ABSTRACT

The Moral Permissibility of Medically-Assisted Suicide

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Despite medical advances the effects of disease, injuries, and old age will continue to occur. While cures have been found for some medical conditions, others continue to take a toll on patients. Although treatments can ease the suffering, they may not eliminate it and in some cases can cause more suffering. Using many articles and texts, I studied the reasons and consequences for someone to be medically euthanized. While the population seeking this route is small, it is steadily growing. The primary reason to consider medically-assisted suicide is suffering from a terminal illnesses or old age. This suffering prevents them from living a simple independent lifestyle. Physicians should offer medically-assisted suicide in such cases. States such as Washington, Oregon, and Montana have laws allowing patient's to pursue medically-assisted suicide. I argue in favor of having the option of medically-assisted suicide available to patients who are permanently disabled by their terminal illnesses.

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THE MORAL PERMISSIBILITY OF MEDICALLY-ASSISTED SUICIDE

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TABLE OF CONTENTS

Chapter One: Introduction 1

Definitions 2

Current Stances 5

Opposing Stances 7

Chapter Two: My Stance 22

What Is Suffering in This Case? 27

Use on Animals 30

Incurable vs. Curable Diseases 31

Physical and Mental 33

Chapter Three: Reasons for Medically-Assisted Suicide 37

A Simple and Independent Lifestyle 37

Euthanasia vs. Suicide 43

Euthanasia vs. Murder 47

Chapter Four: Guidelines to Use Medically-Assisted Suicide . . . 52

Whose Decision Is It? 52

How to Measure the Differences Between Intentions? 54

The Role of the Loved One 58

States That Have Legalized Medically-Assisted Suicide 59

Conclusion 60

Bibliography 66

CHAPTER ONE

Introduction

Generally, a negative weight hangs around the term euthanasia. As a form of palliative care, the patient has the final choice. He is given full control of one of the few things that allows him to maintain his dignity. However, the term is viewed synonymously with murder. It complicates the morality and the ethics of the physician and those of the patient. Additionally, the acts committed by Jack Kevorkian, better known as Dr. Death, more than 10 years ago continue to haunt the minds of the fearful. Despite the stories associated with the term "euthanasia," the act should be offered to patients who feel they are in their final stages of life.

Towards the end of life, some individuals have increasingly limited options to prolong life. When the limitations of age and disease are incorporated, the list shrinks. It can fill with less favorable options, such as eating pureed foods. At some point, this population may begin to seek ways to end their suffering. They may no longer wish to depend on their caretakers, live in pain, or live paralyzed. They may begin to consider death as an option. However, these individuals are unable to find any method to ease their pain. The options available to them do not improve their lives but rather exacerbate the burden. They begin to view death as a form of relief, a form of ending the struggle: the ultimate solution. Some individuals may begin to consider such an option after much thought and deliberation. Therefore, euthanasia should be an option for people in these conditions. They can only live with the assistance of a caretaker. They are bedridden. These patients may not have any sense of consciousness or have lost complete

consciousness. They may live with extreme levels of pain or fatigue, fatigue preventing them from acting on their own. These patients must be limited in their abilities to live on their own. They must have permanent uncontrollable suffering. They may even be in the final stages of life due to their disease. These patients require expensive and extensive medical care.

A patient who is free to do as he or she wishes without physical constraints, should not qualify. If he is still able to step outside of his house and go around town, he should not qualify. A patient whose suffering does not inhibit his ability to live with little aid does not qualify. A patient without a simple lifestyle, some level of an independence, and who continues to suffer despite attempts to improve his life should be given the option of some form of euthanasia.

Definitions

"Happy Death"

The term euthanasia arises from Greek roots. The prefix *"eu"* means good. While the term *"thanatos"* means death. The combination of these two roots results in the target word, euthanasia, as "an easy or happy death." The resulting term provides the ideal image of how most people would prefer their lives to end: happily. People do not want to suffer in their final moments. They want a happy death. What does a happy death require? Generally, it requires that the person die on his or her own terms. These terms could include that he dies with his life fulfilled and/or that he still maintains control of his life until the end.

General Definition

Euthanasia is "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (as persons or domestic animals) in a relatively painless way for reasons of mercy" (Euthanasia, 2013). This definition clearly implies euthanasia requires two people. One person (i.e. a patient) desires to die while the second participant acts on assisting the other in achieving his or her goal. Also it clearly states that euthanasia is an act for reasons of mercy. This implies that the intent of the participant must be good in order for the death of a person to be considered euthanasia. Mercy requires that one take pity on another. In this case, the person has enough mercy to assist the patient in ending his or her life due to its permanently unbearable conditions.

Euthanasia by Action

Euthanasia by action requires a person to actively assist the patient in ending his or her life (Orfali, 2011). Generally, this occurs when a physician places the necessary materials to end one's life, such as a lethal injection of morphine, in the patient's hands. The physician himself could also inject a lethal dose of medication into the patient if he or she is incapable of doing so (Dr. Kevorkian was arrested for this act in particular). However, such assistance is not limited to a physician. Citizens may also partake in this form of mercy killing by providing other methods, such as poison or providing a gun, to die. Euthanasia by action is generally met with the most opposition, as it is falls under the category of homicide. This form of euthanasia is illegal in the United States, but is legal in the Netherlands. Euthanasia by action is also referred to as active euthanasia.

This practice, although illegal to use on humans, is a commonly used on animals. Methods include providing a lethal dose of medication in the form of an injection or pill (Lethal

Injection, n.d.). This medication is usually a strong anesthetic such as sodium thiopental. Other forms include a strong inhalants, cervical dislocation, or shooting the animal in the head.

Euthanasia by Omission

While active euthanasia possesses direct opposition, euthanasia by omission is the general accepted practice in the United States and in some countries in Europe, such as the Netherlands. In this form of euthanasia, the physician or person assisting does not provide the means to directly cause death (Orfali, 2011). In this case, the tools keeping the patient alive are withdrawn and the patient's lifespan is shortened. This method could be withdrawal of care or the removal of life-sustaining machinery such as a dialysis machine. Additionally, the patient may refuse treatment from the doctor by not taking medicine or by refusing to partake in the actions that may sustain his or her life.

Euthanasia by omission may also be referred to as passive euthanasia, however, not without controversy. Being passive, no act should be involved. But euthanasia itself is an act. In its definition, it states it is the "act of killing or permitting someone to die…." Withdrawal of care is in itself an act as it may require pulling a plug or giving the order to halt treatment. Therefore, for the sake of avoiding confusion, passive euthanasia will be referred to as euthanasia by omission.

Voluntary

Voluntary euthanasia consists of the patient volunteering to undergo euthanasia. The patient makes a conscious decision either in the form of a written will or verbal request (Orfali, 2011). For a person to make this decision, the patient realizes that his disease has made him almost incapable of living peacefully or he foresees the disease impairing his

life. Although voluntary euthanasia's opposition refers to it as suicide, the patient sees it as a form of release. To them, an assisting hand hastens an impending death. Doctors should consider this desire carefully. Furthermore, there are two forms of administration. Either the patient himself or herself may administer the lethal dose or the physician may. The patient may request active or passive euthanasia.

Non-Voluntary

Non-voluntary euthanasia does not require the permission of the patient. In this case, the patient is unable to make a decision for him or herself (Orfali, 2011). People who may fall under this category include those in a coma, those who are too young to give consent, the senile, and the mentally unstable. The inability for the patient to decide places the decision in the hands of a family member or loved-one. The family member cannot make this decision if the patient has expressed intent to stay alive. This decision must receive careful review prior to commitment.

Involuntary

On the other hand, involuntary euthanasia does not seek the permission of the patient (Orfali, 2011). In this case, the patient's wishes are either disregarded or ignored. This form of euthanasia should not be endorsed. In this form of euthanasia, the patient's wishes are not considered in the decision. Essentially, a second party murders the patient.

Current Stances

Currently, euthanasia receives considerable criticism. Due to its complex ethical nature, some scholars and governments refuse to support it. It has earned multiple names such as suicide, homicide, and even "mercy killing." Since several parties must act on this decision, it is difficult to view as a black and white issue. Politicians, such as Rick

Santorum, view it only as a form of suicide (Keown, 2012). For many faiths, suicide and murder are sins. Euthanasia incorporates both of these sins. Thus, some people reject the very thought of euthanasia.

In the United States, many states will not legalize the practice of euthanasia. Oregon, Washington, and Montana have allowed for some form of euthanasia. The state of Oregon even passed the Death with Dignity Act allowing the withdrawal of care if the patient wishes it. As the name implies, the patient may choose to end his or her life if it is strongly impaired.

Furthermore, many nations see euthanasia only as homicide since one person (the doctor) injects or provides the medication. Others view it as a medical decision to help the patient. Nations such as the Netherlands and Belgium have legalized it on the grounds that the doctor meets certain legal expectations otherwise, the doctor will be accused of homicide (Griffiths, Weyers, & Adams, 2008).

Some doctors, despite the Hippocratic Oath, would prefer to aid the patient in his or her final wishes. The original Oath stated the physician should not administer any poison to the patient to hasten his or her death. Healers at the time of Hippocrates feared accusations of murder (Preston, 2013). Thus, they placed emphasis on the parts of the oath that clearly stated ways to keep the patient alive. However, with the development of medicine over the last 100 years, the Oath has received some modification. Physicians place emphasis on another part of the Oath: treating the patient as a human being. They must keep the mental ability and economic ability of the patient in mind. With this reinterpreted Oath behind them physicians should be able to approach a patient with euthanasia as an option.

Opposing Stances

While proponents of medically-assisted suicide exist, more opponents exist. Professionals such as Winston Nesbitt, J. Gay-Williams, Kathleen Foley, Daniel Callahan, and Ira Byock have written articles and books giving their reasons for opposing medically-assisted suicide. I will briefly provide a summary of the writings and then consider each of them in turn.

First, Winston Nesbitt argues in his article, "Is Killing No Worse Than Letting Die?," that there is a moral difference between killing and letting an individual die. He argues that both are morally unacceptable but that killing is more reprehensible. He presents two situations that were presented by James Rachels and Michael Tooley. In both, there is an uncle who can inherit a fortune if his young nephew dies. In the first situation, the uncle kills his nephew by drowning in him. Nesbitt says we would easily consider this action immoral and wrongful. In the second situation, the nephew slips in the bath tub and hits his head. The uncle sees this and does nothing in response, letting his nephew die. Both uncles are ready to kill their nephews for the inheritance, but the second one doesn't need to. According to Nesbitt, both uncles are reprehensible because their intents were malicious. Nesbitt goes on with one more situation in which the uncle did not deliberately wish to kill his nephew. Instead he saw his nephew fall, but still lets his nephew drown. In this case, Nesbitt says the uncle is less reprehensible than the uncles of the previous two scenarios since the intent was different. Overall, he states it is better to have people like the uncle from the third scenario. The uncle from the first scenario is a threat to society. Thus, Nesbitt thinks it is more morally wrong to kill than to let die. Nesbitt's argument is

based on the uncles gaining something from the nephews' death. It fails to consider situations in which the second party will not gain anything but acts out of compassion.

For euthanasia, the intent and outcome of killing and letting die do not differ. The goal of euthanasia by omission and active voluntary euthanasia is to alleviate the suffering of the patient in accordance with the patient's will. That is the primary purpose of euthanasia. While Nesbitt's argument is correct when harmful and selfish intent is involved, it cannot apply to a euthanasia case because the second party does not benefit from the patient's death.

In the scenarios that Nesbitt presents, most people would agree with him in that the first two actions are reprehensible due to the malicious intent. However, in regards to euthanasia, intent plays a crucial role. And motive governs intent. In all three of the scenarios, the uncle had something to gain from his nephew's death. Ultimately, he acted in order to ensure that he gained the inheritance, whether he deliberately killed his nephew or did not try to save him. It was a conscious decision with harmful intent. This intent and purpose in the actions, or lack thereof, sets it apart from how medically-assisted suicide should be done. The second party involved in medically-assisted suicide should not intend to harm the patient but ease the suffering for the purpose of gaining something. They should only be motivated by a desire for the good of the patient. What the writer overlooks is the differences between intent and motivation. Just because killing for the sake of gaining something is wrong, doesn't mean that killing on the basis of ending someone's suffering is necessarily wrong. A patient seeking medically-assisted suicide wishes to die. He wishes to be killed in order to be relieved of suffering. A physician, who will not gain

anything from the patient's death, does not intend to kill with a malicious purpose. He is only motivated by the good of the patient.

Nesbitt focuses on the contrast between killing versus not killing. He sees intent as a key factor in determining reprehensibility of killing. Although this may be true, he fails to acknowledge that circumstances will also play a factor in each situation. Rather than the issue being killing versus not killing, it is killing in certain circumstances versus killing in others. For instance, killing in the form of self-defense is not an action that most will find morally reprehensible. We generally do not consider someone who kills in self-defense morally reprehensible. It is believed to be permissible for this individual to kill as last resort in order to avoid harm. The same goes for killing in a just war.

I will next address J. Gay-Williams argument against euthanasia in his article, "The Wrongfulness of Euthanasia." While he can respect the compassion of such a decision, he cannot the thought of killing. He gives a definition of euthanasia as taking another's life when this person's recovery cannot be reasonably expected. He also finds the term "passive euthanasia" misleading because the intent of passive euthanasia is not to kill the patient. Euthanasia is deliberate killing but he argues that passive euthanasia is done to spare the patient from the "indignities of hopeless manipulation" rather than to end suffering. The death is a consequence of the action, not the aim. He approaches the argument from three angles: 1. it goes against natural law, 2. it goes against self-interest, and 3. it has negative practical effects. I will consider each of these points in turn. 1. Williams says euthanasia goes against the natural goal of survival. Cells grow and fight against alien bodies in order to remain alive. Euthanasia goes against this goal by breaking the natural drive for survival. In the argument from self-interest, he says death is

irreversible and goes against our interests. He also says that diseases have been known to miraculously disappear, leading to recovery. In the argument from practical effects, Williams states that doctors and nurses are trying to help patients. Death is failure in their eyes. If a physician begins to end the life of his patients, Williams fears doctors will become more inclined to offer euthanasia. This will lead to an overall decline in medical care. The first slippery step will lead to a harmful fall. While suffering is a sad thing, Williams believes it is a natural part of life and can be managed.

William's concerns with the intent behind passive euthanasia and the three angles he argues from, do not consider the purpose of euthanasia. Although he claims to understand the reasons one my wish to die, he fails to refute these reasons when they are the core of the euthanasia argument.

Williams rejects the name of passive euthanasia. While most experts in this subject find fault in the use of the word passive, Williams dislikes the term euthanasia. He believes people confuse the fact that passive euthanasia's purpose is to "indignities of hopeless manipulations, and to avoid increasing the financial and emotional burden on his family" rather than end the life of the patient (Gay-Williams, 1979, p. 168). Although this may be true, the patient must be made aware by the physician that the patient will likely die. Death is an intended consequence to end the suffering since it is a likely result.

Regarding his argument from nature, it is true that our cells try to heal us of our ailments. It is the natural process for our bodies to fight for survival. However, in that process the body destroys the parts it deems are harmful. Our cells undergo apoptosis and necrosis when the body finds it necessary. In addition, many diseases transform our cells to harm the body rather than help it stay healthy. Cancer, Huntington's disease,

Parkinson's disease, are just some diseases that attempt to destroy the body. In such cases, treatment becomes difficult because one tries to fight the body itself. Sometimes, the body wins and steadily declines. The patient suffers more and more with this decline and although the patient can receive palliative care, it will not eliminate the suffering; it will only temporarily reduce the suffering as it worsens.

In Williams' argument form self-interest, he argues that there is always a chance of survival. Although one can wait on a miracle, it is not something everyone will want to do when suffering from a terminal illness. If the patient wishes to wait for a miracle, he can. However, it is not appreciated how rare miracles are. One can hope for one, but it realistically may not happen. Some may deem it easier to let go after enduring pain and suffering over an extended period of time when the chances of recovery are small.

In his final argument from practical effects, he assumes that walking down the path of euthanasia will turn physicians into murderers. He believes medicine will stop its attempts to save people and will instead become an abused method of legalized killing. However, this should not be the case as patients typically do not want to die. The population that wishes to die due the unbearable suffering is small. It probably will not grow due to the legalization of euthanasia because it goes against our nature to willingly die. The number of individuals may rise slightly, but it likely will not increase as abruptly as expected. The Dying with Dignity Act reveals that these numbers did not change significantly (Beauchamp & Childress, 2009, p. 179). The small number of people that do wish to die should not have this right removed from them. They should not be allowed to suffer because they have lost control over their bodies.

Another opponent, Daniel Callahan, argues that all forms of killing people are immoral in his article, "When Self-Determination Runs Amok." Euthanasia, he fears, will lead to "consented adult killing." He is afraid that if euthanasia is started, it will lead to involuntary euthanasia. He also finds that there is a limit to self-determination. Our decision must be benefit both ourselves and the community. In addition, medicine should promote and preserve life. Callahan finds fault in four arguments typically used in favor of euthanasia: 1. the claim of self-determination 2. the difference between killing and letting die 3. the lack of evidence showing the legal consequences of euthanasia and 4) the compatibility of euthanasia and medicine. Regarding self-determination, Callahan says euthanasia cannot rely on it since two parties are involved. The second party's choice must also be determined but this power over another's life should not be placed in someone else's hands. Another point. Callahan argues is that it is difficult to determine for a doctor whether suffering is unbearable due to the varying levels of tolerance of each patient. In addition, he views omission of treatment and active euthanasia as separate actions. In omission, it is the disease that kills the patient. While omission of treatment can kill someone, there is no guarantee that it will. In active euthanasia, the physician is the direct cause of death. Providing lethal medication will kill the patient, regardless of whether the patient is healthy or unhealthy. Furthermore, Callahan fears that three consequences will arise from the legalization of euthanasia. The first being abuse of euthanasia. This abuse would stem from the second consequence: the inability to produce a carefully phrased law. The final consequence he sees is the ambiguity of the morality of euthanasia. While euthanasia requires self-determination and mercy, he feels that the argument falls apart if one considers self-determination and mercy separately. For instance, a patient unable to

make his own decision lacks autonomy and thus cannot practice self-determination. In the final parts of the argument, Callahan states that euthanasia and medicine cannot go hand in hand. Medicine is not meant to help someone relieve them of their burdens. Medicine treats the biology of the disease, not the despair and anguish that comes as a result. He argues that a physician does not have the knowledge to determine if the suffering can only be resolved by death.

Euthanasia is decision based on the facts made available to the patient. It is based on informed consent. The disease is killing the patient and sometimes the patient may opt for a sooner death because of this. Additionally, the biological issues of the patient have affected his body as well as his mind. Callahan fails to address these facts in his article.

Since euthanasia is a joint and mutual decision made by two people, it necessitates that both individuals agree to the decision. On the other hand, Callahan says that people should not hand their lives over to another, comparing it to slavery (Callahan, When Self-Determination Runs Amok, 1992, p. 52). However, the patient is not handing his life over. The patient has begun to consider dying and approached a professional regarding medically assisted suicide and other options available. The physician's duty is not to directly offer the patient an escape. He must first enlighten the patient of the options that remain and keep euthanasia as a last resort. The physician is trying to help the patient to the best of his abilities. His intentions should not be just to kill the patient. In addition, Callahan argues that the degrees of suffering will vary from patient to patient. Each patient already receives a specialized course of actions set by the physician according to the patient's needs. Thus, the physician can recognize the levels of suffering. Seeking professional advice on important matters is a common practice. For example, people get aid from a

financial advisor. The information gained from this meeting can determine the planning for the next several decades.

Callahan thinks that there is a difference between killing and letting die. He argues that the key difference is causality and culpability. While the disease kills the patient when treatment is omitted, it is the physician who kills the patient in active euthanasia. This makes the physician culpable for the patient's death. Although this is true, Callahan does not address the fact that the patient is made aware by the physician that his disease will kill him. In both omission of treatment and active euthanasia, the second party must make sure the patient is aware of likely effects his decision will have. While the physician may be culpable in active euthanasia, he is also aware of the effects withdrawal of treatment will have. The patient will also know that he will probably die. Thus, while the causes of death may differ, the joint decision to end the suffering makes both parties "culpable." Both parties understand the effects of the decision. Both parties must provide consent. As stated above, the physician and patient make a mutual decision based on all the facts available.

Callahan's final argument rests on the fact that medicine treats the biology of diseases. It is not supposed to treat the despair and anguish that comes with the disease. This is not true. Physicians also treat the mind. Psychiatrists train to treat the various mental disorders, which anguish and despair are a part of. They address the suffering that comes with depression. In some cases, these patients do not recover. If the patient's mental health suffers due to the decline in physical health, the physician's involved must address both issues. Mental and physical issues tie strongly together. It should be no surprise that if either the mind or the body cannot recover, then the individual may not heal. The suffering will continue. While there is a chance of recovery, there is also a chance that the

patient will not recover. For a patient who has lost this chance of recovery for both his mind and body, he should have the option of euthanasia available. He should be assessed to see if his mind can still make rational decisions. If he is found to have an approved level of mental health, then his request to die can be taken seriously by professional parties.

In another article from Daniel Callahan, "Reason, Self-determination, and Physician-Assisted Suicide," scrutinizes the claim that if suffering makes life seem meaningless to patients, patient autonomy says that physicians should understand the requests for assisted suicide. He indicates that this comes close to saying that life can have meaning if it is marked by self-determination, but a "noble and heroic life can be achieved by those who have little or no control over the external conditions of their lives, but have wisdom and dignity necessary to fashion a meaningful life without it" (Callahan, Reason, Self-determination, and Physician-Assisted Suicide, 2002). Only further confusion results when rationality is used to determine the rights and wrongs of euthanasia in a specific case. Callahan also expands on how rational people make wrong decisions all the time. This includes experts of medicine. Medicine has neither the expertise nor the wisdom to relieve all the problems of human mortality, the most important one being why we have to die or ways that seem pointless to us.

It is a foundational moral principle that people ought to help one another. Euthanasia does this because one individual helps alleviate the pain of another. It is not done to hinder the patient but with the intent to help due to the patient's unfortunate circumstances. Callahan does not completely accept this idea. He can empathize with the situation, but his fear that physicians will become legalized murderers outweighs his sympathy with the reasons for physician-assisted suicide. Although some fear is

legitimate, he does not adequately take into account that humans typically do not kill with malicious intent. It is against human nature to do so, and statistics do not bear out the fear.

Callahan claims that he "can well imagine situations that could drive [him] to want such relief or feel driven to want it for others" (Callahan, Reason, Self-determination, and Physician-Assisted Suicide, 2002). If this is true, he should be able to acknowledge the amount of suffering a patient seeking physician-assisted suicide goes through. For a patient seeking euthanasia, the suffering cannot be alleviated by palliative care. Callahan should be able to recognize how death would be a relief to patients in these situation. To a patient feeling insurmountable pain, any form of relief may be desired. However, he strictly opposes the thought of a patient desiring death. He believes that physicians will find it difficult to assess such "hard cases" but the field of palliative medicine functions on the physician's ability to help alleviate the patient's pain. In palliative care, the physician understands how to handle the suffering of these patients. Therefore, they should also be able to understand that the suffering of some patients cannot be alleviated (Ruijs, Kerkhof, & Onwuteaka-Phillipsen, 2013).

Callahan also explains that patients should make their own decisions and act on their own decisions. However, he cannot expect a patient who does not have the ability to move on his own to care for himself. If the patient's suffering cannot be alleviated by the current level of medicine, his options become limited. He cannot take his own life because he does not have control of it. He must instead go along with the physician's actions due to the disability. He may choose to withdraw treatment, but this will result in a rise in suffering as he approaches death. In order to avoid this increase in suffering, it would be easier for the patient to die.

His final concern is that physician integrity will decrease with the legalization of euthanasia. Callahan fears that physicians will begin to act strictly on the patient's requests. However, this fear is faulty. A physician should have the knowledge to recognize when the patient's desires are unreasonable. Physicians assess the level of pain their patients feel daily. A physician well-versed in the trials of dying, will also understand when the patient's request seems reasonable and when it does not. The physician should have the ability to assess what options are available for the patient before fulfilling any requests of euthanasia. He can push for palliative care if he deems it necessary, but his training should also teach him when other options are necessary.

Kathleen Foley defines palliative care in her article, "Compassionate Care, Not Assisted Suicide," and describes the major barriers—physician related, patient related, and institutionally related—that stop patients and families from getting proper care at the end of life. She examines the various aspects of suffering—physical, psychological, existential—in both patient and caregiver and explains how palliative care approaches can be differentiated from physician-assisted suicide. She mentions initiatives trying to improve care as well. She feels we should not confuse compassion with competence in the care of terminally ill patients.

While Foley argues that palliative care offers methods of coping with most pains and sufferings, it does not provide relief for every single patient. It does not necessarily increase a person's lifespan or significantly reduce the quality of what life they have. The suffering can even worsen. For such cases, medically-assisted suicide should be considered because the prolonging of life may also prolong the suffering.

According to her, the emphasis of care should focus on the "quality of life not quantity of life" (Foley, Compassionate Care, Not Assisted Suicide, 2002). This approach is reasonable. Ideally, the patient's should be evaluated and the suffering should be alleviated using palliative medicine. However, there are cases in which the suffering cannot be alleviated. While hospice care does an excellent job of helping its patients, not every patient can be helped. The World Health Organization says so as well: "member states not consider…euthanasia until they had assured the…availability of service for pain relief and palliative care" (Foley, Compassionate Care, Not Assisted Suicide, 2002). The quality of life does not improve but instead worsens. For such cases, these patients should have the option of assisted suicide available to them if they desire it after other options have been ruled out.

Foley also points out that most physicians are not trained to handle "all aspects of palliative care." This is true. Most physicians have not received the appropriate training for end-of-life situations. Therefore, physicians with this specialty should be part of the panel that assesses patients who desire to die. They will be able to speak to patients about other options in addition to medically-assisted suicide. However, sometimes the palliative care goes to an extreme in which the patient must be completely sedated in order to alleviate the pain (Bruce, 2011). When the patient's suffering can only be alleviated by complete sedation, then the physician may offer assisted suicide. The patient is not enjoying life at this point. They have been put to sleep until they die. Therefore, the physician's training should allow him to offer assisted suicide if he finds it necessary to put the patient to sleep.

Opponents of medically-assisted suicide argue that patients should seek palliative care when their suffering becomes too great. Ira Byock argues in favor of palliative care

in his book, *The Best Care Possible: A Physician's Quest to Transform Care Through End of Life,* by his experiences as a palliative care physician. Palliative care aims to help the patient along with his family to alleviate suffering from his terminal illness. Byock does not advocate active euthanasia but he does understand the reasons for euthanasia by omission. However, he also believes in helping the patient continue fighting for life. Palliative care does not only aid in easing the transition into death. By combining the effects of medicine and uniting the community around the patient, the majority of the suffering experienced can be alleviated. This can lead to complete recovery, but such miracles are rare. Byock believes physicians need better training as students in regards to ethical decision making. Students learn about the medicine, but they do not learn enough about how to approach the difficulties of end of life situations. He also feels that the disparity between the arguments between palliative care and physician-assisted suicide can be resolved if the medical community approaches healthcare with a broader perspective. The issues in Byock's thesis are similar to the issues in Foley's thesis. Palliative care does not necessarily relieve a patient from all his or her suffering.

Prior to considering medically-assisted suicide, physicians should propose palliative care as a form of end of life treatment to their patients. The process of palliative care allows patients to reconsider their views on life due the attention they are given. However, when palliative care proves to be unable to lessen the suffering, patients can wish for death to come sooner. In such a case, a professional panel should assess if some other form of assistance is needed.

Byock used several studies to show that people did not wish to die as they approached death. He says that "only 7 percent felt it was very important…to be kept alive

as long as possible" (Byock, 2012). This implies that the other 93 percent would rather end their life. These participants knew of their decreased lifespan and did not wish to be kept alive as long as possible

As Byock states in his book, physicians "allow dying people to leave this life gently, without subjecting them to CPR or mechanical ventilation or dialysis or medical nutrition." Patients choose to have treatment withdrawn or wish to not be resuscitated. They willingly die because they want to end their suffering. The use of a lethal medication also does this. It also lets the patient pass on peacefully, but without an increase in pain. If the patient can withdraw treatment knowing that his suffering will increase, he should also be able to die without that momentary rise in pain.

According to Byock, "physician assisted suicide [has] branded "death with dignity" in a way that implies that people who are dying are not already dignified" (Byock, 2012). The patient does not completely lose his sense of dignity. The limitations placed on him initially affect his sense of pride. People do not mind depending on others as long as they do not lose their total sense of independence (Hillcoat-Nalletamby, 2014). For instance, a patient who needs help in using the bathroom will find it embarrassing. As a result, their pride will be hurt, followed by their dignity. This regression is what affects the patient's dignity.

The ultimate reason we desire to help people is out of love. The health-care professions should "avoid manipulating patients or acting for our own self-gain in any way" because they wish to help their patients out of love (Byock, 2012). The physician should not attempt to take something from the patient for personal gain. In all forms of care, the physician should wish the best for the patient. In some cases, the patient may feel

that living continues to be a burden, despite palliative care. They may still wish to die. In such a case, helping someone die can also be out of love and compassion.

CHAPTER TWO

My Stance

The will of the patient is the moral foundation for decisions about patient care from the patient's side of the equation. Here's why: autonomy allows the patient to maintain control of his life. According to Immanuel Kant, autonomy allows the patient to practice the freedom of making rational choices which define humanity (Johnson, 2008). John Locke also makes autonomy a moral foundation (*Two Treatises of Government*). In most cases, the patient, when provided with the proper information, has the capability to make his own decisions for his life. While the patient's interactions may link him to others, they do not bind him. The patient who suffers should work to make himself better. In the case that he cannot feel better, he still has autonomy. He takes responsibility of his life. His decisions will determine how his life unfolds up until death. Since death is also a part of life, the patient should have control over it. He should have control over how it occurs and when it occurs. It is the final decision over which he has any say.

On the physician's side of the equation, he must aid the patient without doing harm. Since some lives are worse than death, killing is not always a harm. Through informed consent, he should provide information regarding a patient's condition and then work alongside the patient to help the patient. In the case of medically-assisted suicide, the physician recognizes that the suffering the patient feels cannot be controlled by the available practices of medicine. The physician sees that treatments do not benefit the patient. Since the suffering continues, the patient may seek death. For patients with unbearable suffering, death is the better alternative to suffering.

When making medical decisions, two parties are primarily involved: a medical professional and the patient. Loved-ones may also take part in this discussion, but the decision makers should remain the physician and patient. People consider medically-assisted suicide immoral since the physician kills the patient. However, this "killing" does not qualify it as murder. The physician acts compassionately after careful deliberation alongside the patient.

The core of the medical field relies on the fact that physicians and nurses care for their patients. Caring is a "fundamental virtue" that comprises of five other virtues: "compassion, discernment, trustworthiness, integrity, and conscientiousness" (Beauchamp & Childress, 2009). For a physician, compassion focuses on helping another to alleviate his suffering. Discernment entails that the physician makes proper judgments and does not influence the patient. Trustworthiness is the most important of these five and requires that the physician "…will act with the right motives and in accordance with appropriate norms" (Beauchamp & Childress, 2009, p. 41). A physician with integrity will also not sacrifice his own morals. However, with conscientiousness he should act with the motivation to do what is right for the patient.

With these five virtues intact, physicians possess the fundamental virtue of caring. This will allow them to act morally when helping a patient make moral medical decisions. According to Beauchamp and Childress, there exists a cluster of four moral principles: autonomy, nonmaleficence, beneficence, and justice. A balance must exist in order for the physician to act appropriately with the patient.

A patient acts autonomously if he "acts intentionally, with understanding, and without controlling influences that determine [his] actions" (Beauchamp & Childress,

2009). The decision should not have the intent to harm others. Otherwise, this right should supersede other factors. Persons who are mentally stable only have control over their wishes. Since it is the only thing they control, people should respect the ability of a person to determine his or her own bodily destiny. As a result, others should work together to help each other in achieving their goals (Beauchamp & Childress, 2009). If the patient cannot make his or her own decision, a loved-one can be brought in as a surrogate decision-maker. This loved-one must be able to make decisions with the patient's best interests in mind (Neeley, 1994).

Beneficence requires that the physician acts appropriately using the knowledge he possesses. For example, if the physician knows that the patient is not mentally stable, the he should act on the patient's behalf with careful attention. The physician knows that the patient's choices will need additional consideration in such a case (Beauchamp & Childress, 2009).

The physician should not act with the intent to harm the patient. This is the requirement of "nonmalificence." The intent should be to help the patient. In the case of medically-assisted suicide, the physician intends to help the patient alleviate his or her suffering: "Such facts about the physician's motivation and character can make a decisive difference to a moral assessment of the action and the agent" (Beauchamp & Childress, 2009). The physician understands that the patient suffers and approaches death. Additionally, he knows that life-sustaining treatment may further add to the burden. Therefore, if the mentally competent patient expresses the desire to die, and the physician has done his best to determine whether there is any reasonable probability of alleviating

the suffering, the benevolent intent to prevent further harm to the patient can lead to the physician aiding the patient in ending his life.

People tend to fear death. They may fear leaving this life without a sense of achievement. They may not want to leave friends and family behind. They may simply not wish to pass on. However, people facing circumstances that hasten them towards the end may experience a different fear than most others. These people may have a terminal illness. It may not be curable or the cost of the cure is beyond the patient's monetary or physical means. Thus, in the final stages of life, people wish to have an easy and peaceful transition to death (May, 1985). They may not have the capability to live normally anymore. Even if they survive the effects of what should be a fatal illness scars them permanently. The suffering continues in the form of pain or greater limitations placed on the body resulting from the disease's effects. The many things which allowed them to feel normal may decrease substantially, making them feel alienated from everyone else. They can begin to rely on people for help. They cannot use the bathroom alone. Someone must help them when eating. People in this situation want to feel independent. People do not want to feel pain. They do not want to feel the discomfort associated with their illness. They do not want to worry about the time they have left. Their fear lies in the suffering they feel and expect to feel. At this point, they would not mind passing on into the next life.

A person with stage three or stage four cancer, limited to a short time of life left, may consider euthanasia their last resort. He faces the decision of either ending his life or continuing it, filled with physical pain and weakness. If he believes he cannot beat the cancer, he may just shorten his life and approach death head on. Or he may choose to

trudge on, fighting the pain and fatigue to the best of his abilities. Euthanasia by omission is already an available practice. In such a case, euthanasia should be accessible in the form of medically-assisted suicide. Of course, this patient still has time left to live; however, at this point, he may not feel content with living a life disabled.

Another instance in which I believe someone may utilize medically assisted suicide is if he or she has reached the final years of their life. For example, they have lived 80 years and do not expect to live much longer. They believe they have fulfilled their life goals. They understand the life they currently live will come to an end. Again this patient still has time to live. However, aging takes a heavy toll on the body.

Depression can also take a heavy toll on the patient mentally and physically. It can affect one's decision making abilities. In a controlled environment, one can monitor this depression to see if death is a true desire. These people should have a clear understanding of the decision they are making and should not act from the depression.

One should also receive the option of medically assisted suicide if he or she suffers from an injury that prevents a person from maintaining aspects of a normal life. The injury may have left them in a coma, unable to recover. Damage to the brain or heart could have everlasting effects, completely hindering someone. They may not be able to walk or move a large percentage of their body. Damage to the nerves may also limit full mobility. Depending on the severity of these injuries, a proper panel of professionals can determine if a patient should have medically assisted suicide available to them (Berlinger, Jennings, & Wolf, 2013). A single amputation does not fall into this category since the patient will still have many other aspects of his or her life return to normal. For instance, they will still possess the ability to interact with others. They can still eat on their own. However, a

person paralyzed from the neck down has his or her abilities greatly hindered. They may wish to live on. However, in other cases, they will wish to die.

However, this autonomy needs to be balanced with beneficence, nonmalificence, and justice. Although autonomy plays a large role, the patient must have the mental capacity to make such a decision. The physician's duty is to both himself and the patient. Therefore, he must determine what is best for the patient. Ultimately, the patient should have this option available to him or her if it is deemed appropriate for the circumstances. The decision the patient or a loved-one makes, will begin the process of determining if medically-assisted suicide is necessary. It will aid in ensuring the decision is made with sound judgment.

What is Suffering in This Case?

Suffering entails a wide array of ailments. It primarily entails undergoing pain, distress, or hardship (Suffering, 2013). For a patient considering euthanasia, he should feel all the aspects of suffering. This may result from a terminal illness, illness with limited treatment, or even old age. The additive effects of these three things cause farther suffering.

Terminal illnesses will vary. These include cancer, heart disease, Alzheimer's, multiple sclerosis. Let us take cancer in this example. Stage one and stage two are manageable. The cancer remains localized. If the cancer progresses however, a large number of problems begin to arise. In stage three, the cancer has metastasized. The tissues have been affected and the treatment becomes more taxing on the body. The treatment makes the body weaker and one loses his or her appetite due to it. The chances of recovery decrease substantially since the treatment now requires that multiple regions receive

chemotherapy and radiation. The patient also begins to ache and feels pain as his weakness worsens.

Aging generally has many adverse effects (Jong, n.d.). Mobility decreases. We tire more easily and the fatigue overwhelms us at times. Sometimes, our developing disability prevents us from meeting with others and taking part in the community. Our hearing and vision deteriorate, sometimes preventing us from driving. We slowly lose our independence. We may need to start wearing a diaper. Family and friends become crutches for small tasks such as changing a light bulb. The amount of medication we need to take in order to just stay alive increase substantially. The general use of Tylenol or Ibuprofen cannot reduce the pain. Soon we take Lasix for our kidneys and Advair for our lungs. Plavix makes it easier for our hearts to pump blood. Ultimately, we begin to feel like burdens. Our minds and our bodies deteriorate.

The effects of both a terminal disease and old age overlap. For instance, depending on the severity of the disease and the age of the person, mobility significantly decreases. The difficulty of leaving the house when one is sick or old increases more and more. The tiring walk from the bed to the bathroom can even become a burden (Jong, n.d.). This limits the ability to take part in the activities associated with daily living such as meeting people, moving around the house, eating, and more. Of course, with the advent of the internet, people no longer need to leave the house in order to do groceries or general shopping. Facebook and the telephone allow for easy communications, but people feel the limits of being unable to take part in the community. Physical interaction, whether it is an awkward side hug or deep conversation, allows them to remain relevant in society.

Another region of overlap lies in the fact these two things can lead to severe depression, further affecting our ability to heal. Depression can drive us to make foolish decisions, especially when the future is bleak. Life no longer has meaning and death haunts the mind. Suicide appears nice; however, the methods a depressed individual will consider usually do not require the safety and cleanliness of a hospital. Oftentimes, the patient will either shoot himself or overdose on strong medication. These methods of ending life are easily considered inhumane and affect those closes to the victim. The issue then arises as to how medically assisted suicide differs. In this case, the patient does begin to suffer from depression due to his condition. However, the careful consideration involved better prepares people for the inevitable. The process requires the person considering suicide, family members, and the doctor(s) to take time in making this final decision.

Another aspect people sometimes forget to consider is the cost of treatments for some terminal diseases. They can be very expensive. For someone who cannot afford his treatment, the alternative is to endure the disease until death takes him.

Also some diseases leave the patient with little to no chance of recovery. For example, Alzheimer's disease cannot be cured. The treatment only stalls the disease. Accepting treatment should take consideration before deciding if living at this point is worth it. It also takes a heavy toll financially. The monetary effects can play a major role in the decision-making of receiving treatment. Financial struggles can lead to other forms of suffering since one might have to sacrifice other parts of living. For instance, a patient may have to leave his home in order to make ends meet or he may have to refuse treatment in order to maintain other aspects of his life.

Use on Animals

Animal suffering has stood quite prominently in the public eye. The rights of an animal have been brought to light in multiple ways (Frenberg, 1985). Of course the obvious ways include experimentation and animal abuse. The range of rights an animal possesses is phenomenal.

Animals have access to euthanasia while humans do not. After 12 to 15 years of life, the suffering a dog begins to endure becomes quite evident. Arthritis and rheumatism can take over its joints. Cataracts keep it from seeing the owner. Their level of activity remains limited to the house. Their owners take them to the veterinarian to see if any medications can heal this dying best friend. But the options available may be expensive. The vet offers a difficult option: euthanizing the animal (Devine, 1985). The availability of this option is widespread. Many clinics and shelters will provide a painless injection to end the suffering of a loving pet. The animal cannot speak directly to anyone, but the pain appears quite evident. The poor creature begins to move more and more slowly in order to reduce the pain.

The suffering pets feel comes from a judgment call. They are not able to vocalize their discomfort in a language we can understand. The veterinarian, using his or her knowledge from school and experience with animals understands that the animal undergoes great suffering. And yet, they do not possess the same level of sentience or consciousness we do, as far as we can tell (Devine, 1985). We are able to feel many sensations. However, animals do not possess the same level of mental complexity as human in this regard.
On the other hand, we as more sentient and conscious beings can better understand our pain and suffering. When we feel fatigued due to an illness, we can alert others of it. When

we cut ourselves, we can easily locate it and treat it. We know better than to rip the bandage or stitches out. Our awareness allows us to make better judgments for ourselves and for our pets. Because we understand the hardships the animal undergoes, we make the call based on the veterinarians input to put the animal to sleep (Devine, 1985). Despite our higher level of thinking, we still find it inhuman and immoral to commit euthanasia. In the cases which I refer to, the chances of recovery are minimal at best. Despite our ability to comprehend the limitations we each have, we still attempt to keep a dying person alive. Any continued treatment or prolonging of life will lead to a greater burden to the patient. We are able to comprehend this as individuals and caretakers and still are not allowed to aid the dying process. The best we are allowed to do is ease the suffering using high dosages of morphine and other analgesics.

Incurable vs. Curable Diseases

Diseases also come in a great variety. They can vary from the common cold to malaria. Herpes is an example of an incurable virus; however, it will not lead to a quick death. Thus, diseases and ailments that do not have a substantially permanent effect on one's health do not fall into the category of disease where medically assisted suicide can be an option (May, 1985). These diseases must hinder a person tremendously in the ways mentioned earlier. Alzheimer's, on the other hand, leaves permanent damage. The brain slowly deteriorates and memory loss and dementia steadily increase. Huntington's disease also leaves a person permanently damaged and almost unrecognizable as their body takes a quick turn and the brain quickly deteriorates. The effects of such a disease will leave a person in a very undesirable state. Most people would not wish to suffer from a permanent

mental or physical handicap of any kind. However, when a sane person declines, they may not continue living.

People suffering from an incurable disease should have the option of medically assisted suicide available to them. Reasons primarily revolve around the terminal effects the disease has on a person (Pozgar, 2010). Oftentimes, the doctor will ease the transition to death by providing the patient with heavy doses of medication such as morphine (Preston, 2013). However, this does not alleviate the burden of death. Rather it instead prevents the pain from ruling their minds and instead clouds their minds, putting them to sleep. This does not resolve their issue, especially because this state of drugged stupor can last for days or even weeks, depending on the strength of the body in the final stretch (Preston, 2013). Rather than postpone death, it would be better to ease them into death if they wish it. They do not have to continue to think about their impending doom.

Curable diseases also exists in many forms. Majority of these diseases have a treatment of some form that eliminates the patient's ailments. A doctor will have no reason to offer a patient the option of euthanasia. These patients may suffer similarly to those with incurable diseases and the aged; however, upon recovery they usually can return to a normal life; a normal life consisting of the daily activities one went through as a healthy person. This includes eating, sleeping, hygiene, communicating, and other activities of daily living. (Jong, n.d.). However, if the disease permanently prevents a person from partaking in a number of activities, making them feel completely dependent on others, then medically-assisted suicide should be considered. Only in such an instance, can one take seriously the person's wish for euthanasia. For instance, AIDS slowly kills a person (Byock, 2012). Upon the initial infection, the person should not have euthanasia available

to them. As the disease worsens, the patient becomes extremely susceptible to other diseases since it weakens their immune system. If they happen to catch the cold, their system becomes easily compromised. It can develop into pneumonia or worse. The patient can be cured. However, the end result may leave them in a permanently weakened state. Their lungs have weakened and their muscles have deteriorated during the duration of their illness. They might even edge closer to death as a result. If the curable disease does not push them in this direction, patients of this type should not have euthanasia of any kind made available to them.

Physical and Mental

Aging and disease take a heavy toll on the body and mind. The effects coupled with a terminal illness or limited time to live provide a stronger basis to face the decision of euthanasia. The body suffers; however, the mind also follows due to the condition of the body constantly pressing on it. Thoughts of death dwell in the backs of the patients' minds, knowing that the chances of recovery are slim. If they feel pain and/or extreme discomfort, it will loom on their minds.

Aging has obvious effects on the body. In regards to euthanasia, they have surpassed 80 years or at least the body has the health of an average 80+ year old. We lose our independence as a result (Orfali, 2011). The joints weaken and begin to hurt. Bones become more brittle and begin to produce less and less blood. The skin sags. Muscles slowly deteriorate and use energy less efficiently. People can feel it. They do not want to move around as much and tire more easily. Since they tire so easily, the amount of activities they partake in also decreases. Their level of independence decreases as they age. For instance, they need help getting out of bed or preparing meals for themselves.

The suffering prevents people from partaking in their normal activities. They are less inclined to go out. They must constantly see the doctors and take prescribed medications. If they used to exercise extensively, they have to cut back on the amount and intensity. Again, the daily activities they take part in become difficult chores rather than routine ones. Of course aging can receive "treatment" via multiple types of pills and surgeries, but there is no cure-all for aging. Some aspects such as the muscles can receive a boost, but it is temporary and requires constant attention. They can end up in a nursing home and the freedom associated with independence disappears (Preston, 2013). They have digressed almost into a baby-like stage physically, using diapers and consuming non-solid foods. When someone reaches this age, they may undergo a level of humiliation.

The mental handicap that develops with age is substantial for some people. Those who suffer become more and more forgetful. The ability to process may also decline. It makes a person's life extremely stressful to forget details of their day or to lose things constantly. The suffering that results from this takes a toll from the body. The forgetfulness and overall decline of the mind can lead to depression and sadness (Preston, 2013).

Although aging causes one to lose one's independence, it is the combination of physical weakness and the mental decline that should allow euthanasia to be available. With the limitations of the body and the decline of the mind, they can develop into relics of their former selves (Orfali, 2011). The vitality they once had has disappeared and the only thing keeping them from death is the aid of medication and the variety of people who help clean and feed them. Sometimes, the mind can remain intact. This occurs more often nowadays with the medical advances. The healthy mind continues to live on but the body

still cannot keep up. Such a person becomes lost in their thoughts since they have little else to do. They can live happily like this; however, the limitations placed on the body no longer make it a sanctuary but a cage (Orfali, 2011). They are trapped and can no longer do much in their bodies. They may even want to end their lives since they have lost so much of their abilities as the mental burden increases more and more. They suffer because they cannot do anything and have lost their dignity. Thus, they can begin to wish for death.

Disease takes its own toll on a person, both physically and mentally. The suffering disease and injury take on the body can vary. However, when the disease irreversibly damages the body, one might consider euthanasia. They can no longer move willingly without the help of others. For instance, such a person may be kept on a ventilator. They may also undergo tiring physical procedures daily, such as dialysis that hinder their abilities to do anything else. Other aspects to take into consideration are the pain levels a person undergoes. When the pain requires powerful anesthesia in order to alleviate it, then both the pain and the medication affect the patient. When such strong medications are needed in order to cope with the agony on a daily basis, medically-assisted suicide can be considered.

The mental burden and suffering that comes with disease and injury can have stronger effects than the disease or injury themselves. They rest on the mind and one thinks about their effects throughout the day. One notices how he or she is unable to go about their daily business. The physical anguish becomes a mental burden that will not go away. Pain prevents us from thinking properly. Fatigue takes over the body. People in this situation dwell on the weakness but are no longer able to recover from it. This hurts their pride because they require heavy dependence on others. The suffering causes others to

suffer, to a much milder extent, as we are no longer able to act on our own. By becoming a burden unto others, we further add to the mental distress.

CHAPTER THREE

Reasons for Medically Assisted Suicide

A Simple and Independent Lifestyle

A simple and independent lifestyle has a broad range of meanings. The simplicity should stem from the bare necessities of life: shelter, food, water, and human contact. The combination of these four things is necessary for us to survive. What exactly do these things provide? Shelter provides us with protection. It protects us from the elements and other animals. It is an area where we can feel safe and we can consider our property if the conditions are right. Food and water are more obvious necessities of life. They allow us to continue living and to grow. We cannot function without them since they provide fuel for our cells. These three things mainly allow our bodies to remain healthy. Human contact, on the other hand, provides sustenance to maintain a healthy mind and body. As social animals, we need human contact to remain sane. It helps us remain physically healthy the mind properly develops and maintains itself. It allows us to vent our personal frustrations and release bottled emotions. Isolation harms us by preventing us from expressing ourselves. Confined to our thoughts, it become increasingly difficult to communicate comfortably with others.

When the ability to live becomes difficult, it affects these four things. These difficulties can rise in multiple situations where an individual has become physically or mentally disabled. Such circumstances may lead an individual to consider (or accept) death more readily. Although we are social animals, we are not completely reliant upon one another. Despite being social creatures, independence stems from a desire to be self-

sufficient (Hillcoat-Nalletamby, 2014). We do not want others to take on our more personal tasks. We also do not want them to provide for us 100% of the time. We would rather have the capability to make our own money. We do not wish for their assistance when using the bathroom. We do not want them to feed us. We desire to succeed with and without people. We would like to own and live in our own homes and buy our own food. Independence also provides us with pride for our accomplishments. For instance, when a child learns to tie his own shoes or put his clothes on by himself, he swells with pride. Or when an adult buys his own house with the money he or she has earned after years of hard work, they can consider themselves self-sufficient. The need to act independently allows us to maintain a level of dignity. Speaking with friends and family allows us to remain sane; however, the desire to act alone at times is necessary as well to maintain our sanity.

In addition, people include their daily activities when thinking of such a lifestyle. This includes getting out of bed, eating breakfast and more. One is able to use the bathroom without assistance. These activities that we typically take for granted are what truly give us the sense of independence throughout our lives (Hillcoat-Nalletamby, 2014). However, our ability to thrive and live happily does not remain limited to these daily activities. We must also have the ability to leave the house and to do groceries. We need to see friends and family. We must interact with those around us of our own accord in order to sustain healthy minds. The "sense of independence remains linked to the resources [people] can access in order to help them fulfill daily needs" (Hillcoat-Nalletamby, 2014). These activities are a combination of the basic necessities we need to survive and the independence we seek.

When a simple *and* independent lifestyle becomes permanently disrupted due to a severe physical handicap, we should have the option of euthanasia. This disruption creates additional suffering. It hinders the mind's ability to recover or to progress as the body deteriorates due the constraints of old age, injury, and/or disease. Our minds remain healthy from being independent as well as living simply. They may diminish with the restraints made by the body. Permanent physical disabilities that disrupt an independent and simple lifestyle cause many more problems. In addition to having to deal with an injury or the fatigue that comes with age, they must deal with the loss of the basic practices of society. They must adjust to their handicap and in some cases, such as the inability to take care of oneself in the bathroom, they understandably become embarrassed. When these losses start adding up, it can break a person down substantially.

When we cannot do a number of these things due to a limitation placed on us by disease, age, or injury, life becomes disrupted. It slowly becomes less of a life and more and more of a prison. A patient's body encapsulates them, quarantining them. The combination of shelter, food, water, human contact, and a desire for independence allows us to thrive. Even in the past as primitive natives, humans survived in groups. When one of four aspects became disrupted, they suffered terribly. For instance, when famine strikes populations or even just a household, many family members would die. Or if one became bedridden due to an illness like the bubonic plague, it was nearly impossible for one to recover. Although many medical advances have been made, the defining characteristics of suffering have not. This has not changed except in the matter of the degrees we are affected. When a disease or injury affects someone, we have the capability to assist in recovery or aid a person in their time of need.

Certain events cause a significant change to these five requirement. Major injuries, diseases, comatose states, and age are the primary ways someone finds their lifestyle affected tremendously. Of course, for certain events one can adapt to the situation in order to live happily. For instance, someone who loses the ability to use their legs will have difficulty moving around. However, the use of a wheelchair mitigates this difficulty. When adaptation becomes extremely difficult and causes more grievances than benefits, it becomes an issue.

Injuries

Injuries can affect a simple and independent lifestyle. The injury affects more than one of the four necessities to live. For instance, paralysis, brain damage, damage from burns and many more extreme cases have reduced people to a significantly weakened state. The injuries affect our minds as well, sometimes resulting in PTSD (Gardner, Knittel-Keren, & Gomez, 2012). Such injuries limit our independence the most. We can no longer take on daily activities on our own. Feeding ourselves and using the bathroom do not require much aid; however, needing aid with such a simple task affects our perceptions of ourselves and our abilities. When we can no longer do the tasks which we have become so used to doing, it has a negative effect on us. In the case of paralysis, when it has reached the neck, a person can longer act on their own in any way (Taub, Keune, Kodner, & Schwarze, 2014). They require a machine to aid them in breathing, they must undergo dialysis several times a week, and much more. Their life has become difficult and complex due to the large number of treatments they must undergo just to stay alive. Chances of full recovery from paralysis are very rare. Because of this, they also lose a portion of their independence. This loss of independence will vary. But the more a patient must rely on

others, the greater the effect can be. And this loss takes a mental toll on the patient as a well as the loss of their physical abilities. Being left disabled leaves us to primarily spend our time thinking. These thoughts can simmer on the losses of our abilities leading to depression. If they feel they have exhausted the resources available to them, have tired from the constant treatment, or if they feel they have fulfilled their life, they can approach a physician to consider ending their lives under a controlled environment (Taub, Keune, Kodner, & Schwarze, 2014). It is not a requirement that they choose to die. If they wish to live and continue treatments, they have that choice.

Disease and Age

Similar conditions apply to diseases and age, albeit they do not necessarily occur as quickly or dramatically.

The type and stage of the disease determines how terrible the effects are. Minor issues such as the cold and a rash can be eradicated with easy treatments of antibiotics or creams. The effects of such medications are minimal and tolerable.

On the other hand, a disease such as cancer will have varying effects depending on the stage of cancer. At stage one, the basic treatments are relatively low doses of radiation and chemotherapy. Even a surgery may be all that is needed to eliminate it since the tumor is small and localized. In stage two, the strength and duration of doses increase in addition to having surgery (if it is accessible for surgery). In stage three, again the doses have increased and the length of treatment has also increased. The chances of survival have substantially decreased and the cancer has spread. Treatment as well as the disease takes a heavy toll on the body. In stages three and four, the patient suffers immensely. They are substantially weakened by treatment. It also becomes quite costly as well. Lifestyle

becomes disrupted by the treatments and weakness. Chemotherapy significantly reduces the desire to eat, making patients weaker and fatigued. In these late stages of cancer, due to the relatively low chances of both recovery and survival, such patients should have the option euthanasia available to them under the same conditions proposed for a person who has received a catastrophic injury.

The issues associated with old age have been discussed extensively in previous sections. However, I will reiterate some points and add others.

The issues that arise with age tend to be less severe than the injuries and diseases mentioned earlier. They also gradually worsen with time. People's bodies start to slow down, their bodies ache, and they watch their friends die (Hillcoat-Nalletamby, 2014). With the bodies slowing down and weakening, the fatigue affects them more quickly. They become less inclined to socialize and to go out of the house. They may need assisted living or other palliative care in order to function properly. When they see their spouses pass on their depression and desire to go out decreases even further. Sometimes, they realize that they have done all they could have in their life. Thus, they may consider passing on themselves. In this case, after discussing it with their physicians (and if they choose, their children as well) they may opt for medically-assisted suicide. They are able to discuss it with someone to lay out options. After much discussion, they may find that they prefer palliative care. Thus, they are not required to be euthanized. But the option should be available if they wish for it.

Comatose and Vegetative State

Difficulties arise in determining the wills of patients in comatose and vegetative states. Direct communication has become impossible. The individual has lost ability to

move and are kept alive by mechanical means. They are connected to a drip to keep them hydrated and nourished. Usually a machine of some sort aids them in maintaining their bodily functions such as a ventilator to aid in breathing. The options in these cases become severely limited in the number of choices available. Of course, if the patient has filled out a DNR form or expressed in his will how he would want such a situation to be handled, the decision becomes easier (Berlinger, Jennings, & Wolf, 2013). However, for the cases in which such information is inaccessible or does not exist, one must either rely on other methods to determine the next action.

In such a dilemma, we should approach the people closest the patient. They would possess a significantly better understanding of the patient's desires: "A surrogate's role is…to answer the important question, "What would my loved one decide if she could speak to us?"" (Teno, Stevens, Spernak, & Lynn, 1998). Through careful discussion with them, a professional such as a physician can assess if euthanasia should be followed through with it. Such a decision should include an assessment of how the patient acts while awake. For instance, if a person ever vocalized their thoughts on euthanasia, it presents an ideal opportunity to determine what they would want to be done.

Euthanasia vs. Suicide

Most societies consider a suicide a terrible decision. To some it is a sin, to others is a coward's way out, and to even more it just appears wrong. Euthanasia is also a form of suicide. However, the reasoning behind these two acts differentiates the two. Suicide results from a severely altered state of mind and depression. These mental limitations clearly affect individuals tremendously. However, they do not prevent people from trying to find a purpose to continue living. The primary block preventing them from healing

themselves is their mind. Those who died due to euthanasia, although they may have felt depressed, were also physically limited in their abilities to partake in daily living. While an individual who commits suicide could have sought help to fix the situation, a person seeking assistance for suicide usually does not possess any chances of recovery.

Suicide

We can end our lives so easily with little thought if we are unwilling to wait for a natural death. A natural death is one in which we let our life run its course and our cells simply stop functioning due to natural processes. Yet we possess the capability to change the timeline of our lives by bringing it to a standstill sooner than expected. This route typically comes right after one experiences something traumatic. One study showed that people wish to commit suicide if there was "difficulty, or a conflict, within the family: a marital separation, a parent's illness or conflicts with a partner" (Ghio, et al., 2011). In this case, over 300 people who had thought about and/or attempted suicide took part in the study to determine the reasons for it and ways to prevent it. Generally, this attempt on one's own life is selfishly thought out and little consideration is given to the people who will be affected (Ghio, et al., 2011). In addition, the reason for death may not be justified because a solution typically is available. The most common solution found from the previous articles, is a discussion of the issue with another person. Seeking support reduces the chances of suicide (Gooding, Sheehy, & Tarrier, 2013).

Some traumatic event has affected their minds so dramatically, that they do not wish to continue living. The event(s) has become so lodged in their minds that it prevents them from thinking clearly or about anything else. Typically, they can receive proper treatment through discussions with others or medication (Gooding, Sheehy, & Tarrier,

2013). If the individual becomes completely consumed by depression medications that block various receptors can help reduce the effects of depression. However, they fear approaching others or they feel no one will listen to them or that no one will help them. They do not seek the support that could help them out of their dilemma. Such thoughts without proper communication lead one to take dramatic actions (Gooding, Sheehy, & Tarrier, 2013). They seek very dangerous and sometimes painful ways to end their lives. They might have access to a gun, strong medications, or even a dangerous chemical and will use it rashly.

Another aspect suicidal individuals sometimes fail to consider is the effects that their deaths will have on others. For instance, when a teenager attempts or commits suicide, they view themselves as alone. It appears to them that everyone around them will merely forget his or her existence. They do not think about their parents, friends, or other family members who would be affected (Gooding, Sheehy, & Tarrier, 2013). Because of their inability to speak with others out of fear or embarrassment, they isolate themselves and act foolishly. They feel alone and thus they act alone. Euthanasia subjects may also forget to consider the people affected by their deaths. However, since they bring in a second party to assist them, they must explain the suffering they endure. This approach exposes the patient's thoughts and thus can allow others to aid in this decision.

Euthanasia

Euthanasia is a form of suicide. There are many people who suffer from ongoing medical conditions who suffer by living. The difference between medically-assisted suicide and suicide on its own is the difference in a person's independence and the permanent disruption of their lives. These individuals oftentimes are unable to act on their

own due to the limiting factors placed upon them. Their lives are not necessarily in their control. Those who are conscious have the option to refuse treatment to accelerate the dying process but the final stages of their lives will be painful and difficult. And yet, these people who are incapable of ending their lives are legally required to stay alive. They cannot seek assistance from anyone since it would qualify as murder, no matter the situation. Although their death can appear justified, they must continue suffering.

As I mentioned earlier, euthanasia means "good death." By good, this means that the person has achieved a level of contentment with their lives. Ideally, the situation would have people believe they have left their mark on the living. They have left a legacy they are proud of and are content with dying. But this cannot be the case every time. In most cases, people desperately want to regain control of their lives, but simply cannot due to their situation. One study revealed that those who wish to be euthanized are not all suicidal. According to the study, "none of those who did not have clinical depression had suicidal thoughts" (Brown, Henteleff, Barakat, & Rowe, 1986). They are not consumed by thoughts of taking their own life, for the most part (Brown, Henteleff, Barakat, & Rowe, 1986). Their deaths are acceptable since the person has achieved a level of achievement that they themselves and others find reasonable. Their circumstances have placed heavy burdens on them preventing them from living happily and peacefully. They have reached a conclusion after discussing the issue with the appropriate people. They have approached family members, friends, or professionals about the state of their lives and ultimately decide that their time has come. In agreement with the consultant over the subject, they have an approved reason to end their lives. And with this decision and the aid of another party, they undergo euthanasia.

Another key difference between euthanasia and suicide is that a person who desires to undergo euthanasia has approached someone else for assistance. He or she has had thoughts of suicide but typically does not have the ability to act on his or her own. Thus, they approach someone else for assistance (Tamayo-Valazquez, Simon-Lorda, & Cruz-Piqueras, 2012). By approaching others, people considering euthanasia may gain assistance on the issue that is bothering them. They provide themselves with an opportunity to communicate with someone else and to make sense of the situation. Sometimes, they may change their minds. Other times, people they speak to understand the struggles the victim is undergoing. Through this understanding they can take the steps to ease the transition into death.

Euthanasia vs. Murder

Euthanasia is a controversial subject. The greatest issue of controversy regarding euthanasia is determining how it differs from murder. Generally both require two parties, one who dies and one who kills or aids in the death. However, a huge distinction must be made between the two in order to set them apart: intent.

The purpose behind euthanasia is to aid someone. It is to help end their suffering. In its purest case, the party aiding with the suicide does not have an ulterior purpose behind aiding this person. In addition, both parties have agreed to partake in the suicide. The act is not done blindly and careful thought precedes the act.

Murder on the other hand, has a dark purpose behind it. It is "the killing of a human being by a sane person, with intent, malice aforethought" (Hill & Hill, 2002). In addition, the intent behind murdering a person is one-sided. The victim does not have a choice in the matter. This intent can result from a rash decision made in the heat of the moment. For

example, a husband may kill his wife out of anger after learning about her infidelity. It can also be premeditated. For instance, a gang member intending to kill someone who wronged him will attack his victim with a gun or knife. In both cases the victims could not defend themselves and they also did not wish to die. The intent to harm without consent separates murder from euthanasia.

Currently, the legal status regarding euthanasia varies from state to state. The states of Oregon, Washington, and Vermont have legalized medically-assisted suicide. All other states keep medically-assisted suicide on a "to be determined" basis. In other words, they have no set laws regarding its legality but instead leave it to the jury to decide the fates of the involved parties. On the other hand euthanasia by omission, in the form of withdrawal of care, is a common practice. However, the legality of active euthanasia should be reconsidered. Since it provides a form of aid to the patient, fulfilling their wishes, the differences should allow for reconsideration of euthanasia in the form of medically-assisted suicide.

The Different Intentions

There is a scenario that people address when regarding euthanasia. This is where the difference in intentions makes a significant difference between euthanasia and murder. This scenario includes a mother and her three daughters. The mother suffers from a late stage of cancer, placing her under tremendous pain and ultimately into a coma. She expressed a desire to medically assisted suicide prior to falling into a coma. The three children thus must make the decision to allow their mother to undergo euthanasia. They have heard their mother's wishes and now must make a decision. In addition, the mother

has a large inheritance to pass on to her daughters. Now the three daughters each have their own reasons for aiding their mother to end her misery.

The first daughter truly wishes to help her mother. She has seen her mother in pain every day, in and out of consciousness. She does not even think about the inheritance because she loves her mother.

The second daughter's views are slightly different. She cares for her mother but she also wants the inheritance. The additional money will help her pay her bills but she also does not wish to see her mother die as a result. Thus, she is indifferent in the method of her mother's impending death. She can allow her mother to die from the disease or allow her to undergo euthanasia.

Now the third daughter is completely different. She does not care for her mother. She knows of her inheritance and wishes to gain it as soon as possible. The money, she believes will solve all her problems. Thus she also wishes to end her mother's life, but with clear selfish and murderous intentions.

Now these three positions each present different intents that distinguish euthanasia from murder. The first daughter has the best intentions and wishes to aid her mother. This entails what should be required in order for someone to undergo medically assisted suicide. The second daughter's intentions differ from her first sister. She does need the money and thus has reason to see her mother dead for selfish reasons. But she does not wish to see her mother dead immediately, making her innocent of killing her mother. The third sister has the most evil intentions. She wishes to see her mother dead, the sooner the better. She qualifies as a murderer, guised with good intentions of easing her mother's pain.

Dr. Death

Euthanasia should require a process to determine the patient's ability to make decisions, the family members/friends to make decisions, and if the situation deems euthanasia an option.

The most prominent proponent of euthanasia was the infamous Dr. Jack Kevorkian, also known as Dr. Death. He partook in physician-assisted suicide for 130 different patients between 1990 and 1998 (Grace, 1999). He assisted many patients suffering from terminal illnesses such as cancer. However, the methods which he undertook and the process of his decision making do not make for reasonable methods.

"Dr. Death" primarily used two methods when euthanizing patients. He rarely killed the patients himself, leaving the choice with the patient (Belluck, 1999). His primary instrument consisted of a device which he invented that would inject the patient with lethal chemicals intravenously. The chemicals allow the patient to ease into death. This was done by their own decision since they pushed the button. In the second method he used his patients by exposing them to carbon monoxide via a mask.

Although one can empathize with his reasoning behind his actions, the methods he uses do not justify the ends. While his methods are painless, his methods of assessment were inadequate. He did not take second opinions from other physicians and thus made his decisions on his own. For such a controversial decision, additional opinions regarding it would be beneficial. Thus a second opinion aids with covering any loose ends: "…mandatory second opinion…uncovers a significant number of discrepant diagnoses and pathologic review should be undertaken…" (Kronz, Westra, & Epstein, 2000) His ability to assess the patients' mental states were limited as he did not have any specialized training

in this area. His focus as a physician was as a researcher in anatomical and clinical pathology. He did not specialize in psychology. To making such ethical decisions, a psychiatrist goes through extensive training regarding ethics (Morenz & Sales, 1997). His understanding of what went through the minds of people with terminal illnesses was limited to what he saw. His decision to aid people relied primarily on his empathy (Grace, 1999). With this lack of proper information, his decisions had great potential to be flawed. There could be potential for the patients to change their minds. Although Dr. Kevorkian could empathize with patients, his choices did not follow the typical guidelines physicians follow when making controversial decisions. Multiple physicians assess the more difficult cases, each providing their own analysis of the situation. If one does not possess the knowledge to make a sound choice, he can make referrals to someone who does. Dr. Kevorkian did none of this. He took it upon himself to take the lives of 130 people. This is where the greatest issues arose from Dr. Death. Although he assisted many people, the means to the end are not justified.

CHAPTER FOUR

Guidelines for Medically-Assisted Suicide

Various situations have been discussed regarding the types of situations in which euthanasia should receive consideration. The option for euthanasia should only be administered when the patient's life has been severely and permanently disrupted. The process to determine if it should be administered requires several people. Of course it will require the patient (if they have the ability to make decisions), a physician willing to administer the suicide, a physician willing to provide a second opinion regarding the situation, a psychiatrist, and a family member/close friend to aid with the decision. Once the aforementioned people have assessed if they can pursue medically-assisted suicide, then the next steps can be taken. However, if at any time the patient changes his or her mind, he or she may do so.

Whose Decision Is It?

The most important voice in any situation regarding euthanasia is the patient considering it. This is already evident from the fact that a patient can accept or refuse treatment. And although withdrawal of treatment or omission of treatment is a difficult action for the physician, it needs to be done (Andrews, 2003). This person must have his/her life affected in such a way that they cannot live a simple and independent lifestyle ever again. Upon permanent disruption of this lifestyle, this person realizes the difficult of living and thus should have the option to die on their terms. At this point they may approach a physician regarding the next steps. They should have the options of both

passive and active euthanasia available to them (Chetwynd, 2004). It is the patient's right to decide how their life should end. When a person typically commits or attempts to commit suicide, they do not receive a punishment. To the person, it provides them with some control over their lives in order to escape a situation. Thus, the same concept should apply to someone medically, physically, and/or mentally handicapped if they wish it.

An institution such as the hospital or government should not be allowed to make this decision since they are larger entities. An individual's personal decision offers them an opportunity to present some control in their lives. It offers the individual an opportunity to change their life as they see fit. However, when a large group makes the decision to end someone's life without consulting the individual, it takes away the patient's right.

Decision if Patient is Incapable

Sometimes a patient's condition prevents them from making any decisions. Such patients have either become paralyzed or comatose, rendering them unable to communicate in any form. Thus, the decision for euthanasia must go to the next available voice. The decision to be made from here on out must be in the patient's best interest (Berlinger, Jennings, & Wolf, 2013). The person's written will is the next source of information regarding the patient's desires. If the patient's written will does not mention anything regarding their current state, then the next of kin or close friend will have the option of making the decision for the patient: "…substituted judgment where the family's best assessment of the patient's desires is respected" (Neeley, 1994).

However, the patient's inability to communicate must be guaranteed. Oftentimes, paralyzed or comatose patients still maintain some level of awareness but are unable to visibly communicate. One method to determine their level of awareness is by speaking to

them while they take an MRI (Pfeiffer, 2012). The level of brain activity presented by the MRI in response to the questions will show if they can understand. This newly found information allows for a new path to communicate from. In other advances in technology, some patients have become limited in what parts of their bodies they can move due to fatigue or paralysis. Some may still be able to move their eyes. With this movement, they can look at a specialized computer monitor that will register the movement of their eyes (Boyle, 2010). At this point, if the patient wishes to die, the next steps may be taken.

All forms of communication with the patient should be used before a surrogate decision-maker can be used. If the patient cannot communicate in any way, they do not have a written statement regarding their immobile state, and they do not have any close family members or friends willing to aid the situation then the decision comes to a standstill. Little can be done aside from maintaining the state of the patient until more information comes forward.

How to Measure the Differences Between Intentions?

Differentiating between intentions is crucial when the patient is incapable of making their own decision. At this point, close family members or friends should receive an assessment of their abilities to make the decision for the patient if the patient has not expressed the wish to be euthanized otherwise in their will or previous forms. The ideal way of doing this is by interviewing each party willing to take part in the decision, giving them a psychological examination (Berlinger, Jennings, & Wolf, 2013). Questions should include the following:

1. What is their purpose in agreeing to euthanize their loved one?
2. What do they gain from this person's death?

3. Has the patient ever expressed any wish to be euthanized?
4. Would they themselves ever consider euthanasia?
5. Can they explain the struggles the patient is currently undergoing?
6. Do they understand the effects of the suffering?

Depending on their answers to these questions will determine their suitability to make the decision for the patient.

Of course an issue is determining this family member's or friend's honesty. Thus one way to help in this matter is to weigh the value of what they have to gain from the patient's death when regarding the answers to these questions. For instance, if the person will gain a large amount of wealth, it allows the psychiatrist to potentially put less weight in the next of kin's responses to the questions. Other options include asking other people of their assessment of the family member's/friend's honesty. The combination of these methods will provide more information regarding the intent of the family member and/or friend.

The Doctor's and Psychiatrist's Role

The Doctor's Role. The doctor throughout this entire process must try his or her best to remain impartial. He or she has the best medical knowledge of the patient and thus can only provide options based off of this knowledge. The doctor must offer all available options to the patient and/or related parties he believes are necessary (Whitney, McGuire, & McCullough, 2004). He may tell him or her of the various ways the patient can cope with their ailments. He or she must explain the problems the medical issues will cause. For the most part, the doctor should not suggest the option of medically-assisted suicide unless absolutely necessary. For instance, if the patient is expected to die, he may provide

the option in order to end the patient's suffering sooner. On the other hand, if the patient requests to be euthanized then the physician should try to the best of his or her abilities to assess the situation to determine if euthanasia is needed.

Upon the determination that the patient does have a viable case, he or she may then approach other physicians to gain second opinions regarding the case. He should also have an expert, such as a psychiatrist, to determine the mental state of the patient. If all professional parties come to agreement that the patient has suitable reason to undergo euthanasia, then the process progresses to fulfill the patient's wishes.

The most criticized role in this whole process lies with the doctor. The practice of euthanasia puts the doctor under great scrutiny as it breaks from his typical roles As the provider for the medications to lay someone to rest, the doctor aids and abets the patient in committing suicide. Under the Hippocratic Oath, a physician must work to keep the patient from dying. They are not permitted to provide any toxin to kill the patient, according to the oath. They are required to assist the patient until he or she feels better. But if the chances for recovery are slim, one must reconsider the role of the physician: "Increasingly, the role of the physician is seen as one that is intimately involved in issues related to patient dignity and ending suffering, not just preserving life" (Norman, 2012). While the advances in medicine and technology have improved the lives of many, it has also revealed the cases beyond help. It has not placed limitations on us, but keeps revealing the limits which we must surpass. In the case of a stroke victim whose brain has partially died, rendering them weak, the doctor cannot do much. He can provide the appropriate medication to make the patient's life less difficult, but this does not solve the problem. The medication only makes the effects of the stroke more bearable. If the stroke patient returns

to the physician seeking death as a way to "cure" him of his ailment, then the physician cannot turn away. The physician may offer other options of relief and treatment (Byock, 2012). However, the patient may refuse treatment to speed up the dying process, but that does not provide immediate relief from the suffering. The suffering would actually increase, causing more pain. The physician's duty is to treat a patient's aches and pains, but sometimes a complete cure is impossible. Thus, the physician's role must change. Instead, should find other methods to cure the patient, death being a possibility if the chances for recovery are not in the foreseeable future.

Some may argue that a doctor cannot provide the means to kill a patient because it steps beyond the realm of medicine. By offering such a service, some may think they are attempting to take the role of God. They claim the doctor steps outside his or her limits by interfering with the natural process of death. However, that is the primary duty of a doctor. They do not replace God (Crysdale, 2003). They interfere with regular biological processes daily not in the hopes of playing as of replacing God, but in order to aid the patient. They perform surgeries and prescribe medications with the intent of keeping the patient alive. Therefore, it should not appear so extreme that the doctor may try to reverse the role by aiding the terminally ill patient with his or her death.

The Psychiatrist's Role. The purpose of this position is to assess the mental condition of the patient if the acting physician feels the patient is unstable. As it turns out, not all patients seeking death do so out of depression (Norman, 2012). Of course, in such cases there will most likely be some form depression. But a mental instability from a variety of disorders, including depression, can play a dominant role in the decision making process. Determining the patient's mental stability provides vital information regarding

their ability to make sound decisions regarding their wellbeing. For instance, a depressed patient will more likely act recklessly to escape from the depression even if their medical condition is manageable and treatable (Petersen, et al., 2003). If the psychological examination finds that their instability affects their decision making, the psychiatrist can recommend that the physician refuse to medically euthanize the patient. The physician would not prescribe the medication for medically-assisted suicide due to the patient's inability to think clearly.

The Role of the Loved One

The patient has the right to alert someone or have someone alerted of their wish to die. This person should be close to the patient but should also have the ability to make well-thought out decisions. Ideally, this would be the patient's spouse. If not the spouse then children, parents, or close friends should be approached. The purpose of this friend is to provide support while aiding the patient in making their decision (Berlinger, Jennings, & Wolf, 2013). This is already practiced in many medical decisions: "Particularly toward the end of life, the process of decision making is often complex and dependent on the concrete details of the patient's medical condition, the benefits and burdens of treatment, sensitivity to patient's previously expressed wishes, and shared goals of care" (Kaldijan, Shinkunas, Bern-Klug, & Schultz, 2010). This allows the patient to communicate with a loved one to discuss the effects of death. While death allows the patient to end his or her suffering, it will inevitably cause grief for others. The death will affect children, parents, friends, and more. Thus, properly discussing the idea of suicide with others will clarity and closure.

The ability to discuss the situation allows the patient to further reflect on their choice (Byock, 2012). We tend to listen more closely to people we are close to in times of distress. Sometimes we just need someone to tell us not to follow through with a decision in order to realize we do not genuinely desire making it. Speaking to a loved one provides us another perspective for the suffering one endures.

If after this discussion the patient still wishes to die then the loved one should provide support. Throughout the process, the loved one will make sure the physician receives all the relevant information and that the patient is not withholding information.

If necessary, the family member/friend may have to become the surrogate decision-maker (Kaldijan, Shinkunas, Bern-Klug, & Schultz, 2010). They will also undergo psychoanalysis in order to determine their mental state. The information they provide will be taken into account by the physician who would assess the patient's medical status. This next of kin will have to have considerable understanding of the patient. They will have to be able to express their thoughts in regards to what they believe are in the patient's best interests.

States That Legalized Medically-Assisted Suicide

As mentioned earlier, four states have legalized medically-assisted suicide: Oregon, Washington, Vermont and Montana (Frequently Asked Questions, 2013). All except for Montana have processes in determining whether medically-assisted suicide is necessary.

Oregon, Vermont, and Washington

Oregon passed the Death and Dignity Act in October of 1997 and Washington passed its act in November of 2008. Vermont passed a similar act in May of 2013 (Frequently Asked Questions, 2013). The process used for medically-assisted suicide is

similar to the one I offered previously, but with minor changes. The patient must first fulfill several requirements that a physician of Oregon will assess to determine the patient's qualification. The patient must be at least 18 years of age, a resident of Oregon, capable of making his/her own medical decisions, and must be diagnosed with a terminal illness predicting that they have 6 months left to live. After these conditions are met, the process can begin.

First, the patient must make an oral request with the physician at least twice with 15 days in between each request. Second, the patient must make a written request with at least two witnesses. Third, the attending physician and a consulting physician must confirm the patient's diagnosis and prognosis. Fourth, they must determine if the patient actually can make his/her own medical decisions. Fifth, if the two physicians believe the patient is mentally impaired (such as depression) the patient must be referred to a psychological examination. Sixth, the physician must lay out all options for the patient on the table such as comfort care, hospice care, and pain control. And finally, the physician may request that the patient alert his/her next of kin. The physician will then offer the patient an opportunity to change his or her mind over a 15 day waiting period upon which the physician will alert the Oregon Health Authority of the prescribed lethal medication. The patient then has a 48 hour time period to wait before picking up the prescription.

Conclusion

Euthanasia in all its forms produces a strong negative image. It makes people think of death, killers, and Dr. Death. However, some people fail to recall why two parties are involved in the decision. The most important voice in this situation is the patient's. They have found that the physical struggles due to their various medical issues along with the

various treatments used to keep them alive have exhausted them. They have utilized the various methods that could reduce the suffering, but in some cases this is not enough. Thus, the patient may wish to undergo euthanasia. As an "easy or happy death", the patient dies on his or her own terms in order to die on their own terms. The second party involved (a doctor) can only act if given permission by the patient. This mercy killing is to allow the patient to die on his own terms when his health condition causes him to suffer.

There are multiple forms of euthanasia: euthanasia by action, omission, voluntary, non-voluntary, and involuntary. Euthanasia by action, in the form of medically-assisted suicide, is the topic at hand. Most states and countries deem euthanasia illegal from the physician's standpoint. It qualifies as murder. However, opinions of medically-assisted have slowly been changing. Oregon, Washington, and Montana have passed laws legalizing medically-assisted suicide (the preferable path when considering euthanasia). Furthermore, some physicians have changed their stances in regard to medically-assisted euthanasia as well. Such physicians acknowledge that not all patients can be cured of their terminal illnesses.

The suffering of these patients who wish to undergo euthanasia is pretty severe. They should primarily find that their intense physical pains, distresses, and/or hardships take a heavy toll on their bodies as well as their minds. Terminal illnesses, such as cancer in its final stages, place the body under great stress. The treatments as well as the mutated cells take resources and energy away from the patient. It weakens them and can exasperate already existing weaknesses. A distinction must be made between incurable versus curable health issues. The factors that must be taken into account are the severity of the ailment, duration of treatment, and the side effects of the treatment. The most important of the three

should be the severity of the ailment. For example, the common cold will not cause someone to wish for their death. They may wish for it during the time they have the cold, but not once the cold is gone. Whereas, someone with a terminal illness such as Huntington's disease will wish for death while their death is still in their control. The duration of the cold will be couple weeks. However, Huntington's disease does not have a cure. It will affect the individual for the rest of their lives. It will reduce them into an immobile doll, unable to act on their own at all. Thus the suffering must have some permanent effect.

The effects of injuries will also differ a great amount. For instance, someone who became a quadriplegic after a car accident will suffer more than someone whose leg was amputated. Someone who has a pacemaker to keep his heart in rhythm will have more problems than someone who cut their finger while cooking. The severity of these injuries must be taken into account to see if their lives have been so dramatically and permanently affected.

In addition, the costs of these treatments must also be taken into account. These costs add additional burdens. Sometimes, people cannot afford the various treatments. Thus, the patients may have to give up on treatments and deal with their diseases directly. These medical fees become an additional factor to consider for these terminal illnesses.

The process of aging has been combatted for a long time. Despite the efforts to escape death, the effects can still be felt. In the late years of life one feels tired, skin droops, body systems slow down, and more. As we begin to weaken, we notice that our daily activities become more and more difficult. These struggles slowly get worse and worse. At some point, it becomes difficult to live as one used to. Of course, one can adapt to these

oncoming sets of problems. But when problems become collective inhibitory factor, the options become limited. Joint pain, a weakening heart, and more are some of the medical issues that can arise. Incontinence becomes more common among this age group and the desire to live may decrease. The psychological effects of these drops in health also build. Sometimes people become overwhelmed and at this late stage in their lives they no longer wish to deal with these problems. They may wish to prolong their lives. When their independence and ability to live a simple lifestyle continually decrease, it can become more and more difficult to continue to wish living.

The individuals suffering from these various conditions may suffer from depression. But the objective of bringing in a second party to aid the decision of medically-assisted suicide is to ensure such patients have discussed their thoughts with other people. Alone, people tend to make large mistakes. They may entertain thoughts of suicide as a form of escape. However, if they fail to approach someone for help, this situation remains labelled suicide. They did not wish to seek help to discuss the situation and make some sense of it.

In euthanasia, they can discuss what goes through their minds and try to explain the suffering they currently undergo. They also have suicidal thoughts but they have approached another person to help them with this process. This second party, hopefully a physician and/or a family member, will allow them to express their concerns. They can provide a better explanation of the unending suffering they undergo due to their disabilities.

In order for someone to consider medically-assisted suicide, his medical issues must cause several things. As mentioned earlier, people can get by due to having some level of independence and having a simple lifestyle. We wish to be independent when we

get out of bed. We do not want people to help us with our daily routine of getting ready such as brushing our teeth or using the toilet. We like to feed ourselves most of the time. The whole point being that there are daily activities we do not really consider valuable until we lose them. These actions that we take for granted become a natural part of our day to day activities. When actions we take for granted are taken away, we start to fall apart. Permanently disrupting a simple independent lifestyle has the potential to completely change one's life.

Dr. Kevorkian has put medically-assisted suicide in the spotlight. The topics regarding his actions attempted to distinguish between murder and euthanasia. He served his time as a murderer and his attempts to aid those patients were not disregarded in the long run. Medically-assisted suicide brings in a second party to aid the death. But this person, the physician, does not have a personal gain by ending a patient's life. They do not bear ill will towards the patient. Murder requires dark intentions for personal gain. For instance, one might wish to murder because they do not want a secret to come out or they may gain a large sum of money for it. The physicians only wish to help their patient to the best of their abilities. And if this patient's options have become so limited that medically-assisted suicide becomes a viable option, then the physician should take their wishes into consideration. This difference in intentions separates the euthanasia from murder.

A proposed method to determine if euthanasia needed is already in use by three states: Washington, Oregon, and Vermont. The first thing needed is a cry for help. The patient must seek help and it must be his or her decision to seek out euthanasia. The patient must then undergo a psychoanalysis to determine if the patient can make sound decisions. If the patient suffers from a mental disorder, including clinical depression, they will not

qualify for medically-assisted suicide. If the patient cannot make a decision on his or her own, a family member may be brought in to make the decision on the patient's behalf. However, they must also be assessed by the physician and psychologist to determine their abilities to make these medical decisions. The patient or the family member making the decisions must be asked specific questions regarding their intent and integrity.

In addition, the physician must also determine the necessity of medically-assisted suicide. The degrees of suffering will vary. Thus, the physician must determine if the health of the individual has permanently disabled the patient. For instance, if the patient has a kidney infection, the patient's level of suffering will be high. However, this suffering should also be temporary. The infection will be treated and the patient will be on his or her way to a full recovery. Whereas a patient whose 80 years has brought along all the aches and pains, will never make a full recovery. The suffering this individual will feel will not go away without the aid of some miracle. It can be controlled with a variety of expensive medications, but it will not end. The physician in this case should deem the case reasonable enough to present medically-assisted suicide as an option. The patient then must undergo a waiting period after the decision before a lethal medication can be prescribed.

Due to unbearable and permanent suffering, the right to have medically-assisted suicide should remain available to patients. This option should remain a choice. It should not be forced onto the patient by any large institution. If the patient cannot communicate in any fashion, the decision must be done by a loved one. Through euthanasia we alleviate suffering. While there are multiple ways of doing this, speaking with a physician will provide the best method of determining the necessity of euthanasia.

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