

ABSTRACT

Physician-Assisted Dying: A New Model for Current Clinical Application

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Physician-Assisted Dying is a practice that has become more prominent in medicine in the last two decades. In its long and varied history, it has affected multiple cultures and garnered diverse responses from the people of that time. Typically, the main two factors associated with physician-assisted dying include patient autonomy and sanctity of life. However, a new model is needed that combines these two factors along with “social value” to more accurately show the effects each has on both society and individuals with fatal diseases. As an added benefit, the model can be used to analyze both legal policies that have been enacted and individual patients who wish to utilize physician-assisted dying to avoid suffering. Finally, physician-assisted dying is a practice that will only grow in the coming years due to current medicine, and so current physicians and other healthcare providers must consider its clinical application in the future.

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PHYSICIAN-ASSISTED DYING
A NEW MODEL FOR CURRENT CLINICAL APPLICATION

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TABLE OF CONTENTS

Acknowledgements	iii
Dedication	iv
Chapter One: History of Physician-Assisted Dying	1
Chapter Two: Introduction of the New Model	16
Chapter Three: Applying the Model to Society	29
Chapter Four: Applying the Model to Individual Cases	43
Chapter Five: The Future of Physician-Assisted Dying	54
Bibliography	61

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DEDICATION

To my parents, Kevin and Kimberly Maher.

Thank you for all the love and support you have given me.

CHAPTER ONE

History of Physician-Assisted Dying

In order to fully understand physician-assisted dying, the practice must be viewed in a historical setting to understand its impact on healthcare. Physician-assisted dying, contrary to popular belief, has not been restricted to the last century. Rather, the history of physician-assisted dying and euthanasia stretches throughout most of human history, impacting the people and ideas of the time in various manners.

The origins of euthanasia can be seen as far back as the civilization of Ancient Greece. In this time, death was glorified rather than feared; what people feared was to be forgotten. Part of this philosophy was that most Greeks did not think there was an intrinsic value to life. Rather, Greeks feared the debilitating effects of time and age, believing that it reduced their posthumous fame due to their perceived weakness near their death(Katsouda 2005). Many would rather end their life at an earlier age than risk the pain of a long, drawn out illness. In some areas like the island of Kea, actively seeking death was actually considered brave and honor-worthy. Katsouda notes that “rather than growing older and ill, they preferred a mass exodus from life by drinking hemlock, in a festive atmosphere like that of the ancient symposia, when they drank wine in the name of their gods”(2005).

Perhaps the most extreme example of willful euthanasia and suicide was in the warlike nation state of Sparta. The Spartans had a value system that had no place for anyone seen as unfit or weak. Infants and invalids were often put to death due to their inability to contribute to the martial society; any perceived weakness in this society was

treated with disgust and disdain, and was quickly removed from the populace. In Sparta, it was commonly held that “a person ill-suited for health and service to the state was better off dead than alive”(Dowbiggin, 2005, p. 8). While this region’s view of euthanasia was extreme, other cultures like that of the Romans were more moderate in their use of euthanasia.

The early Romans had a tolerant view of euthanasia and actively used it themselves. In this culture, suicide was not considered to be immoral due to the fact that the Romans did not have the belief of the sanctity of life. Indeed, “the ancient Greeks and Romans did not think that all human life had an inherent value”(Dowbiggin, 2005, p. 8). Therefore, taking one’s life was not a failure on their part; it was viewed as a victory over fate. Dowbiggin confirms this when he states, “...the freedom to kill oneself was a sign of one’s autonomy and one’s power over the vagaries of existence”(2005, p. 9).

However, not all Greeks and Romans shared in this tolerant view of suicide. The Stoics believed that there existed a cosmic plan in which no person could avoid their duty, and that two conditions had to be met in order for a person to have an acceptable suicide. The first condition stated that “the person’s motivation had to fit an acceptable category, such as a chronic or incurable disease”(Manning, 1998, p. 7). The second condition stated that “the person had to weigh his or her responsibilities to others”(Manning, 1998, p. 7). In other words, the Stoics believed euthanasia was acceptable under certain circumstances; however, they did not believe in indiscriminate suicide or euthanasia as the Spartans did. On the other hand, the Pythagoreans opposed euthanasia completely, as it went against their belief that human life was a gift from the

gods. The Pythagoreans believed that “to artificially terminate one’s life was a violation of the god’s commands”(Manning, 1998, p. 7).

Plato and Aristotle, two of the most well known philosophers in human history, both wrote on euthanasia and physician-assisted dying. Interestingly enough, their opinions diverged on this subject. Plato opposed suicide except in the cases of chronic or incurable illness. Much like the Spartans, Plato held that “the chronically ill and disabled were useless both to themselves and to the state” (Manning, 1998, p. 7). However, he opposed the idea that a person can take another’s life; indeed, he stated that “doctors should be punished by death, if by administering any sort of drug they contribute to the termination of life”(Papadimitriou, 2007, p. 26). From this viewpoint, it could be presumed that Plato would have approved of physician-assisted dying.

Aristotle, however, did not tolerate euthanasia or suicide at all and took an unusual stance at this time. Rather than thinking it noble to try and control one’s fate, Aristotle thought it cowardly to commit suicide. Aristotle thought it more noble “[to face] death courageously as an important test of moral virtue”(Manning, 1998, p. 7). In addition, Aristotle believed that having someone take their own life deprived society of a productive worker, giving an argument from the basis of one’s role in society.

Most notably Hippocrates, considered the father of western medicine, clearly opposed euthanasia and physician-assisted dying in the Hippocratic Oath. It states, "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death," thus leaving the reader with no doubts to his meaning. However, records indicate few physicians abided by the Hippocratic Oath in its entirety, choosing to ignore anything that disrupted their own practice. In addition, the Hippocratic Oath was not known to

every physician in the region; therefore, they could not have abided by its tenants due to their lack of knowledge of its existence. For the most part, physicians could choose whether or not to directly give euthanasia or indirectly by giving their patients poison; or as Carrick states it, physicians “possessed what may be described as a *discretionary* professional right to assist in abortion or voluntary euthanasia”(Carrick, 2001, p. 180).

The Greek and Roman societies were forever changed, however, with the arrival of Christianity. Christianity (and Judaism to a certain degree) directly influenced the views of euthanasia and suicide by putting a new emphasis on the belief of the sanctity of life due to the commonly held notion that all life was a gift from God. Dowbiggin notes that “on multiple occasions in the Old Testament, God is acknowledged to exercise an absolute sovereignty over life and death”(2005, p. 12). To the Christians and Jews, taking one’s life directly contradicted the notion that life was a gift from God, and thus was a sin. Indeed, death was often seen as the punishment for sin, while life was meant to be used to honor and love God. Fusé notes that “death has historically carried the connotations of ‘divine punishment,’ ‘undesirability,’ and ‘something negative’”(1997, p. 15). Thus, committing suicide was tantamount to choosing sin over God’s love.

Early church leaders such as Augustine solidified the belief that suicide was a sin in their writings, further condemning it as an affront to God. Augustine wrote in *City of God* that suicide was simply another form of murder; the only difference between homicide and suicide then was the recipient of the act. Dowbiggin summarizes this by simply stating that suicide “was a sin and a crime prohibited by the sixth of the Ten Commandments”(2005, p. 12). Fusé further supplements this reasoning, stating other aspects of Augustine’s argument such as “...the body is the temple of God...” and

“...each human body is the vehicle of an immortal soul...” and “...life is the most precious gift of God...”(Fusé, 1997, p. 17).

Later on, Thomas Aquinas added to these arguments in his own writings, rejecting the idea of suicide completely. His three main arguments concluded that “1. Taking one’s life was a challenge to God and was a mortal sin and crime; 2. Suicide was a sin against justice because it meant renunciation of one’s responsibilities to one’s community; 3. To go against such basic natural instinct was against nature”(Fusé, 1997, p. 18). Thomas Aquinas thus not only solidified the idea of suicide being a sin, but also applied a view that suicide affected society as a whole, as Aristotle did.

The belief that suicide (and in turn euthanasia) was morally wrong was firmly planted in the minds of those who considered themselves Christian, and this belief became especially true during the Medieval Ages. The idea was so pervasive that “the anti-suicide consensus was reflected in clerical doctrine and secular literature and law”, thus almost eliminating the debate of euthanasia and suicide (Dowbiggin, 2005, p. 16). Committing suicide became one of the worst sins a person could do, and was subject to what the Church considered to be suitable punishments. Fusé expounds upon this, stating “at the Council of Orleans in 533, the Church denied burial to anyone who committed suicide while being accused of a crime... and at the Council of Braga in 563, no funeral rites were allowed to any suicide...” (1997, p. 18).

This belief in turn affected the physicians of this time, who were closely intertwined with the church through the many hospitals being built to accommodate the sick and suffering. These hospitals were privately owned by the Catholic Church, and thus the belief of euthanasia and suicide being sins permeated the medical field. In

addition, there was a shift in the ideas toward caring for patients: “physicians began to feel the moral obligation to care for as well as cure patients” (Dowbiggin, 2005, p. 18). Failing in this, the physicians felt it their duty to stay with their patient through the bitter end, providing what comfort they could.

This did not translate to easing the patient’s discomfort at their time of death through euthanasia or pain relief. This was due in part to the belief that patients were meant to suffer, as their suffering brought them closer to God. Dowbiggin elucidates even further by saying “those in pain, distress, and despair were meant to be comforted in all physical and moral ways, but suffering was also viewed as punishment for past sins and a means of emulating the passion of the Savior himself” (2005, p. 18). Death was so widespread and common at this time that it became a constant for the people. Wars, such as the Protestant Reformation, erupted in which millions were killed for their religious beliefs. Plagues, such as the bubonic plague, wiped out millions due to the poor sanitation. Famine spread across the countryside as people starved due to poor harvests. Death was seen as unavoidable, and thus no one thought to hasten it through euthanasia and suicide. Rather, “the tribulations of death, when imminent, were more to be accepted stoically than avoided through aggressive human intervention” (Dowbiggin, 2005, p. 19).

In addition, the physicians of this time were limited in what they could do for their patients, as the medicine was not very developed. Most patients simply did not live long enough to suffer from chronic conditions such as cancer and diabetes. Rather, they often died of infections, famine, or war, thus leading to quick deaths that physicians simply could not prevent. Since patients were not lingering around as they are today, there was simply no need for euthanasia and, therefore, it was not developed.

However, the birth of the Renaissance once again brought the ethics of suicide and euthanasia into question. The Renaissance brought about a “departure from the deo-centric view (‘God is the measure of all things’) to anthropo-centric view (‘man is the measure of all things’), the assertion for the autonomy of knowledge, multiplicity of truth-claims and a belief that the human body must be looked upon as natural and good and not as a source of temptation and sin” (Fusé, 1997, p. 19). This change of view in turn influenced notable authors such as Thomas More and John Donne to comment on euthanasia and suicide, challenging their sinful nature.

Thomas More was widely considered to be a devout Catholic, even accepting to be executed by King Henry VIII rather than compromise his own beliefs. However, in his novel *Utopia*, More writes:

If the patient finds these arguments convincing, he either starves himself to death, or is given a soporific and put painlessly out of his misery. But this is strictly voluntary, and, if he prefers to stay alive, everyone will go on treating him kindly as ever. Officially sanctioned euthanasia is regarded as an honourable death-but if you commit suicide for reasons which the priests and the Bencheaters do not consider adequate, you forfeit all rights to either burial or cremation, and your body is just thrown unceremoniously into a pond (More, 1965, p. 102).

In this paragraph, More clearly points out that in the “perfect” society euthanasia is accepted and deemed honorable, as long as it is used correctly. He also plainly states that euthanasia is strictly voluntary, thus seemingly endorsing autonomy over sanctity of life or society. Whether More actually believed this or wrote it as merely a delusion is still debated; however, many pro-euthanasia groups have used this passage in their arguments over the centuries, proving its value.

John Donne took a more definitive stance on suicide, arguing that humans could not pass judgment on others since that would be to presume what God’s true purpose

was. He also pointed out that “society professed a faith in the sixth commandment’s prohibition against murder when it simultaneously made exceptions for capital punishment and killing in wartime” (Dowbiggin, 2005, p. 24). Donne’s work went mostly unnoticed, and the debate on euthanasia and suicide remained unchanged until the 18th century.

The 18th century was notable in the fact that this was the first time in centuries that there were philosophers who were supportive of suicide since Ancient Greece and Rome. Philosophers like Voltaire, d’Holbach, Montesquieu, and Hume argued against the laws punishing those who had committed suicide, justifying their arguments by pointing out that the punishments affected the living more than those that had died. Most officials agreed with these sentiments, and “even those who were less willing to question the moral prohibitions against suicide thought these laws were barbaric and had outlived any useful purpose” (Dowbiggin, 2005, p. 33). The secular laws on suicide were thus stricken down, turning suicide from a crime into a cultural taboo. However, a united front to gain more support for suicide was never accomplished, as these philosophers often argued for it in different contexts.

The 19th century proved to be the starting point on the true debate of euthanasia. By this time medicine had begun to advance, allowing physicians to treat their patients more effectively. In the 1840s, anesthetics such as ether and chloroform were discovered, allowing doctors to operate on patients for the first time without causing severe pain to the patient. With time, anesthesia was widely used in surgeries, allowing physicians a greater ability to help their patients than ever before; however, physicians also began to consider the possibility of using anesthetics to kill their patients. The first

to suggest using anesthesia to kill the suffering or frail was Samuel Williams, arguing that ““worthwhile life should replace the old doctrine that all human life was sacred”” (Dowbiggin, 2005, p. 50). By challenging the older belief of the sanctity of all life, Williams may have unwittingly sparked a chain of events which would set self-autonomy and the belief in the sanctity of life at odds with each other. Suffice to say, Williams certainly breathed life back into the euthanasia debate.

The euthanasia movement was further bolstered by Darwin’s theory of evolution in *The Origin of Species*, in which Darwin explained survival of the fittest and natural selection. Scientists began to apply this theory to social and biological principles, eventually even applying it to the sick and dying. Miller notes that “this biological and social philosophy may have promoted the idea that society should assist its weakest members to end their lives, not for merciful motives but for economic and eugenic ones” (1998, p. 12). This mode of thought thus put one’s role in society as the most important factor, and ultimately was influential in much of what happened in the Nazi concentration camps.

At the beginning of the 20th century, the euthanasia debate was well and truly alive again. Groups in the United States and Great Britain petitioned their governments so that it might be legalized; however, none of these groups had too much success. At the same time in Germany, euthanasia was hotly debated among the legal and medical fields. One of the more hotly debated topics discussed which groups could be euthanized: those who were suffering, those considered as mentally challenged, and those in a coma. Professor Binding, a specialist in criminal jurisprudence, and Dr. Hoche, a psychiatrist, came up with a process to allow for controlled euthanasia, with the caveats

that one must be terminally ill and “must have either requested death or consented to dying” (Wilke, 1998, p. 6). Thus, Binding and Hoche maintained that euthanasia should not be allowed for the mentally handicapped or those in a coma, since their express permission would not be available. The process also outlined “a three-person panel of professionals and the ability of the person to withdraw consent at any time,” and recommended “that the initiative be made by the patient in the form of an ‘application for permission’” (Wilke, 1998, p. 7).

However, Hoche and Binding’s suggestions were ultimately overridden by the Nazi party coming into power in the 1930s. That is not to say that the euthanasia program was immediately used for eugenic purposes; the first euthanasia to be permitted were for “defective” infants and children, followed by “an adult program for an ‘easy death’ for incurably sick and mentally ill Germans,” showing compassion for those suffering from debilitating disease (Wilke, 1998, p. 8). Euthanasia was meant as an aid for the German people, and, ironically, in this program it was decided that “Jews did not deserve the ‘benefit’ of psychiatric euthanasia” (Wilke, 1998, p. 9). Physicians were under no pressure to participate in the program, maintaining the voluntary nature of the program.

The euthanasia program quickly grew out of control in the hands of the Nazi party. The Nazis began to worry less for the patients, and put more effort into forming the “superior” race. In other words, the Nazi’s put more emphasis on one’s role in society than autonomy or sanctity of life. In order to accomplish this, the “Committee for the Scientific Treatment of Severe and Genetically Determined Illness was formed to determine whether and how a euthanasia program for children and adults would operate”

(Wilke, 1998, p. 10). This in turn led to the T-4 program, which was implemented to administer euthanasia on an organized basis. It was still required for the patient to give permission to be euthanized (or in the case of the mentally handicapped, their parents or guardians' permission). With time however, the Nazi's began killing tens of thousands of the mentally impaired without the express permission of their guardians. While the program was shut down until World War II, it is estimated that "80,000 to 100,000 people had been killed under the T-4 program" (Wilke, 1998, p. 11).

With the beginning of World War II, the euthanasia program of Germany ceased to exist; in its place, the Nazis implemented the concentration camps responsible for the genocide of millions of people. At this point, the Nazis were no longer caring for their people; they were simply removing what they considered was weak to their society. In this regard, the Nazis completely did away with the sanctity of life and autonomy, only caring for the society as a whole. To consider what the Nazis did to be euthanasia is wrong, as the death that they advocated was far from good or peaceful.

Naturally, after seeing how badly euthanasia was abused by the Nazis, the world was reluctant to implement any sort of euthanasia program. Movements in the United States and Great Britain lost much of their support after the horrors of the concentration camps, and the debate on euthanasia seemed to die. The sole exception was in the Netherlands, where doctors had refused to participate in the Nazi's genocide. The debate on euthanasia quickly grew in the public domain, eventually coming to a head in 1971.

At this time, Dr. Geertruida Postma was brought up on murder charges after injecting her mother with a dose of morphine. Her mother had been living in a nursing home, in which she suffered from partial paralysis, deafness, and had great difficulty

speaking. It was revealed that she “had unsuccessfully attempted suicide and had begged her daughter for help” (Tulloch, 2005, p. 97). After witnessing her mother’s incredible suffering, Dr. Postma gave her mother a lethal injection and “informed the director of the nursing home what she had done, who reported the death to the police” (Tulloch, 2005, p. 98). Dr. Postma was found guilty, although she was given a relatively light sentence of a one-week suspended sentence and probation for a year, suggesting a sort of public acceptance for the action.

With this case, the unspoken support for euthanasia quickly became public, as hundreds of people began writing to the government showing support for the practice. Doctors began to sign open letters admitting to also performing euthanasia. With the support of the public, the euthanasia debate could not be ignored any longer in the Netherlands. In 1984, a proposed set of criteria was set up to allow for euthanasia called the Rotterdam criteria. The criteria are as follows:

- The patient must have made a voluntary request
- The request had to be well considered
- The wish for death had to be enduring
- The patient had to be suffering unacceptably
- The doctor had to have consulted a second doctor, who agreed with the proposed course of action (Tulloch, 2005, p. 99).

In addition, the cause of death had to be clearly stated as euthanasia or physician-assisted dying, with the medical examiner reporting to the district attorney. As long as the physician abided by these criteria, he could not be prosecuted for euthanizing his patient. While it can be argued that these criteria are vague at times, they were incredibly

influential on both the Death with Dignity Act and the Netherlands law. Indeed, one can see the ghost of the Rotterdam criteria in both laws, which are more specific in their requirements.

The state of Oregon was one of the first governments to legalize physician-assisted dying, calling it the Oregon Death with Dignity Act. The law passed by a very narrow margin of fifty one percent in 1994. The law was delayed, however, by the District Court until 1997, when citizens voted against repealing the act by sixty percent, suggesting more support for physician-assisted dying. The Death with Dignity Act operates under the restrictions that the patient must:

- Make two verbal requests to the physician, at least fifteen days apart.
- Make a written request to the physician.
- The patient's physician should call in a second physician to confirm the diagnosis and progress, and the competence of the patient to make the request: any sign of depression meant the patient must be referred to counseling.
- The patient's physician should inform the patient of alternatives, such as pain management and palliative care.
- The physician should request that the patient notify his next of kin of the request (Fulloch, 2005, p. 66).

The Death with Dignity Act has had few problems since its inception. Since 1997, a yearly report has been published and been made available to the public to ensure proper procedure is followed by all those involved. In addition, it has influenced other states such as Washington and Montana to pass laws and acts allowing for physician-assisted dying. With time, it is conceivable that more states will pass similar laws

allowing for physician-assisted dying.

After decades of debate, the Netherlands fully legalized euthanasia and physician-assisted dying through the Termination of Life on Request and Assisted Suicide (Review Procedures) Act in 2002. This law required that physicians must:

- be satisfied that the patient has made a voluntary and carefully considered request
- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement
- have informed the patient of his or her situation and further prognosis
- have come to the conclusion, together with the patient, that there is no other reasonable alternative
- consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
- have exercised due medical care and attention in terminating the patient's life or assisting in his or her suicide.

In addition, this law provided oversight for euthanasia and physician-assisted dying in the Netherlands, ensuring that all physicians that participate in the program adhere to the criteria and report the deaths correctly.

With the success of the euthanasia program in the Netherlands, other countries began to reconsider the illegality of physician-assisted dying or active euthanasia. Some countries, such as the United Kingdom and Australia, still maintain their laws despite a sizable portion of the public supporting euthanasia. Belgium in the meanwhile has legalized euthanasia and physician-assisted dying in a program similar to that of the

Netherlands.

CHAPTER TWO

Introduction of the New Model

Throughout its history, the debate on physician-assisted dying has seemingly revolved around two central ideas: patient autonomy and sanctity of life. This is unsurprising, as these two ideas are almost complete opposites. However, with the advancement of medicine over the past century, I believe there is another factor that influences this debate, one that has gained more emphasis over the past two centuries. That factor is the idea of social value—namely, one’s role in society.

The inclusion of social value brings about a completely new dynamic in the debate of physician-assisted dying and gives new weight to factors that have not always been considered due to the limited effectiveness of medicine. This new dynamic is best pictured as follows:

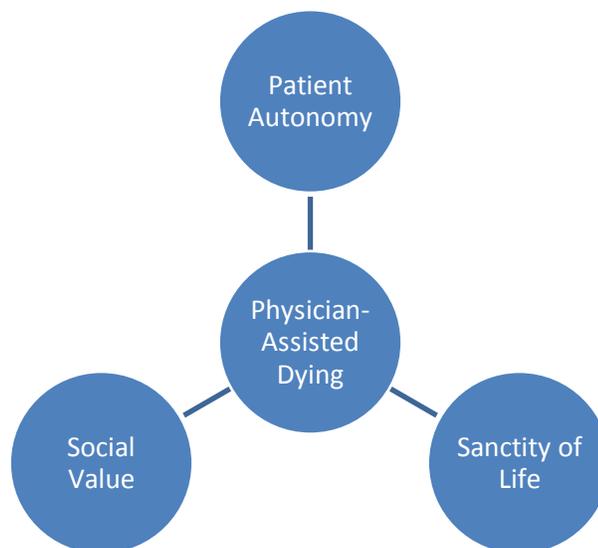


Figure 1: The New Model for Physician-Assisted Dying

As the diagram indicates, the issue of physician-assisted dying is no longer limited to the back and forth debate of autonomy versus the sanctity of life. Rather, a delicate new balance is formed and requires more careful consideration of physician-assisted dying and its consequences on medicine, politics, and civilization.

The rest of this paper will investigate the three factors affecting physician-assisted dying, different physician-assisted dying programs in varying countries, individual cases, and will finally suggest what the future holds in store for physician-assisted dying.

Patient Autonomy

The idea of patient autonomy is nebulous at best. With as many cultures, philosophies, time periods, and people that have tried to give meaning to this term, it follows that there is no set definition or understanding for autonomy. Indeed, Schermer notes that autonomy is “a term that is loosely associated with several ideas such as freedom, privacy, voluntariness, the ability to choose for oneself, and so on” (2002, p. 3).

For the purposes of this paper, I will refer to patient autonomy according to the definition given in the Federal Register of 1979. It states:

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons’ considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so. (1979).

To begin with, the definition of autonomy clearly states that the person must be “capable of deliberation.” In other words, this person must be able to make responsible decisions that consider the consequences of any action that might be taken. Therefore,

anyone unable to make a choice on the matter of their own death (i. e. the clinically insane, minors, etc.) would not classify as being autonomous. However, this definition of autonomy becomes cloudy in the face of depression.

A patient's depression has the potential to affect her judgment, making them choose rash or inadvisable decisions that another person might not make. Therefore, it is not impossible for a terminally ill patient to choose physician-assisted dying when he or she normally might avoid it. Oregon state law requires that the patient undergo a psychological assessment to interpret if the patient is clinically depressed. However, I would argue that depression does not have as big an impact on end-of-life decisions for the simple fact that it would make sense for a patient to be depressed at her eventual death.

To face the looming specter of death without having some fear or depression would be viewed as abnormal. As patients come closer to death, they respond in a variety of ways. Some undertake life-affirming actions, such as mending relationships and visiting family. Others may turn to religion and hope for a miracle. Still others are affected deeply by their impending death and feel sorrow, anger, regret, and a multitude of other negative emotions. However, none of these responses to death are wrong or strange. In fact, many patients will go through all of these coping mechanisms while dealing with death. Some will fight for every second they have left, while others will simply wish for a way out. It is feasible to believe that patients with poorer prognoses or more invasive treatments may consider physician-assisted dying or cessation of treatment more carefully than those who respond well to their treatments.

It is thus easy to see why many patients who consider physician-assisted dying are depressed. This does not mean that it should be withheld from them, however, as they still are capable of choosing their own treatments. With the knowledge that they will die in mere months, some patients might wish to end their lives sooner so that they might avoid the pain, loss of quality of life, and terror that a slow death brings. This line of thought goes against many religions and philosophies. For example, Kass argues that “the person who engages in physician-assisted dying will, obviously, be dead, and someone who is dead can no longer exercise her autonomy” (Gill, 2005, p. 55). However, there are arguments that question why these teachings might be wrong. Gill counters this, stating “she will not be able to exercise her autonomy in the future no matter what she does. Hers is not a decision to prevent herself from being able to make future decision, because future decisions will not be hers to make regardless” (2005, p. 57). In effect, Gill suggests that by choosing to undergo physician-assisted dying, a patient is giving herself a final chance at autonomy.

Another factor to consider with patient autonomy is the semblance of control. To many, being diagnosed with a terminal illness takes away their capacity to make their own decisions on how they live. Many must undergo countless procedures and tests in an attempt to keep them alive as long as possible, all the while lowering quality of life as they lose the ability to perform mundane tasks. As Gill points out, “the limited amount of time a person with a terminal disease has left to live eliminates many of the options that constitutes decision making...[and] the nature of many terminal diseases can preclude big decision making in a manner that is distinct even from the amount of time a person has left to live” (2005, p. 58).

To some, choosing physician-assisted dying or refusing treatment is tantamount to taking back some control over their lives. Rather than endure the morbidity of their disease, some may choose to avoid it and allow death to come naturally, or even end it quickly. Gill states that “such a person’s ability to make big decisions will be nonexistent in all the futures between which she must choose” (2005, p. 58). Thus, by choosing to die, a patient is not revoking her right to make decisions in the future. Rather, she is choosing to make what is most likely going to be her last “big” decision for her life.

Patient Autonomy is of vital importance to physician-assisted dying. With that in mind, health care professionals must realize that for many, any semblance of control is preferable to none. In addition, we must consider how depression affects the mindset of those who are dying, and ensure their true wishes are fulfilled as much as possible.

Sanctity of Life

The world is full of many religions and philosophies. While they have their differences, many religions have a common view of suicide in that they forbid it. Many of these religions and philosophies believe that life is sacred and thus believe in its sanctity. Therefore, to take one’s life or another life is viewed as morally wrong.

Because of these views, sanctity of life and physician-assisted dying have been at odds since physician-assisted dying began to be more considered by modern medical societies. Many believe physician-assisted dying to be a direct violation of the gift of life and oppose it fully. These views are held across many religions, cultures, and ethnicities. For example, the Catechism of the Catholic Church uses the sixth commandment as a deterrent to physician-assisted dying. Specifically, the Catholic Church’s view on physician-assisted dying is as follows:

Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded. (549)

In short, the Catholic Church denies any sort of death short of natural causes. Islam seems to have similar views. In a study conducted by Aghababaei on the views of euthanasia held by Muslims, the researchers found that 62% of the sample group who underwent the experiment did not believe it to be morally acceptable (Aghababaei, 2013, p. 337). In this, Islam shares a similar view of suicide to that of Christianity, believing it to be a sin against God.

Despite the negative views of suicide held by many religions, there are many who feel that physician-assisted dying is not inherently wrong. In fact, in many societies, this view is rapidly changing to one of support. For example, in Hinduism killing oneself for selfish reasons was condemned. However, “Hinduism venerated enlightened people who voluntarily decided their mode of death” (Sinha 2012, p. 5). Sinha then states that “the Indian mind would not consider the thought of euthanasia and physician-assisted dying as sacrilege” (2012, p. 5). Therefore, while Hinduism might not outright support physician-assisted dying, it certainly appears to be open to the idea.

Support for physician-assisted dying extends to other religions and philosophies as well. While many Christians are still opposed to suicide, particularly physician-assisted dying and euthanasia, there are those who support it. For example, in an article researching various views of physician-assisted dying and euthanasia across Europe, Delkeskamp-Hayes reports of a Father Bartmann who has the view that “suicide should not be judged, and one must ‘respect’ dying people who voluntarily put an end to their

lives” (Delkeskamp-Hayes, 2003, p. 5). Bartmann’s opinion goes so far as to suggest that Protestant doctrine should accept physician-assisted dying.

While other religious leaders may not agree with Bartmann’s view, there are those who believe concessions can be made for physician-assisted dying. For example, Delkeskamp-Hayes reports that Father Schotsmans does not support physician-assisted dying; however, he has the view that “an evil that is practiced in secret is better controlled when rendered transparent, even if that rendering involves legally permitting the evil” (2003, p. 4). Another minister in this article, Schirmacher holds a similar opinion, in that he believes “that not all suicides are illicit to the same degree” and that “suicides undertaken in order to anticipate a certain death or to escape unbearable suffering” are excusable, to a point (2003, p. 5-6). Despite their disagreements with physician-assisted dying, both of these priests seem to acknowledge the fact that it is a deep and complicated issue that often must be considered from multiple points of view.

This issue becomes even more complicated when it is viewed by a medical professional. In this, nurses and doctors have unique views in that they deal with death on a constant basis and thus often have to see patients whom they have become close to die. For example, in Gielen’s article on the views of nurses towards euthanasia, he writes that “a majority of respondents in each religious group favored the legalization of euthanasia or were prepared to assist in euthanasia themselves” (Gielen, 2009, p. 7). While initially surprising, Gielen then reveals that this support stemmed from “several studies [that] seemed to demonstrate the more dominant influence of professional experience or secular ethics on nurses’ attitudes” (2009, p. 7). Despite the teachings of their respective churches, the nurses had gained their own views of physician-assisted

dying from their personal experiences. When questioned about this, “several nurses said they were aware of the apparent contradiction between being religious and euthanasia, but nevertheless did hold the conviction that euthanasia should not always be illegal because they had come across situations in which they had thought it would have been the better option” (2009, p. 7).

Sanctity of Life encompasses many philosophies and religions and has drastically shaped the development of physician-assisted dying. For much of its history, sanctity of life has been a hindrance to any physician-assisted dying program due to the perceived lack of compassion for human life. However, as medical technology prolongs life expectancies, more people are coming to reconsider physician-assisted dying programs as an act of mercy to those suffering from debilitating diseases.

Social Value

Social Value is the newest factor that has an influence on physician-assisted dying. Social value includes the financial considerations that a patient must consider on his treatment, the influence the family and friends of the patient have on the decision, and the morals and personal values that a patient has grown up with. In a sense, social value is the meaning a patient imparts on his own life.

Social value has always had been present in physician-assisted dying to a certain degree; this can especially be seen in the Stoics’ belief that the person who wishes to die must consider his or her obligations to others. However, this role has become more pronounced in the past century with the advancement in medicine. In the middle ages, the life expectancy was around thirty years; people simply did not live long enough to warrant ending their lives more quickly through physician-assisted dying. Current

medical technology has allowed humans to live longer, but not without significant socioeconomic costs.

End-of life care costs are quickly proving to be the most costly part of current healthcare. Jennings reports that “end-of life care spending [costs] 10 to 12% of total healthcare spending in the United States...and approximately 25-30% of Medicare program benefits are spent on care at the end of life” (Jennings, 2011, p. 302). Wang adds to this, reporting, “One out of every four Medicare dollars, more than \$125 billion, is spent on services for the 5% of beneficiaries in their last year of life” (Wang). In other words, the United States of America spends an exorbitant amount of money on end-of life care, often with little to no benefit to the patient due to the disease. Despite this amount of money spent, there is little to no difference in the quality of care given to the patient, calling into question why so much is spent on end-of life care at all.

Compounding this problem is the ineffectiveness of hospice care. Originally seen as a means to combat the end-of life care costs, the high costs of hospice have resulted in the need for more limitations to be imposed on the programs. For example, any patients that hope to benefit from the Medicare Hospice Benefit must be:

certified as having a life expectancy of 6 months or less if the illness runs its normal course...and that while on the MHB, regular Medicare coverage is suspended and providers will only be reimbursed for services that have a palliative intent, [meaning] that to be on hospice the individual must forgo any additional ‘curative’ medical treatments. (Jennings, 2011, p. 307)

To illustrate these regulations, Byock gave this example on Medicare and hospice programs: “Thus, if a seventy-five-year-old hospice patient with advanced lung cancer is admitted to the hospital with respiratory failure and dies after three days, his bill for upward of \$27,000 would belong to the hospice program” (Byock, 2012, p. 104).

Therefore, it is easy to see why many hospice programs are insufficient in their care; it is for the simple reason that they do not have the proper funding to care for their patients. Until sufficient changes have been made to the current hospice care programs, it will not be a viable option for many suffering from fatal diseases.

In addition to the considerations that must be given for the costs of end-of-life care, society must also confront the grim facts about the actual process of terminal diseases. For many, debilitating disease will take away their basic human abilities such as being able to move, talk, or even clean themselves. In her article on Right-to-Die societies, Judd notes that bad odors and bodily leakages such as urine and excrement are viewed negatively in society, causing feelings of shame and lost dignity in those who are unable to control their own bodies (2011, p. 228). These people then must rely on others to care for them, furthering their own embarrassment and shame at this loss of control of their lives.

This loss of independence is traumatic to many, adding to their negative emotions at the ends of their lives. In addition, many fear just how dependent they will become on others. With the current costs of end-of-life care, many patients may be unwilling to have their families risk going into financial debt in order to pay for their treatments. Others may refuse to be taken care of, choosing to forgo treatments that would take away their dignity and independence. In short, many patients consider dying in a quick and peaceful manner preferable to a long process in which they must be taken care of financially and physically by caregivers and family.

Finally, to say that a patient's loved ones have no impact on the decision to end his or her life is inaccurate. The influence a family has on a patient's care should not be

underestimated, as the family wields tremendous influence on the decisions being made for health care. In some cases, the patient may pursue physician-assisted dying as a means to protect the family from financial or emotional burdens that come with a prolonged death. In other cases, the influence of the family may persuade or dissuade the patient from the decision of physician-assisted dying and into considering hospice or palliative care. Regardless of how the family influences the decision, it must be noted that the family does indeed influence the decision in a meaningful way.

Social value is the third and final aspect of the new model, and represents the current state of end-of-life care. In this, society must take into account end-of-life costs, as there could be a limit to how many people can be helped with limited funds. In addition, hospice care represents an alternative solution for curative treatment and physician-assisted dying; however, it must undergo changes to be a viable option. The loss of dignity that many patients perceive due to their loss of control of their bodies will cause some to consider physician-assisted dying more than others. Finally, the influence the family has may impact the decisions made by the patient in the waning days of life.

Interactions of the Three Factors

The three factors, as stated before, act as a balance in how physician-assisted dying is controlled and decided upon; in this manner, they are closely intertwined and affect each other, thus modifying the balance. For example, patient autonomy and sanctity of life have been considered opposites due to their contrasting views in medicine. However, in terms of the model, they are necessary to each other due to the balance each imposes on the other. Sanctity of life ensures that lives will not be thrown away without any sort of regard, ensuring that physician-assisted dying is not abused by patients (i. e.

patients that are considered suicidal). At the same time, patient autonomy ensures that the patient's wishes are fulfilled even against any possible religious reservations held by family members or close friends.

Social value and patient autonomy also affect each other, in that patient autonomy must be balanced with the patient's personal values and societal norms. For example, the patient might wish to undergo physician-assisted dying in order to avoid expensive medical treatment or a perceived feeling of shame for their inability to care for themselves brought about by society's views of decency. Simultaneously, patient autonomy is tempered by societal morals and views, limiting patients in their actions to avoid making rash decision. In addition, societal views directly affect any physician-assisted dying program, determining the laws that govern it.

Finally, sanctity of life and social value are closely intertwined and provide the final balance in the model. Much of social value is derived from religious views held by society and individuals, thus shaping the laws and customs that most people abide by. Concurrently, the view of sanctity of life and religion itself is hardly static; as ideas and outlooks change in society, religions and their views on sanctity of life also change, explaining how the current views of sanctity of life have become more open in recent years.

Applying the Model to Individuals

The first part of this chapter dealt with physician-assisted dying as in societal terms, dealing with current issues and developments in the three factors that affect physician-assisted dying. However, the model is effective in that it can also be applied in a much narrower sense, that of the individual. Obviously, choosing to undergo or avoid

physician-assisted dying is a deeply personal decision that can have many ramifications. Therefore, it requires a great deal of thought and preparation to come to this conclusion, which in turn is affected by the three factors of the model.

Each of the three factors has a differing amount of importance to each individual patient. For some, patient autonomy is more important than maintaining life. For others, the sanctity of life overcomes the ability for patients to make their own decisions. For the rest, putting their family first in terms of finances or care has more significance than maintaining their lives for a few more short months. Regardless of which factor the patient identifies more with, each patient is indeed affected by all three factors in some way. One factor does not simply overcome the other two; rather, the factors are constantly shifting with the emotions and decisions the patient must deal with at the end of his life. Some patients originally intent on physician-assisted dying may come to realize that they do wish to live their remaining days in hospice with their families, thus they would put less weight in patient autonomy and more into social value and sanctity of life. On the other hand, other patients may feel that their disease is indeed too much to live with and decide to undergo physician-assisted dying, thus putting less significance into sanctity of life and more into social value. Finally, some patients intent on physician-assisted dying due to their unwillingness to put their family through financial burdens may decide that palliative care is a better alternative, thus putting less weight into social value and more into patient autonomy. No matter the reason, the physician-assisted dying model should be considered a dynamic, shifting model rather than a static one.

CHAPTER THREE

Applying the Model to Society

In the past several decades, several governments throughout the world have legalized physician-assisted dying programs or are working to legalize them. The most well known programs are that of the Netherlands and Oregon's Death with Dignity Act, which were both put in place within the last twenty years. Despite their similarities, each law is distinctive from the other with its own strengths and weaknesses. The model will be used to analyze each of these laws, and the end of the chapter will have final comments on what can be improved with the law to ensure that each factor of the model has been given proper thought.

Oregon's Death with Dignity Act(1997)

Oregon's Death with Dignity Act has been in place for over sixteen years. In order to ensure control is maintained, the Oregon Health Authority reviews each case for every year and publishes a public report with all the relevant statistics. In addition, the Oregon Health Authority reports any transgressions against the law to the Board of Medical Examiners, and should it be determined the physician broke any of the rules, the physician would be subject to disciplinary action.

In its sixteen years, the Death with Dignity Act has had increasing amounts of patients requesting for physician-assisted dying each year. In 1998, 24 patients were prescribed medication for the express purpose of ending their life; of these, 15 died as a direct result of taking this medication, while the rest died from their disease before taking

their medication or chose not to take the medication. In 2013, 122 people were prescribed medication with the intent to end their lives; of these, 71¹ died as a result of taking this medication (see Figure 2). Twenty-eight of the patients who were prescribed medication chose to not take it, and subsequently succumbed to their disease shortly thereafter. 31 additional patients received their prescription; however it is unknown whether they ingested it at this point.

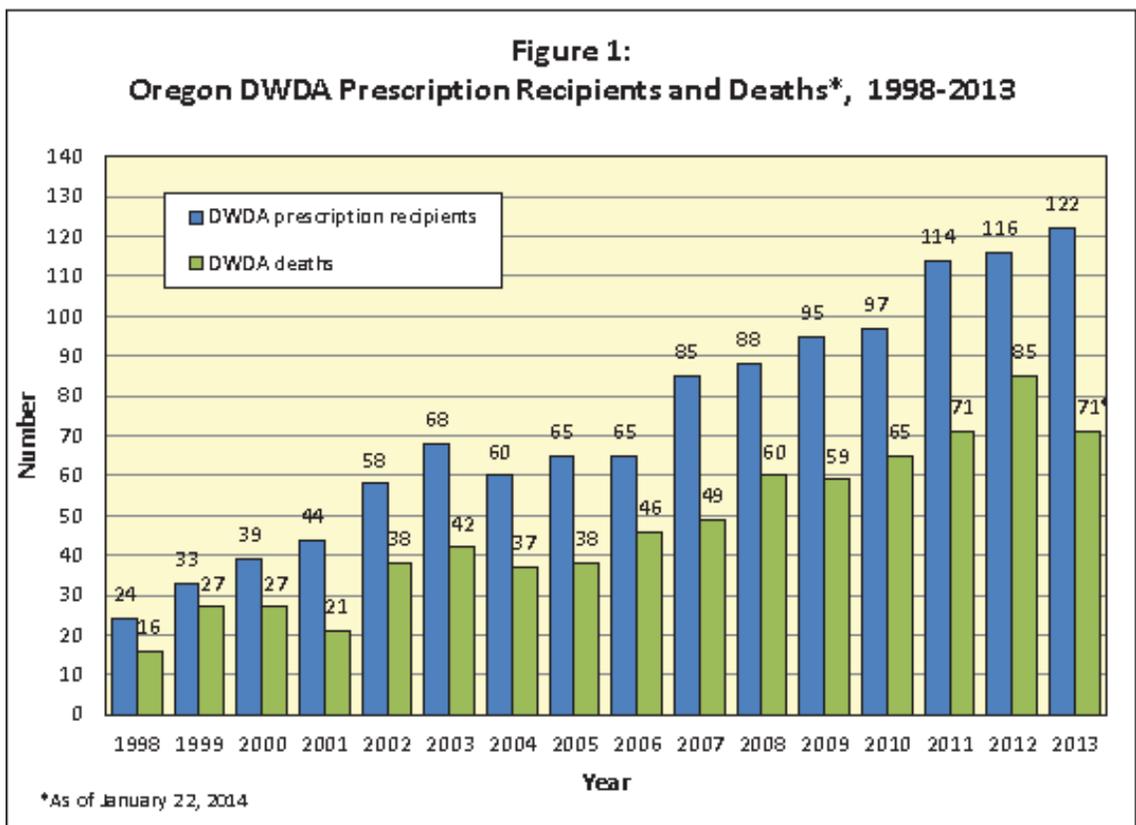


Figure 2: Oregon DWDA Prescription Recipients and Deaths, 1998-2013

In 2013, 69. 0% of the deaths through physician-assisted dying were patients aged 65 years or older, and 64. 8% had cancer. Ninety-seven percent of the patients were able to die in their own home, and 85. 7% of the patients were enrolled in hospice care at the

¹ 8 patients were prescribed medication in 2011 and 2012, but only died this year.

time they were prescribed medication. Two patients of the 71 that died in this time were referred for psychiatric evaluation by their physicians.

One hundred twenty-two prescriptions were given to patients in 2013 by 62 different physicians, who ranged from 1-10 prescriptions each. Prescribing physicians were present at the time of death for only eight patients, showing a downward trend over the last few years. However, no referrals were made to the Oregon Medical Board for failure to comply with the regulations set forth by the Death with Dignity Act.

In total, 1173 patients have been prescribed medication for physician-assisted dying, representing a very small proportion of the state's population. It should also be noted that many who were prescribed the medication chose not to actually take it; of the 1173 patients who have been given a medication to end their lives, only 752 have died as a direct result of taking it.

In chapter one, the specific requirements of the Death with Dignity Act were listed to give an idea of the law. Statistically speaking, the Death with Dignity Act seems to be moderately successful. However, the fact that this law deals in such a controversial topic means that our society cannot simply apply statistics to it. Rather, we must subject the law to constant scrutiny in order to insure the law is not being abused in any way. For this reason, the rest of this section will analyze each of the requirements by applying the model to insure each of the three factors is given proper credence.

The patient must be 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months.

The first requirement of the Oregon Death with Dignity Act involves the prognosis, age, and ability of the patient to make health decisions of their own volition. Through this requirement, restrictions are placed so that anyone cannot go through with physician-assisted dying and confines it to terminally ill patients who are legally recognized as adults and residents of Oregon. The restrictions also ensure that sanctity of life is upheld, preventing any suicidal tendencies from those who suffer from mental illness or depression. In addition, it ensures patient autonomy is upheld as it explicitly states that the patient must make the decision on his or her own. Social value is not as influential in this requirement; however, it is more strongly pronounced in other requirements.

The patient must make two verbal requests to the physician, at least fifteen days apart.

This requirement is influenced by all three of the factors listed in the model. The patient is able to make a request to go through the physician-assisted dying program, thus showing their autonomy. However, this autonomy is also balanced with social value and sanctity of life in the time requirements imposed on the patient. The respect for sanctity of life is maintained through the time limit; thus, the patient has some time to reconsider their choice. In addition, this time restriction also allows the patient time to contact any family members or loved ones, giving them ample opportunity to reconsider their decision. Finally, should the patient maintain their decision, they are able to reassert their autonomy.

The patient must make a written request to the physician.

As with the previous requirement, the patient's autonomy is asserted when they make this request. Since written requests are typically more official, this requirement has more weight, and most patients will treat it as such; however, should the patient maintain his choice, the written request will act as legal documentation. Furthermore, this requirement makes the factors of sanctity of life and social value even more impactful, as the decision must be made as a formal written request, giving it legal credence. This requirement has the potential to completely change the patient's mind due to the gravity of the request. Family members and loved ones will have a chance to further dissuade the patient from this course of action, thus respecting sanctity of life and allowing social value to have a role.

The patient's physician should call in a second physician to confirm the diagnosis and progress, and the competence of the patient to make the request: any sign of depression meant the patient must be referred to counseling.

This requirement deals more with the factors of social value and sanctity of life. By ensuring a second opinion is gained by another physician, respect for the sanctity of life is maintained by the doctors, ensuring that no rash decisions are made by either the physician or the patient. Furthermore, the other physician ensures that the prognosis for the patient is indeed grim enough to warrant physician-assisted dying. Social value is ensured in that the second physician also brings a different set of morals and values, while at the same time giving the patient an honest prognosis on what he can expect in the coming weeks or months, thus having the ability to affect the patient's decision.

Finally, patient autonomy is also respected, in that the physicians ensure that the patient is making the decision in a rational manner, and not simply succumbing to their fear of pain and dying.

The patient's physician should inform the patient of alternatives, such as pain management and palliative care.

As with the previous requirement, this part of the law deals more significantly with social value and sanctity of life. By giving the patients multiple options, the physicians ensure that the patients are not under the impression that their options are limited to physician-assisted dying or no treatment, thus giving social value credence. In this, patients can choose to undergo different treatments such as palliative care or hospice in addition to physician-assisted dying, and be able to maintain their sense of self worth and dignity. Furthermore, by giving patients alternative options, the physicians also give sanctity of life its proper gravity by attempting to dissuade the patient from their current course. Finally, the patient's autonomy is respected as the choice is ultimately the patient's; thus, all three factors have some role in this requirement.

The physician should request that the patient notify his next of kin of the request.

This requirement deals primarily with social value, as having the patient consult with the family will be a large influence on their decision. For some patients, simply seeing the family members or loved ones may influence the patient enough to reconsider his decision. Sanctity of life and patient autonomy have less impact on this requirement, and are better represented in the other requirements.

Final Comments on Death with Dignity Act

Each of the requirements of the Death with Dignity Act was clearly made with the intent to preserve and respect sanctity of life while also giving proper weight to patient autonomy. In addition, the law also gives proper credence to the considerations of social value in the consideration of the patient's family and financial stability. By giving consideration to all of these factors, the Death with Dignity Act represents a well balanced physician-assisted dying program.

That being said, it is not without its flaws. For example, the fact that fewer physicians have been present for their patients' deaths is worrying, as it seems to imply that physicians give their patients the medication and consider their part done with this patients' care. This could be construed as callousness or selfishness on the physicians' parts, and may lead many to believe that the physicians are simply trying to get rid of their patients. Arguments could be made to this claim; for example, the majority of the patients from 2013 were at home when they died. In addition, it could be argued that the physicians were attending to other patients.

No matter the true reason, in order to prevent arousing public anger, physicians participating in the Death with Dignity Act should strongly consider being present at their patients' bedside at the time of their death as a final comfort to them. Concessions could be made if, for example, the family wants to be alone with the patient at his or her time of death, but the physician should make every attempt to be present at the time of death.

Another concern is the number of requests that a physician might be given. In the statistics, it was noted that 61 physicians were requested for physician-assisted dying and ranged from 1 to 10 requests. Since there were only 67 deaths total, it seems unnerving

to think one physician was involved with a sixth of those deaths alone. While many reasons may exist as to why that particular physician was requested so many times, much of the public may become worried should it perceive that one physician is helping so many to die and may lead to another controversial figure such as Dr. Kevorkian, or Dr. Death. To prevent this, physicians who have so many requests should be closely analyzed by those involved in the Death with Dignity Act to ensure proper protocol is being followed and that the patients are not being coerced into this action.

Despite these flaws, the Death with Dignity Act has fulfilled each and every requirement that was set forth. The Oregon Health Authority ensures that the criteria set forth by the Death with Dignity Act is followed and ensures that the statistics are available to the public. The fact that fewer than 1200 people have requested for physician-assisted dying over sixteen years shows that the program is under control. Furthermore, the restrictions themselves show that proper credence was given to sanctity of life, patient autonomy, and social value. Therefore, the Death with Dignity Act can be considered a stable physician-assisted dying program that gives a proper recourse for patients.

Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)

The Netherlands was the first country to consider a physician-assisted dying program after World War II. After the Postma case of 1973, the Dutch people began to debate the possibility of a physician-assisted dying program until it passed the Termination of Life on Request and Assisted Suicide Act in 2002. While the law itself followed that of the Death with Dignity Act passed by Oregon in 1994, the different sets of criteria that were formulized in the 1980's certainly had an impact on the criteria used

in Oregon. I acknowledge that the Netherlands law allows for euthanasia as well; however, the fact that it allows physician-assisted dying in the law and has similar criteria to the Death with Dignity Act are reason enough to analyze it in the same manner as the Death with Dignity Act.

The Netherlands law differs from the Death with Dignity Act in several ways. Most notably, the program does not give permission for patients to undergo physician-assisted dying. Rather, the physicians act according to their patients' wishes, and their actions are analyzed after the fact by a committee comprised of a lawyer, a physician, and an ethicist. Should the three members find no problems, the case is considered to have followed all criteria and procedures. However, if even one committee member has any issue with the case, the case is analyzed closely at monthly meetings.

In 2012, 4,188 notifications of euthanasia or physician-assisted dying were received by the committees that oversee the program; of these, 3,965 patients died of euthanasia, 185 died of assisted suicide, and 38 died of a combination of the two. This represented an increase since 2011, which had 3,695 notifications. Of these deaths, 3,251 requests for euthanasia or physician assisted suicide were made by patients suffering from cancer, making it the most common reason for the request. Furthermore, 3,355 patients died in their home, 194 patients died in hospitals, 139 in nursing homes, 206 in a care home, 250 in hospice, and 64 in other areas.

As can be seen, the Netherlands had almost four times as many requests in 2013 as the Death with Dignity Act has had in the sixteen years it has been active. Euthanasia and physician-assisted dying are therefore much more commonly practiced in the Netherlands; it should be noted, however, that the Netherlands has a culture very

different from the United States, which is why their debates of euthanasia throughout the 1980's influenced the Death the Dignity Act. Indeed, it is this very openness that seems to influence the Termination of Life on Request and Assisted Suicide Act's criteria.

As with the Death with Dignity Act, the Termination of Life on Request and Assisted Suicide Act must be analyzed by more than statistics. For this reason, the criteria for this act will be analyzed in the same manner as the Death with Dignity Act.

The physicians must be satisfied that the patient has made a voluntary and carefully considered request.

This first criterion is influenced primarily by patient autonomy and sanctity of life in the model. Patient autonomy is ensured in that the patient himself must request for euthanasia or the physician-assisted dying; the physician and family cannot request for it themselves, ensuring the program remains voluntary. At the same time, sanctity of life is also maintained due to the requirement that the request must be well-considered, preventing patients from attempting suicide for unwise reasons. Social value is not as prominent as the other two factors, however, the consideration required to make a request for physician-assisted dying implies the patient is well aware of the hardships and financial difficulties that may occur in the near future. Thus, all three factors have a role in this criterion.

The physicians must be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement.

This criterion deals almost exclusively with the sanctity of life. By having this requirement, patients are prevented from ending their lives due to depression or some

other factor that affects their judgment. While this requirement is not as stringent as that of Oregon's Death with Dignity Act, the criterion was made in the same spirit, and thus helps to ensure few people without serious illness are able to take advantage of this program to end their lives prematurely.

The physicians must have informed the patient of his or her situation and further prognosis.

This criterion deals with all three factors of the model. The patient must have clear knowledge of their prognosis and what will come in the coming months, and then he is free to choose his treatment, preserving his autonomy. At the same time, this knowledge ensures that the physician is not leading the patient to a set conclusion of his death, thus ensuring that the patient can try alternative treatments should he wish. Finally, it can be assumed that the patient will also have knowledge of the financial burdens and other hardships that will come with the disease; therefore social value also plays a role.

The physicians must have come to the conclusion, together with the patient, that there is no other reasonable alternative.

This criterion involves all three factors of the model in a more unique way. By having this collaboration between the physician and the patient, the choice of undergoing this program is quite similar to that of a normal treatment option, thus ensuring patient autonomy. At the same time, sanctity of life is also maintained in that should either the patient or the physician decide against this course of action, it can be halted to preserve the patient's life. Finally, the discussion between the physician and patient should ensure

the patient knows of the financial requirements and hardships that would be required for other treatments. Therefore, all three factors are represented in this criterion in a more unique fashion from the other criterion of both laws.

The physician must consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled.

This criterion is almost identical to the one seen in the Death with Dignity Act. Just as in Oregon, all three factors have a role in this criterion. The primary factors affected are sanctity of life and social value. Sanctity of life is respected by having a second physician see the patient, ensuring no rash action is being taken by either the patient or the attending physician. At the same time, the second physician brings a different set of morals and values that may influence the patient's decision. However, the second physician must also share the prognosis, including any physical debilitations or financial burdens that might come with the disease.

The physician must have exercised due medical care and attention in terminating the patient's life or assisting in his or her suicide.

This criterion is unique in that it mostly deals with the physician after the patient's death, ensuring that the physician followed the proper procedure and gave the necessary care to the patient at the time of death. For this reason, this final criterion deals with both social value and sanctity of life. While the patient is about to die, the physician is still required to treat him with the utmost respect and care, giving due credence to the sanctity of life and also the sanctity of death. Furthermore, by giving the patient this care, the

physician ensures the patient dies with dignity and as little pain as possible, showing how much social value has a role in this final criterion.

Final Comments on Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

Much like the Death with Dignity Act, the Termination of Life on Request and Assisted Suicide Act clearly shows great respect for patient autonomy, sanctity of life, and social value. With its criteria, this law ensures that physician-assisted dying is available to any patient who desires it, while also ensuring that the program remains under control.

However, there are drawbacks to the law as well. For example, the criteria for the Termination of Life on Request and Assisted Suicide Act seem to be much more vague than that of the Death with Dignity Act. While this allows for a greater range for interpretation, it also may cause problems when under close scrutiny by government officials. A possible way to rectify this problem would be to include stipulations that would limit how the criteria could be interpreted.

In addition, the Termination of Life on Request and Assisted Suicide Act differs from the Death with Dignity Act in that more responsibility is given to the physician rather than the patient. Physicians therefore seem to be more trusted in the Netherlands; however they remain under intense scrutiny by the law. This may present problems as it can prove to be difficult to keep track of these physicians. Should any physician ignore any of the criteria, his or her patients would suffer, and the physician-assisted dying program would have to be shut down. Therefore, it may be advisable for less

responsibility to be given to physicians, and more given to the government and the patients themselves.

The Termination of Life on Request and Assisted Suicide Act is similar to the Death with Dignity Act in its attempt to allow people to die without suffering; however, the law differs in many ways as well. The criteria in Netherlands allow for more interpretation, the program is much more widely used than in Oregon, and the law simply analyzes the cases and does not give permission to them. The program seems to be under control however, and as long as it remains this way, there should be no reason as to why it would be shut down.

CHAPTER FOUR

Applying the Model to Individual Cases

Up until this point, the model has been used to analyze physician-assisted dying as a program, or in a societal view. The model does not stop at this point, however. Rather, it can also be applied to individuals, as different people will put more emphasis on different factors than others. In this, each of the three factors that affect a patient will have differing levels of influence on the patient. For example, the patient's wish for autonomy may overcome his desire to live, therefore, patient autonomy would be more of an influence than that of the sanctity of life. In other words, the model shows that each patient will be influenced by each of the factors in different ways, and will affect their decision on physician-assisted dying.

To illustrate how the model applies to individuals, hypothetical cases² will be used to show how each of the three factors influences the patients' decision to undergo physician-assisted dying. Each of these cases was chosen in order to demonstrate that no two patients or cases are alike, as each person lived in different circumstances and suffered from different types of disease. By using these examples, it will show that the physician-assisted dying program and the model itself only work on a case-to-case basis, and that no sweeping statements can be made that can include every patient and every case that goes through with physician-assisted dying.

² These cases are taken from multiple sources given by Physician-assisted dying Programs. Details were adjusted to better accommodate the paper, while maintaining the central idea of each case.

Case Report 1

In 2007 the patient, a seventy year old Caucasian male, was diagnosed with a gastric tumor. After treatment for four years, the tumor had metastasised to his bones and abdomen, ultimately resulting in metastasis in his ileus, further deteriorating his condition. His physician determined that his prognosis had no hope of recovery, with only palliative treatment being an option. At this time, the patient made his first request for physician-assisted dying.

The patient suffered from increasing pain in the lower abdomen, in addition to the inability to eat, great difficulty drinking, nausea, vomiting, and severe weight loss. The patient also stated that he suffered from the lack of control over his life and the hopelessness of his situation. The patient believed his cancer and suffering to be unbearable, and made a second request for assisted dying. The physician informed the patient of other options; however, the patient maintained his desire for physician-assisted dying. The physician agreed to his patient's request, and had the patient fill out the required forms. The patient then informed his family of his decision and began making the necessary preparations for his death.

The attending physician informed the patient about his situation and prognosis as the disease progressed. Following proper protocol, the attending physician had another independent physician view the patient. The second physician viewed the medical history and all other relevant paperwork, followed by speaking with the patient personally. The second physician used this information and the interview itself to determine whether the prognosis was accurate and if depression was the main reason behind the request. From his analysis, the physician determined that the attending

physician's prognosis was correct, and while the patient displayed some depression, it was determined to be normal. However, the physician still recommended that the patient speak to a therapist.

The therapist learned that the patient's wife had died of cancer years beforehand, and that he did not want his son to go through the same suffering as he did. Despite this, he agreed to wait until his son arrived before he took his prescription. When his son arrived, the patient and his son spent several hours together, in which time the patient convinced his son that physician-assisted dying was what he truly wanted. They also discussed funeral arrangements and other such legal matters to make it easier for the son after his death.

The patient was given his prescription after fifteen days. The patient chose to die at home with his son and a few close friends around him, and died within two days of returning home. The physician was not present at the time of death, due to the patient dying in his own home.

Analysis of Case 1

This first case is a near perfect example of each of the three criteria given in the model. Patient autonomy is demonstrated throughout the case as the patient is given alternative options, while at the same time being informed of what was occurring. The patient was then able to make an informed decision on his own health, and was not pressured into the decision by his physician. Sanctity of life was also clearly demonstrated, as the physician suggested palliative treatment to deal with the disease in a more comfortable fashion. Despite this, the patient refused to live with his disease any longer and chose to undergo physician-assisted dying. Finally, the patient showed how

his social value impacted his decision, as his lack of control over his body and situation was a partial cause as to why he chose physician-assisted dying.

However, it was noted by the second physician that the patient seemed to display some depression at his condition. While it should be expected for a patient to be depressed to some degree, it could be argued that more could have been done to ensure that the patient wasn't making his decision because of this depression. Furthermore, the patient decided to die in his own home, preventing the physician from being present in the home. While it is possible that the patient may have preferred that only his family and friends be present at his deathbed, it can also be argued that the physician should be present at the time of death for his patient.

Case Report 2

The patient, a sixty-three year old African-American woman, had extensive orthopedic problems, particularly with her hip. In 1997 she had had a total left-hip replacement with no complications. In 2005, the patient's right hip was in need of replacement. She underwent the surgery with no complications at the time; however, she developed a deep infection in the area a month after the procedure. The patient was immediately hospitalized and underwent eight operations over a six month period, during which time she made inquiries into physician-assisted dying.

While the infection itself was cured, the damage it inflicted on the hip virtually destroyed it. Her right leg therefore had become much shorter and could bear hardly any weight. Her disability was compounded with cardiac and pulmonary problems due to sepsis, and eventually she suffered from kidney failure. In a week's period, she underwent two major surgeries in an attempt to remove two growing abscesses in her

abdomen. Despite the medical care given to her, the patient remained septic and quickly declined. At this point, the patient requested physician-assisted dying of her physician once more, and began filling out the necessary paperwork.

The patient's health declined quickly, and the physician discussed alternative options such as hospice with her. The patient maintained her wish for physician-assisted dying, but agreed to contact her family. Her husband had died several years beforehand, however she had two sons and a daughter with whom she had remained close. The sons and daughter all agreed to come see their mother as soon as possible, but each of them lived several hours away.

In that time, a second physician was called in to confirm the diagnosis. After reading the patient history and speaking with the patient herself, the physician agreed at her prognosis of less than two weeks to live and did not detect any depression. However, the physician also noticed more hesitancy in the patient for physician-assisted dying, and determined that the patient was having second thoughts due to her family coming to see her. The physician reminded her of her other options, yet the patient still preferred physician-assisted dying and was given the prescription. The patient maintained that she would not take the prescription until she had a chance to speak with her family.

A few hours later her eldest son arrived with his own family, and understood her wish for physician-assisted dying. Her second son was not as accepting; but he came to agree with his brother and mother after a long discussion. Her daughter, the youngest, was the last to arrive the next morning. Of the siblings, she was the most spiritual, and completely disagreed with her mother on her decision. The mother requested that the physician explain the situation fully to her daughter and sons, and the physician obliged

as best she could. After almost an hour, the daughter had not changed her mind and had convinced her brother that their mother should avoid the physician-assisted dying and instead undergo palliative care. The eldest son and the mother continued to argue for it, but also seemed to be considering other options more closely. At this point, the physician left the family in private to discuss what they should do.

After several hours, the physician returned to the patient's room, where the patient informed her that she had chosen not to take the prescription and spend her remaining time with her family, particularly her two grandchildren from her eldest son. The physician arranged for hospice care in the patient's home. A week later, the patient died peacefully in her sleep with her sons and daughters around her bed.

Analysis of Case 2

In this second case, the three criteria of the model were all given proper credence. The patient maintained her autonomy throughout the entire ordeal, as she was given all her possible choices while not being coerced into any of them in particular. Furthermore, she displayed her autonomy when she chose not to take her prescription and to live her remaining days with her family.

Sanctity of life was made present through her physician, who offered her alternative options to physician-assisted dying, as well as through her daughter, who ultimately helped persuade her mother to live the last few days with her family. It could also be argued, however, that the physicians did not do enough to try and persuade her to consider other options, as she displayed hesitancy before her family had arrived. This argument is difficult, however, as trying to persuade the patient to consider her other options may also have been interpreted as a loss of the patient's autonomy.

Finally, social value was displayed through the family itself. Each of her children had an influence on the patient's decision, ultimately resulting in the patient deciding to live out the last few days with her family. While the patient did not die from her prescription, the effectiveness of the program itself was displayed due to the actions taken by the physicians, the patient, and her family.

Case Report Three

In 2013, a thirty-five year old man had been working near his home. The patient fell off a roof he had been working on top of and fell sixteen feet to the ground, breaking his spine in the process. When friends and family found him, he was rushed to the nearest hospital and put on life support. At this point, the physician determined that the patient had suffered massive internal injuries including internal bleeding and that he would be completely paralyzed from the neck down. While life support was maintaining his condition at this point, the physician's prognosis was that his body would deteriorate to the point of death within a few months. The physician also informed the patient that removing life support would cause the patient to die within days, weeks at the most. The patient decided that he would not remain on life support, but that he did not want to wait to die by simply removing it. Thus, the patient requested to remain on life support until he had fulfilled the time limit required for physician-assisted dying.

The patient had been recently married in August of that year and had a two year old son. He declared himself to be an outdoorsman and handy man, and did not think he could live without being able to move, let alone hold his child. After several extensive discussions with his wife, family, and friends, the patient chose to undergo physician-assisted dying under the reasoning that he would only be a burden to them for the next

few months that he had left to live. Furthermore, he stated that he doubted that his family would not be able to afford the necessary medical bills that would come with any treatment. Despite his family's arguments to the contrary, he maintained his decision and filled out the required paperwork for physician-assisted dying after being in the hospital for two weeks. His wife was the main opponent to his wish of physician-assisted dying, but the patient remained resolute with his decision.

The physician discussed alternative options with the patient, however the patient refused to consider any other recourse. The physician then requested that a second physician investigate the case in order to ensure proper protocol was followed. The physician agreed with the diagnosis and prognosis for the patient and also took time to discuss alternative options for the patient. Despite this, the patient refused to consider any other treatment options.

After a few days, the patient was given his prescription. The patient took time to say goodbye to his friends and family, and took the medication at the end of the day. He died peacefully in his sleep with his wife and parents in the room.

Analysis of Case Three

This final case shows itself to be influenced by all three factors of the model, while also showing a more tragic side of medicine. The patient in this case is much younger than the previous two, implying that he had a full life ahead of him before his accident. In addition, the patient had a young son and wife to take care of, whereas the other patients in the previous examples had fully grown children as well as spouses that had already died. Finally, this example exhibited trauma rather than chronic disease to be the cause for the patient to request physician-assisted dying.

In this case, the patient showed his autonomy in his fierce independence, and chose to maintain that autonomy by using physician-assisted dying to end his life on his own terms rather than to live several months hooked up to equipment without the ability to do much as move. However, the sanctity of life was respected in that the patient was given other options in order to live his remaining days with his family; however in this case the patient's wish for autonomy overcame his willingness to live. His social value was shown to revolve around his ability to move and care for himself. When that was taken away, he did not wish to become a burden to his family and friends physically and financially, and so chose to end his life on his own terms rather than wait for the end. Despite his wife's protestations, the patient showed that he valued his autonomy and his family's financial stability over his own life and that of his wife's opinion. In this way, the patient's desires were honored and the physician-assisted dying program fulfilled its purpose.

Final Comments on Cases

These cases were each chosen in order to provide a specific example of how different each person is when considering death. Additionally, they were also chosen in order to show different aspects of physician-assisted dying itself so that it might clarify the difficulty of these choices at the end of life.

The first case was chosen as the "perfect" case, showing how physician-assisted dying can be used as a relief from pain and suffering. The patient had lived what many would consider a full life, managed to say good-bye to his son and friends, and finally was able to die at peace in his own home. Besides his depression, his case was uncomplicated and straightforward.

The second case, on the other hand, was meant to seem more difficult. At first, the patient claimed she wanted to undergo physician-assisted dying; however, physicians later noticed some hesitancy in her actions. Later, when her children arrived, her hesitation only grew as she attempted to discuss it with her daughter, who was adamantly opposed to this course of action. At the end of the case, the patient chose to forego physician-assisted dying, choosing to remain in hospice until her death.

The main idea of this case was that physician-assisted dying is not a treatment for everyone. There are many patients who might choose to live out the rest of their days with their families, just as there are patient who might wish to end their suffering through physician-assisted dying. Neither choice is wrong or deplorable; however both choices should be respected by family and physicians alike.

Finally, the third case was meant to show the tragic side of medicine. In this case, a relatively young man has three choices: to live with heavy medical intervention for a few more months, to refuse treatment and allow himself to die naturally, or to turn to physician-assisted dying to end his life. His own values and beliefs made the first choice unviable, despite his young wife and child having to live without him. The second choice was also undesirable as he might linger for a time, putting his family in financial straits. Therefore, the patient chose the third option so that he would not have to be cared for, and so that his family would not have to spend exorbitant amounts of money to maintain his life for a few more months.

This case served three purposes. First, it drove home the idea of social value and how it might interact with physician-assisted dying. Second, it shows that medicine must often deal with tragedy, and that different people will respond in drastically different

ways. Finally, it shows that there are times in which physician-assisted dying is not chosen for the patient's benefit, but for the benefit of his family.

No matter what the case is, or what the circumstances are, physician-assisted dying is a course of action available to many people. To some, it may be an unacceptable choice that should not be made. For others, it may be the last autonomous choice they are able make. Finally, some may turn to it as it may be the last comfort they can have in this life.

CHAPTER FIVE

The Future of Physician-Assisted Dying

As the previous chapters indicate, physician-assisted dying is a burgeoning practice that has become more apparent to the public eye in recent years. As it becomes more publicized, society's understanding of it changes due to modern ideas and philosophies. In addition, as medicine continues to improve, more patients are living longer with diseases that may not necessarily be curable, thus implying even further discussion of physician-assisted dying programs taking root around the world. As it stands, physician-assisted dying is a practice that will not be fading into obscurity in the near future.

Since the Death with Dignity Act passed in 1997, many states and countries have considered or even legalized physician-assisted dying programs. In the United States, Washington passed its own Death with Dignity Act in 2008, becoming the second state in the United States to have this kind of law. In 2009, Montana established a court decision in which physician-assisted dying would be permissible with a court order; however, it did not establish a program itself. In 2013, Vermont became the third state to form a physician-assisted dying program and the fourth state to legalize it. Finally, in January of 2014 New Mexico came closer to legalizing physician-assisted dying in a court decision that held that “this court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying”(Eckholm).

Throughout the world, euthanasia and physician-assisted dying laws are also becoming legalized. For example, the Netherlands passed their own version in 2002, followed closely by Belgium that same year. In 2009, Luxembourg established its own euthanasia law, becoming the third member of the European Union to legalize a physician-assisted dying and euthanasia program. Other countries that allow physician-assisted dying include Colombia and Switzerland; however, neither has an established program. France, Britain, and Canada have also considered passing a physician-assisted dying law, although none of these three countries has done so despite high public support.

Interestingly enough, Belgium recently passed a law allowing patients under 18 to undergo euthanasia or physician-assisted dying with the permission of their parents and physicians in February 2014. The law is similar to the original except for two factors, the first difference being that this version of the law has no minimum age requirement for the patient to undergo physician-assisted dying or euthanasia. The second difference balances the first in that any minors requesting for physician-assisted dying or euthanasia must show they understand the nature of their request, and must also have the permission of their parents and their physicians. Furthermore, the child must be evaluated by a pediatric psychiatrist or psychologist to ensure the child has the capacity for discernment before the patient's wishes can be granted. It remains to be seen whether this law will have any success, but in the coming months and years it can be assured that it will be under high scrutiny by both policy makers and people from other countries around the world.

The public attention being given to physician-assisted dying is not limited to policy making. The media also has a role in the acceptance of physician-assisted dying

by the public. In fact, it can be argued that the media has a greater role in physician-assisted dying due to the heavy influence it has on public opinion, which ultimately is the deciding factor on whether a physician-assisted dying program can be established. News stories and documentaries bring public attention to physician-assisted dying and can influence the public opinion to one of support or denial, depending on how it is portrayed. The Internet in particular is a constant source of information on physician-assisted dying cases and heavily influences the opinions of younger generations due to its ease of access.

In popular television shows such as *Scrubs* and *Grey's Anatomy*, there have been episodes that explored the matter of physician-assisted dying. These particular episodes had a tremendous impact on the public for two reasons. First, many millions of people watch each of these shows, and are thus exposed to the issue of physician-assisted dying. The second impact is that these shows are able to display some of the emotional tones that are associated with physician-assisted dying rather than the purely factual news articles that display it. Society as a whole seems to be more responsive to emotions than facts, causing many to form opinions of physician-assisted dying that they had not from news articles or documentaries.

For example, on the NBC television network's episode of *Scrubs* ("My Number One Doctor") airing on December 6, 2007, Dr. Elliot Reid has a young patient named Shannon who is suffering from Amyotrophic lateral sclerosis (Lou Gehrig's disease). In the course of the episode, Dr. Reid learns that Shannon had attempted to commit suicide by overdosing on her medications. When confronted by this, Shannon states that she has the right to die before becoming completely paralyzed and suffocating to death, forcing

Dr. Reid to decide whether she should inform Shannon's nurse of her intent to take her own life. After gaining the advice of other doctors who claim that Dr. Reid should inform the nurse, Dr. Reid eventually overcomes her own moral objections and decides that it should indeed be Shannon's decision.

The writers managed to display all three of the factors of the physician-assisted dying model. Shannon clearly wanted to take her own life, displaying patient autonomy. Dr. Reid, on the other hand, had strong moral objections on this and was also advised by several other doctors to inform Shannon's nurse, showing sanctity of life. Finally, Shannon stated early in the episode that she had said goodbye to all of her friends and held a premature funeral, thus showing her consideration of her loved ones and exhibiting social value. The problem with the episode lay in the fact that it was almost solely from Dr. Reid's perspective, rather than allowing the viewer to see how Shannon herself might be feeling. Despite this, the episode invokes deliberation in the viewer and certainly displays the emotional turmoil that comes with physician-assisted dying.

On the ABC television network's episode of *Grey's Anatomy* ("Suicide is Painless") airing on March 25, 2010, a similar situation is presented in which Dr. Hunt is the second physician requested by a patient suffering from terminal cancer for physician-assisted dying. Dr. Hunt adamantly refuses to honor the patient's request despite the patient's wishes, and much of the episode explores his reluctance through his war experiences. Adding to the episode is the husband's fear of allowing his wife to die, exploring his fears to a minor degree. Later in the episode, Dr. Sloan instead gives the clearance for the patient to go through with her request and she is given her prescription.

The episode ends with the patient taking the prescription and laying with her husband until she passes away.

As with the *Scrubs* episode, the writers of this episode had each of the three factors displayed. The patient clearly wished to die rather than waste away from her cancer, but she had to convince her husband and her doctors to achieve this. Dr. Hunt advocated for sanctity of life, arguing that a cure might be found for her cancer and that she should live for her husband. Finally, social value was displayed through the husband, who must grapple with his emotions on his wife's sickness and imminent death.

Similarly to *Scrubs*, the episode was too fixated on how the physician felt about physician-assisted dying rather than focusing on the patient and her husband. However, *Grey's Anatomy* had a much better example of social value through the husband, who at one point held the medicine bottle and remarked that he was holding the medicine that would end his wife's life, showing his own anxiety and fear. In the end, the episode provided an exceptional example of Washington's physician-assisted dying program and gave the viewer a better view of how physician-assisted dying also involved the patient's family.

As physician-assisted dying programs begin to develop and become more common to the public eye, society's scrutiny of these laws will only increase. Therefore, governments and policy makers must make every effort to be open to society on their laws and restrictions in order to ensure the continuation of the program. By remaining open, there is a less likely chance that the programs will be portrayed inaccurately by media sources, preventing the programs from being discontinued. Additionally, any new

laws must have some sort of process in which each and every case is assessed in order to prevent physician-assisted dying from being misused in any way.

Research must also be taken in several areas of physician-assisted dying. For example, hospice and palliative care must undergo changes in order to better accommodate patients who are dying, while not bankrupting the programs themselves. After this is achieved, research can be undertaken to see whether patients would prefer physician-assisted dying to palliative care or hospice, since the latter provides the patient with a couple more days or weeks of life. Other research may include Belgium's new law allowing minors to undergo physician-assisted dying, public perception of euthanasia versus physician-assisted dying, the effectiveness of information sessions for dying patients and their families, surveys on public opinion of physician assisted dying, and many more.

Conclusion

Physician-assisted dying has been a heavily debated topic for centuries. Throughout these years, it has been affected equally by the ideas of patient autonomy and sanctity of life. As modern medicine progresses, however, we must also consider the role of social value and how family, finances, and personal values and morals affect a patient's decision to undergo physician-assisted dying. Physician-assisted dying programs must take each of these factors into account when deciding policy, while also understanding that each of these factors influences patients differently. Finally, physician-assisted dying will continue to be a medical practice in the near future, and will be influenced by public opinion and the media. To ensure its continuation, programs must be open to the public and conduct research to ensure that patients who are suffering have

every option available to them at the end of their lives.

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