situation is one that might contain moral and ethical dilemmas, such as genetic testing prior to birth or end-of-life care. As science and technology further increase the abilities of doctors and advance the field of health care, the role of health care ethics will change and only continue to increase in importance. Thus, it is vital that health care administrators be properly trained to meet the current and future challenges of ethically helping patients receive the best care.

Healthcare is changing and opportunity awaits”. (Saint Joseph’s University, 2017).

Saint Joseph’s University. (2017). How the four principles of health care ethics improve patient care, Retrieved from, <http://online.sju.edu/graduate/masters-health-administration/resources/articles/four-principles-of-health-care-ethics-improve-patient-care>

**USE!!!**

“Quality and kindness form the basis for the decisions we make in both medicine and business. Some decisions are obvious, some routine, some automatic. Others are more complex and may put our values to the test.

Every Dignity Health hospital has an ethics committee whose role is to educate, develop policy and support clinical decision making. These committees offer multi-disciplinary ethics consultation to help patients, families, surrogates, and health care providers address uncertainty or conflict. During a consultation, the committee considers the medical facts and patient preferences, as well as the views of family, friends, and caregivers. Social, spiritual, legal, and administrative factors are carefully weighed.

We make it our mission to consistently respect the values of our patients and to promote basic values of fairness, justice, and integrity. Above all, we vow to do no harm.

**Statement of Common Values**

The Dignity Health Statement of Common Values describes the guiding values for our whole organization—hospitals, care centers, business offices, and partnerships. Our Catholic hospitals have an additional responsibility to carry out the Ethical and Religious Directives for Catholic Health Care Services.

In living our mission, we strive to deliver compassionate, high-quality, affordable health care; serve and advocate for those sisters and brothers who are poor and disenfranchised; and partner with others in the communities we serve to improve the quality of life. In carrying out our healing ministry, we embody the values of dignity, collaboration, justice, stewardship, and excellence. Dignity Holding the value of dignity means we show respect for persons, not for anything they do or any rank they hold, but because they reﬂect the face of God. Because persons are created in communities, respecting dignity also means working toward the common good within the communities we serve. The common good is realized when economic, political and social conditions protect and promote the basic rights of all persons and enable them to reach their common goals. We respect the dignity of all persons without regard to age, gender, sexual orientation, religion, culture, race, ethnicity, gender identity or economic, immigration or employment status. We believe that health care is a social good and a community service and that access to health care is a fundamental right of all persons. For Dignity Health, respecting the dignity of persons requires reverence at every stage of life’s journey from conception to natural death. Therefore, direct abortion is not performed. Reproductive technologies in which conception occurs outside a woman’s body will not be part of Dignity Health’s services. This includes in vitro fertilization. In the context of a mutually respectful and healing relationship with the physician and the clinical team, patients have the right to make medical decisions, including accepting or rejecting treatment, and must give free and informed consent before any intervention. They also have a right to make an advance directive and to name a surrogate decision maker, and they or their surrogates must have access to medical and other information regarding their care. At the same time, patients have a right to privacy--of their persons and of their medical information—and must be able to trust that our record- keeping and information systems are reliable and safe. Patients’ families are an integral part of their care, and patient advocates are welcome. There is no obligation to begin or continue treatment, even life-sustaining treatment, if from the patient’s perspective it is an excessive burden or offers no reasonable hope of beneﬁt. Death is a sacred part of life’s journey; we will intentionally neither hasten nor delay it. For this reason, physician- assisted suicide is not part of Dignity Health’s mission. Although pain management in all its forms is critical in allowing a person to die comfortably and with dignity, palliative care is consistent with all types of treatment and is not limited to those persons who are at the end of life. We attend to all dimensions of the person and consider professional spiritual care essential to our service. Spiritual care encompasses the full range of spiritual services integrated with patient care, including skilled listening presence that assists people of all faiths and those of no faith to tap their own beliefs, values and spiritual practices as they experience illness, trauma, recovery and loss. Consistent with the spiritual foundation of our legacy, we extend this spiritual care to families and coworkers as well as patients. Collaboration We understand that the social fabric is woven in partnership with all who are called to serve the community. Our ability to realize our mission depends on our relationships and linkages with others: health care providers, community leaders, physician organizations, government agencies, employers, health plans and individuals. Ours is a community of service and work—we recognize our complex responsibilities as health care providers to patients and their families, as employers, and as corporate citizens. Our commitment to collaboration fosters recognition of richness in diversity of culture and experience. (p.1)

The provision of health care is characterized by necessary hierarchies and by many rules and regulations; however, collaboration marked by trust, transparency and commitment to continuous improvement means that our best work is accomplished by teams of moral equals, with respect for one another’s personal and professional gifts. Collaboration among spiritual leaders and communities of faith extends our ability to support the religious preferences and spiritual needs of those we serve. Our commitment to advocate for reasonable and accessible care for all who need it requires us to engage actively in the development of health care networks and avenues that better ensure the health of populations. Justice The American ideal of blind justice is balanced at Dignity Health by a biblical sense of justice that is concerned with righting imbalances of power and that expresses a preferential option for the poor. We have a special responsibility for persons who are poor or vulnerable, helping them through direct service and acting as an advocate to change structures oppressive to them. We have a moral responsibility to participate in efforts to reform the national health care system that will result in a more equitable distribution of health care goods and a more rational use of common resources. Dignity Health treats employees—the hands and heart of the ministry—justly and respectfully, recognizing that a meaningful and humanizing work environment gives people a voice in matters affecting their work; respects and promotes their personal health and professional growth; and provides a just wage. We strive to promote a just culture and workplace relationships that are fair, trusting, and accountable.

**Stewardship**

Stewardship is the protective care we give our treasures in order to pass them on to the next generation. Our treasures are our human and ﬁnancial resources, our environment, our heritage, and the trust the public places in us. We guard the safety and integrity of these things carefully. Health care resources belong to the community and as a health care system we are stewards of those resources with the responsibility to use them in a way that advances the health status of the community. In addition, we acknowledge our common duty to be stewards of the earth, and we recognize that we must use the earth’s resources in ways that are equitable and ecologically sound. When resources are scarce, we have the responsibility to prioritize their use fairly and publicly. Excellence Motivated by compassion and professional integrity, we strive to provide the best care for every patient, at the right time, in the right setting, at an appropriate cost. We recognize that consistency in the way patients with similar conditions are treated is more likely to lead to better outcomes and, with humility and determination, we participate actively in opportunities to improve our service. We strive to implement evidence-based practices in order to promote safe, high-quality, efﬁcient care that puts patients and their families at the center. Resolution of Unforeseen Issues Dignity Health’s founders are women religious, for whom contemplation and action are linked in every decision. That tradition has come down to us in the way we go about making important, values-based decisions, speciﬁcally in the use of a discernment process that requires signiﬁcant aspects of the decision be weighed in light of our core values. We try to be sure that stakeholders—people who are affected by the decision—can contribute appropriately to the decision. Options are considered in light of the core values, and after a period of reﬂection and respectful discussion, a decision is made that balances and honors the relevant values. This process is especially important when decisions are complex, or when the values involved may conﬂict. When issues that are unanticipated in this document arise between Dignity Health and its partners, we expect all to contribute to a decision that serves the common good. (p.2)

“The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: “I was ill and you cared for me” (Mt

25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death. Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. “Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person.” (p.14)

**The Professional-Patient Relationship**

“A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient’s convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability”. (pp.18-19)

**Directives**

“23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person’s health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patient’s information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person’s intentions and values, or if the person’s intentions are unknown, to the person’s best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient’s wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person’s surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate

alternatives, including no treatment at all.

28. Each person or the person’s surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.16 The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.17

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.18

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop’s pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives. (p.22)

**Issues in Care for the Seriously Ill and Dying**

“Christ’s redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.35Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the

helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective

management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for (p.29) formulating a true moral judgment about the use of technology to maintain life. The use of life sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.37 (p.30)

The Church’s teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is “an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.”38 While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a “persistent vegetative state” (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

**Directives**

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever

information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally

legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.39

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the

community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the

“persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care.40 Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be “excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.”41 For instance, as a patient draws close to

inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.42

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness

without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.43 (pp.30-33) (USCCB, 2009).

United States Conference of Catholic Bishops, (USCCB). (2009).

*Ethical and Religious Directives for Catholic Health Care Services* (5th ed.), Retrieved from, <https://www.dignityhealth.org/-/media/cm/media/documents/PDFs/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.ashx?la=en>

**MAKING CHOICES: A FRAMEWORK FOR MAKING ETHICAL DECISIONS**

“Decisions about right and wrong permeate everyday life. Ethics should concern all levels of life: acting properly as individuals, creating responsible organizations and governments, and making our society as a whole more ethical. This document is designed as an introduction to making ethical decisions.  It recognizes that decisions about “right” and “wrong” can be difficult, and may be related to individual context. It first provides a summary of the major sources for ethical thinking, and then presents a framework for decision-making.

**WHAT IS ETHICS?**

Ethics provides a set of standards for behavior that helps us decide how we ought to act in a range of situations. In a sense, we can say that ethics is all about making choices, and about providing reasons why we should make these choices.

Ethics is sometimes conflated or confused with other ways of making choices, including religion, law or morality. Many religions promote ethical decision-making but do not always address the full range of ethical choices that we face. Religions may also advocate or prohibit certain behaviors which may not be considered the proper domain of ethics, such as dietary restrictions or sexual behaviors. A good system of law should be ethical, but the law establishes precedent in trying to dictate universal guidelines, and is thus not able to respond to individual contexts. Law may have a difficult time designing or enforcing standards in some important areas, and may be slow to address new problems. Both law and ethics deal with questions of how we should live together with others, but ethics is sometimes also thought to apply to how individuals act even when others are not involved.Finally, many people use the terms morality and ethics interchangeably.  Others reserve morality for the state of virtue while seeing ethics as a code that enables morality. Another way to think about the relationship between ethics and morality is to see ethics as providing a rational basis for morality, that is, ethics provides good reasons for why something is moral.

**2. TRADITIONAL ARRANGEMENT OF THE FIELD OF ETHICS:**

There are many systems of ethics, and numerous ways to think about right and wrong actions or good and bad character.  The field of ethics is traditionally divided into three areas: 1.) meta-ethics, which deals with the nature of the right or the good, as well as the nature and justification of ethical claims; 2.) normative ethics, which deals with the standards and principles used to determine whether something is right or good; 3.) applied ethics, which deals with the actual application of ethical principles to a particular situation.  While it is helpful to approach the field of ethics in this order, we might keep in mind that this somewhat “top down” approach does not exhaust the study of ethics. Our experience with applying particular ethical standards or principles can inform our understanding of how good these standard or principles are.

**Three Broad Types of Ethical Theory:**Ethical theories are often broadly divided into three types: i) Consequentialist theories, which are primarily concerned with the ethical consequences of particular actions; ii) Non-consequentialist theories, which tend to be broadly concerned with the intentions of the person making ethical decisions about particular actions; and iii) Agent-centered theories, which, unlike consequentialist and non-consequentialist theories, are more concerned with the overall ethical status of individuals, or agents, and are less concerned to identify the morality of particular actions. Each of these three broad categories contains varieties of approaches to ethics, some of which share characteristics across the categories. Below is a sample of some of the most important and useful of these ethical approaches.  
  
**i.) Consequentialist Theories:**

**The Utilitarian Approach**  
Utilitarianism can be traced back to the school of the Ancient Greek philosopher Epicurus of Samos (341-270 BCE), who argued that the best life is one that produces the least pain and distress.  The 18th Century British philosopher Jeremy Bentham (1748-1832) applied a similar standard to individual actions, and created a system in which actions could be described as good or bad depending upon the amount and degree of pleasure and/or pain they would produce. Bentham’s student, John Stuart Mill (1806-1873) modified this system by making its standard for the good the more subjective concept of “happiness,” as opposed to the more materialist idea of “pleasure.”

Utilitarianism is one of the most common approaches to making ethical decisions, especially decisions with consequences that concern large groups of people, in part because it instructs us to weigh the different amounts of good and bad that will be produced by our action. This conforms to our feeling that some good and some bad will necessarily be the result of our action and that the best action will be that which provides the most good or does the least harm, or, to put it another way, produces the greatest balance of good over harm. Ethical environmental action, then, is the one that produces the greatest good and does the least harm for all who are affected—government, corporations, the community, and the environment.

**The Egoistic Approach**One variation of the utilitarian approach is known as ethical egoism, or the ethics of self- interest. In this approach, an individual often uses utilitarian calculation to produce the greatest amount of good for him or herself. Ancient Greek Sophists like Thrasymacus (c. 459-400 BCE), who famously claimed that might makes right, and early modern thinkers like Thomas Hobbes (1588-1679) may be considered forerunners of this approach. One of the most influential recent proponents of ethical egoism was the Russian-American philosopher Ayn Rand (1905-1982), who, in the book *The Virtue of Selfishness* (1964), argues that self-interest is a prerequisite to self-respect and to respect for others. There are numerous parallels between ethical egoism and laissez-faire economic theories, in which the pursuit of self-interest is seen as leading to the benefit of society, although the benefit of society is seen only as the fortunate byproduct of following individual self-interest, not its goal.

**The Common Good Approach**  
The ancient Greek philosophers Plato (427-347 BCE) and Aristotle (384-322 BCE) promoted the perspective that our actions should contribute to ethical communal life life. The most influential modern proponent of this approach was the French philosopher Jean-Jacques Rousseau (1712-1778), who argued that the best society should be guided by the “general will” of the people which would then produce what is best for the people as a whole. This approach to ethics underscores the networked aspects of society and emphasizes respect and compassion for others, especially those who are more vulnerable.

**ii.) Non-consequentialist Theories:**

**The Duty-Based Approach**The duty-based approach, sometimes called deontological ethics, is most commonly associated with the philosopher Immanuel Kant (1724-1804), although it had important precursors in earlier non-consequentialist, often explicitly religious, thinking of people like Saint Augustine of Hippo (354-430), who emphasized the importance of the personal will and intention (and of the omnipotent God who sees this interior mental state) to ethical decision making. Kant argued that doing what is right is not about the consequences of our actions (something over which we ultimately have no control) but about having the proper intention in performing the action. The ethical action is one taken from duty, that is, it is done precisely because it is our obligation to perform the action. Ethical obligations are the same for all rational creatures (they are universal), and knowledge of what these obligations entail is arrived at by discovering rules of behavior that are not contradicted by reason.

Kant’s famous formula for discovering our ethical duty is known as the “categorical imperative.” It has a number of different versions, but Kant believed they all amounted to the same imperative. The most basic form of the imperative is: “Act only according to that maxim by which you can at the same time will that it should become a universal law.” So, for example, lying is unethical because we could not universalize a maxim that said, “One should always lie.” Such a maxim would render all speech meaningless. We can, however, universalize the maxim, “Always speak truthfully,” without running into a logical contradiction. (Notice the duty-based approach says nothing about how easy or difficult it would be to carry out these maxims, only that it is our duty as rational creatures to do so.) In acting according to a law that we have discovered to be rational according to our own universal reason, we are acting autonomously (in a self-regulating fashion), and thus are bound by duty, a duty we have given ourselves as rational creatures. We thus freely choose (we *will*) to bind ourselves to the moral law. For Kant, choosing to obey the universal moral law is the very nature of acting ethically.

**The Rights Approach**  
The Rights approach to ethics is another non-consequentialist approach which derives much of its current force from Kantian duty-based ethics, although it also has a history that dates back at least to the Stoics of Ancient Greece and Rome, and has another influential current which flows from work of the British empiricist philosopher John Locke (1632-1704). This approach stipulates that the best ethical action is that which protects the ethical rights of those who are affected by the action. It emphasizes the belief that all humans have a right to dignity. This is based on a formulation of Kant’s categorical imperative that says: “Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means to an end.” The list of ethical rights is debated; many now argue that animals and other non-humans such as robots also have rights.

**The Fairness or Justice Approach**  
The Law Code of Hammurabi in Ancient Mesopotamia (c. 1750 BCE) held that all free men should be treated alike, just as all slaves should be treated alike. When combined with the universality of the rights approach, the justice approach can be applied to all human persons. The most influential version of this approach today is found in the work of American philosopher John Rawls (1921-2002), who argued, along Kantian lines, that just ethical principles are those that would be chosen by free and rational people in an initial situation of equality. This hypothetical contract is considered fair or just because it provides a procedure for what counts as a fair action, and does not concern itself with the consequences of those actions. Fairness of starting point is the principle for what is considered just.

**The Divine Command Approach**As its name suggests, this approach sees what is right as the same as what God commands, and ethical standards are the creation of God’s will. Following God’s will is seen as the very definition what is ethical. Because God is seen as omnipotent and possessed of free will, God could change what is now considered ethical, and God is not bound by any standard of right or wrong short of logical contradiction. The Medieval Christian philosopher William of Ockham (1285-1349) was one of the most influential thinkers in this tradition, and his writings served as a guide for Protestant Reformers like Martin Luther (1483-1546) and Jean Calvin (1509-1564). The Danish philosopher Søren Kierkegaard (1813-1855), in praising the biblical Patriarch Abraham’s willingness to kill his son Isaac at God’s command, claimed that truly right action must ultimately go beyond everyday morality to what he called the “teleological suspension of the ethical,” again demonstrating the somewhat tenuous relationship between religion and ethics mentioned earlier.  
  
**iii.) Agent-centered Theories:**

**The Virtue Approach**  
One long-standing ethical principle argues that ethical actions should be consistent with ideal human virtues. Aristotle, for example, argued that ethics should be concerned with the whole of a person’s life, not with the individual discrete actions a person may perform in any given situation. A person of good character would be one who has attained certain virtues. This approach is also prominent in non-Western contexts, especially in East Asia, where the tradition of the Chinese sage Confucius (551-479 BCE) emphasizes the importance of acting virtuously (in an appropriate manner) in a variety of situations. Because virtue ethics is concerned with the entirety of a person’s life, it takes the process of education and training seriously, and emphasizes the importance of role models to our understanding of how to engage in ethical deliberation.

**The Feminist Approach**In recent decades, the virtue approach to ethics has been supplemented and sometimes significantly revised by thinkers in the feminist tradition, who often emphasize the importance of the experiences of women and other marginalized groups to ethical deliberation. Among the most important contributions of this approach is its foregrounding of the principle of care as a legitimately primary ethical concern, often in opposition to the seemingly cold and impersonal justice approach. Like virtue ethics, feminist ethics concerned with the totality of human life and how this life comes to influence the way we make ethical decisions.

**Applied Ethics  
  
Terms Used in Ethical Judgments**Applied ethics deals with issues in private or public life that are matters for ethical judgments. The following are important terms used in making moral judgments about particular actions.

Obligatory: When we say something is ethically “obligatory” we mean that it is not only right to do it, but that it is wrong not to do it.  In other words, we have a ethical obligation to perform the action.  Sometimes the easiest way to see if an action is ethically obligatory is to look at what it would mean NOT to perform the action.  For example, we might say it is ethically obligatory for parents to care for their children, not only because it is right for them to do it, but also because it is wrong for them not to do it.  The children would suffer and die if parents did not care for them.  The parents are thus ethically “obligated” to care for their children.

Impermissible: The opposite of an ethically obligatory action is an action that is ethically impermissible, meaning that it is wrong to do it and right not to do it.  For example, we would say that murder is ethically impermissible.

Permissible: Sometimes actions are referred to as ethically permissible, or ethically “neutral,” because it is neither right nor wrong to do them or not to do them.  We might say that having plastic surgery is ethically permissible, because it is not wrong to have the surgery (it is not impermissible), but neither is it ethically necessary (obligatory) to have the surgery.  Some argue that suicide is permissible in certain circumstances.  That is, a person would not be wrong in committing suicide, nor would they be wrong in not committing suicide.  Others would say that suicide is ethically impermissible.

Supererogatory: A fourth type of ethical action is called supererogatory.  These types of actions are seen as going “above and beyond the call of duty.”  They are right to do, but it is not wrong not to do them.  For example, two people are walking down a hallway and see a third person drop their book bag, spilling all of their books and papers onto the floor.  If one person stops to help the third person pick up their books, but the other person keeps on walking, we somehow feel that the person who stopped to help has acted in a more ethically appropriate way than the person who did not stop, but we cannot say that the person who did not stop was unethical in not stopping.  In other words, the person who did not help was in no way obligated (it was not ethically obligatory) to help.  But we nevertheless want to ethically praise the person who did stop, so we call his or her actions supererogatory.

**3. FRAMEWORKS FOR ETHICAL DECISION-MAKING:**

Making good ethical decisions requires a trained sensitivity to ethical issues and a practiced method for exploring the ethical aspects of a decision and weighing the considerations that should impact our choice of a course of action. Having a method for ethical decision making is essential. When practiced regularly, the method becomes so familiar that we work through it automatically without consulting the specific steps. This is one reason why we can sometimes say that we have a “moral intuition” about a certain situation, even when we have not consciously thought through the issue. We are practiced at making ethical judgments, just as we can be practiced at playing the piano, and can sit and play well “without thinking.” Nevertheless, it is not always advisable to follow our immediate intuitions, especially in particularly complicated or unfamiliar situations. Here our method for ethical decision making should enable us to recognize these new and unfamiliar situations and to act accordingly.  
  
The more novel and difficult the ethical choice we face, the more we need to rely on discussion and dialogue with others about the dilemma. Only by careful exploration of the problem, aided by the insights and different perspectives of others, can we make good ethical choices in such situations.

**Three Frameworks**Based upon the three-part division of traditional normative ethical theories discussed above, it makes sense to suggest three broad frameworks to guide ethical decision making: The Consequentialist Framework; The Duty Framework; and the Virtue Framework.

While each of the three frameworks is useful for making ethical decisions, none is perfect—otherwise the perfect theory would have driven the other imperfect theories from the field long ago. Knowing the advantages and disadvantages of the frameworks will be helpful in deciding which is most useful in approach the particular situation with which we are presented.

**The Consequentialist Framework**  
In the Consequentialist framework, we focus on the future effects of the possible courses of action, considering the people who will be directly or indirectly affected. We ask about what outcomes are desirable in a given situation, and consider ethical conduct to be whatever will achieve the best consequences. The person using the Consequences framework desires to produce the most good.

Among the advantages of this ethical framework is that focusing on the results of an action is a pragmatic approach. It helps in situations involving many people, some of whom may benefit from the action, while others may not. On the other hand, it is not always possible to predict the consequences of an action, so some actions that are expected to produce good consequences might actually end up harming people. Additionally, people sometimes react negatively to the use of compromise which is an inherent part of this approach, and they recoil from the implication that the end justifies the means. It also does not include a pronouncement that certain things are always wrong, as even the most heinous actions may result in a good outcome for some people, and this framework allows for these actions to then be ethical.

**The Duty Framework**In the Duty framework, we focus on the duties and obligations that we have in a given situation, and consider what ethical obligations we have and what things we should never do. Ethical conduct is defined by doing one’s duties and doing the right thing, and the goal is performing the correct action.

This framework has the advantage of creating a system of rules that has consistent expectations of all people; if an action is ethically correct or a duty is required, it would apply to every person in a given situation. This even-handedness encourages treating everyone with equal dignity and respect.

This framework also focuses on following moral rules or duty regardless of outcome, so it allows for the possibility that one might have acted ethically, even if there is a bad result. Therefore, this framework works best in situations where there is a sense of obligation or in those in which we need to consider why duty or obligation mandates or forbids certain courses of action.

However, this framework also has its limitations. First, it can appear cold and impersonal, in that it might require actions which are known to produce harms, even though they are strictly in keeping with a particular moral rule. It also does not provide a way to determine which duty we should follow if we are presented with a situation in which two or more duties conflict.  It can also be rigid in applying the notion of duty to everyone regardless of personal situation.

**The Virtue Framework**  
In the Virtue framework, we try to identify the character traits (either positive or negative) that might motivate us in a given situation. We are concerned with what kind of person we should be and what our actions indicate about our character. We define ethical behavior as whatever a virtuous person would do in the situation, and we seek to develop similar virtues.

Obviously, this framework is useful in situations that ask what sort of person one should be. As a way of making sense of the world, it allows for a wide range of behaviors to be called ethical, as there might be many different types of good character and many paths to developing it. Consequently, it takes into account all parts of human experience and their role in ethical deliberation, as it believes that all of one’s experiences, emotions, and thoughts can influence the development of one’s character.

Although this framework takes into account a variety of human experience, it also makes it more difficult to resolve disputes, as there can often be more disagreement about virtuous traits than ethical actions. Also, because the framework looks at character, it is not particularly good at helping someone to decide what actions to take in a given situation or determine the rules that would guide one’s actions. Also, because it emphasizes the importance of role models and education to ethical behavior, it can sometimes merely reinforce current cultural norms as the standard of ethical behavior.

**Putting the Frameworks Together**By framing the situation or choice you are facing in one of the ways presented above, specific features will be brought into focus more clearly. However, it should be noted that each framework has its limits: by focusing our attention on one set of features, other important features may be obscured. Hence it is important to be familiar with all three frameworks and to understand how they relate to each other—where they may overlap, and where they may differ.

The chart below is designed to highlight the main contrasts between the three frameworks:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Consequentialist** | **Duty** | **Virtue** |
| **D**eliberative process | What kind of outcomes should I produce (or try to produce)? | What are my obligations in this situation, and what are the things I should never do? | What kind of person should I be (or try to be), and what will my actions show about my character? |
| **Focus** | Directs attention to the future effects of an action, for all people who will be directly or indirectly affected by the action. | Directs attention to the duties that exist prior to the situation and determines obligations. | Attempts to discern character traits (virtues and vices) that are, or could be, motivating the people involved in the situation. |
| **Definition of Ethical Conduct** | Ethical conduct is the action that will achieve the best consequences. | Ethical conduct involves always doing the right thing: never failing to do one's duty. | Ethical conduct is whatever a fully virtuous person would do in the circumstances. |
| **Motivation** | Aim is to produce the most good. | Aim is to perform the right action. | Aim is to develop one’s character. |

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Because the answers to the three main types of ethical questions asked by each framework are not mutually exclusive, each framework can be used to make at least some progress in answering the questions posed by the other two.

In many situations, all three frameworks will result in the same—or at least very similar—conclusions about what you should do, although **they will typically give different reasons for reaching those conclusions.**

However, because they focus on different ethical features, **the conclusions reached through one framework will occasionally differ from the conclusions reached through one (or both) of the others.**

**4. APPLYING THE FRAMEWORKS TO CASES:**

When using the frameworks to make ethical judgments about specific cases, it will be useful to follow the process below.

**Recognizing an Ethical Issue**One of the most important things to do at the beginning of ethical deliberation is to locate, to the extent possible, the specifically ethical aspects of the issue at hand. Sometimes what appears to be an ethical dispute is really a dispute about facts or concepts. For example, some Utilitarians might argue that the death penalty is ethical because it deters crime and thus produces the greatest amount of good with the least harm. Other Utilitarians, however, might argue that the death penalty does not deter crime, and thus produces more harm than good. The argument here is over which facts argue for the morality of a particular action, not simply over the morality of particular principles. All Utilitarians would abide by the principle of producing the most good with the least harm.

**Consider the Parties Involved**Another important aspect to reflect upon are the various individuals and groups who may be affected by your decision. Consider who might be harmed or who might benefit.

**Gather all of the Relevant Information**Before taking action, it is a good idea to make sure that you have gathered all of the pertinent information, and that all potential sources of information have been consulted.

**Formulate Actions and Consider Alternatives**Evaluate your decision-making options by asking the following questions:

Which action will produce the most good and do the least harm? (The Utilitarian Approach)  
  
Which action respects the rights of all who have a stake in the decision? (The Rights Approach)

Which action treats people equally or proportionately? (The Justice Approach)

Which action serves the community as a whole, not just some members?   
(The Common Good Approach)

Which action leads me to act as the sort of person I should be? (The Virtue Approach)

**Make a Decision and Consider It**After examining all of the potential actions, which best addresses the situation? How do I feel about my choice?

**Act**Many ethical situations are uncomfortable because we can never have all of the information.  Even so, we must often take action.

**Reflect on the Outcome**What were the results of my decision?  What were the intended and unintended consequences? Would I change anything now that I have seen the consequences?

**5. CONCLUSIONS:**

Making ethical decisions requires sensitivity to the ethical implications of problems and situations.  It also requires practice. Having a framework for ethical decision making is essential. We hope that the information above is helpful in developing your own experience in making choices”.

**Acknowledgements:**

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<https://www.brown.edu/academics/science-and-technology-studies/sites/brown.edu.academics.science-and-technology-studies/files/uploads/Framework.pdf>

**Why Ethics Codes?**

“Ethics codes are as old as antiquity. Religious traditions and civic cultures have codes as their foundations. The Mosaic Decalogue (Ten Commandments) is the keystone for Judaism, Islam and Christianity. Pericles made the Athenian code the underpinning of ancient Greek politics and culture. In each case codes carry general obligations and admonitions, but they are far more than that. They often capture a vision of excellence, of what individuals and societies should be striving for and what they can achieve. In this sense codes, which are often mistaken as part of law or general statements of mere aspiration, are some of the most important statements of civic expectation” (p.3). (Gilman, 2005).

“When applied to certain classes of people – public servants, doctors – codes are the ultimate terms of reference. They are the framework upon which professions are built. Often codes are what professionals use to make the claim that they are “professionals” and are often the founding document for a profession, e.g. the Hippocratic Oath.2 While it is true that not all such oaths are codes, it is often the case that codes are built into oaths or other related ceremonies related to become a professional. They can be found in the ceremonies ordaining religious leaders in many faiths, and in swearing the oath of office for many political leaders around the world” (p.4)

**The Purpose of Codes**

“Codes of ethics are written to guide behavior. Any final analysis of the impact of a code must include how well it affects behavior. (p.6) Codes are not designed for “bad” people, but for the persons who want to act ethically. The bad person will seldom follow a code, while most people – especially public servants -- welcome ethical guidance in difficult or unclear situations. The average person is not grossly immoral but often tempted, and sometimes confused, by what appears to be a virtuous path. (p. 7) No code, no matter how severely enforced will make truly bad people good. However, ethics codes can have a demonstrable impact on the behavior of bad people in organizations. When everyone clearly knows the ethical standards of an organization they are more likely to recognize wrongdoing; and do something about it. Second, miscreants are often hesitant to commit an unethical act if they believe that everyone else around them knows it is wrong. And, finally corrupt individuals believe that they are more likely to get caught in environments that emphasize ethical behavior”. (pp. 7-8)

“the use of ethics codes in public service can have a positive impact in several ways. First, codes of ethics increase the probability that people will behave in certain ways. They do this partially by focusing on the character of their actions and partly by focusing on sanctions for violations. In addition, reliance on codes can reduce the sacrifice involved in an ethical act.

Second, good ethics codes can focus public servants on actions that result in doing the right things for the right reasons. Ethical behavior should become a habit and effective codes allow both bureaucrats and elected officials to test their actions against expected standards. Repeated over time this kind of habit becomes inculcated in the individual and ingrained in the organization.

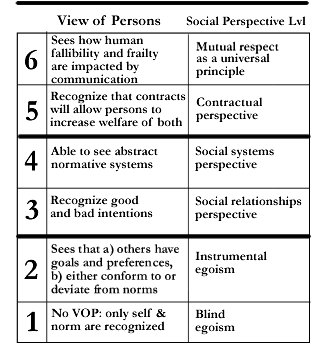
Third, codes of ethics do not take away one’s own moral autonomy or absolve the public servant from the obligation to reason. Codes of ethics provide at most a strong prima facie reason to act in a certain way. However, these can be overridden by strong, reasoned objection. The expectation is that the norm is not to violate the code and such violations can only be justified because of a higher ethical principle.

Fourth, codes of ethics can function as a professional statement. That is it expresses the public service’s commitments to a specific set of moral standards. This has both cognitive and emotive value.13 Cognitively it gives a person joining a profession, civil service, a clear set of value to which they are expected to subscribe. Not all individuals are comfortable working as civil servants and codes can clarify expectations. Codes can help provide the pride of belonging to a group or a profession. Pride is a critical emotion in motivating individuals to see themselves as professional”. (pp.8-9)

“Codes are not self-implementing. Printing a code of conduct and placing it on a wall, is not implementation. There must be an institutional fabric for developing the code, communicating it, interpreting it, training or education on the code, enforcing it and assessing it. A recent global study of ethics systems identified eight discrete elements of these programs that are used by governments around the world. Each of these elements can be expressed differently in organizations. But together they form a whole cloth of prevention and make the code operational as part of the organizational culture (p.25)

“We know from a variety of studies that adults can approach ethical issues from a range of different perspectives. Perhaps the best know research was a thirty-year longitudinal study of the moral development in children conducted by Lawrence Kohlberg at Harvard University. Although there has been criticism of his work, none of the critiques deny that adults in a general population vary in their stages of moral development. (See Figure 2.) Researchers have found that there are statistical distributions of adults across all six of his developmental stages. Each stage presents discrete issues in code implementation. (p. 29)

**Figure 2. Kohlberg’s Stages of Development of Moral Values**



The importance of this work, as well as the social psychology research at the Center for the Study of Ethical Development at the University of Minnesota,46 has contributed several key elements to understanding what must go into an ethics code and why they work. First, because individuals approach ethics problems with “different” lenses a code must be able to address multiple levels of meaning.47 Some individuals only want to know “what will happen to them” if they violate the code; others want to understand the rule; while still other want to know what principles underlie the rules. Good codes address all of these levels”. (p.30)

“Secondly, empirical research at the University of Minnesota strongly supports the notion that ethics can be taught. Because of this codes must persuasively address the range of approaches public servants use to analyze ethical questions. A good code then becomes the foundation for good pedagogy. Ethics education (or training) programs become far more effective if they are based on codes that can be understood, and analyzed, at several different epistemic levels.

It is also important to weave the new code into the pre-existing fabric of the organization. That is, the new code must be accompanied by any necessary changes to institutions, conduct penalties, civil service rules or legal regimes. There must be special care to account for values that have been added or are now not part of the code, as well as behaviors newly added to be unacceptable or behaviors that are now acceptable. The most common mistake in launching a code is the assumption that the code stands on its own. Codes have a dynamic relationship in government and care must be taken to avoid confusion and ineffectiveness that could result from code revision”. (p.31)

“Ethical values and principles in codes must have both cognitive and emotive elements. They must appeal to reason, as well as the emotional content of patriotism, loyalty or professionalism. Effective codes of conduct focus on a manageable list of inappropriate behaviors articulated in a clear and concise manner. Both of these should be written for the intended audience, not specialists in the area. They must also have penalties associated with them that are appropriate and timely. Most successful codes have both administrative and criminal penalties. In the vast majority of ethics cases administrative penalties (demotion, salary reduction, and dismissal) are the most appropriate penalties. However, certain acts warrant criminal or civil penalties. (p. 70)

“If the role of multi-national organizations is to help in the development of transitional societies, then effective code development must be one essential part of a long-term strategy. This is an opportunity to get at corruption at its roots and in the most efficient manner. Successful codes are one of the keys. As Victor Hugo wrote:

**Mightier than the tread of great armies, is an idea whose time has come”** (p.76) (Gilman, 2005).

Gilman, S.C., PhD. (2005). Ethics codes and codes of conduct as tools for promoting an ethical and professional public service: Comparative successes and lessons, prepared for the PREM, the World Bank, pp.1-76, Retrieved from, <https://www.oecd.org/mena/governance/35521418.pdf>