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Assisted Death: Historical, Moral and
Theological Perspectives of
End of Life Options

by

Catherine W. Bando

A thesis presented to the

Faculty of the Department of
Theological Studies
Loyola Marymount University

In partial fulfillment of the
Requirements for the Degree
Master of Arts in Theological Studies

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I. Introduction

The purpose of this paper is to examine historical, moral and theological perspectives of physician-assisted death. I seek to demonstrate that arguments that oppose the morality and legalization of assisted death are stronger than arguments that support it. Our society has become more and more secular and, in many ways, separated from religious traditions. This separation runs parallel with a general surge of individual claims for personal autonomy that prevail over an ethos of strong communities. Individualism hurts communities and contributes to the degradation of our earthly realm. Individuality is driving humanity to seek methods to control life that include the cessation of end-of-life suffering through assisted death. In addition to asserting the philosophical, theological and moral arguments against assisted death, I seek to demonstrate that improved education about end-of-life palliative alternatives would help to minimize the fear of end-of-life suffering that drives the work of advocacy groups to support the legalization of assisted death.

I begin by providing a definition of the various forms of assisted death. I provide a history of euthanasia, suicide,¹ and physician-assisted suicide. The next sections provide a summary of various opinion surveys about physician-assisted death, the legality of euthanasia and physician-assisted death around the world, and current trends in life expectancy and causes of death that have contributed to the surge of legalization movements in nations and states. A summary of various faith traditions is provided with a concentration on documents of the Roman Catholic Church, which examine the concepts of sanctity of life; human dignity, freedom and autonomy; death and suffering; and mercy. The paper examines certain methods of analysis in Catholic morality including the principle of double effect, proportionalism, intentionality, and the moral rules that

¹ Origins of the word suicide date to the seventeenth century and are from the Latin *sui*, which means “of oneself” and *cidium* or *cida*, which means “a killing.” Accessed April 12, 2018, <http://www.dictionary.com/browse/suicide>.

guide physician-patient relationships. The next section of the paper is an examination of the four normative principles in bioethics as they relate to assisted death: (1) beneficence, the norm to receive only beneficial treatments; (2) non-maleficence, the norm that a physician should “do no harm”; (3) respect for autonomy, the norm to respect the individual; and (4) justice, the norm to fairly distribute resources among autonomous individuals. I then address concerns about the possibility of a “slippery slope” in connection with the legalization of assisted death. And finally, I examine the relative advantages of palliative alternatives to physician-assisted death. My thesis is that the use of palliative alternatives is morally and ethically superior to physician-assisted death or euthanasia.

II. Physician-Assisted Suicide and Euthanasia Defined

Assisted death is so controversial that even the term cannot be agreed upon; it is variously referred to as physician-assisted suicide and physician-assisted death or dying. It is noteworthy that the great American bioethicist Edmund Pellegrino (c. 1920 – 2013) believed there is not much difference between assisted suicide and voluntary active euthanasia.² He stated, “In both cases the intentional end is death and the physician and patient are both participants.”³ It is important to define clearly the various forms of euthanasia that lead to premature death. Euthanasia is defined in Catholic Church doctrine as “an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.”⁴ The definitions of the forms of euthanasia compared to physician-assisted suicide provided below will facilitate a better understanding of the concepts examined later in this paper.

² Edmund D. Pellegrino, “The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia,” in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp, (Upper Saddle River, NJ: Prentice Hall, 1996), 166.

³ Ibid.

⁴ Vatican Congregation for the Doctrine of the Faith, “Declaration on Euthanasia,” in *Euthanasia: Moral and Pastoral Perspectives*, Richard M. Gula (New York, NY; Mahway, NJ: Paulist Press, 1994), 72-3.

Definitions of Euthanasia and Physician-Assisted Suicide⁵

Term	Definition
Voluntary Active Euthanasia	<i>Intentionally</i> administering medications to cause the patient's death at the patient's request and with full informed consent.
Involuntary Active Euthanasia	<i>Intentionally</i> administering medications to cause the patient's death without the patient's request and without full informed consent; typically, the patient is incapable of making the request to die.
Voluntary Passive Euthanasia	Withholding or withdrawing life-sustaining medical treatments with the patient's request or advance directive. The purpose is to either avoid pain and suffering or avoid a prolonged death.
Involuntary Passive Euthanasia	Withholding or withdrawing life-sustaining medical treatments from a patient without the consent of the patient. Usually the patient is incapable of making the request to die. The purpose is to avoid a prolonged death.
Physician-Assisted Suicide	A physician providing medications or other means to a patient with the understanding that the patient <i>intends</i> to use the drugs to commit suicide.

There has been some disagreement regarding the differences between physician-assisted suicide and voluntary passive euthanasia. Physician-assisted suicide is an act that includes prescribed medications that intentionally accelerates death where voluntary passive euthanasia typically does not intentionally include prescribed medications that lead to death.⁶ In some cases, during the treatment of a patient who has elected voluntary passive euthanasia, a normal dose of pain relievers such as morphine will hasten the patient's death based on the patient's deteriorated

⁵ W. Bradford Patterson and Ezekiel J. Emanuel, "Euthanasia and the Care of Cancer Patients," *Journal of Clinical Oncology* 12, no.7 (July 1994): 1518; table 1, cited and restated in Michael Manning, *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* (New York, NY: Paulist Press, 1998), 3, and further restated for purposes of this paper.

⁶ Robert F. Weir, ed., *Physician-Assisted Suicide*, (Bloomington, IN: Indiana University Press, 1997), viii.

condition and the person's inability to tolerate the normal dose.⁷ Based on testimony heard at a public radio event on April 29, 2015, morphine is quietly and intentionally used by family members to hasten death.⁸ While Catholic teaching does not like the use of the term "passive" euthanasia, medical treatments that impose disproportionate burdens compared to the potential benefits may be forgone or withdrawn provided the intention is to avoid a prolonged death and the intention is not to cause death.⁹ Physician-assisted suicide is the situation in which a physician provides the specific means and instructions to a patient with the intention of ending the patient's life, but the patient performs the act of ending his or her life. The physician is typically not present when the patient ends his or her life and the physician typically does not know the exact time that the patient intends to end his or her life. The physician provides a prescription for a lethal dose of drugs, usually barbiturates, and provides instructions to the patient to administer the lethal dose. Surveys of participating physicians, particularly in States where physician-assisted suicide is legal, indicate that participating physicians do not consider the action immoral.¹⁰ However, the outcome of such surveys depends on how the subject is phrased.¹¹ Most physicians consider voluntary and involuntary active euthanasia to be immoral when physicians are involved.¹²

I will use the term physician-assisted suicide *only* to refer to the situation when a patient self-administers the ingestion of a lethal dose of physician-prescribed drugs. This is to differentiate it from physician-assisted dying or physician-assisted death, which are the terms used in literature to describe *either* physician-assisted suicide or euthanasia. The term euthanasia usually refers to

⁷ Stephanie O'Neill, Moderator, *The End of Life Option Act: A 'Right to Die' for Californians*, (89.3 KPPC, Wednesday, April 29, 2015, 7:00pm - 8:30pm), accessed March 8, 2018, <http://www.scpr.org/events/2015/04/29/1692/Physician-assisted-suicide>.

⁸ Ibid.

⁹ Michael Manning, *Euthanasia and Physician-assisted Suicide: Killing or Caring?* (New York, NY: Paulist Press, 1998), 2.

¹⁰ Weir, xi.

¹¹ O'Neill.

¹² Manning, *Euthanasia*, 3.

active euthanasia, which is when a lethal dose is administered by a physician to cause death. I will use the term physician-assisted death or physician assisted dying to describe both physician-assisted suicide and active euthanasia and the individual terms to specify either assisted-suicide or euthanasia.

III. Historical Perspectives of Suicide and Assisted Death

The historical context of physician-assisted suicide demonstrates that philosophers, theologians and practicing physicians have had opposing views about death and suicide over the course of written history. It is therefore not surprising that the debate continues in contemporary society. This section summarizes the progression of thought on the subject from ancient Greek and Roman history through the origins of contemporary medical ethics and Church doctrine.

a. Ancient Greece and Rome; the Hippocratic Oath

Euthanasia in Greek means good (*eu*) death (*thanatos*). Culturally, many Greeks considered suicide as the humane choice when facing the curse of sickness.¹³ The ancient view of death and suicide was that the most important consideration in death was that the person should approach it with “peace of mind and minimal pain.”¹⁴ A person could arrange the circumstances of their death, including taking measures to shorten life. Greeks and Romans preferred “voluntary death over endless agony” and, upon request, physicians frequently gave patients medication to hasten death.¹⁵ The ancients didn’t relate to the modern negative connotations of the word “suicide” but considered voluntary death morally acceptable if it brought an end to the suffering of individuals who were dying.¹⁶ Greek city magistrates kept a supply of hemlock to hasten death

¹³ Kant Patel, “Euthanasia and Physician-Assisted Suicide Policy in the Netherlands and Oregon,” *Journal of Health & Social Policy* 19, no. 1 (21 Oct 2008): 38

¹⁴ Manning, *Euthanasia*, 6.

¹⁵ Ezekiel J. Emanuel, “The History of Euthanasia Debates in the United States and Britain,” *Annals of Internal Medicine* 121, no.10 (15 November 1994): 783.

¹⁶ Edwin R. DuBose, “A Brief Historical Perspective,” in *Choosing Death: Active Euthanasia, Religion, and the Public Debate*, ed. Ron Hamel (Philadelphia, PA: Trinity Press, 1991), 16.

in the event a person was “overwhelmed by fate.”¹⁷ The Greek Stoics approved early termination of life as long as the person was not doing so to avoid responsibilities and provided the person’s condition was determined to be either incurable or to be causing insurmountable suffering. Socrates opposed suicide and stated that “man was a prisoner who had no right to open the door of his prison and run away...A man should wait and not take his own life until God summons him.”¹⁸ Yet when Socrates was condemned to death, he brought about his own death on the basis that his body was an impediment to reaching philosophical truth.¹⁹ The term “Socratic Death” has been used to describe a death that occurs prior to the demise of personhood where a person loses continence, mobility and is confined to a nursing facility.²⁰ The death of Socrates had considerable impact on philosophers who opposed his action including Plato, Aristotle and the Pythagoreans. Aristotle asserted in the fifth book of the *Nicomachean Ethics* that a man who kills himself commits a crime against the state but not toward himself.²¹ Prior to Socrates’ death, the Pythagoreans, held a different view of the early termination of life that may have influenced early Christian theologians. They opposed suicide because it disrespected human life that was valued by the gods.²² Suffering was related to compensation for prior wrongdoing and should not be terminated early.

The Hippocratic School was a small group of physicians in ancient Greece that sought to build public trust in physicians by opposing euthanasia.²³ The name is attributed to Hippocrates

¹⁷ John J. Paris, “Notes on Moral Theology: Active Euthanasia,” *Theological Studies* 53, no. 1 (1992), 116.

¹⁸ Van Rensselaer Potter, “On Dying with Personhood: Socratic Death,” *Perspectives in Biology and Medicine* 43, no. 1 (Autumn 1999): 103.

¹⁹ Arthur J. Droge and James D. Tabor, *A Noble Death: Suicide and Martyrdom Among Christians and Jews in Antiquity* (San Francisco, CA: Harper San Francisco, 1992), 20.

²⁰ Potter, 103.

²¹ Aristotle, *Nicomachean Ethics*, trans. W. D. Ross (Ontario, CN: Batoche Books: Kitchener, 1999), 5.11, 89.

²² Manning, *Euthanasia*, 7.

²³ Weir, vii.

(late fifth century BCE) who is considered the father of medicine in Western culture.²⁴ Prior to Hippocrates, medicine consisted of trial and error practices and the use of magic. Hippocrates introduced a rational approach to medicine that did not separate medical practice from religion. The practice of medicine by Hippocrates was considered a sacred act.²⁵ The basic tenants of the Hippocratic Oath were that patients "were more than objects" and that the physician must care for every suffering person, "even for those with incurable afflictions."²⁶ The original Hippocratic Oath pledged to "never give a deadly drug to anybody if asked for it, nor...make a suggestion to this effect."²⁷ The modern Hippocratic Oath swears a physician to uphold a number of ethical standards in the practice of medicine. Unlike the original Hippocratic Oath, only 14% of modern Hippocratic Oaths prohibit the use of euthanasia.²⁸

The Roman philosopher Seneca (4 BCE – 65 CE) provides moral instruction about dying in his *Moral Letter to Lucilius, No. 70*, which is titled "On the Proper Time to Slip the Cable."²⁹ He identifies human dignity as living well, not merely living. "Accordingly, the wise man will live as long as he ought, not as long as he can...dying well means escape from the danger of living ill."³⁰ He asserts that it is more important to die honorably than to suffer a humiliating death. Seneca's letter is addressed to persons who are either condemned to death or dying from disease. Seneca suggests that suicide secures the dignity of the human person; "The best thing which eternal

²⁴ Hagop Kantarjian and David P. Steensma, "Relevance of the Hippocratic Oath in the 21st Century," *The ASCO Post*, October 15, 2014, accessed March 8, 2018, <http://www.ascopost.com/issues/october-15-2014/relevance-of-the-hippocratic-oath-in-the-21st-century.aspx>.

²⁵ David F. Kelly, Gerard Magill, Henk ten Have, eds., *Contemporary Catholic Health Care Ethics*, 2nd ed. (Washington, DC: Georgetown University Press, 2013), 6.

²⁶ Ibid.

²⁷ The Hippocratic Oath as quoted by DuBose, "A Brief Historical...", 18, and in Tom Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York, NY: Oxford University Press, 2013), 329.

²⁸ Peter Tyson, "The Hippocratic Oath Today," *Nova Posted* 03.27.01, PBS SOCAL, accessed March 8, 2018, <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

²⁹ Seneca, *Moral Letter to Lucilius, No. 70*, accessed April 13, 2018, <https://ethicsof suicide.lib.utah.edu/selections/seneca/>

³⁰ Ibid.

law ever ordained was that it allowed us one entrance into life, but many exits...it is not important whether we die faster or slower, but whether we die decently or wretchedly.”³¹ He instructs dying persons to identify a means to cause their own death rather than to suffer the more humiliating death by another person or from the wretchedness of disease. Seneca’s message is that human dignity is denigrated when one is publicly killed.³² In his *Epistle 101 to Lucilius*, he argues that suicide is preferable to crucifixion.³³ Seneca was an advisor to the Emperor Nero (37 – 68 CE) who was known for tyranny and the slaughter of many Christians. Following an assassination attempt, Nero condemned Seneca to death by suicide, although Seneca was not actually involved in the assassination attempt.³⁴ Seneca severed his veins, suffered for an extended time and was eventually aided in death by several soldiers.³⁵

With the exceptions of the philosophy of the Stoics and Seneca, most ancient philosophers opposed suicide. Socrates’ suicide was in response to being condemned to take his own life, but he openly opposed the action prior to taking the hemlock. Seneca’s instruction to “slip the cable” was probably influenced by his witnessing of the many and horrific death sentences by crucifixion that occurred during the first century of the Roman empire. Roman soldiers were known to make a spectacle of public crucifixions by developing various positions to hang their victims as witnessed by Seneca; “I see crosses there, not just of one kind but made in many different ways: some have their victims with head down to the ground; some impale their private parts; others stretch out their arms on the gibbet.”³⁶

³¹ Ralf Stoecker, “Dignity and the Case in Favor of Assisted Suicide,” *Human Dignity and Assisted Death*, ed. Sebastian Muders (New York, NY: Oxford University Press, 2018), 31.

³² Thomas Habinek, *Brill’s Companion to Seneca: Philosopher and Dramatist*, ed. Gregor Damschen and Andreas Heil (Leiden, Netherlands/Boston, MA: Brill Publishing, 2014), 22.

³³ Joe Zias, “Crucifixion in Antiquity: The Evidence,” *CenturyOne Foundation*, 1998, accessed April 14, 2018, <http://www.mercaba.org/FICHAS/upsa/crucifixion.htm>.

³⁴ Elizabeth Asmis, Shadi Bartsch and Martha C. Nussbaum, “Seneca and his World,” in *Seneca: Anger, Mercy, Revenge*, ed. Robert A. Kaster and Martha C. Nussbaum (Chicago, IL: University of Chicago Press, 2012), viii.

³⁵ Habinek, 21.

³⁶ Seneca, *Moral Essays*, trans. John W. Basore (Cambridge, MA: Harvard University Press, 1946), 69.

b. Biblical passages on Suicide

Biblical passages that make references to suicide do not relate to assisted death in the context of the technological interventions available today in response to individuals who suffer from interminable pain.³⁷ Hebrew Bible examples of suicide are found in 2 Samuel 17:23 when a former advisor to King David hung himself to negate a rebellion against God's anointed, King David. Another example is found in 1 Kings 16:18-19, which is a narrative about the suicide of Zimri who had usurped the throne from God's anointed and rightful heir. The New Testament example in Matthew 27:3-5 is the narrative about Judas' suicide after betraying Jesus. Each of the suicide narratives describe individuals who have gone against God's purposes. Assisted suicide examples are found in Judges 9:50-66, 1 Samuel 31:4-5 and 2 Samuel 1:16. These Old Testament cases relate to situations of war, which are quite different from the contemporary context of physician-assisted death, which relates to suffering from illness.

c. Augustine and Early Christian Theology of Suicide

Augustine (c. 354-430) was among the early and most influential theologians who expressly wrote about the prohibitions of suicide. His contemporaries, Ambrose (c. 339-97) and Jerome (c. 345-419) also expressly condemned suicide particularly in the face of torture leading to death.³⁸ The Augustinian Christian community was on the verge of annihilation because of excessive martyrdom during the Roman persecution of Christians, which started with the Roman Emperor Nero (c. 37 – 68) in the first century. They were either sought out and killed by Roman authorities, volunteered for or provoked martyrdom, or killed themselves in the face of persecution.³⁹ Martyrdom was partially founded on the belief that in death Christians would reach

³⁷ Eric Beresford, ed., *Care in Dying*, 18-19, accessed March 9, 2018, <https://www.anglican.ca/wp-content/uploads/2010/10/care-in-dying.pdf>. Describes Biblical narratives about suicide.

³⁸ Darrell W. Amundsen, "The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide" in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 12.

³⁹ *Ibid.*, 11.

the highest spiritual state and union with God. Christians longed for a release from the bondage of sin that they connected to their worldly existence. In death, they could be united to the blessed life with God that lay beyond.⁴⁰ Christians believed that martyrdom was a perfect display of love toward God and was therefore the desired form of death.⁴¹ Christian virgins and married women committed suicide to avoid defilement: an action that was considered virtuous by Christian authors, including Tertullian (c. 155 –240), Eusebius (c. 263 – 339) and Jerome (c. 347 – 420).⁴² The proliferation of Christian suicides and martyrdom, particularly in light of suicide to protect chastity, led Augustine to write against suicide in *City of God*.⁴³ Augustine’s condemnation of suicide was based on the following premises: (1) scripture does not specifically permit it, (2) it violates the fifth commandment, (3) killing oneself is homicide since it is not an authorized, punishable killing, and (4) suicide allows no opportunity for repentance.⁴⁴ In Augustine’s treatise *De Patientia* he espoused patient endurance and suffering as representing “an essential component of God’s sanctifying work.”⁴⁵ Augustine’s positions became accepted as fundamental Christian tenants even though his positions were not firmly rooted in the Christian scriptures, practices and traditions of the time.⁴⁶ However, Augustine showed grace toward women, in particular, who previously committed suicide to protect their chastity, by stating that a divine command must have authorized such acts.⁴⁷ The origins of official opposition to suicide in the Christian tradition is attributed to the work of Augustine and it has been affirmed by theologians over the course of Christian history.

⁴⁰ Margaret Pabst Battin, *Ethical Issues in Suicide* (Englewood Cliffs, NJ: Prentice-Hall, 1995), 29 and 63.

⁴¹ Amundsen, 13.

⁴² Ibid., and Battin, *Ethical Issues*, 63.

⁴³ Augustine of Hippo, *City of God*, I.20, “That Christians have no authority for committing suicide in any circumstances whatever,” accessed March 27, 2018, <https://www.gutenberg.org/files/45304/45304-h/45304-h.htm>.

⁴⁴ Amundsen, 20.

⁴⁵ Ibid., 22.

⁴⁶ Battin, *Ethical Issues*, 29.

⁴⁷ Amundsen, 24.

d. The Medieval Perspective of Thomas Aquinas

The ethics of killing according to Thomas Aquinas (c. 1225-1274) is addressed in *Summa Theologiae* II.II.64. Aquinas's position is rooted in Aristotelean philosophy and Augustinian theology. He specifically addressed suicide in Article 5 where he affirms Augustine's position with a direct quote from *City of God*: "Hence it follows that the words 'thou shalt not kill' refer to the killing of a man—not another man' therefore, not even thyself. For he who kills himself, kills nothing else than a man."⁴⁸ The Thomistic view of suicide is that it is contrary to the love that people should have for themselves as God's creation. He establishes that suicide is "always a mortal sin"⁴⁹ because it is contrary to this natural law. Aquinas embraced the Platonic philosophy that our lives are not ours to dispose of because we belong to God.⁵⁰ Aquinas argued that suicide and assisting in suicide was never permissible, but not only as a violation against a person's God-given life; he also embraced the Aristotelian view that every person is part of a greater whole that makes suicide a violation against and injurious to the community as a whole and a crime against the state.^{51, 52}

Aquinas related suicide and killing to the ethics of authorization where no one can kill intentionally unless specifically authorized to kill. Authorization can only come from God with the understanding that such authorization is determined by specific social roles that are established

⁴⁸ Augustine of Hippo, *City of God*, I.20.

⁴⁹ Thomas Aquinas, *Summa Theologiae*, II-II.64.5, accessed March 27, 2018, http://www.documentacatholicaomnia.eu/03d/1225-1274,_Thomas_Aquinas,_Summa_Theologiae_%5B1%5D,_EN.pdf.

⁵⁰ Loretta M. Kopelman and Kenneth A. De Ville, "The Contemporary Debate Over Physician-Assisted Suicide," in *Physician-Assisted Suicide: What are the Issues?*, ed. Loretta M. Kopelman and Kenneth A. De Ville (Dordrecht, Netherlands; Boston, MA: Kluwer Academic Publishers, 2001), 18.

⁵¹ Aristotle, *Nicomachean Ethics*, V.11, accessed March 27, 2018, <https://socialsciences.mcmaster.ca/econ/ugcm/3113/aristotle/Ethics.pdf>.

⁵² Loretta M. Kopelman, "Does Physician-Assisted Suicide Promote Liberty and Compassion?" in *Physician-Assisted Suicide*, 87.

for the common good.⁵³ Aquinas established that “no man is judge on himself...but he may commit himself to the judgment of others.”⁵⁴ Aquinas confirmed that authorities may condemn one to death but that we are not separately authorized to condemn ourselves to death.

Aquinas established that “the ultimate and most fearsome evil of this life is death.”⁵⁵ To choose death is a greater evil than the lesser evil of any level of unhappiness in this life, even the avoidance of sin. In taking one’s life, one eliminates the possibility for repentance. Even a woman who is violated by force (raped) should not kill herself because “there is no stain on the body” provided she does not consent. Aquinas elevated the prohibition against suicide to include all cases, even women in the face of “defilement.”

e. Position of Thomas More

Considering the official opposition expressed by Catholicism’s greatest theologians, it may be surprising to read the words of a Catholic saint who suggests that a person should end life by their own hand or the hand of another.

But if the disease be not only incurable, but also full of continual pain and anguish, then the priests and the magistrates exhort the man (seeing that he is not able to do any duty of life, and by over-living his own death is noisome and irksome to others and grievous to himself) that he will determine with himself no longer to cherish that pestilent and painful disease; and ...either dispatch himself out of that painful life, as out of a prison or rack of torment, or else suffer himself to be willingly rid of it by another.⁵⁶

Thomas More’s (c. 1478-1535) *Utopia* describes an ideal state, and he advocated that laws be established to control rather than the absolute prohibition of aiding people who wanted to die on the condition that it brought relief to a person who was close to death and in interminable pain.

⁵³ Aquinas, *ST II-II.64.5*, and Joseph Boyle, “Sanctity of Life and Its Implications: Reflections on James Keenan’s Essay,” in *Choosing Life: A Dialogue on Evangelium Vitae*, ed. Kevin W. Wildes and Alan C. Mitchell (Washington, DC: Georgetown University Press, 1997), 73.

⁵⁴ Aquinas, *ST II-II.64.5*, reply to Objection 2.

⁵⁵ Aquinas, reply to Objection 3.

⁵⁶ Thomas More, *Utopia and A Dialogue of Comfort*, 1516, ed. John O’Hagan (London, UK; New York, NY: Dent/Dutton, 1951), 98.

There were no analgesics in the sixteenth century. More's primary motivation was to establish laws to protect family members who may otherwise unlawfully relieve the suffering of a loved-one.⁵⁷ More was not a theologian. He was a lawyer and political advisor to King Henry VIII. His opposition to Henry VIII's separation from the Catholic church resulted in his conviction of treason and beheading. He was beatified by Pope Leo XIII in 1886, canonized by Pius XI in 1935 as a martyr of the church. In 2000, he was declared "Heavenly Patron Statesman of Politicians" by John Paul II.⁵⁸

f. Physician and Patient Opinion Surveys on Assisted Death

The subject of physician-assisted death continues to be controversial with a considerable difference of opinion about the morality of it among medical associations, religious organizations, physicians and the public. The World Medical Association (WMA) first articulated its opposition to physician-assisted death shortly after World War II in 1948, developed its official opposition in 1992,⁵⁹ and affirmed its strong opposition to physician-assisted death in 2017 in response to proposals in Australia.⁶⁰ However, the WMA considers voluntary passive euthanasia to be a "basic right of the patient even if ... such a wish results in death."⁶¹ The British Medical Association

⁵⁷ Sissela Bok, "Euthanasia," in *Euthanasia and Physician-Assisted Suicide: For and Against*, ed. Gerald Dworkin, R. G. Frey, Sissela Bok (Cambridge, UK; New York, NY: Cambridge University Press, 1998), 107. Bok reported that the average life expectancy was over 80 years. The average life expectancy in the United States dropped in recent years and in 2016 it was 78.6 years due to the increased deaths of younger persons in connection with the opioid epidemic according to the Center for Disease Control website. Accessed April 13, 2018. [https://www.cdc.gov/nchs/data/16.pdf](https://www.cdc.gov/nchs/data/hus/16.pdf).

⁵⁸ Catholic News Agency, "St. Thomas More, 'Heavenly Patron of Statesmen and Politicians,' remembered June 22," *Catholic News Herald*, 23 May 2016, accessed April 14, 2018, <http://catholicnews herald.com/184-news/faith/faith-june/99-st-thomas-more-heavenly-patron-of-statesmen-and-politicians-remembered-june-22>.

⁵⁹ The World Medical Association's Statement on Physician-Assisted Suicide is "Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient." Accessed January 22, 2018, <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/>.

⁶⁰ WMA Press Release, "World Medical Association Reiterates Strong Opposition to Physician Assisted Suicide and to Australia Bill," 27 October 2017: accessed March 8, 2018, <https://www.wma.net/news-post/world-medical-association-reiterates-strong-opposition-to-physician-assisted-suicide-and-to-australian-bill/>.

⁶¹ WMA, accessed March 27, 2018, <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/>.

voted to affirm its opposition to assisted death at its annual meeting in 2016 in response to a motion to adopt a neutral stance.⁶² The Catholic Church's opposition is articulated in the 1980 *Declaration on Euthanasia*.⁶³ An expanded discussion of the Church's position is provided in Sections IV and V of this paper.

Several surveys were reviewed that reflect mixed responses about aid in dying by the public and medical community over the last twenty years, with increasing support from medical professionals in recent surveys. A survey published in *The Lancet* from 1996 reported that about two thirds of oncology patients and the public found physician-assisted death acceptable for patients with "unremitting pain."⁶⁴ A survey published in the *New England Journal of Medicine* in 1998 reported that, if it were legal in the US, 36% of physicians would provide a prescription for a lethal dose of medications and 24% would provide a lethal injection, if requested.⁶⁵ The survey also reported that 18.3% of physicians had received requests for assisted suicide while 11.1% had received requests for euthanasia.⁶⁶ The two surveys clearly indicate that there was a difference in opinion about the subject between physicians and patients in the 1990's. More recent surveys indicate that medical professionals are leaning in favor of physician-assisted death. A group of researchers conducted a survey that was published in the *Journal of Pain Symptom Management* in 2013 that indicated over 66% of the medical professional respondents thought

⁶² Kmietowicz, Zosia. "BMA Annual Meeting: Doctors Vote to Maintain Opposition to Assisted Dying." *BMJ* 353, no. 3486 (22 June 2016): 353, accessed March 8, 2018, <http://www.bmj.com/content/353/bmj.i3486.full>.

⁶³ Congregation for the Doctrine of Faith, *Declaration on Euthanasia*, 5 May 1980, approved by John Paul II, submitted by Franjo Cardinal Seper, Prefect, and Jerome Homer, Archbishop of Lorium, Secretary to the Sacred Congregation for the Doctrine of the Faith, accessed March 8, 2018, <https://www.catholicnewsagency.com/resources/life-and-family/euthanasia-and-assisted-suicide/declaration-on-euthanasia>.

⁶⁴ Ezekiel J. Emanuel, E.R. Daniels, D. L. Fairclough, and B.R. Claridge, "Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public," *The Lancet* 347, No. 9018 (29 June 1996): 1805-1810.

⁶⁵ Diane E. Meier, Carol-Ann Emmons, Sylvan Wallenstein, Timothy Quill, R. Sean Morrison, and Christine K. Cassel, "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *The New England Journal of Medicine* 338 (April 23, 1998): 1193-1201.

⁶⁶ *Ibid.*

physician-assisted suicide was ethical and should be legal. The survey also examined opinions about the ethics of euthanasia and whether it should be legal for competent and incompetent patients. The researchers were surprised that healthcare professionals were more favorable regarding the use of voluntary active euthanasia for incompetent patients who had advanced directives for aid in dying with 62.2% and 68.1% in favor of ethics and legality, respectively. The support for the use of euthanasia for competent patients was lower at 51.6% and 58.2% in favor of the ethics and legality, respectively. The stronger support for the use of authorized euthanasia for incompetent patients may be based on the attitudes of medical professionals who indicated in another survey that incompetent patients receive a lower level of care than competent patients.⁶⁷ A survey published by *Clinical Review & Education* in 2016 indicated the same trend of support by medical professionals.⁶⁸ However, it is noteworthy that the 2016 survey concluded that physician assisted death is “increasingly being legalized, remain[s] relatively rare and primarily involve[s] patients with cancer.”⁶⁹ Actual 2016 statistics compiled for the states of Oregon and California support this finding with fewer than .37% and .08% of deaths (respectively) attributed to physician-assisted suicide. The California statistics were probably lower because the law was effective for slightly over half of the year while the practice was available in Oregon for nearly twenty years.

⁶⁷ Xin Gao, Holly G. Prigerson, Eli L. Diamond, Baohui Zhang, Alexi A. Wright, Fremonta Meyer, and Paul K. Maciejewski, “Minor Cognitive Impairments in Cancer Patients Magnify the Effect of Caregiver Preferences on End of-Life Care,” *Journal of Pain Symptom Management* 45 no. 4 (April 2013): 650-659.

⁶⁸ Ezekiel J. Emanuel, Bregje D. Onwuteaka-Philipsen, John W. Urwin, and Joachim Cohen, “Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe,” *Clinical Review & Education* 316, no. 1 (July 5, 2016): 79-90.

⁶⁹ *Ibid.*, 88.

**2016 Statistics
California and Oregon⁷⁰**

State	California *	Oregon
Deaths	138,973	35,799
Requests	191	204
PAS Deaths	111	133
Natural Deaths	21	36
Undetermined	59	54
Requests (%)	0.14%	0.57%
PAS Deaths (%)	0.08%	0.37%
Natural Deaths (%)	0.02%	0.10%
Undetermined (%)	0.04%	0.15%

* California death statistics have been annually adjusted to reflect that PAS became effective on June 9, 2016.

A survey of geriatric nurses conducted in 2017 reflected that 83.5% supported the use of euthanasia for competent individuals with advance directives who suffer unbearably. A similar level of support at 83% for incompetent individuals was reported in the survey.⁷¹ The recent surveys clearly indicate a trend of support for physician-assisted death by medical professionals compared to surveys from the 1990's.

g. Positions of Faith Traditions on Assisted Death

A 1991 report of various faith traditions, prepared by Ron Hamel and Edwin DuBose in their book *Choosing Death*, demonstrates that most faith traditions either have official positions

⁷⁰ Oregon Death Dignity Act, Data Summary 2016, accessed April 10, 2018, <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf>;
California End of Life Options Act, 2016 Data Report, accessed April 10, 2018, <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Options%20Act%20Report.pdf>; California Cancer Facts & Figures 2016, accessed April 10, 2018, http://www.ccrca.org/pdf/Reports/ACS_2016_FF.pdf.

⁷¹ G. Bravo, C. Rodrigue, M. Arcand, J. Downie, M. F. Dubois, S. Kaasalaine, C.M. Hertough, S. Pautex, and L. Van den Block, "Nurses' Perspectives on Whether Medical Aid in Dying Should be Accessible to Incompetent Patients with Dementia: Findings from a Survey Conducted in Quebec, Canada," *Geriatric Nursing* (3 January 2018): 1-7, accessed January 16, 2018, [http://www.gnjournal.com/article/S0197-4572\(17\)30319-1/fulltext](http://www.gnjournal.com/article/S0197-4572(17)30319-1/fulltext).

that oppose euthanasia or generally oppose it.⁷² Further research shows that fourteen (61%) of the twenty-three faith traditions identified have official positions that oppose euthanasia while another seven (30%) either have no position or do not prohibit it.⁷³ Through further research or through the interpretation of certain religious traditions' basic tenants, seven of the faith traditions that do not have official positions or have no specific prohibition against assisted death, are likely to generally oppose euthanasia. The Unitarian Church and United Church of Christ indicate that they would support legislation that would legalize voluntary passive euthanasia. The traditions that have no official position on euthanasia either do not have the necessary organization structure to take a position or, if they have an organization structure, they intentionally provide for autonomy regarding moral decisions to dioceses, congregations, or to individuals. For example, there are over thirty types of Baptist churches and each congregation is autonomous. The Episcopal church in the US and the Anglican Communion internationally have governance structures that consist of autonomous dioceses. Decisions made within the Anglican Communion are not binding on dioceses or individuals so there is great latitude on moral issues.⁷⁴ However, there is little support for active euthanasia in the Episcopal Church and the Anglican Communion, and strong opposition has been expressed. The Episcopal Church adopted a resolution in 1991 stating that "it is morally wrong and unacceptable to take a human life in order to relieve the suffering caused by incurable illness."⁷⁵ The Anglican Archbishop of Canterbury, Justin Welby, has spoken against it, but the

⁷² Ron P. Hamel and Edwin R. DuBose, "Views of the Major Faith Traditions," in *Choosing Death: Active Euthanasia, Religion and the Public Debate*, ed. Ron Hamel (Philadelphia, PA: Trinity Press International, 1991), 54-101.

⁷³ The issue was under discussion with the Disciples of Christ in 1991. In 1996, a statement in opposition to euthanasia was approved by the faith and witness commission. In 1991, the United Methodist Church was divided on the moral determination of active euthanasia, but the further research indicates the church has taken a position that opposes it. Accessed April 5, 2018, <http://www.umc.org/what-we-believe/what-is-the-united-methodist-stance-on-assisted-suicide>.

⁷⁴ Hamel and Dubose, 68.

⁷⁵ Episcopal Church Archives, The Acts of Convention, Resolution Number: 1991-A093, accessed April 30, 2018, https://episcopalarchives.org/cgi-bin/acts/acts_resolution.pl?resolution=1991-A093.

morality of assisted death continues to be debated throughout the Anglican communion.⁷⁶ Mennonite churches are also autonomous but aid in dying is not likely to receive support.⁷⁷ The reformed Presbyterian church does not support active euthanasia, and Hamel and Dubose report that they have determined that it is “not necessarily regarded as inconsistent with respect for life.”⁷⁸ Further research of the Presbyterian position indicates that the Advisory Committee on Social Witness took a definitive stance against euthanasia but that the church continues to not prohibit the practice.⁷⁹ Hinduism has no universal scripture or hierarchy, but for a physician to aid in actively interrupting a person’s end-of-life process could produce negative karma and, on this basis, it is likely that most Hindus would oppose euthanasia.⁸⁰ However, it is the “state of mind” of the physician and the patient that is the primary concern in Hinduism.⁸¹ The moral determination could be based on whether the physician or patient considered the aid in dying to be criminal or heroic.⁸² There is great diversity in the teachings and sects of Buddhism and there is no official position on euthanasia. Based on the precept to refrain from destroying life, which establishes the sanctity of life regardless of its condition, it is unlikely that Buddhists would support euthanasia.⁸³ Based on the further analysis, 91% of the faith traditions identified by Hamel and DuBose either officially oppose euthanasia or opposition is implied in documents or traditions of the faiths. Only two traditions, the Unitarian Church and the United Church of Christ, officially support efforts to legalize euthanasia. The following chart was created to summarize the work of Hamel and Dubose

⁷⁶ *The Guardian*, “Church of England Split Over Assisted Dying as Debate Looms, (15 July 2014), accessed April 30, 2018, <https://www.theguardian.com/society/2014/jul/15/assisted-dying-suicide-church-of-england-split>.

⁷⁷ Hamel and Dubose, 80.

⁷⁸ Hamel and Dubose, 85.

⁷⁹ Steven D. Aguzzi, “Suffering Redeemed: A Reformed Argument Against Physician Assisted Suicide and Euthanasia,” *Theology Matters* 17, no. 2 (Mar/Apr 2011): 2.

⁸⁰ Hamel and DuBose, 95.

⁸¹ Arvind Sharma, “The Hindu Tradition: Religious Beliefs and Healthcare Decisions,” in *Religious Traditions and Healthcare Decisions* (Park Ridge, IL: The Park Ridge Center, 2002), 12, accessed May 1, 2018, <http://www.trinity-health.org/documents/Ethics/4%20Religious%20Traditions/Hinduism/Hindu.pdf>.

⁸² *Ibid.*

⁸³ Hamel and DuBose, 97-99.

and has been updated to reflect the research summarized above. The red circles with arrows pointing left indicate faith traditions that do not have official positions against assisted dying but based on interpretations of the tradition or other information, would trend toward opposing assisted death.

Views of Major Faith Traditions Voluntary Active Euthanasia

Tradition	Opposed	No Position	Not Prohibited	Supports
Judaism	X			
Islam	X			
Roman Catholic	X			
Adventists		← (X)		
Baptist		← (X)		
Southern Baptist	X			
American Baptist	X			
Disciples of Christ	X			
Episcopal		← (X)		
Jehovah's Witness	X			
Mormon	X			
Lutheran – Missouri	X			
Lutheran – Evangelical	X			
Mennonite		← (X)		
United Methodist	X			
Presbyterian			← (X)	
Unitarian				X
United Church of Christ				X
Eastern Orthodox	X			
Greek Orthodox	X			
Russian Orthodox	X			
Hinduism		← (X)		
Buddhism		← (X)		
TOTALS	14	6	1	2
Totals (%)	61%	26%	4%	9%

h. International and US Aid in Dying Laws

Euthanasia and physician-assisted suicide are legal in five countries in the world: Netherlands, Belgium, Canada, Colombia and Luxembourg; and physician-assisted suicide is legal Switzerland and certain states in United States (California, Colorado, Hawaii, Oregon, Montana, Vermont and Washington, plus the District of Columbia).^{84, 85} Hawaii is the most recent state to enact laws, which is another indication that the trend toward advocacy of laws that legalize aid in death are on the rise. On April 5, 2018, Hawaii’s Governor David Ige signed a bill that legalized medically assisted death.⁸⁶ The following table identifies where assisted death and euthanasia are legal and indicates either the date when laws were enacted or when the interpretation of laws stopped to forbid it.

International Euthanasia and Assisted Death Laws

Method	Nation/State	Year Legalized
Assisted	Switzerland	1942
Euthanasia & Assisted	Netherlands, Luxembourg, Belgium, Columbia	2001, 2008, 2009, 2015
Assisted	Oregon, Washington, Montana, Vermont	1997, 2008, 2009, 2013
Euthanasia & Assisted	Canada	2016
Assisted	California, Colorado, Washington DC	2016
Assisted	Hawaii	2018

⁸⁴ ProCon.org, “State-by-State Guide to Physician-Assisted Suicide,” accessed April 17, 2018, <https://euthanasia.procon.org/view.resource.php?resourceID=000132>.

⁸⁵ Derek W. Braverman, Brian S. Marcus, Paul G. Wakim, Mark R. Mercurio, and Gary S. Kopf, “Health Care Professionals’ Attitudes About Physician-Assisted Death: An Analysis of Their Justifications and the Roles of Terminology and Patient Competency,” *Journal of Pain and Symptom Management* 54, no. 4 (October 2017): 539.

⁸⁶ Sophia Yan, “Medically Assisted Suicide Becomes Legal in Hawaii,” *Associated Press*, Apr 5, 2018, accessed April 17, 2018, <http://abcnews.go.com/Health/wireStory/hawaii-legalizes-medically-assisted-suicide-54267794>.

While euthanasia and assisted suicide became legal in the Netherlands in 2002, the courts tolerated the practices beginning in the 1970s.⁸⁷ Assisted suicide with the help of another non-medical person is not subject to prosecution in Germany, Switzerland and Finland⁸⁸ and laws are unclear in a number of countries.⁸⁹ Assisted death has been legal in Switzerland since 1942 and does not require the aid of a physician but it is a crime if the motive is determined to be selfish.⁹⁰ Switzerland also has “suicide tourism” because it does not require citizenship for aid in dying and no medical condition is required.⁹¹ The variety of laws about assisted death in the US are another representation of the controversial nature of aid-in-dying: thirty-nine states have laws prohibiting assisted suicide, which include three states (Alabama, Massachusetts and West Virginia) that prohibit it under common law, and four states (Nevada, North Carolina, Utah and Wyoming) that are unclear on the legality of assisted suicide.⁹²

The passage of laws that legalized assisted-suicide by the California legislature followed many weeks of heated debates about the subject. People were shocked when Jerry Brown, a former Jesuit seminarian, signed the legislation into law on October 5, 2015. He stated “In the end, I was left to reflect on what I would want in the face of my own death ... I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to

⁸⁷ Patel, 40.

⁸⁸ Erwin Stolt, Hannes Mayerl, Peter Gasser-Steiner and Wolfgang Friedl, “Attitudes Towards Assisted Suicide and Euthanasia Among Care-Dependent Older Adults (50+) in Austria: The Role of Sociodemographics, Religiosity, Physical Illness, Psychological Distress, and Social Isolation,” *BMC Medical Ethics* 18, no. 71 (December 7, 2017): 2.

⁸⁹ Braverman, 539.

⁹⁰ Stolt, et al, “Attitudes Toward Assisted Suicide and Euthanasia,” 2.

⁹¹ Saskia Gautier, Julian Mausbach, Thomas Reisch and Christine Bartsch, “Suicide Tourism: A Pilot Study on the Swiss Phenomenon,” *Journal of Medical Ethics*, 41, no. 8 (August 2015): 611.

⁹² ProCon.org, “State-by-State Guide to Physician-Assisted Suicide,” accessed April 17, 2018, <https://euthanasia.procon.org/view.resource.php?resourceID=000132>.

others.”⁹³ Jerry Brown’s action put the patient at the forefront of the physician-assisted death controversy. The End of Life Option Act established the laws necessary to allow physicians to prescribe drugs to terminally ill patients in California who desire a legal means to control the end of their life.⁹⁴

i. Life Expectancy Trends and End-of-life Suffering

So, what has led to the surge of legalization of assisted death in nations and states? Advances in medicine during the twentieth century have resulted in the increase of life expectancies from approximately forty-seven years in 1900 to nearly eighty years today in developed nations.^{95,96} Prior to the twentieth century, most people died either unexpectedly from childbirth, war, or accidents, or relatively quickly from infectious diseases like dysentery, cholera, influenza, plague, smallpox, typhoid fever, pneumonia or tuberculosis.⁹⁷ The process of dying typically lasted a matter of hours, days or a few weeks.^{98,99} Today people may live longer, but they are more likely to die from chronic diseases such as cancer, cardiovascular disease, neurodegenerative disease, or diabetes, which all are typically accompanied by longer periods of progressive life-limiting declines in health. Today, the end-of-life process from chronic disease

⁹³ Patrick McGreevy, “After Struggling, Jerry Brown Makes Assisted Suicide Legal in California,” *Los Angeles Times*, October 5, 2015, accessed March 9, 2018, <http://www.latimes.com/local/political/la-me-pc-gov-brown-end-of-life-bill-20151005-story.html>.

⁹⁴ The End of Life Options Act became effective June 9, 2016 and allows competent terminally ill patients who are diagnosed with an incurable and irreversible disease and who are expected to live fewer than six months to request aid-in-dying prescriptions and permits physicians to legally write prescriptions. The patient must be 18 years or older, be a California resident, have the capacity to make medical decisions, must voluntarily request the prescription without influence from others and must be able to self-administer the prescription. Accessed March 27, 2018, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15

⁹⁵ In 1900 life expectancy in the US was 46.3 years for men and 48.3 years for women. Accessed March 14, 2018 <http://www.demog.berkeley.edu/~andrew/1918/figure2.html>

⁹⁶ Joseph A. Raho, “Bioethics at the End of Life: Introduction” (lecture, Loyola Marymount University, January 11, 2016), Slide 12.

⁹⁷ Raho, Bioethics lecture, January 11, 2016, Slide 6.

⁹⁸ Daniel Callahan, *Troubled Dream of Life: In Search of a Peaceful Death* (Washington, DC: Georgetown University Press, 2000), 43.

⁹⁹ Joseph A. Raho, January 11, 2016 lecture, Slide 6.

extends to many months or years.^{100, 101, 102} The slow deterioration of health is often accompanied by a progressive decline in the quality of life for the patient, which also impacts the lives of family members and friends who provide care.¹⁰³ The changes in patients' quality of life include the loss of mobility and the increased reliance on care from others for basic needs as patients become bedridden. These changes in life are related to the degenerative nature of chronic disease. In addition to physiological losses, patients develop a sense of phenomenal loss because they can no longer experience aspects of life that they previously enjoyed.¹⁰⁴ As difficult as it is to accept death, many people fear prolonged existential suffering at the end of life more than death itself. Most people hope for "a death that is without demise of their physical, cognitive and moral stature; in other words, a death that preserves their life as a person."¹⁰⁵ Humanity's general fear of suffering has driven us to mold the world to our purposes. The American comedic writer Woody Allen concisely represents a common American view toward death and dying: "It's not that I'm afraid to die. I just don't want to be there when it happens."¹⁰⁶ The desire for individual control seems greater in a contemporary society where technological medical advances can prolong life. Individuals desire the ability to control the medical machines that they may not fully understand. Many people have observed the slow decline in the quality of life of a friend or loved-one at the

¹⁰⁰ Leon R. Kass, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco, CA: Encounter Books, 2002), 37-38.

¹⁰¹ Eric J. Cassel, M.D., "The Nature of Suffering and the Goals of Medicine," *New England Journal of Medicine*, 306 no. 11 (March 18, 1982): 639-645.

¹⁰² Callahan, *Troubled Dream*, 76.

¹⁰³ Ka-Chi Cheung, Vikki Wai-Kee Lau, Ka-Chun Un, Man-Sheung Wong, and Kwok-Ying Chan, "Advance Care Planning for Patients with Advanced Neurology Diseases," *Annals of Palliative Medicine*, 9 no.10, (Oct. 13, 2017), 1.

¹⁰⁴ James Giordano, "Pain Care at the End of Life: Preserving Dignity," in *Pain: Mind, Meaning, and Medicine: Collected Essays on the Philosophical and Ethical Dimensions of Practical Pain Management*. 32-38, (Glen Mills, PA: PPM Communications, Inc., 2009), 33.

¹⁰⁵ Giordano, *Pain: Mind, Meaning, and Medicine*, 34, citing J. Harrold, and J. Lynn, *A Good Dying*. (New York; Hayworth Press, 1998.)

¹⁰⁶ Woody Allen, *Without Feathers* (New York, NY: Ballantine Books, 1983), 106, as quoted by Cathleen Kaveny in *Laws Virtues: Fostering Autonomy and Solidarity in American Society* (Washington, DC: Georgetown University Press, 2012), 142.

end of life and develop a fear of experiencing a similar demise. The fear of losing one's quality of life and experiencing physical pain together with the desire to seek a means to control end of life suffering have led to a recent surge of court rulings, statewide voter initiatives and legislative actions to develop laws that legalize physician-assisted dying in nations and states. Control is achieved through advance medical directives and may also include the use of lethal prescriptions, where legal, to avoid unwanted suffering and useless living.

IV. Roman Catholic Position on Assisted Death

The Roman Catholic Church had no comprehensive statements about assisted death prior to Pius XII, who wrote a statement of opposition to the practice of eugenic euthanasia by German National Socialists in 1943.¹⁰⁷ In 1965, the Vatican II document *Gaudium et spes* was the next document that condemned euthanasia as a violation “against the integrity of the human person.”¹⁰⁸ Euthanasia, or assisted death, was specifically prohibited and morally binding on Catholics in the *Declaration on Euthanasia* (the “*Declaration*”), which was approved by Pope John Paul II in 1980.¹⁰⁹ The Roman Catholic Church opposes the direct ending of human life while it morally justifies the withdrawal of life-sustaining treatments if it does “not offer a reasonable hope of benefit or entail[s] an excessive burden, or impose[s] an excessive expense on the family” and provided the intention of the withdrawal of treatments is not to cause death.¹¹⁰ The doctrine establishes that it is wrong to intentionally cause one's death; equating the action to murder.

¹⁰⁷ Pius XII, *Mystici Corporis*, Acta Apostolica Sedis, 35 (July 20, 1943), 239. Quoted in Manning, *Euthanasia*, 21.

¹⁰⁸ *Gaudium et spes*, Pastoral Constitution on the Church in the Modern World, December 7, 1965, §27, accessed April 3, 2018, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html#deat.

¹⁰⁹ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (May 5, 1980), accessed April 3, 2018, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

¹¹⁰ United States Conference of Catholic Bishops, “Ethical and Religious Directives for Catholic Health Care Services,” Fifth Edition, David J. Malloy, General Secretary, November 17, 2009, 30, accessed March 22, 2018, <file:///C:/Users/cathe/Dropbox/LMU/Systematic%20Theology/Research%20Paper/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

Suicide is “a rejection of God’s sovereignty and loving plan.”¹¹¹ It is also “a refusal of love for self, the denial of the natural instinct to live, a flight from the duties of justice and charity owed to one’s neighbor, to various communities, or to the whole of society”¹¹² The *Declaration* specifically prohibits the killing of a person who may be suffering from an incurable disease or a person who is dying. It also prohibits a person from requesting to be killed. Neither the suffering person nor another person can request the killing of a suffering person because it is a “violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.”¹¹³ While the *Declaration* specifically prohibits suicide and establishes the doctrine of the church on the subject of euthanasia, it provides language that pastorally identifies certain situations that may be exceptions in cases of suicide. It recognizes that “there are psychological factors that can diminish responsibility or even completely remove it,”¹¹⁴ indicating an exception for cases of severe mental illness. The *Declaration* implies that when a person sacrificially dies for a “higher cause, such as God’s glory, the salvation of souls or the service of one’s brethren,”¹¹⁵ the situation is permissible. The *Declaration* establishes that the proper response to requests from the gravely ill for aid in dying is to provide the person with “love, the human and super-natural warmth with which the sick person can and ought to be surrounded.”¹¹⁶

The prohibition of any form of assisted death is included in the Catechism of the Catholic Church.¹¹⁷ The Catechism states that those who persist to live in a state of mortal sin and do not

¹¹¹ *Declaration on Euthanasia*, in Gula, *Euthanasia*, 71-72.

¹¹² *Ibid.*, 72.

¹¹³ *Ibid.*, 73.

¹¹⁴ *Ibid.*, 72.

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*, 73.

¹¹⁷ Catechism of the Catholic Church, under Euthanasia, paragraph 2277 states “Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.” Accessed March 22, 2018, <https://www.catholicnewsagency.com/resources/life-and-family/euthanasia-and-assisted-suicide/euthanasia-catechism-of-the-catholic-church>.

repent before death, subject themselves to hell, an everlasting separation from God. The Catechism states that “to die in mortal sin without repenting and accepting God's merciful love means remaining separated from him forever by our own free choice. This state of definitive self-exclusion from communion with God and the blessed is called "hell.””¹¹⁸ The *Declaration* identifies physician-assisted suicide as murder and murder is categorized as a mortal sin under Catholic moral norms.

John Paul II affirms the Church's opposition and establishes his own unequivocal opposition to assisted death in *Evangelium Vitae* in 1995.¹¹⁹ He states that “euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person.”¹²⁰ John Paul II's encyclical affirms church doctrine that is based on “natural law and upon the written word of God.”¹²¹ He characterizes euthanasia as “malice proper to suicide or murder.”¹²² John Paul II's purpose in *Evangelium Vitae* is to confront the “danger of distorted ethical arguments when they justify practices that run counter to the scriptural and natural law foundations of morality.”¹²³ He establishes that “no intention, motive, circumstance, or presumed benefit can justify what is an intrinsically evil act.”¹²⁴ He unequivocally establishes that euthanasia and physician-assisted suicide are always morally wrong.

¹¹⁸ Catechism of the Catholic Church, “IV. “Hell,” paragraph 1033, accessed March 20, 2018, http://www.vatican.va/archive/ENG0015/_P2O.HTM.

¹¹⁹ Catholic News Agency (CAN), “Euthanasia – Excerpt from *Evangelium Vitae*, Catholic News Agency,” March 25, 1995, accessed March 9, 2018 <https://www.catholicnewsagency.com/resources/life-and-family/euthanasia-and-assisted-suicide/euthanasia-excerpt-from-evangelium-vitae>.

¹²⁰ John Paul II, *Evangelium Vitae*, (Vatican City: Libreria Editrice Vaticana, 1995), 65.

¹²¹ Ibid.

¹²² Ibid.

¹²³ Edmund D. Pellegrino, “*Evangelium Vitae*, Euthanasia, and Physician-Assisted Suicide: John Paul II's Dialogue with the Culture and Ethics of Contemporary Medicine,” in *Choosing Life: A Dialogue on Evangelium Vitae*, ed. Kevin Wm. Wildes and Alan C. Mitchell (Washington, DC: Georgetown University Press, 2007), 239.

¹²⁴ Ibid.

Recent documents of the Roman Catholic Church together with treatises and documents by Catholic theologians over history are valuable resources about assisted death. They have established a tradition that, when closely examined, are challenging to argue against.

V. Theological and Secular Considerations

Assisted dying represents one of the greatest issues of divergence between the Catholic Church and society.¹²⁵ Society is trending toward an interpretation of human life as “utilitarian statistical, relative good, disposable at the will of individuals and societies when circumstances or personal choice dictate.”¹²⁶ The twentieth century has challenged the sovereignty of humanity over God by “assigning meaning, purpose, and value to human existence.”¹²⁷ Pope John Paul II’s *Evangelium Vitae* addresses the major arguments presented by proponents of assisted dying that are based on the preservation of human dignity, human autonomy and freedom, relief from human suffering. These concepts are discussed below.

a. Human Dignity, Freedom and Autonomy

The concept of human dignity is used in arguments to support and to oppose assisted dying. Those opposed to assisted dying connect human dignity with the value of life and claim it is violated when a person is provided aid in dying. Those in favor of assisted dying claim that human dignity is respected when a person wants to die and is provided the means to end suffering. The word “dignity” is often used by proponents of assisted dying as the defining term to identify advocacy movements and organizations. *Dignitas* is the name of a leading organization in Switzerland that advocates for assisted dying. Their welcoming statement is “To live with dignity - To die with dignity, the Swiss self-determination, autonomy and dignity group.”¹²⁸ Laws that

¹²⁵ Ibid., 237.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ www.Dignitas.ch, accessed March 29, 2018, <http://www.dignitas.ch/?lang=en>.

legalize assisted suicide in the states of Oregon and Washington and Washington, DC are titled “Death with Dignity” Acts. These Acts seem to draw a connection between the preservation of human dignity and assisted dying. So, what concepts of human dignity are used to support both arguments? What properties of the human person establish human dignity?

A single definition of human dignity is not easily determined, and the concept is debated among philosophers and theologians. The divergent definitions among philosophers and theologians represent an indication of the challenge we face in developing a concise concept for human dignity. The German philosopher, Ralf Stoeker, defines human dignity as “inviolable, inalienable, and of utmost importance for ethics.”¹²⁹ He asserts that human dignity is variable and can be subject to social interpretations over the course of a lifetime as a person either achieves greater social stature or falls into despair. Based on this concept of human dignity, a person’s human dignity can be regarded with respect or disdain, honor or humiliation, exaltation or degradation.¹³⁰

The contemporary concept of human dignity can be traced to the philosophy of Immanuel Kant in his *Groundwork of Metaphysics of Morals* where he establishes that there is an inherent “inner worth” in the human person that cannot be valued.¹³¹ This human worth is based on the rational nature of the human person that cannot be weighed against other values.¹³² Kant asserts that “*a rational nature exists as an end in itself*” and “*humanity, as an end itself.*”¹³³ Kant also asserts that autonomy is the ground of human dignity and is related to the rational nature of the

¹²⁹ Stoeker, 39.

¹³⁰ Ibid., 40.

¹³¹ Immanuel Kant, *Groundwork of the Metaphysics of Morals*, ed. Mary Gregor and Jens Timmermann, revised edition (Cambridge, UK: Cambridge University Press, 2012), 4:435 and 4:446, as referenced by Jeff McMahan in “Human Dignity, Suicide and Assisting Others to Die,” in *Human Dignity and Assisted Death*, ed. Sebastian Muders (New York, NY: Oxford University Press, 2018), 19-20, emphasis in the original.

¹³² McMahan, 19.

¹³³ McMahan, 20, quoting Kant *Groundwork*, 4:429, emphases in original.

human person. Some Kantian philosophers use this interpretation as the basis to oppose assisted dying; human dignity has an unquantifiable worth and cannot be compromised to relieve a person from any unpleasantness of life.¹³⁴

While the Catholic Church concept of human dignity is equally complex, it establishes a human dignity that is not variable based on a person's achievements. It is grounded in the Genesis creation story, where all humanity is created in the image of God and is granted dominion over creation. The creative action and dominion of humanity are pronounced as "good." This establishes humanity as having an almost divine stature. Yet humanity is not God, as demonstrated in the commandment to not eat of the fruit that only God could digest. This establishes a separation of humanity from God that occurs prior to the fall when humanity abused the commandment.¹³⁵ It is in the action of the fall that humanity establishes a will contrary to the commandment from God. The dignity of the human person is anthropological and can be chronicled in four categories as: (1) created in the image of God, (2) chosen by God, (3) ordered to God in grace and (4) alienated from God by sin.¹³⁶

Chapter One of *Gaudium et spes* is titled "The Dignity of the Human Person." It identifies humanity's struggle between good and evil, between "grandeur and misery," as part of the human experience.¹³⁷ *Gaudium et spes* specifically calls humanity to respect their bodies and to glorify God. Humanity is endowed with an intellect that "surpasses the material universe" because "he shares the divine mind ... which gives man the ability to pass through visible realities to those

¹³⁴ McMahan, 21. The opposition to suicide has an exception in the cases of loss of rationality. Clearly, Kantian philosophy connects human rationality to human dignity.

¹³⁵ Kelly, 11.

¹³⁶ John F. O'Grady, *Christian Anthropology: A Meaning for Human Life* (New York, NY: Paulist Press, 1976), 10-94, as summarized in *Contemporary Catholic Health Care Ethics*, 11.

¹³⁷ *Gaudium et spes*, Pastoral Constitution of the Church in the Modern World, (December 7, 1965, section 13, accessed March 31, 2018, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html).

which are unseen.”¹³⁸ It is in the depths of the conscience that humanity has a natural inclination to love “the good” and avoid evil. It is the inclination toward the good that is identified in *Gaudium et spes* as human dignity.¹³⁹ The purpose of human dignity is communion with God and it is through freedom that humanity can chose goodness. Section 27 of *Gaudium et spes* identifies euthanasia as an insult to human dignity and a “supreme dishonor to the Creator.” It furthermore asserts that it is more harmful to “those who practice than those who suffer.”

The Catholic Church’s *Declaration on Euthanasia* was approved by John Paul II in 1980 and continues the concepts of human dignity that are established in *Gaudium et spes*. The *Declaration* states that our human dignity is rooted in the creation story and redemptive actions of God toward humanity. Humanity was created by God with an original goodness and intentional free will that is the basis of human dignity. Humanity was created by God to share in the divine life with a concomitant responsibility as co-creator. This theological foundation establishes human dignity as a primordial value for humanity’s faithfulness to the good.¹⁴⁰ The *Declaration* states that attempted murder or murder is a “crime of utmost gravity” and that “suicide is equally wrong as murder and represents a rejection of God’s sovereignty and loving plan.”¹⁴¹

Human dignity is grounded in free will, which is the autonomy that gives humanity the ability to understand and make voluntary decisions. It is through freedom that humanity can chose goodness. But it seems that advancements in technology during recent centuries have resulted in individuals becoming more and more autonomous, and in many ways separated from God. Many individuals have become isolated from communities that previously provided a framework of support. This isolation may be a contributing factor to the increase in a human sense of ownership

¹³⁸ Ibid., Section 15.

¹³⁹ Ibid., Section 16.

¹⁴⁰ Kelly, 10.

¹⁴¹ *Declaration on Euthanasia*, I.

over their bodies. A sense of bodily ownership leads to a sense of entitlement to make life and death decisions. The advocates of physician-assisted death consider an individual's freedom to control their life to be a basic human right and a matter of human dignity. In other words, a person's right to choose life or death is a matter of individual freedom. Similarly, advocates believe that physicians must respect a patient's freedom and self-determination as a primary value. Other values like individual responsibility to others and the physician's oath to protect and sustain life become secondary.¹⁴² This liberal ethical interpretation could be expanded to say any person who interferes with a person's autonomy is disrespecting the individual's freedom and human dignity, disrespecting life, even in dying.

Cardinal Walter Kasper asserted that as a matter of freedom, Christians need to acknowledge and support systems of government that insure that humankind is free from limitations that constrain freedom.¹⁴³ This fact often puts the Church at odds with certain aspects of government. Christian freedom is freedom *for* God and *for* neighbor.¹⁴⁴ The meaning of freedom is represented by love. Human freedom is completed by accepting the love of God and affirming freedom among persons.¹⁴⁵ The secular order can protect the freedom of the individual if it is not oppressive. In this light, it could be argued that physician-assisted death is a freedom that individuals should not be denied, regardless of the Church's moral position.

b. Death and Suffering

An examination of the theological nature and meaning of death and suffering helps us to understand our custodial responsibilities toward life. The Genesis creation story establishes that

¹⁴² Gula, *Euthanasia: Moral and Pastoral Perspectives*, 8.

¹⁴³ Walter Kasper, *The Christian Understanding of Freedom in the Modern Era: The Meeting and Confrontation between Christianity and the Modern Era in a Postmodern Situation* (Milwaukee, WI: Marquette University Press, 1988), 41.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

humanity is destined to transcend and to move beyond the limitations of life to union with God by grace. The issue of human transcendence and the grace of God toward that end is embraced in the mystery of faith and grounded in the universal salvific will of God that all will be reunited with God. The Christological event is the final self-communication of God to man, which demonstrates the importance of humanity to God.¹⁴⁶ It is God's grace that balances the physical nature of humanity with the spiritual nature of humanity.

Christians are reconciled to God through the death and resurrection of Christ. Such joy and anticipation of union with God in death could sway our fear of relieving a person from suffering. But, the Christian tradition has forbidden suicide as a form of relief from suffering since the time of Augustine. Death is also viewed as a separation – an alienation of self from self, the other and God because of sin. When death is viewed with fear and dread, it seems logical to do everything we can to sustain life. The dying process often involves pain and suffering. The Christian view of suffering was articulated by St. Paul in Romans 5:3 when he said, “we welcome our sufferings”, indicates that there is value in suffering.¹⁴⁷ As imitators of Christ, many Christians believe that the way to salvation is *through* suffering. Suffering can have a redemptive value to Christians and is the way to union with God after death. It is through the process of suffering that individuals mature, learn and evolve into compassionate human beings. However, suffering, in secular society, is generally not believed to be of value. It can be viewed as evil and something that we should seek to eliminate. Christians are specifically called to provide charitable work that brings relief to suffering in the world. So, there is a contradiction in the Christian life. On one hand suffering is valued and on the other hand Christians are called to relieve suffering. The relative value of

¹⁴⁶ Kelly, 16-17.

¹⁴⁷ Battin, *Ethical Issues*, 55.

suffering and the examination of alternative methods to relieve end-of-life suffering are critical in the final analysis of the determining the morality of physician-assisted dying.

c. Mercy

The concept of mercy is central to the Christian story. Mercy is the showing of compassion toward another person. God's mercy is manifest in the Christological event where God becomes man and takes sin, evil and suffering upon himself in death; taking our place and conquering death. In God's mercy, Christ's death is the "death of death."¹⁴⁸ Mercy is a fundamental attribute and the organizing center of God's attributes.¹⁴⁹ God's goodness and mercy are visible in the world through our love toward one another. As the Apostle John wrote: "No one has ever seen God: if we love one another, God lives in us, and his love is perfected in us."¹⁵⁰ The horrific scene of 200 people leaping to their deaths from the World Trade Center on 9/11 was juxtaposed by the presence of a beloved Franciscan friar and Catholic priest, Father Mychal Judge, who served as a chaplain to the New York City Fire Department. Father Mychal was struck by a falling body and killed while he repeatedly prayed over bodies at the base of the World Trade Center, saying "Jesus, please end this right now! God, please end this!"¹⁵¹ A challenging question would be whether a merciful God was answering Father Mychal's prayers when he was struck by a falling body, or whether he was unintentionally murdered by a falling body.

Another provocative interpretation relates to the final hours of Jesus life; could it be that God the father showed mercy to Jesus as he suffered death on the cross? Or did Jesus give up his spirit voluntarily because it is impossible for Jesus as God to be subject to the corruption of the

¹⁴⁸ Kasper, *Mercy*, 75.

¹⁴⁹ *Ibid.*, 88-9.

¹⁵⁰ 1 John 4:12 (New Revised Standard Version).

¹⁵¹ Michael Daly, *The Book of Mychal: The Surprising Life and Heroic Death of Father Mychal Judge* (New York, NY: St. Martin's Press, 2008), 336.

flesh?¹⁵² Jesus died before the two men who were crucified with him. John’s testimony is that the soldiers broke the legs of the men who were crucified with Jesus, a measure undertaken to quickly cause death to the two men by suffocation. John testifies that “when they came to Jesus and saw that he was already dead, they did not break his legs.”¹⁵³ The scripture continues by stating “These things occurred so that the scripture might be fulfilled, ‘None of his bones shall be broken.’ And again, another passage of scripture says, ‘They will look on the one whom they have pierced.’”¹⁵⁴ Was Jesus’ death accelerated by a merciful God? Should we also show mercy upon the suffering in their final hours, and aid them to the glory of union with their creator? Through this analysis, physician-assisted death could be viewed as an act of mercy; a physician’s mercy toward the suffering of a dying patient.

d. Sanctity of Life

The fundamental inclination to be alive and the pursuit of existence is undergirded by the doctrine of creation; being is good and therefore to be alive is good. Life is better than death, and living is sacred. It is the sanctity of life that is a core element in the analysis of physician-assisted dying. If the fundamental inclination is to live, which entails a norm to support life and the norm against murder, killing of any kind, suicide and any action that compromises human life is ethically out of order with this natural inclination. The question is whether all aspects of life are better than non-life. The challenge is that we cannot pass easily from the natural inclination to support every natural aspect of life. For example, disease is a natural thing, and humanity seeks to confront and eliminate disease. Also, suffering is a dimension of reality, but there is a natural human inclination to eliminate or alleviate suffering. Our instincts to preserve life and to relieve suffering are natural,

¹⁵² Droge and Tabor, *A Noble Death*, referencing Tertullian, *Apology* 21.19; Origen, *Against Celsus* 2.11, 22.

¹⁵³ John 19:33 (NRSV).

¹⁵⁴ John 19:36-7 (NRSV).

and a conflict arises when the relief of suffering eliminates life. Christian ethics are derived through human reason informed by faith that gives meaning to that natural inclination. Certain issues must be filtered through the human reason informed by faith to determine that certain behaviors are in fact not ethical, while they are natural behaviors. We can deduce that human reason informed by faith is an appropriation of God's natural law.¹⁵⁵ The human instinct is to relieve suffering, and yet if the relief of suffering is at the expense of causing the early termination of life, it does not work with the Church's moral construct to preserve life as sacred. Life is sanctified by God and belongs to God; not to humanity. The sanctity of life is a core component of Catholic morality and is at the center of the Church's opposition to physician-assisted dying.

VI. Methods of Analysis in Catholic Morality

I will now examine physician-assisted death through a few of the analytical tools developed in Catholic moral methods, but first I would like to establish the context in which medical ethics were established.

a. Origins of Medical Ethics

Early Christian physicians considered the practice of medicine to have religious significance as they considered their work to represent an imitation of Christ; "to heal as Christ healed and to save as Christ saved."¹⁵⁶ As the Roman Empire collapsed, Christian communities took up the caring for the sick through the work of monasteries and by establishing hospices for travelers and indigents.¹⁵⁷ The work of the physician was closely tied to religious vocation until the emergence of modern science during the Enlightenment beginning in the eighteenth century. The modern view was that interreligious disputes were attached to reactionary authoritarianism

¹⁵⁵ Roberto Dell'Oro, "The Morality of Human Actions" (lecture, Loyola Marymount University, Los Angeles, CA, April 6, 2015).

¹⁵⁶ Kelly, 6.

¹⁵⁷ Ibid.

that caused considerable suffering to people.¹⁵⁸ For the first time, medicine became a secular practice. The Church responded by establishing “pastoral medicine” bridged the gap between secular medicine and Christianity. Pastoral medicine was the precursor to medical ethics. Medical ethics were established by the Church in the 1960s. Medical ethics were the precursor to the field of bioethics, and together with medical ethics they connect the practice of medicine to Christian anthropology and the greater considerations of human existence.¹⁵⁹

a. The Principle of Double Effect

The principle of double effect is a pre-Vatican II principle that examines two or more effects, each of which may be independently interpreted as good or bad, but when examined together may have a good effect that outweighs the bad effect. If both actions are determined to have a good effect, there is no question as to the morality of the effect. Similarly, if the action only has an evil effect, there is no question. From the perspective of Catholic health care morality, the principle of double effect proposes that an action with both good and bad effects is right if four conditions are met: (1) the act itself is not morally wrong, (2) the bad effect must not cause the good effect, (3) the agent must not intend the bad effect (as to the end to be sought) and (4) the bad effect must not outweigh the good effect.¹⁶⁰ Analysis of a situation is challenging under normative ethics, when there is some question as to whether the action has a good or bad effect, or whether there is some degree of good and evil. Using the principle of double effect, it does not seem possible to consider physician-assisted suicide to be a morally right action. The first requirement of the principle requires that the act itself not be morally wrong. In the context of Catholic medical ethics, intentionally terminating life is always morally impermissible. The only

¹⁵⁸ Ibid. 7.

¹⁵⁹ Ibid., 8.

¹⁶⁰ Ibid., 105.

circumstance under which a physician could morally provide sedation to a patient is with the patient's consent and only if the intention is to not cause the patient's death. The Catholic *Declaration on Euthanasia* specifically states that assisted dying is morally wrong, and assisted dying is *the* act itself. While it appears not to be necessary to proceed further, because all four conditions are required if the principle of double effect is to be used, examination of the second requirement demonstrates that the principle of double effect could also not be used to morally justify physician-assisted death; the bad effect, which is death, causes the good effect, which is relief of suffering. Also, the third requirement is failed because both agents, the patient and the physician, intend the bad effect that is death.

b. Proportionalism

Proportionalism is a normative method of Catholic healthcare ethics that dates to the late 1960's. Generally speaking, it states an evil action is moral if it is counterbalanced by a proportionate reason taking various criteria into consideration.¹⁶¹ The Catholic moral theologian Richard McCormick (c. 1922-2000) established three criteria of proportionalism: (1) the means will not cause more harm to achieve the value, (2) no less harmful way is available to protect the value, and (3) the means to achieve the value will not undermine it.¹⁶² Physician-assisted death is likely to be considered immoral on the basis of McCormick's third criteria alone. The means, which is a lethal dose of drugs, to achieve the value, relief of suffering, undermines life by eliminating it altogether. However, if it is determined that the life of the patient, who is dying anyway, is of less value than the patient's suffering, we may be able to use the first criteria to examine the question. We first need to determine which factor is the value and which factor is the

¹⁶¹ Ibid., 86.

¹⁶² Richard M. Gula, *Reason Informed by Faith: Foundations of Catholic Morality* (Mahwah, NJ: Paulist Press, 1989), 273-4.

harm. Is death the harm or the value? Is suffering the harm or the value? If it is determined that a patient's death is imminent, and the patient's suffering cannot be relieved with any other means, then the harm of death may be considered less harmful than the harm of suffering. The value is the relief of suffering, which is of greater value than death in this situation. This use of proportionalism is likely to be criticized because it violates the universal norm that living is better than dying. Another proportionalist view may analyze the situation differently, depending on the circumstances. For example, if suffering can be relieved with another means such as continuous deep sedation (described later) or pain medications, then the value of relief from suffering by accelerating the time of death represents a situation that is more harmful. The harm of death has greater value than the harm of suffering, which makes the action immoral. One objection to the use of proportionalism to justify physician-assisted death is that it promotes relativism and subjectivism. For example, in the case of a suffering, dying person, who is the subject, death may have a relatively greater value that is not of equal value to another subject, a healthy person. We have used both relativism and subjectivism in determining that suffering is of greater value than death in this situation. The use of proportionalism in determining the morality of physician-assisted death would be criticized based on the norm that life is of greater value than death in all circumstances. Furthermore, the use of proportionalism to justify physician-assisted death fails McCormick's second criteria, which is there is no less harmful way to protect the value. Suffering can be relieved through another means that does not involve killing the subject. Continuous deep sedation can relieve the suffering of a dying person. Proportionalism theory could be applied to determine that, rather than accelerating the time of a dying person's death with the administration of a lethal dose of barbiturates, the dying person can be sedated to relieve suffering.

c. Intentionality

The historical roots of the concept of intention can be traced to the works of medieval scholastic philosophy. The scholastics considered intention to be the union between something in the mind of the person doing the act and the moral quality of the act itself.¹⁶³ It was Thomas Aquinas (c. 1225 –1274) who established that the moral interpretation of an act was determined by what was intended by the person. Such intent was based on the motivations underlying the action, considering the circumstances of the event.¹⁶⁴

There are differences among intention, desire and motivation that can be distinguished. Desire is a wish that someone has. A wish or desire does not *make* something happen. We must *intend* to make something happen. Intention is the decision process that determines which specific action will be taken to make something happen. Motivation is the underlying reason for desire. Motivation is also not intent. It is the emotional underpinning of desire; for example, the emotions of love or hate. Our love may motivate our desire to provide relief from suffering to a person. If a person dies while we are providing relief, but we do not intend for the person to die, our desire for the person's relief from suffering is not related to the moral aspects of the person's death.¹⁶⁵

Intention is concerned with the underlying reasons that we perform an action. The action may be good, but if our motivation for the action is not good then our action may be determined to be an immoral act.¹⁶⁶ Aquinas' famous example is almsgiving. If our intent in giving alms is to elevate our status in a community (or to receive a tax deduction) rather than to relieve the suffering of the poor, the almsgiving is morally wrong even though the action itself is good. Good intentions are not enough to make a bad act morally good. This concept supports the moral judgment that the good intention, which is relief from suffering, is not sufficient to justify the bad intention, which

¹⁶³ Pellegrino, "The Place of Intention", 164.

¹⁶⁴ Ibid., 165.

¹⁶⁵ Ibid.

¹⁶⁶ Ibid.

is causing death, in the case of assisted suicide or euthanasia. A good action with a bad intent is morally wrong.¹⁶⁷ For example, it would be morally wrong to shout the word “fire” as a warning in a situation where there was no fire and when the agent simply wants to cause others to panic. Aquinas’ moral determination weighs the relative goodness or harm that an action caused.¹⁶⁸ Aquinas’ view was between that of Immanuel Kant (c. 1724 –1804) and Thomas Mill (c. 1773–1836.) The view of Kant was that the will must be conformed to the moral law, so certain actions such as assisted suicide could never be considered good because of the level of wrongness of the act itself. The work of Mill established that the moral determination of an act depends on the consequences of the act. Balancing the interior and exterior aspects of the act is very important to the understanding of the moral psychology behind intentionality.¹⁶⁹ If the underlying intention of a physician who provides a lethal dose of drugs to a dying patient is to free up a room in an overcrowded hospital, or to save the cost of sustaining the patient’s life, or if the physician determines arbitrarily that the patient’s life is not worth saving on the basis of life style or the patient’s perceived contribution to society, the physician’s actions can be determined to be immoral. If the physician’s intention is to provide relief from suffering, and there are no other means of relieving the patient’s suffering, the physician’s action *may* be a moral action, subject to determining that there is no other means to relieve suffering, and subject to determining whether relief from suffering is of greater value than letting life run its course in a dying patient.

The Catholic Church’s *Declaration on Euthanasia* defines euthanasia as “an action or an omission which of itself or by intention causes death in order that all suffering may in this way be eliminated.”¹⁷⁰ The key word in the definition is *intention*. Any person who *intentionally* causes a

¹⁶⁷ Ibid., 165.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ *Declaration on Euthanasia*, II.

person to die is committing murder. In the case of assisted dying the means to intentionally bring about a person's death are a lethal dose of medications or the intentional withdrawal or withholding of life-sustaining treatments. It is "a violation of divine law, and offense against the dignity of the human person, a crime against life, and an attack on humanity."¹⁷¹ Even when dying persons ask to be relieved of their suffering and ask for death, the *Declaration* identifies such requests as "an anguished plea for help and love" and they should be provided "human and supernatural warmth" rather than to be murdered.¹⁷²

d. Normative Ethics and Moral Norms

Normative ethical theory is based on the consideration of three subject areas: (1) whether people are praiseworthy or blameworthy agents; (2) whether actions or patterns of action are right or wrong (good or evil); and (3) the identification of what is of ultimate value.¹⁷³ Normative ethics could be used to determine whether physician-assisted death is ethically right or wrong as a secular matter. As to the first subject, in a situation when physician-assisted death is legal, we can establish that the participating agents are free to decide. In this case, the agent can either be praised for the action or blamed and take responsibility for the outcome. Subjectivity comes into consideration here because the relief of suffering can be considered praiseworthy while both the patient and the physician can be blamed for the negative outcome, which is death. The second consideration may also be subjective, is the action right or wrong? What is the action; relief from suffering or a lethal dose of drugs? The last consideration is also subjective. Is the ultimate value the relief of suffering or sustaining life?

¹⁷¹ Ibid.

¹⁷² Ibid.

¹⁷³ Kelly, 50.

From a Catholic morality perspective, the magisterial documents have established moral norms. The moral norms established by the magisterium are considered expressions of moral truths.¹⁷⁴ The moral norm not to murder is an absolute norm in Catholic morality. We may consider the Catholic moral norm not to murder as a directive that removes the subjectivity of physician-assisted death. The Catholic moral norm not to murder describes and evaluates the action of physician-assisted death as unjust and determines that it can never be justified as morally right.

VII. The Patient-Physician Relationship: Roles and Responsibilities

Until recently, most physicians considered physician-assisted suicide to be a violation of the professional and personal integrity of a physician.¹⁷⁵ The modern physician's oath affirms that "the health of my patient will be my first consideration."¹⁷⁶ The Oath further states "I will maintain the utmost respect for human life...I will not use my medical knowledge contrary to the laws of humanity."¹⁷⁷ Integrity of a physician represents a moral virtue that is demonstrated through the consistent application of a physician's primary values, which are to heal and to provide comfort to patients. Physician-assisted suicide may be viewed as inconsistent with and a direct violation of the physician's professional integrity to heal and comfort. It is also often considered a violation of the physician's obligation to provide a general continuity of patient care with accuracy, timeliness and veracity.¹⁷⁸

The patient-physician relationship can be described as a partnership between the physician and patient involving either continuous care during a particular illness or a life-long relationship

¹⁷⁴ Gula, *Reason Informed by Faith*, 283.

¹⁷⁵ Robert Young, *Medically Assisted Death*, (Cambridge, UK; New York, NY: Cambridge University Press, 2007), 113. Young further states that active voluntary euthanasia and even the referral of a patient to someone who will participate in either physician-assisted suicide or active voluntary euthanasia is inconsistent with professional integrity.

¹⁷⁶ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York, NY: Oxford University Press, 2013), 333, quoting the Physician's Oath from The World Medical Association's Declaration of Geneva (1948), accessed March 9, 2018 <http://www.cirp.org/library/ethics/geneva/>.

¹⁷⁷ Beauchamp & Childress, 333.

¹⁷⁸ *Ibid.*, 303.

that begins with health, continues through sickness and concludes with death.¹⁷⁹ The quality of healthcare is substantially better when the physician-patient relationship is one of continuous commitment to the care of the patient.¹⁸⁰ Ideally the commitment involves an approach of mutual decision making by the patient and physician. Such relationships cannot be standardized because each situation is based on a variety of circumstances that deal with people with varying cultural, social and economic backgrounds. A physician's intuition must supplement the intelligent flow of information between the patient and physician.

Given that dying can be a protracted process, patients need to fully trust that their physician can determine what treatments are beneficial and whether treatments can be more harmful than good. The patient needs to trust that the physician will work with them to determine when life can no longer be prolonged. The patient needs to mutually decide with their physician whether to withdraw or withhold treatment and must never feel abandoned by the physician.¹⁸¹

The moral norm of fidelity represents the physician's obligation to "faithfully carry out or abstain from carrying out an activity."¹⁸² The question of fidelity can be argued for and against physician-assisted suicide. The patient is vulnerable and puts his/her trust in a physician to provide healing or comfort. It seems to me that the very nature of physician-assisted suicide, on one hand, represents a lack of fidelity because the physician abandons the patient who is left to his/her own devices to take the prescribed medications that cause death. Such abandonment could be viewed as a disloyal breach of fidelity.¹⁸³ On the other hand, a physician's aid in a patient's death may be

¹⁷⁹ Timothy E. Quill, *Caring for Patients at the End of Life: Facing an Uncertain Future Together* (New York, NY: Oxford University Press, 2001), 59.

¹⁸⁰ *Ibid.*, 63.

¹⁸¹ *Ibid.*, 60.

¹⁸² Beauchamp and Childress, 324.

¹⁸³ *Ibid.*

viewed as an act of fidelity and non-abandonment since the physician is making the patient's final desire to prematurely end their life possible.

a. The Case of Karen Quinlan: Veracity and Fidelity

The Karen Quinlan case had a significant impact on the field of bioethics. My purpose here is to consider the case in connection with the patient-physician relationship and the values of veracity and fidelity. In 1975, twenty-one-year old Karen Quinlan suffered a cardiopulmonary arrest and was placed on a ventilator through a tracheotomy. After several months, Quinlan's condition was determined to be an irreversible coma and later she was designated to be in a persistent vegetative state. Her family believed that ventilation represented an unreasonable treatment and requested that ventilation be withdrawn.¹⁸⁴ Quinlan's physician disagreed with the family and requested that a court appoint a guardian who would make the determination of whether ventilation could be withdrawn. A judge appointed Karen Quinlan's physician as her guardian and the physician continued ventilation.¹⁸⁵ Following a series of court appeals, it was determined that Quinlan's ventilation could be withdrawn. Ventilation was gradually withdrawn, rather than being withdrawn immediately and she survived until 1985 with hydration and nutrition support. The point here, for purposes of our analysis, is that the physicians' initial refusal to withdraw treatment combined with the eventual and gradual withdrawal of treatment demonstrated the physicians' fidelity and veracity to Quinlan. The fact that when the medical team was forced to withdraw ventilation and that they did it gradually rather than withdrawing it suddenly that may have caused Quinlan to die, reflects the physicians' fidelity and veracity toward Quinlan's care.

¹⁸⁴ Willard Gaylin, "Who Should Decide? The Case of Karen Quinlan," *Christianity and Crisis* 35, no. 22, (January 19, 1976): 324.

¹⁸⁵ Raymond Devettere, "Life-Sustaining Treatments-Ventilators-The Case of Karen Quinlan," *Practical Decision Making in Health Care Ethics: Cases and Concepts*, 3rd ed. (Washington, DC: Georgetown University Press, 2009), 152-156. Following a series of court appeals, it was determined that Quinlan's ventilation could be withdrawn. Ventilation was gradually withdrawn by Quinlan's physicians and she survived for ten years with hydration and nutrition support. She was allowed to die from an untreated case of pneumonia in 1985.

Another crucial factor to consider in this case is the physician-patient relationship. Physicians normally make a judgment about a patient's capacity to make appropriate medical decisions. The determination should be consistent with the patient's history, religious beliefs and other societal factors.¹⁸⁶ In the case of Karen Quinlan, the appointed physician had no prior relationship with the patient. The lack of a physician-patient relationship in the case of Karen Quinlan, and the physicians' failure to follow her family's wishes could be viewed as a case of paternalism and a violation of the norm to determine what is in a patient's best interests.

In examining physician-patient relationships, we must consider the autonomous rights of both the patient and the physician. Patient rights suggest that physicians have obligations to aid patients with consideration to the relevant circumstances. However, patient rights must be within the constraints of the physician's autonomous rights.¹⁸⁷ If a patient requests assistance in committing suicide, the physician has an autonomous right to decline such a request based on the individual values of the physician. Examination of the physician-patient relationship is critical when ethicists make a moral determination in the case of physician-assisted suicide.

VIII. Methods of Analysis in Bioethics

As mentioned earlier, the field of bioethics emerged in the 1960's following a long tradition of medical ethics where, in Western civilization, physicians were closely tied to Christian religious vocation. The field of bioethics utilizes several normative theories that determine acceptable methods of evaluation of conduct. Normative theories are guided by four moral principles: (1) respect for **autonomy**, the norm to respect the individual; (2) **non-maleficence**, the norm to "do no harm" to an individual; (3) **beneficence**, the norm to provide only beneficial treatments to an individual; and (4) **justice**, the norm to fairly distribute resources among autonomous individuals.

¹⁸⁶ Quill, *Caring for Patients at the End of Life*, 44-48.

¹⁸⁷ *Ibid.*, 67.

I will now examine the morality of physician-assisted death through the four moral principles established in the field of bioethics.

a. Autonomy

The principle of autonomy in bioethics relates to the absolute and independent authority that an individual has over their medical decisions. Autonomy has been the cornerstone of “right to die” advocates in connection with advancing physician-assisted suicide laws in various states. Such advocates claim that respect for autonomy is a matter of respecting a person’s human dignity. Liberal democracies have demonstrated support for the respect of human dignity in providing individuals with laws that protect the freedom to choose various aspects of their lives while providing laws that protect human creativity and ingenuity.¹⁸⁸ Advocates of physician-assisted suicide believe that the ability to determine the time of an individual’s death is a matter of human rights and autonomy. The physician’s overall respect for the autonomy of patients overlaps with aspects of the principles of beneficence and non-maleficence. Respect for autonomy includes “concern for their welfare, respect for their wishes, respect for the intrinsic value of their lives and respect for their interests.”¹⁸⁹ However, sometimes a patient’s wishes conflict with what a physician determines to be in the patient’s best interests for their welfare.¹⁹⁰ As individuals shape their lives through free choice they develop intrinsic values. It is therefore necessary for the physician to determine what is of intrinsic value to the individual when balancing the wishes of a patient that conflict with the patient’s best interests or the physician’s values. The expression of a person’s autonomy may be a situation when a patient considers ending their life as a form of relief from suffering. The question is whether the physician’s respect for the person’s autonomy could

¹⁸⁸ Kass, *Liberal Democracy*, 50.

¹⁸⁹ John Harris, “Euthanasia and the Value of Life,” in *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, ed. John Keown, (Cambridge, UK; New York, NY: Cambridge University Press, 1995), 10.

¹⁹⁰ I am referring to competent patients here.

override the paternalistic tendency not to participate in providing the required life-ending prescription based on non-maleficence or the physician's values. Or, considering Catholic teaching in the *Declaration on Euthanasia*, a patients' requests to die may be heard as expressions of the need for "love, the human and super-natural warmth with which the sick person can and ought to be surrounded,"¹⁹¹ and as a need for assurance that medical assistance can ease anxieties and relieve suffering related to the end-of-life process.

The principle of autonomy gives the highest value to individual's self-determination. The individual's autonomous right to create the end of their life may be considered part of the person's creative right to shape their life.¹⁹² Dilemmas arise when the self-determination of the patient's choices conflict with the physician's medical expertise or values. A physician's concern for the welfare of the patient must be balanced and may have greater importance than the physician's respect for individual's autonomous creative right to determine aspects of their life, including their death. In other words, the principle of beneficence may be of greater importance to the physician than respect for the patient's autonomy.

We will now discuss a case where a patient diagnosed with Alzheimer's disease was aided by a physician in dying prior to the progression of the disease. Dr. Jack Kevorkian (c. 1928 – 2011) was an American pathologist who claimed to have aided over 130 people in dying with the use of a death machine called a "Thanatron."¹⁹³ He intravenously connected the patient to the machine and the patient would push a button that would start the flow of drugs that culminated in potassium chloride and the death of the patient.¹⁹⁴ The first patient he aided in dying in 1990 was Janet Adkins who had been diagnosed with Alzheimer's disease in 1989. Kevorkian had limited contact with

¹⁹¹ *Declaration on Euthanasia*, II.

¹⁹² Harris, 11.

¹⁹³ Brienne Prusak, "'U' Medical School Alum Dr. Kevorkian Dies at 83," *The Michigan Daily*, June 4, 2011, accessed March 8, 2018, <https://www.michigandaily.com/news/u-medical-school-alum-kevorkian-dies-83>

¹⁹⁴ Beauchamp & Childress, *Principles*, 183.

Adkins before connecting her to the Thanatron. He did not attempt and probably did not have the expertise to confirm Adkins' diagnosis.¹⁹⁵ Kevorkian's justification for aiding Adkins and others in dying was based on the principle of autonomy. Adkins expressed her autonomous desire to die before losing her cognitive abilities and Kevorkian provided the means for her death. Kevorkian's actions were "almost universally" condemned by "Lawyers, physicians, and writers in bioethics."¹⁹⁶ There were many reasons cited for the outcry of objections, but a primary ethical consideration in the Adkins case is that Kevorkian did not have an adequate patient-physician relationship to aid her in dying. Adkins was only 54 at the time of her death and was not yet debilitated.¹⁹⁷ If Kevorkian had a closer relationship with Adkins, the ethical determination of his actions based on his respect for her autonomy *may* have been different. Under the circumstances and considering the preliminary stages of Adkins' disease, it is hard to imagine how Kevorkian's actions could be considered morally ethical.

I believe that the consideration of a patient autonomy alone does not morally justify physician-assisted suicide. The patient's relationship with their physician is more important in determining the appropriateness of physician-assisted suicide. The physician needs to be given an opportunity by the patient to take into consideration the values and priorities of the patient so that the physician satisfies the obligation to provide beneficial treatment to the patient and to not provide a treatment that is maleficence to the patient. Furthermore, it is important that a patient who requests aid in dying has a psychological examination to confirm that the patient's desire to die is related to the underlying disease and not related to psychological depression, which could

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ Ibid.

be treated through counseling, therapy or antidepressant medications. I will now turn our examination to the principles of beneficence and non-maleficence.

b. Beneficence

The principle of beneficence relates to the positive steps of an agent to contribute to the welfare of a person.¹⁹⁸ The physician has an obligation to use professional expertise to balance whether medical interventions would be beneficial or not to a patient.¹⁹⁹ Beneficent actions of a physician are normally associated with providing curative treatments, relief from suffering or life-sustaining treatments. The question I will consider here is whether physician-assisted suicide could be considered an act of beneficence. I will examine two cases involving Timothy E. Quill, a palliative care physician from the University of Rochester Medical Center, Rochester, NY²⁰⁰ to address the question of whether physician-assisted suicide could be considered a morally ethical act as a matter of beneficence.

The case of Diane Trumbull demonstrates Timothy Quill's argument that physician-assisted suicide can be justified based on beneficence. Such an act of beneficence would depend on the patient-physician relationship. The case of Diane Trumbull was when the patient clearly requested to die rather than experience suffering, and the degradation associated with her disease. Quill described a very personal situation in the case of Trumbull that demonstrated the importance of a strong physician-patient relationship. Trumbull was diagnosed with leukemia and the proposed treatments were "risky, painful and often unsuccessful."²⁰¹ Trumbull decided to forego treatment so that she could preserve the quality of her life for as long as possible. Trumbull's highest priority was her quality of life. Trumbull was more terrified of the possibility of an inferior

¹⁹⁸ Ibid., 202.

¹⁹⁹ Ibid., 241.

²⁰⁰ Timothy E. Quill, M.D., Profile, University of Rochester Medical Center, accessed March 9, 2018, <https://www.urmc.rochester.edu/people/23067752-timothy-e-quill>.

²⁰¹ Beauchamp and Childress, 184.

quality of life and suffering than she was of death. Quill had a strong relationship with Trumbull and thoroughly understood her priority to have a high quality of life. When her disease progressed to the point that the quality of her life was unbearable, she said her good-byes, asked for one hour of privacy, took the lethal dose of barbiturates that Quill had prescribed, and peacefully died on her couch with her favorite shawl.²⁰² Quill justified his actions on the basis of “careful clinical assessments, assurance of adequate palliative care, respect for the patient’s values, and the commitment not to abandon the patient.”²⁰³ Quill considers non-abandonment to be most closely related to the principle of beneficence.²⁰⁴

The clinical case of Diane Trumbull in 1991 led to the 1997 Supreme Court decision *Vacco v. Quill* where the Court determined that the State of New York’s ban on physician-assisted suicide was constitutional and that the Equal Protection Clause of the Fourteenth Amendment to the Constitution did not protect a patient’s right to authorize a physician to end their life.²⁰⁵ The decision was combined with the case of *Washington v. Glucksberg* to determine that the Constitution did not prohibit states from enacting laws to legalize physician-assisted suicide.²⁰⁶

A second clinical situation described by Quill is the case of Cynthia.²⁰⁷ This is not a case of physician-assisted suicide, but a case of voluntary passive euthanasia and is relevant to the discussion of physicians’ obligations of beneficence to patients. Cynthia was a 37-year-old graduate student in psychology and a practicing Buddhist. She was devastated when, following dyspeptic symptoms, she was diagnosed with terminal metastatic gastric adenocarcinoma.²⁰⁸ As a

²⁰² Quill, *Caring for Patients*, 38.

²⁰³ *Ibid.*, 67.

²⁰⁴ *Ibid.*, 68.

²⁰⁵ “Vacco v. Quill,” Wikipedia, Accessed April 30, 2018, https://en.wikipedia.org/wiki/Vacco_v._Quill.

²⁰⁶ Cathleen Kaveny, *Law's Virtues: Fostering Autonomy and Solidarity in American Society* (Washington, DC: Georgetown University Press, 2012), 163.

²⁰⁷ Quill, *Caring for Patients*, 60. Cynthia’s full name is not provided by Quill.

²⁰⁸ Quill, *Caring for Patients*, 60.

practicing Buddhist, Cynthia was concerned that being kept alive with sedation would impair her consciousness. As the tumor in her abdomen grew, she was kept alive with artificial nutrition and hydration, together with an appropriate dose of intravenous morphine to relieve pain. When Cynthia's condition deteriorated, she requested the withdrawal of nutrition and hydration but agreed to increase the levels of morphine. Cynthia was prepared to die but did not want to be perceived as committing suicide.²⁰⁹ Cynthia died peacefully.²¹⁰ Quill considered the intentional act, the withdrawal of nutrition and hydration, that allowed Cynthia to die to represent an act of non-abandonment and an act of beneficence.²¹¹ Quill stated that it would have been abandonment, and a lack of beneficence to not withdraw Cynthia's intravenous hydration based on Cynthia's wishes to stop the treatment.

The cases discussed demonstrate that a physician's aid in dying may be determined to be morally ethical based on beneficence when a strong physician-patient relationship existed. The case of Diane Trumbull reflected a situation in which Dr. Quill knew the patient very well. Dr. Quill believed that her particular circumstances justified his aid in assisting her death. The Kevorkian/Adkins case demonstrated a case where the physician did not have a significant enough relationship or sufficient knowledge of her medical history to aid in her death. The overwhelming reactions to Dr. Kevorkian's actions were that the use of his "death machine" was a violation of the principle of non-maleficence that was exacerbated by Kevorkian's lack of a strong relationship with his patients. Each case must be carefully examined based on the circumstances and the physician-patient relationship. The moral determination of assisted-suicide based on beneficence depends on the extent and quality of the physician-patient relationship.

²⁰⁹ Ibid., 62.

²¹⁰ Ibid., 60-62, Quill did not specify whether Cynthia's cause of death was respiratory failure related to an overdose of morphine, the withdrawal of hydration or her underlying disease. Cynthia's death is considered morally ethical because the intention for using morphine was to provide relief from suffering and not to cause Cynthia's death.

²¹¹ Quill, *Caring for Patients*, 68.

c. Non-Maleficence

The principle of non-maleficence is a significant principle in connection with physician-assisted suicide. Non-maleficence obligates a physician to abstain from causing harm to others.²¹² "First, do no harm" is the phrase that is often quoted to represent the principle of non-maleficence. Providing a lethal prescription to a patient can clearly be viewed as a harmful act. The physician's action has a direct connection to the death of the patient and death is a bad outcome in any physician's practice. However, could it be considered an act of harm for a physician to let a patient continue to suffer when a patient has requested relief from suffering through physician-assisted suicide? I will examine some of the rules associated with non-maleficence and the principle of double effect to address this question.

The *prima facie* moral rules associated with non-maleficence in connection with physician-assisted suicide include the rules to not kill, to not cause pain or suffering and to not incapacitate.²¹³ First, the moral rules to not kill and to not incapacitate are clearly violated in the situation of physician-assisted suicide. Some physicians may consider that the rule to not cause pain or suffering could outweigh the moral rule to not kill. A physician could be viewed to cause pain and suffering if they fail to honor a patient's voluntary desire to accelerate their death with the physician's assistance. Failure to provide the lethal prescription may be viewed as negligence in the physician's breach of duty to provide the patient with the desired means to relieve pain and suffering. The determination of such negligence would depend on whether there is a standard of practice that would require a physician to provide the lethal prescription. While laws are being enacted to govern physician-assisted suicide, it is not a standard practice. Regardless, the standard

²¹² Beauchamp & Childress, *Principles*, 150.

²¹³ *Ibid.*, 154.

practice argument is not convincing as a support for physicians to provide lethal prescriptions to dying patients.

Cases of voluntary passive euthanasia, when life sustaining treatments are withdrawn or withheld, could be considered acts of non-maleficence. Even though withdrawal or withholding of treatment will lead to a patient's death, such actions have been determined to be morally ethical when the treatment will only prolong the patient's end-of-life suffering and provided the intention is not to cause the patient's death, but the intention is to relieve the patient from burdensome suffering that is associated with the treatments.

d. Justice²¹⁴

Healthcare resources are limited, and the principle of justice is used to determine how resources may be ethically distributed. The utilitarian theory of distributive justice would examine the physician's participation in assisted suicide as it relates to the good of society. The utilitarian view may be that it would be better, primarily in futile situations, for a physician to terminate life early so that the physician's time and energy can be allocated to others in society who would derive greater benefit from the physician's care.²¹⁵ In a broader sense, the physician may consider that the utilization of any healthcare resources to sustain a life that is imminently futile represents an unjust allocation of healthcare resources. For example, to the extent a dying patient who requires medical treatments that could be allocated to a patient with a better likelihood of survival, the allocation of resources to the dying patient may be considered unjustified, from a utilitarian point of view. From a utilitarian point of view, it may be determined that it would be better to end a person's life through physician-assisted suicide or some other form of euthanasia so that the

²¹⁴ The framework of this section was based on Beauchamp & Childress chapter titled "Justice," in *Principles of Biomedical Ethics*, 249-301.

²¹⁵ Beauchamp & Childress, *Principles of Biomedical Ethics*, 254-55.

healthcare resources could be reallocated to a patient with a greater likelihood of survival. The application of this utilitarian view would violate the dying individual's basic human right to life and to receive health care and, in my opinion, would be unethical.

From a libertarian theory of justice, a physician could justify assisted suicide on the basis that it is the patient's legal right to terminate their life early.²¹⁶ If the physician follows the law, his/her participation in aiding a patient in dying can be justified. Similarly, from an egalitarian perspective, the physician could justify the action to the extent assisted-suicide is legal and since it should be equally available to all people.²¹⁷

The communitarian theory of justice would take into consideration the physician's action in aiding a patient to die and the impact the action would have on the patient's community.²¹⁸ The patient's community may be as small as the patient's immediate family or could be expanded to consider the larger community in which the patient lives. There are many factors that need to be considered in the communitarian analysis including the societal, emotional and economic impact of the physician's action. I believe it would be difficult to justify physician-assisted suicide using communitarian theory because of the substantial number of factors that need to be considered.

Recent theories of justice have emerged including a theory called capabilities theory. The core of the capabilities theory relates to the sustenance of ten individual capabilities, the first of which is "life." Life would obviously be violated if a physician aided a patient in ending their life, so it isn't necessary to evaluate the capabilities theory to justify assisted suicide any further. Additional new theories of justice, such as the "well-being" theory have similar and obvious limitations in justifying physician-assisted suicide.²¹⁹

²¹⁶ Ibid., 255-56. This situation relates only to patients in States and nations where assisted-suicide laws have been enacted.

²¹⁷ Ibid., 256-7.

²¹⁸ Ibid., 257-8

²¹⁹ Ibid., 259-60.

A final consideration regarding justice is that of exploitation or coercion. This is a situation where a third party coerces an individual to terminate their life early based on the third party's self-interest or because of allocation of resources. There may be a situation where the costs of life-sustaining therapies are draining the financial resources of the patient. In this case, the patient's heirs may intentionally or inadvertently coerce the patient to request assisted dying. To the extent that laws are enacted that permit assisted suicide, this aspect of justice would implore the physician to have sufficient knowledge about their patient and the patient's family and friends to determine that the patient has not been coerced to terminate their life early.²²⁰

While ethicists may strive to use the utilitarian theory of justice to morally defend physician-assisted suicide, I believe that such a determination represents an extreme application of the intent of the utilitarian theory. While libertarian and egalitarian theories speak for themselves and to the rights of patients, I don't believe that application of the theories should outweigh the determinations against physician-assisted suicide that would be made under either the capabilities or well-being theories. Overall, I believe it is challenging to determine that physician-assisted suicide is a moral practice for a physician to undertake based on the principle of justice.

IX. The "Slippery Slope" Theory

Humankind is prone to something known as the "slippery slope." The slippery slope is when actions that may seem inconsequential and small lead to related actions with grave consequences. The concept of the slippery slope has been hotly debated in connection with the legalization of physician-assisted suicide. The question is, if laws are enacted that allow euthanasia, will abuses grow incrementally and over time that will eventually be used to rationally (or irrationally) justify other forms of euthanasia that are not even intended to be legal such as

²²⁰ Ibid., 267-70.

involuntary active euthanasia? Beauchamp and Childress argue that “the slope of the trail toward the unjustified taking of life could be so slippery and precipitous that we ought never to embark on it.”²²¹ This seems to be a warning that physician-assisted suicide should not be legalized based on the slippery slope.

The Holocaust is an example of the use of euthanasia and the slippery slope. The Nazis had a killing program that started with “mercy” killing by physicians of physically or mentally disabled infants. This led to the killing of mentally disabled children and eventually to the killing of disabled adults. If the Nazis believed that the quality of certain individuals’ lives was not good enough to continue living; they determined that those individuals were better if they were dead.²²² The killing of innocent people, without consent, led to the Nazis’ *Final Solution*, which resulted in killing six million Jews plus non-Aryan people whom the Nazis considered racially inferior.

Examination of euthanasia practice in the Netherlands before specific laws were enacted demonstrates an example of the slippery slope theory. The use of euthanasia was originally authorized in the Dutch Penal Code. In 1984, the Dutch Supreme Court determined that a physician could rely on the Code to justify killing a patient but there were no laws that specifically governed the use of euthanasia.²²³ The Royal Dutch Medical Association adopted rules for the use of euthanasia to specifically restrict its use to cases of voluntary active euthanasia and to prohibit involuntary cases. There is evidence that the Dutch slipped and that the rules were not sufficient to protect society from slipping toward the prohibited practice of involuntary active euthanasia. The Dutch established the Rummelink Commission to examine the practice of euthanasia in 1989 and they commissioned the van der Maas Survey that was concluded in 1991.²²⁴ The Survey

²²¹ Beauchamp & Childress, *Principles*, 179.

²²² Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases*, Seventh Edition (New York, NY: McGraw Hill Education, 2015) 45.

²²³ Keown, *Euthanasia Examined*, 261.

²²⁴ *Ibid.*, 262.

reported that the professional safeguards prohibiting involuntary active euthanasia were widely disregarded. The Survey disclosed that over 10,000 lives were shortened by euthanasia in 1990 and that most of the deaths (5,500) were not authorized by the patients. One thousand of the cases specifically used a lethal drug without an explicit request from the patient.²²⁵ While there are vagaries in the reporting procedures in the Dutch system, the results of this survey clearly indicate that the slippery slope theory should be a concern where specific laws are not enacted and enforced.

In the Netherlands, laws were enacted in 2001 and became effective in 2002 that regulate euthanasia and physician-assisted suicide. A unique aspect of the Dutch laws is that patients who expect to lose cognitive function are allowed by law to leave an advance directive for euthanasia. A nationwide poll in 2001 indicates that 86% of Dutch people supported the new laws.²²⁶ The practice is not decriminalized but the law legitimizes it when the procedures identified in the law are followed.²²⁷ The procedures, first, establish various eligibility and informed consent criteria for the care of patients, and second, establish various reporting requirements. The use of euthanasia or assisted suicide must be reported to a regional review committee, which determines whether the physician acted appropriately within the established criteria for euthanasia or assisted suicide. If criminal activity is suspected, a public prosecutor investigates the situation.

The Dutch courts demonstrated a reluctance to prosecute doctors for murder in situations where the care criteria are not followed. A situation was reported where a doctor provided assisted suicide to a person who was not terminally ill but who was “tired of life”²²⁸ and the court didn’t

²²⁵ Ibid., 282.

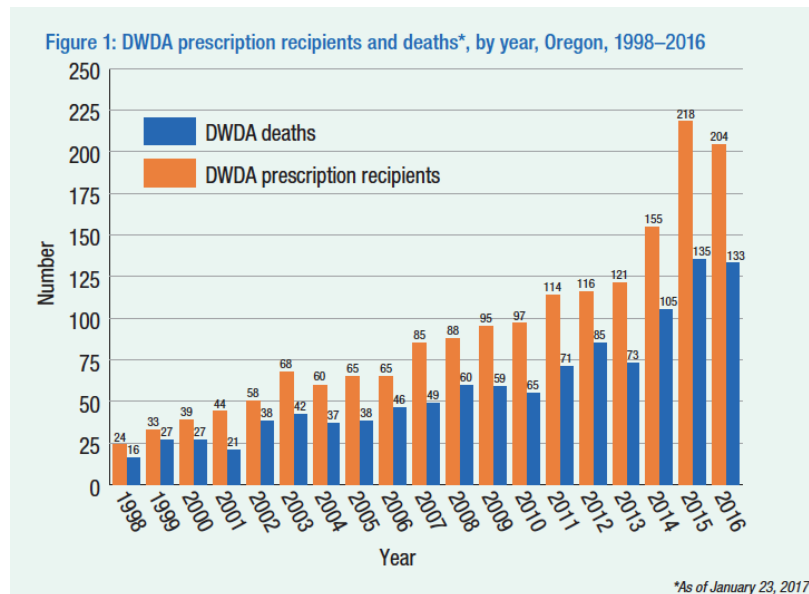
²²⁶ Tracy Sutherland, “Dutch First with Legal Euthanasia,” *The Australian* (April 12, 2001): 10. As referenced in Kant Patel, “Euthanasia and Physician-Assisted Suicide Policy in the Netherlands and Oregon: A Comparative Analysis,” *Journal of Health & Social Policy* 19, no. 1 (21 Oct 2008): 37-55.

²²⁷ Patel, 40.

²²⁸ Ibid., 44.

sentence the doctor to jail. A lower court acquitted the doctor.²²⁹ This is problematic because the Dutch courts do not enforce the legal criteria for the use of euthanasia or assisted suicide.

State of Oregon statistics indicate an increase in the use of physician-assisted suicide over the last twenty years. During the first full year of its availability, 1998, only 24 people requested a prescription and only 16 people died from the ingestion of the drugs representing .08% and .05% of the 29,281 total deaths in the state. The most recent data for 2017 shows that 218 people requested prescriptions and 143 people died from ingesting the medications representing .60% and .37% of the 36,498 deaths in Oregon. The chart below shows the trend of increased use of physician-assisted suicide in Oregon.



While it appears that the use of physician-assisted suicide has increased over the years in the State of Oregon, there is no evidence that there are abuses in the practice that could be identified as “slippery slope.” The use of involuntary active euthanasia would be considered the primary abuse and no reports were discovered that show evidence of its use. The use of physician-assisted suicide in Oregon remains to be relatively low, less than one half of one percent of all deaths use

²²⁹ Ibid., 44.

it. Over the last twenty years, 77.9% of the patients in Oregon who used physician-assisted suicide were diagnosed with a form of terminal cancer; 10.5% had neurological diseases.²³⁰

During the first partial year of the availability of physician-assisted suicide in California (2016), 191 people requested a prescription and 111 people died from the ingestion of the drugs representing .14% and .08% of the 138,973 deaths in the state.^{231, 232} We can expect the use of physician-assisted suicide to increase over the years in California, to the levels observed in Oregon, as the public becomes more aware of its availability. 65% of the persons who used physician-assisted suicide in California suffered from cancer and 20% suffered from neuromuscular disease.

The reported use of assisted deaths in the Netherlands is much higher than it is in the US at 4% of all deaths in 2016, which is up 10% from 2015.²³³ The Netherlands conducts a major study on assisted death very five years and determined that 23% of assisted deaths are unreported.²³⁴ Based on the lack of enforcement of abuses in the Netherlands and the number of assisted deaths that are not reported as required by the 2001 law, it seems that the slippery slope would be more likely to occur in the Netherlands than the US, where the general trend to use assisted suicide is generally increasing, but at a very moderate pace.

Bioethicists Tom Beauchamp and James Childress state that the legalization of physician-assisted suicide could lead to a general deterioration of the respect for human life. They describe

²³⁰ Oregon Health Authority, Oregon Death with Dignity, Data Summary 2016, accessed April 14, 2018, www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf. Statistics are from the 2017 report, accessed April 14, 2018, <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>.

²³¹ This number is adjusted to represent the date from which physician-assisted suicide was available; June 9, 2016. The actual number of deaths in the State of California in 2016 was 248,118.

²³² California End of Life Option Act 2016 Data Report, accessed April 14, 2018, <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report.pdf>.

²³³ The Dutch News reported 6,091 assisted deaths in 2016 compared to 5,561 in 2015.

²³⁴ European Institute of Bioethics, accessed April 14, 2018, <https://www.ieb-eib.org/en/document/report-2016-euthanasia-in-netherlands-488.html>.

protections against physician-assisted suicide and various forms of euthanasia as “one thread” that holds together the fabric of human life. They assert that as threads are taken away, a general deterioration in the moral behavior of humanity may occur.²³⁵ This trend is evidenced by a movement in the Netherlands and Belgium called “tired with life” that undermines the existing euthanasia laws.²³⁶ People who are “tired with life” are typically over 70 years and do not suffer from a terminal illness. The people have non-fatal afflictions and suffer from the fragility of advanced age. It is believed that requests from people who are “tired with life” may account for the sharp increases in assisted deaths in the Netherlands between 2009 and 2010 (from 2,636 to 3,136), which is a trend that continues.²³⁷

In addition to the slippery slope there are concerns that the legalization of physician-assisted suicide could lead to the deterioration of the quality of palliative care that is currently available to dying patients.²³⁸

X. Palliative Care and other End-of-Life Options

The primary tools used in comprehensive palliative care to manage end-of-life suffering are pain management and the withdrawal or withholding of life sustaining treatments. Comprehensive palliative care has been established as *the* standard of care for the dying by the American Board of Internal Medicine and the American Medical Association.²³⁹ Additional end-of-life options, which are not considered standard practices of care in medicine, include the voluntary cessation of nutrition and hydration and palliative sedation.

²³⁵ Beauchamp & Childress, *Principles*, 180.

²³⁶ M.J. Shariff, “Assisted Death and the Slippery Slope – Finding Clarity Amid Advocacy, Convergence, and Complexity,” *Current Oncology* 19, no. 3, (June 2012): 149.

²³⁷ Shariff, 149.

²³⁸ Beauchamp & Childress, *Principles*, 180.

²³⁹ Quill, *Caring for Patients*, 488.

There are two types of terminal suffering at the end-of-life. I use the term “physiological suffering” to describe the direct neuro-physical pain that is brought about by disease. The term “existential suffering” is used to describe indirect suffering that does not have a direct causal relationship with the patient’s underlying medical condition. Existential suffering occurs when patients lose their ability to experience life as they did prior to the onset of debilitating disease. Social relationships change because of terminal illness. Patients who face terminal illness often lose a sense of purpose and their lives feel meaningless. Existential suffering may also include concerns about being a burden to others.

a. Pain Management

Pain Management includes the use of analgesics to manage physiological pain. The type of analgesics range from aspirin to powerful opiates such as codeine and morphine.²⁴⁰ Pain management has been broadly accepted by medical, legal and religious groups to treat physiological pain at the end of life and is considered a standard practice of care.²⁴¹ The justification for the use of high-dose opioids rests on the proportionality of the patient’s relief from suffering, which is of greater importance than the side-effects of the opioids. While the intent of the use of high-dose opioids is to relieve suffering, occasionally a patient becomes unconscious from the opioids until death. Unconsciousness is considered morally justified based on the rule of double effect; the patient’s relief from suffering is proportionally greater than the patient’s unconsciousness until death. Death is not the intended outcome of pain management although there is a possibility that gradual increases in the dosage of opioids could lead to cardiopulmonary failure and death. Situations where death is caused by an overdose of opioids during pain management have been morally justified on the basis that the intent was to relieve suffering rather than to cause

²⁴⁰ Quill, *Caring for Patients*, 489.

²⁴¹ *Ibid.*

the death of the patient. It is worthy to note that when death is directly attributed to an overdose of opioids, the intent of the physician may be morally challenged. The determination of intent is nuanced, and it is not always possible to determine a physician's actual intent with full certainty.

b. Withdrawal or Withholding of Life Sustaining Treatments

The withdrawal or withholding of life sustaining treatments (WWLST) is when it is decided by patients or patients' surrogate decision makers to either withdraw life sustaining treatments that are currently being administered or to withhold life sustaining treatments that were never initiated. Treatments that are withdrawn or withheld include a broad range, such as respiratory support in the form of ventilators, chemotherapy for the treatment of cancer, dialysis for kidney disease, artificial nutrition and hydration, and cardiopulmonary support. WWLST is sometimes considered voluntary passive euthanasia. WWLST is often accompanied with other palliative measures such as pain medications and sedation to provide relief from physiological suffering as a patient gets closer to death. WWLST at a patient's or surrogate's request has broad legal and ethical acceptance even if a patient intends death when the continuation of treatment could extend the patient's life.²⁴² WWLST is an accepted standard practice of care in medicine when the treatments are determined to be futile or when the treatments would be more burdensome to the patient than beneficial. While advocates of assisted dying suggest that WWLST is equivalent to assisted dying, it can be argued that they are not the same. In the case of assisted dying the physician directly facilitates the patient's death. In the case of the WWLST, the patient dies from physiological complications of the underlying disease or from dehydration. The physician does not directly assist the patient in dying. The fact that the physician is not directly involved in killing the patient is an argument for the superiority of WWLST over assisted dying.

²⁴² Ibid., 490.

c. Voluntary Cessation of Nutrition and Hydration

Voluntary cessation of nutrition and hydration (VCNH) is another end-of-life option that a patient could consider. The patient decides to stop eating and drinking. This is different from a situation when a patient is receiving artificial nutrition and hydration and the treatment is withdrawn in the case of WWLST. Typically, a patient will die within one to three weeks. The patient needs to express their wishes in an advance directive to avoid receiving ancillary life sustaining treatments and to authorize pain medications or sedation to eliminate physiological suffering. The medical team's role in this situation is to maintain the comfort of the patient during the dying process. Often death is not otherwise imminent from the underlying disease. The patient may choose this option when facing a prolonged terminal illness that compromises their human dignity or other existential considerations. Voluntary cessation of eating and drinking is widely accepted as a legal, moral and ethical option for terminally ill patients, but it is not considered a standard practice of care in medicine. Like WWLST, the physician does not directly assist the patient in dying.

d. Palliative Sedation

Palliative Sedation involves the monitored use of medications to cause intermittent reduced consciousness or continuous unconsciousness until death. There are various levels of palliative sedation from “mild sedation” where consciousness is maintained, to “intermittent sedation” to “deep sedation” where the patient is almost or completely unconscious. The National Hospice and Palliative Care Organization (“NHPCO”) defines palliative sedation as “the minimum level of consciousness reduction required to decrease awareness of distress to a level tolerable by the

patient.”²⁴³ The term “palliative sedation therapy” or “PST” is used to describe situations when a patient receives either mild or intermittent sedation and the term “continuous deep sedation” or “CDS” describes permanent sedation and unconsciousness until death. Sedative drugs such as phenobarbital, sodium thiopental or a midazolam infusion are titrated until sedation is achieved.²⁴⁴ Both PST and CDS are considered last resort therapies when pain medications are no longer effective. Artificial hydration and nutrition are not continued during PTS and CDS because such treatments are considered futile. The patient typically dies from either the underlying disease or from dehydration.

PST and CDS do not require enabling legislation and are becoming generally accepted practices in end-of-life situations where physiological suffering cannot be managed with pain medications. However, sedation methods are not yet considered a standard practice of medical care. PST and CDS have been accepted by the NHPCO for the treatment of terminally ill patients who are close to death and for relief from intractable and intolerable suffering.²⁴⁵ The rule of thumb is that a patient is considered close to death when their prognosis is within two weeks of death. The ethical determination of PST or CDS for existential suffering has not been determined by the NHPCO and is subject to further ethical discussions. CDS is ethically considered aggressive symptom management. The proper administration of CDS is not intended to directly lead to death and medical teams who monitor CDS are required to take safeguards to avoid CDS from directly causing death.

²⁴³ Timothy W. Kirk, and Margaret M. Mahon, “National Hospice and Palliative Care Organization (NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients,” *Journal of Pain and Symptom Management* 39 no. 5 (May 2010): 920.

²⁴⁴ Alvaro Sanz Rubiales, F. Baron Duarte, and M.L. del Valle Rivero, “Do We Need a More Precise Definition of What Sedation Is?,” *Cuadernos de Bioteca* 26 no. 86 (Jan-Apr 2015): 111.

²⁴⁵ Kirk, “National Hospice,” 915.

While existential suffering can be equally intense to physiological suffering, PST and CDS are generally not recommended treatments for situations when existential suffering is the only form of suffering experienced by a patient. But to the extent counseling fails to relieve a patient from existential suffering, the National Hospice and Palliative Care Organization (NHPCO) suggests that PST rather than CDS may be used.²⁴⁶ The rationale is that physiological suffering is induced by disease and is appropriately treated by medical practice. The NHPCO's position is that existential suffering is indirectly related to the underlying disease and should only be medically treated as a last resort.

XI. Analysis of Palliative Sedation compared to Physician-Assisted Dying

I now seek to set forth arguments relating to the moral and ethical superiority of palliative sedation over physician-assisted dying.

a. The US Supreme Court and Physician-Assisted Suicide

In the case *Washington v. Glucksberg*, the U.S. Supreme Court determined that the State of Washington's ban on physician-assisted suicide was *not* unconstitutional.²⁴⁷ In response to whether assisted suicide was unconstitutional, Justice O'Connor's opinion stated that she saw no need to address the question because of the availability of alternatives such as "obtaining medications...to the point of causing unconsciousness and hastening death."²⁴⁸ The opinion has been interpreted to mean that sedation was legally and ethically available to treat end-of-life suffering and that sedation achieved the same goal. It therefore was not necessary for the Supreme Court to consider the constitutional aspects of assisted suicide.²⁴⁹ In not considering assisted

²⁴⁶ Ibid., 921.

²⁴⁷ *Washington et al., v. Glucksberg et al.*, 521 U.S. 702 (Supreme Court 1997), accessed March 10, 2018, <https://supreme.justia.com/cases/federal/us/521/702/case.html>.

²⁴⁸ Kasper Raus, Sigrid Sterckx and Freddy Mortier, "Is Continuous Sedation at the End of Life an Ethically Preferable Alternative to Physician-Assisted Suicide?" *The American Journal of Bioethics* 11, no. 6 (2011): 33, referencing *Washington v. Glucksberg*, 1997, 736-737.

²⁴⁹ Raus, 33.

suicide, the opinion indirectly stated that sedation was preferable to assisted suicide.²⁵⁰ The Supreme Court determined that a ban on assisted suicide was not unconstitutional, which has been interpreted to mean that states could enact laws to permit assisted suicide. Chief Justice Rehnquist's opinion quoted the American Medical Association statement "physician-assisted suicide is fundamentally incompatible with the physician's role as healer."²⁵¹ Rehnquist furthermore stated that physician-assisted suicide challenged the physician's role as healer because it could be viewed as bringing harm to the patient.²⁵² In a brief to the Supreme Court, the American Geriatrics Society argued that physician-assisted suicide was not better than sedation because sedation was currently legal and "can always eliminate symptoms in persons near death."²⁵³ In *Washington v. Glucksberg* Justice Stevens provided a contrary opinion stating that a physician's refusal to aid a patient in hastening death could be viewed as abandonment and harmful to the physician-patient relationship.²⁵⁴ With the exception of Justice Stevens' opinion, Supreme Court opinions and data tend to support palliative care and sedation as superior to physician-assisted suicide.

b. Equivalency or Non-Equivalency of CDS and Euthanasia

Samuel LiPuma argues that CDS is equivalent to assisted-dying in that both involve killing.²⁵⁵ LiPuma defends his argument on the basis that CDS eliminates consciousness with the absence of neocortical (higher brain) functioning, which he equates to death. He proceeds to defend his position by establishing three definitions of death: (1) higher brain death, (2) whole brain death, or (3) cessation of cardiopulmonary function. In response to LiPuma's argument, Joseph Raho and

²⁵⁰ Ibid.

²⁵¹ Ibid., 37 quoting *Washington v. Glucksberg* 1997, 731, referring to Council on Ethical and Judicial Affairs 1993.

²⁵² Ibid.

²⁵³ Ibid., 35, referencing a brief to the Supreme Court from the American Geriatrics Society (Lynn et al. 1997).

²⁵⁴ Raus, 38.

²⁵⁵ Samuel H. LiPuma, "Continuous Sedation until Death as Physician-assisted suicide/euthanasia: A Conceptual Analysis," *Journal of Medicine & Philosophy* 38, no. 2 (April 2013): 190-204.

Guido Miccinesi prepared a thesis that contests LiPuma's position.²⁵⁶ Raho and Miccinesi identified that continuous sedation is proportional to the patient's condition and does not always result in full unconsciousness. Physician-assisted suicide causes death immediately (within one hour) and is not considered proportional to the patient's condition. Physician-assisted suicide leads to permanent unconsciousness because the patient is dead within an hour. Raho and Miccinesi demonstrated that continuous sedation is not equal to neocortical death and therefore is not equal to assisted dying. With CDS the patient is not dead but in a reversible state of sedation.

When CDS is used, the intention is to sedate the patient until death. On this basis, it has been argued that physician-assisted suicide and CDS until death are essentially the same. In both cases the patient does not return to consciousness prior to death. Even though the ends of CDS and physician-assisted suicide are the same, it has been suggested that CDS is a preferable alternative to the practice of assisted dying because in the case of CDS, the patient could be revived and made conscious if circumstances warranted it. In the case of assisted dying, the patient cannot be revived after the medications are taken.

c. Appropriateness of Physician-Assisted Death as a Medical Treatment

It can be argued that palliative care and sedation are more in line with the normal role of a physician while physician-assisted death is not. End-of-life pain can be relieved by pain medications, and to the extent pain medications are not sufficient, patients can be relieved from pain through sedation. Such relief from physiological pain is consistent with the integrity of a physician as a healer; with the interpretation of "healer" as one who provides relief from suffering. It is not necessary for a physician to engage in the morally controversial practice of physician-

²⁵⁶ Joseph A. Raho and Guido Miccinesi, "Contesting the Equivalency of Continuous Sedation until Death and Physician-assisted Suicide/Euthanasia: A Commentary on LiPuma," *Journal of Medical Philosophy* 40, no. 5 (Oct 2015): 529-53.

assisted suicide to relieve pain when other less controversial alternatives are available. Furthermore, a physician should not be required to participate in physician-assisted suicide if it violates the physician's conscience.²⁵⁷

d. Existential Considerations

The purpose of assisted death is to bring about the immediate death of the patient to relieve either physiological or existential suffering, and it has been argued that it is superior to CDS because it relieves existential suffering as well as physiological suffering. The purpose of continuous sedation is to lower consciousness to relieve a patient from refractory suffering. While it is generally accepted that the purpose of CDS is to relieve patients from physiological suffering that cannot be treated with pain medications, to the extent that a patient experiences existential suffering from the loss of autonomy or dignity, CDS will provide relief because the patient loses consciousness. A person must be conscious to experience existential suffering. However, the ethical use of CDS to relieve existential suffering alone is still being debated.

The driving argument behind the legalization of assisted death is that patients want to control end-of-life physiological pain *or* existential suffering. It has been argued that while a sedated patient loses control at the end of life, the patient who uses assisted death controls their death. In my many conversations with individuals about the subject of assisted death, an overwhelming number of people support it because of their desire to control their own end-of-life suffering. People are concerned about being a burden to others; particularly if they lose cognitive functions and linger on for many years. There is empirical evidence that the preference of assisted death over CDS primarily relates to patients who seek control at the end of life and obtain relief

²⁵⁷ Franklin G. Miller and Howard Brody, "Professional Integrity and Physician-Assisted Death," *Hastings Center Report* 25, No. 4 (May-June 1995): 8.

from existential suffering.²⁵⁸ Oregon data for the period 1998 to 2009 showed that 81.1% of assisted death patients suffered from cancer and the reasons for choosing physician-assisted suicide were mostly existential rather than physiological reasons. Similar data from the Netherlands demonstrated that most people who chose assisted death were seeking to relieve existential suffering. Choosing euthanasia for physiological pain was stated in only 36% of the cases.²⁵⁹ The majority of patients who chose CDS did so for relief from physiological suffering. Patients who chose assisted death did so to retain a sense of control and because of the loss in human dignity that was related to their disease. While the use of CDS was reported to be extremely rare, in the Netherlands and Belgium patients who received sedation tended to be older than patients who sought assisted death. A clear disadvantage of CDS compared to assisted death was that the patient lost control over the dying process.

Assisted death is unreported and a rare practice in U.S. where it is not legal. Its use has been reported in situations of extreme suffering when CDS is not an effective option. Timothy Quill described a patient who suffered from uncontrollable bleeding that was related to a tumor in his mouth.²⁶⁰ The patient's condition was imminently terminal and not treatable. The patient refused CDS for existential reasons. He was concerned about the trauma his family would experience if he were to suffocate from the uncontrolled bleeding. After consulting with the medical team, the physician provided the patient with a lethal dose of barbiturates that were ingested by the patient without the physician's presence. The family was present, and the physician was available by telephone, in the event problems were to occur. The patient died without

²⁵⁸ Raus, 35. The authors note that requests for CDS are rare.

²⁵⁹ Ibid.

²⁶⁰ Timothy E. Quill, Barbara Coombs Lee, and Sally Nunn, "Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative. University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel." *Annals of Internal Medicine* 132, no. 6 (March 21, 2000): 492. The name of the patient was not provided in the article.

complications and the physician's aid in the patient's death was not reported.²⁶¹ The situation described by Quill is controversial. Assisted death was used in response to both the physiological and existential suffering of the patient. While I do not know the exact circumstances of the situation, it seems to me that if CDS was used, the physician could have eliminated the possibility of the patient choking with the use of a suction mechanism, like the suction used by a dentist during dental surgery.

Arguments for assisted death over CDS are based on patient autonomy and beneficence in the form of relief from suffering. I would argue that a patient has no more autonomy with assisted death than CDS. In both cases the patient loses control over death. The primary difference is that with assisted death, death occurs immediately, and the cause of death can be directly attributed to the lethal dose. With CDS, death normally takes longer and is attributed to either the underlying disease or to dehydration.

XII. Conclusion

Voluntary death and assisted dying has been debated by philosophers, theologians, humanists, politicians and judicial authorities throughout the course of written history and there is far more evidence that opposes assisted death than support for it. This evidence is juxtaposed with the trend in secular society today toward the acceptance and legalization of assisted death. The secular support of assisted death runs parallel with the trend toward greater self-determination, a fear of end-of-life suffering and a growing level of passivism and general disregard for faith traditions. I believe that the subjects of physician-assisted suicide, euthanasia, aid in dying, or whatever terminology one chooses to use, present an opportunity for faith communities to confront our growingly secular society with humane alternatives that don't involve killing. Comprehensive

²⁶¹ Quill, "Palliative Treatments," 492.

palliative care treatments including continuous deep sedation are superior alternatives to assisted death. The primary argument supporting palliative alternatives is that the patient dies naturally; the physician does not directly cause the patient's death. I believe the ends of medicine are to heal, promote health, and when situations are futile, to help patients achieve a good death.²⁶² Edmund Pellegrino stated, "A good death does not...include killing the patient, nor can one be a good physician and do so."²⁶³ There is nothing "good" about suicide or euthanasia that cannot be achieved with palliative alternatives.

Secular society and the church are at odds about the morality and use of euthanasia. Secular society has increasingly claimed control of life and claims that denying a person access to euthanasia is a violation of a person's autonomous human dignity. The church claims that human dignity is endowed by God as we are created in God's image. The notion of autonomy is recognized by the Church in our human dignity. As autonomous Christian persons, we rely on our faith, informed by reason, to make moral decisions. Christians recognize that their autonomy is embedded in a community of faith, which is not the same as the autonomy of Western individualism. Life is sanctified by God and belongs to God; not to individual humans. To the Church, the voluntary ending of life is not a decision that can be made by humans; it is "a grave violation of the law of God ... and is murder."²⁶⁴

Public support for assisted death is strong and the legalization of the practice is likely to continue. Considering its probable continued use, I believe we need to be prepared to care for families, friends and communities who are associated with persons who utilize assisted death. I would like to use the quote of Pope Francis when he was asked about homosexuality, "who am I

²⁶² Miller and Brody, "Professional Integrity," 11.

²⁶³ Edmund D. Pellegrino "Doctors Must Not Kill," *The Journal of Clinical Ethics* 3, No. 2 (Summer 1992): 102.

²⁶⁴ John Paul II, *Evangelium Vitae* (Vatican City: Libreria Editrice Vaticana, 1995), 65.

to judge”²⁶⁵ in connection with assisted death. We need to be prepared to express love and compassion to those who grieve.

XIII. Personal Appropriation

The study of bioethics was described as a progression from “intellectual intuition to intellectual arguments. At the end of the journey, arguments back up intuition or prove it to be wrong.”²⁶⁶ My early intuition on the subject, which was neither informed and certainly not intellectual, was that physician-assisted suicide was an ethically justifiable practice on the basis that a person has an autonomous right to request a physician to relieve them from suffering at the end of their life. I now have a better understanding of palliative care and my hope is that all people can either be sufficiently or permanently sedated so that they do not suffer at the end of life and so that they do not need to involve another person in their death. And, while I am an Episcopalian, I have read the documents of the Roman Catholic Church on the subject. The *Declaration on Euthanasia* is beautifully and compassionately written. The post-Vatican II document *Gaudium et spes* has the most beautiful description of human dignity and it clearly condemns anything that violates life. John Paul II was very clear in *Evangelium Vitae* that euthanasia is a violation against God. These are important documents that should be considered by persons of all faith traditions. My opinion about the morality of physician-assisted suicide has changed from my early intuition that it should be a legal option to dying persons, to it should be a legal option in very limited circumstances, to the opinion that it should never be legalized based on the dignity of the human persons as created by God and good. Furthermore, the availability of effective palliative measures to ease end-of-life suffering alleviates the need for assisted death.

²⁶⁵ Joshua J. McElwee, “Francis Explains ‘Who am I to Judge?’,” *National Catholic Reporter*, January 10, 2016, accessed April 30, 2018, <https://www.ncronline.org/news/vatican/francis-explains-who-am-i-judge>.

²⁶⁶ Roberto Dell’Oro, “The Ethics of Death and Dying” (lecture, Loyola Marymount University, Los Angeles, CA, November 30, 2015).

XIV. Resources for the Dying

During the Middle Ages, a treatise called “*Ars Moriendi*” was written in response to the horrific suffering associated with the Black Plague when up to 50% of the European population died in the middle of the fourteenth century.²⁶⁷ Because of the devastation, there were insufficient clergy, people trained in medicine and family members to be at the side of people when they were dying. *Ars Moriendi* means the “art of dying” and was used to guide patients toward a “good death.” It seems that contemporary society needs a new *Ars Moriendi* to help people prepare for the end-of-life. Prior to advances in medicine, people generally died from infectious diseases that led to a comparatively quick death that lasted only a few weeks. We are now living to advanced ages and people generally die following chronic illnesses that linger for many months or even for many years. We are fortunate to live longer. The negative aspect of our living longer is that the end-of-life process of death has become prolonged and we are witnessing significant suffering.

A new *Ars Moriendi* or “Art of Dying” is critically needed to prepare people for death. Most people fear a prolonged, painful and burdensome death. Like the medieval treatise, a new *Ars Moriendi* could provide assurances to those who care for patients as well as to the patients themselves who face terminal illnesses

“The challenge for bioethics is to create a framework for teaching an aging population to prepare for death and to support one another through the dying process.”

Dr. Lydia Dugdale
“The Art of Dying Well”
Hastings Center Report 40
No. 6 (Nov-Dec 2010): 23

that the end-of-life process can be manageable and pain free. It could assure them that they are not likely to suffer intolerably at the end-of-life. The religious nature of the medieval treatise could be expanded to cover the plurality of belief systems in the world. A manual or web-based portal could

²⁶⁷ Will Dunham, “Black Death ‘Discriminated’ Between Victims,” ABC Science News, January 29, 2008, accessed February 20, 2018, <http://www.abc.net.au/science/articles/2008/01/29/2149185.htm>

provide details about the palliative care options and would expand the information provided in this paper. If a new *Ars Moriendi* were readily available and written in terms that could be comprehended by people with various levels of education, I believe that the existential suffering of patients facing terminal illness could be minimized as they learn that morally and ethically defensible methods of relief from physiological suffering are readily available. Furthermore, a spiritual/philosophical section of a new *Ars Moriendi* may provide comfort to patients who fear being a burden to others at the end of life. I believe that the broad public support of physician-assisted suicide and voluntary active euthanasia would diminish if people understood the options available to relieve suffering at the end of life.

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