



Assisted Suicide & Euthanasia | *White Paper* **WorldYouthAlliance**

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I. Introduction

Increased life expectancy and ageing populations have made end-of-life care a pressing need, particularly in developed countries, where these trends are strongest. Medical advancements now cure once untreatable diseases, and can prolong life much longer than before for those with illnesses that remain incurable. Yet these advances cannot prevent ageing itself, or the limitations it causes, such as decreased mobility, loss of sight and hearing, dementia, or pain. The best way to support patients approaching the end of their lives is now a matter of intense debate.

The “right to die” movement claims that the answer is to allow medical professionals to hasten death, directly through euthanasia, or indirectly, through physician assisted suicide (PAS). It asserts that there is a right to choose the manner of one’s death, even as part of the right to life, and as a human right. This, proponents insist, is necessary for “death with dignity.” Although many countries still ban the practices, there has been a significant increase in the number of jurisdictions allowing the practices in recent years.

This white paper will critically examine the “right to die” and what is required to respect the dignity of each person in end-of-life care in light of law, policy, and practice, with a special concern for the protection of the vulnerable. First, it will discuss assisted suicide and euthanasia within international human rights law, and then provide an overview of existing national and subnational laws permitting the practice. Next it will discuss the primary arguments for assisted suicide, namely autonomy and suffering, and how those arguments fall short, before moving on to concerns about disability prejudice, the risk of coercion, and the effects of the practice on the medical profession. Finally, the paper will discuss how best to care for those approaching the end of their lives in a way that respects their dignity: improved physician-patient relationships in the end-of-life care context, palliative care, and psychosocial support.

Definitions

For the purposes of this paper, euthanasia is the “intentional killing by act or omission of a dependent human being for his or her alleged benefit.”¹ Physician assisted suicide (PAS) means “physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).”² PAS differs from euthanasia in that the patient is the one administering the drug to him or herself, while in euthanasia a different person (usually a doctor) is the one who administers the lethal drug.

Euthanasia, by act or omission, as well as PAS, share the common intent “to cause or hasten the patient’s death.”³ The intent also distinguishes euthanasia and PAS from stopping what is sometimes characterized as “overly aggressive therapy[, which is the] exaggeratedly stubborn struggle against inevitable death.”⁴ Sometimes prolonging treatment is disproportionately burdensome on the patient, with no prospect of improvement. Such futile

¹ EUR. PARL. ASS. RES. 1859, ¶ 5, Council of Europe (Jan. 25, 2012).

² Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 ANNALS INTERNAL MED. 576, 578 (2017).

³ GIACOMO PERICO, PROBLEMI DI ETICA SANITARIA 138 (1992).

⁴ ETIENNE MONTERO, EUROPEAN INSTITUTE OF BIOETHICS, ETHICAL POINTS OF REFERENCE IN CARING FOR PEOPLE NEARING THE END OF LIFE 2 (2010) available at <https://www.ieb-eib.org/fr/document/ethical-points-in-caring-for-people-nearing-end-of-life-260.html>.

treatment can be withdrawn at the request of a patient. There is a long-standing medical and legal tradition supporting the rights of patients to refuse unwanted treatment, even though this refusal may hasten death,⁵ accepting “death as a natural consequence of the underlying disease progression.”⁶

On other occasions, the doctor can administer pain killers with the primary intent to alleviate the patient’s pain, even though death can occur as an unintended consequence. In both cases, there is no primary intention to hasten the patient’s death and in both cases the physician’s action is not the cause of death. Therefore, these actions should be clearly distinguished from euthanasia by omission as defined above.

Finally, in some cases of severe suffering, the person can be sedated to alleviate pain. In this case, “a physician uses sedatives to reduce or take away the consciousness of a patient until death follows.”⁷ The intent behind the action also plays the crucial role. If the primary goal is to alleviate pain, while accepting death as a possible consequence, and the act is termed “palliative sedation.”

This paper does not offer a rule on which interventions constitute overly aggressive or futile therapy, as the advancement of medical technology, the nature and progression of the condition, how the intervention works, and other factors all influence perceptions of them.⁸ Rather, it encourages early communication and thoughtful decision-making that respects the dignity of the person and human life as a fundamental good.

II. Assisted Suicide and Euthanasia in Law

A. International law

Much of the discussion surrounding assisted suicide and euthanasia is framed in the context of rights, such as a right to die, and in attempting to frame euthanasia as a human right. Meanwhile, those countries which permit assisted suicide or euthanasia have received criticism from international bodies because of the potential abuse of human rights. This conflict of views invites closer examination of human rights law and its views on the topic.

International human rights are created by treaty and by custom.⁹ Treaties are binding agreements between States.¹⁰ The United Nations’ explicit commitment to human rights and the recent memory of large-scale violations of these rights led to the drafting and adoption of numerous human rights treaties in the first few decades of the UN’s existence, and several more in ensuing years. States parties to the treaties participate by submitting reports to treaty

⁵ See *Cruzan v Director, Mo. Dep’t of Health*, 497 US 261, 305-06 (1990) (Brennan, J., concurring); *Washington v. Glucksberg*, 521 U.S. 706, 726 (1997).

⁶ Liliana De Lima et al., *International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide*, 20 J. PALLIATIVE MED. 8, 14 (2017).

⁷ Kasper Raus et al., *Is Continuous Sedation at the End of Life an Ethically Preferable Alternative to Physician-Assisted Suicide?*, 11 AM. J. BIOETHICS 32, 32 (2011).

⁸ Distinctions between “medical” and “nonmedical” interventions, or “ordinary” and “extraordinary” means of care are often not clean cut or universally agreed on. See NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 209 (2006).

⁹ DAVID J. BEDERMAN, *THE SPIRIT OF INTERNATIONAL LAW* 33 (2006); Statute of the International Court of Justice art. 38(1), June 26, 1945, 33 U.N.T.S. 993.

¹⁰ Vienna Convention on the Law of Treaties arts. 2(1)(a), 11, *opened for signature* May 23, 1969, 1155 U.N.T.S. 331, 333.

monitoring bodies who offer non-binding¹¹ recommendations to assist them in meeting their treaty obligations.¹²

The right to life is recognized in several human rights treaties.¹³ Under treaty law, the terms are understood according to their ordinary meaning in light of the context and purpose of the treaty, and parties may only invoke supplementary materials in cases of ambiguity.¹⁴ No human rights treaty includes a provision creating a “right to die” or a “right to assistance in dying.” Article 6 of the International Covenant on Civil and Political Rights (ICCPR) expressly protects the right to life, but does not mention a right to die,¹⁵ and no similar right to die or control the manner of one’s death is expressly listed in any treaty.¹⁶

The United Nations Human Rights Committee has expressed concern at the ease of access to and increasing requests for assisted suicide, particularly in light of the right to life.¹⁷ The Committee on the Rights of the Child has similarly encouraged the Netherlands, a country where child euthanasia is legal, to strictly monitor its practice and consider prohibiting it.¹⁸ Moreover, the Committee on the Rights of Persons with Disabilities began an inquiry in May 2019 upon application from the parents and siblings of a quadriplegic French man whose food and water were removed at the request of his wife in line with France’s passive euthanasia law.¹⁹

However, some have interpreted a right to life broadly, to include a right to control the end of life, specifically through assisted suicide and/or euthanasia. In October 2018, the U.N.

¹¹ TMBs have only limited authority granted by the treaties which create them, which does not include the authority to create rights. *See, e.g.*, International Covenant on Civil and Political Rights art. 40-42, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; International Covenant on the Elimination of All Forms of Racial Discrimination part II, art. 8-9, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195; Convention on the Elimination of All Forms of Discrimination against Women arts. 17-22, *opened for signature* Mar 1, 1980, 1249 U.N.T.S. 13; Convention on the Rights of the Child arts. 42-45, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC]; Convention on the Rights of Persons with Disabilities art. 34, *opened for signature* Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD].

¹² Office of the High Comm’r for Hum. Rts., The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies 21, www.ohchr.org/Documents/Publications/FactSheet30Rev1.pdf (last visited Sept. 25, 2018).

¹³ *See, e.g.*, ICCPR, *supra* note 11, art. 6; CRC, *supra* note 11, art. 6; CRPD, *supra* note 11, art. 10.

¹⁴ Vienna Convention on the Law of Treaties, *supra* note 10, arts. 31-32.

¹⁵ ICCPR, *supra* note 11, art. 6.

¹⁶ *See id.*; CRC, *supra* note 11, art. 6; CRPD, *supra* note 11, art. 10.

¹⁷ U.N. Human Rights Committee, Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, Concluding observations of the Human Rights Committee—NETHERLANDS ¶ 7, U.N. Doc. CCPR/C/NLD/CO/4 (Aug. 25, 2009)

¹⁸ U.N. Comm. on the Rts. of the Child, *Concluding observations on the fourth periodic report of the Netherlands* ¶¶ 28-29, U.N. Doc. CRC/C/NLD/CO/4 (July 16, 2015). This is especially troubling in light of statements by a Dutch teenaged survivor of sexual assault that her country had no specialized mental health facilities for teenagers; she requested euthanasia but was refused and later died by refusing to eat or drink. Jon Henley, *Dutch girl was not ‘legally euthanized’ and died at home*, THE GUARDIAN (June 5, 2019), <https://www.theguardian.com/world/2019/jun/05/noa-pothoven-netherlands-girl-not-legally-euthanised-died-at-home>. Although authorities refused euthanasia in this case, at least one Dutch woman in her 20s was allowed euthanasia on the basis of mental illness following childhood sexual abuse. Diana Tourjée, *Sexual Abuse Victim in Her 20s Allowed Suicide by Doctors in Netherlands*, VICE (May 11, 2016), https://www.vice.com/en_us/article/mgm8b3/sexual-abuse-victim-in-her-20s-allowed-suicide-by-doctors-in-netherlands.

¹⁹ *UN body weighs in on French right-to-die case*, THELOCAL.FR (May 5, 2019), <https://www.thelocal.fr/20190505/un-body-weighs-in-on-french-right-to-die-case>. Vincent Lambert, the patient, was not dying, and food and water constitute essentials needed for life, unlike higher level interventions that maintain organ function, for example, without which the patient would die. Lambert died after several days without nutrition.

Human Rights Committee adopted a General Comment which suggested that, while suicide generally should be prevented, assisted suicide for those with serious illness does not violate the international right to life, but requires safeguards and regulation to prevent coercion.²⁰ Although this comment is not binding, as it comes from a treaty monitoring body, it is influential as a statement of the committee's interpretation of the right to life. As the committee has now accepted that a right to die may be part of the right to life, it is unlikely to examine whether assisted suicide poses unique risks or problems, regardless of the concerns raised by various international and national bodies. These concerns include the state's interest in protecting life, preventing abuse and coercion, particularly of the vulnerable, and maintaining the integrity of the medical profession. These interests were cited in several of the court cases discussed below, and are also addressed in subsequent sections.

The issues of assisted suicide and euthanasia have come before the European Court of Human Rights several times. The court has generally refused to overrule practices in Member States related to the end of life, leaving matters, including bans on assisted suicide and withdrawal of sustenance, to national legislatures and procedures. The case of *Pretty v. United Kingdom* involves the fullest examination to date of whether a right to die exists under European human rights law.

In that case, a British woman with motor neuron disease challenged the United Kingdom's prohibition on assisted suicide, arguing that it violated her rights under the European Convention of Human Rights (ECHR).²¹ If her disease had not physically prevented her, she could have ended her life herself, but because of her inability to do so, she challenged the criminal provisions which prevented her husband from ending her life for her.²² Pretty argued that the ECHR article 2 right to life included "a right to choose whether or not to go on living... not life itself."²³ The court flatly rejected the idea that there is a negative right (to die) implied in article 2.²⁴

The court also rejected the assertion that failure to allow her aid in ending her life constituted torture, inhuman, or degrading treatment under ECHR article 3, which has been

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understood to ban direct ill-treatment by authorities.²⁵ While acknowledging that quality of life and end of life concerns, including choosing the manner of one's death, could fall within the right to private and family life under ECHR article 8,²⁶ the court ultimately held that the UK government was within its authority to ban assisted suicide based on its interest in protecting the vulnerable and that therefore the

²⁰ Human Rights Committee General comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life, U.N. DOC. CCPR/C/GC/36 (Oct. 30, 2018). The comment mentions terminally ill patients as an example of "afflicted adults." *Id.* It does not suggest that the practice should be provided to children.

²¹ *Pretty v. United Kingdom*, No. 2346/02 §§ 7, 32, Eur. Ct. H.R., Apr. 29, 2000.

²² *Id.* §§ 8-10.

²³ *Id.* § 35.

²⁴ *Id.* §§ 39-40.

²⁵ *Id.* §§ 52-53.

²⁶ *Id.* §§ 65, 67.

interference was justified.²⁷ The court also rejected the idea that a belief in assisted suicide for herself constituted a belief within the scope of the ECHR article 9 protections for freedom of religion or belief.²⁸ Finally, the court was not persuaded that Pretty's inability to end her own life meant that a difference in legal treatment of suicide (not a crime under UK law) and assisted suicide (a crime) constituted unlawful or even avoidable discrimination, or that the aim of the ban (protecting the vulnerable) could be preserved while carving out an exception for cases like hers.²⁹

The European Court of Human Rights has had several rulings since then. Despite its previous caution, in *Haas v. Switzerland*, the court suggested that its *Pretty* decision *had* found that the right to respect for private life does include the choice to avoid an undignified death, as long as the person ending their life was of sound mind.³⁰ Even so, the court upheld a law requiring a prescription for a lethal dose of medication, recognizing the state's interest in protecting life and preventing abuse.³¹ In a subsequent case, *Koch v. Germany*, a man brought a case because his wife was denied access to a lethal dose of narcotics to end her life where they lived in Germany.³² His wife, who was paralyzed, eventually endured a challenging transport to Switzerland, where she ended her life with the assistance of the pro-assisted suicide organization Dignitas.³³ Despite its earlier statement in *Haas*, in *Koch* the court recognized a wide "margin of appreciation" in the application of Article 8 rights with respect to assisted suicide, noting that only four member states allowed the practice and it did not enjoy consensus among states parties to the treaty.³⁴ It required Germany to thoroughly examine the claim domestically,³⁵ but not necessarily to permit the requested action.

Gross v. Switzerland, in which a plaintiff sued the state for not being prescribed a lethal medication, led to a further development of this principle, when the court held that a lack of clear guidelines regarding the provision of lethal prescriptions for those without terminal diseases did violate her Article 8 right to respect for private and family life.³⁶ However, the judgment was rendered by a divided court (four judges in favor, three against), and included a strong dissent from the interpretation of Article 8.³⁷ The decision was voided when it emerged that the plaintiff had committed suicide by lethal prescription a year and a half before the original decision was handed down and concealed her death with the help of a spiritual advisor in order for her case to continue.³⁸

These cases do not produce a firm rule so much as the application of principles of law to particular legal frameworks. While the European Court of Human Rights has not expressly held that allowing assisted suicide violates rights under the European Convention on Human Rights, it

²⁷ *Id.* §§ 74, 78.

²⁸ *Id.* §§ 82-83.

²⁹ *Id.* § 88.

³⁰ *Haas v. Switzerland*, No. 31322/07, §§ 50-51, Eur. Ct. H.R., Jan. 6, 2011.

³¹ *Id.* §§ 56-58.

³² *Koch v. Germany*, No. 497/09 §§ 9, 11, Eur. Ct. H.R., Dec. 12, 2012.

³³ *Id.* § 12.

³⁴ *Id.* §§ 69-70.

³⁵ *Id.* § 71.

³⁶ *Gross v. Switzerland*, No. 67810/10 §§ 67-69, Eur. Ct. H.R., May 14, 2013 (2d Section), *voided by* *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

³⁷ *See* *Gross v. Switzerland*, No. 67810/10 Dissent §§ 6-9, Eur. Ct. H.R., May 14, 2013 (2d Section) (JJ. Raimondi, Jočiene, and Karakaş, dissenting), *voided by* *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

³⁸ *Gross v. Switzerland*, No. 67810/10 §§ 29-34, 37, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

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has found state interests in the protection of life and prevention of abuse to be compelling reasons justifying bans on the practice. In the Swiss cases, given the legality of assisted suicide, it has both upheld restrictions on lethal medications and, in the voided decision, suggested that legal requirements have to be clear so that those seeking assistance to end their lives understand the requirements to do so.

This disparate treatment suggests that the court

is applying the provisions and principles of the Convention in line with the nature and purposes of the laws of each country, rather than assessing whether European human rights law requires or bans assisted suicide, limiting itself in recognition of the margin of appreciation on areas of law lacking consensus.

Just as international law does not require assisted suicide, there is also no customary law giving the right to die or end one's life as one likes. Customary international law arises from the practices of states acting out of a sense of legal obligation (*opinio juris*).³⁹ There are two key elements of customary law. The first involves questions such as whether the rule has been followed, and how consistent and how long the practice has been in place.⁴⁰ The second element requires an assessment of whether a practice has been accepted as law—indicating that states believe it is an obligation, rather than simply a beneficial option.⁴¹ It is the harder element to establish of the two. As the vast majority of countries do not allow the practice, general practice does not exist. This also implies that states do not believe that they have an obligation to permit it. Moreover, in the *Pretty* case discussed above, the European Court of Human Rights rejected the argument that its acceptance of assisted suicide in one country meant that laws banning the practice in another country had to be overturned.⁴²

B. National and subnational laws permitting euthanasia and/or assisted suicide

Switzerland decriminalized the practice of assisted suicide when done without “selfish motives” in 1918,⁴³ although it failed to create a clear legislative framework around the practice.⁴⁴ In 2001, the Netherlands became the first country to adopt national legislation legalizing assisted suicide and euthanasia, after tolerating the practice for some years.⁴⁵ In 1997, Colombia decriminalized both PAS and euthanasia by Constitutional Court decision, although

³⁹ BEDERMAN, *supra* note 9, at 33.

⁴⁰ *Id.*

⁴¹ *Id.* at 33, 36.

⁴² *Pretty*, No. 2346/02 § 41.

⁴³ Saima A. Hurst & Alex Mauron, *Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians*, 326 *BMJ* 271, 271 (2003). As the title suggests, although doctors may participate, such as through lethal medications, people without medical training can also help others' suicide, and organizations exist for this purpose. See, e.g., *Exit at a Glance*, EXIT, available at <https://exit.ch/en/who-is-exit/>.

⁴⁴ See *Gross*, No. 67810/10 §§ 67-69, Eur. Ct. H.R., May 14, 2013 (2d Section), voided by *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

⁴⁵ Jacqui Wise, *Netherlands, first country to legalise euthanasia*, 79 *BULL. WORLD HEALTH ORG.* 580, 580 (2001).

the government failed to provide regulations for some time.⁴⁶ The U.S. state of Oregon began allowing PAS for adults in 1997,⁴⁷ following a U.S. Supreme Court decision which found no right to assisted suicide, but did not prohibit the states from allowing the practice.⁴⁸

Since then, both assisted suicide and euthanasia have been implemented in more jurisdictions, and some have expanded it by law or in practice beyond terminally ill, mentally competent adults. The Dutch legislation had required that the predicate medical condition have no chance of improvement, but not that it be terminal, and allows it for children without parental approval, including those as young as twelve, if they are considered to understand the nature of the action.⁴⁹ In fact, even infants can be euthanized under the Groningen Protocol with parental request.⁵⁰ Moreover, at least one young Dutch woman's euthanasia request was granted on the basis of mental illness following childhood sexual abuse.⁵¹ Belgium legalized euthanasia for those with incurable conditions in 2002,⁵² and in 2014 extended it to minors of any age following a psychological assessment that they understand the nature of their request and if they experience incurable physical pain.⁵³

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⁴⁶ Corte Constitucional [C.C.], mayo 20, 1997, Sentencia C-239/97, §§ II(C)(3), III available at <http://www.corteconstitucional.gov.co/relatoria/1997/c%2D239%2D97.htm>.

⁴⁷ William Claiborne, *'Death With Dignity' Measure May Make Oregon National Battlefield*, Washington Post, June 27, 1997, at A19. Oregon's legislature passed a bill in 2019 amending its act to facilitate assisted suicide through means besides swallowing, which some argue blurs the line between assisted suicide and euthanasia as it could require more active involvement from a second person to administer the lethal medication. Markian Hawryluk, *Bill reopens debate over assisted suicide in Oregon*, BEND BULLETIN (Apr. 27, 2019), <https://www.bendbulletin.com/localstate/7117862-151/bill-reopens-debate-over-assisted-suicide-in-oregon>. As of writing, the Oregon legislature has considered expanding the means of assisted suicide to include injections for patients unable to swallow, which some consider a gradual inching towards euthanasia as it requires greater participation from medical professionals to set up the lethal dose. Kristian Foden-Vencil, *Oregon Considers Expanding Its Death With Dignity Law*, OR. PUB. BROADCASTING (May 10, 2019), <https://www.opb.org/news/article/oregon-assisted-suicide-death-with-dignity-expansion-bill/>.

⁴⁸ Glucksberg, 521 U.S. at 735.

⁴⁹ Wet van 12 april 2001 toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Law of 12 April 2001 on termination of life on request and assisted suicide], Stb. 2001 p. 194 (Neth).

⁵⁰ Matthew Schofield, *Newborns at the heart of Dutch euthanasia debate*, EDMONTON J., Oct. 20, 2004 at A15; Eduard Verhagen & Pieter J.J. Sauer, *The Groningen Protocol—Euthanasia in Severely Ill Newborns*, 352 NEW ENG. J. MED. 959, 961 Table 2 (2005).

⁵¹ See Tourjée, *supra* note 18.

⁵² Loi du 28 mai 2002 relative à l'euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002.

⁵³ Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, en vue d'étendre l'euthanasie aux mineurs [Law amending the law of 28 May 2002 on euthanasia, with a view to extending euthanasia to minors] of Feb. 28, 2014, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], Mar. 12, 2014. The amended law requires a child psychiatrist or psychologist to assess whether the child understands the nature of his or her illness and request; it does not include an age limit. [Law of 28 May 2002 on euthanasia] § 3.

Luxembourg passed a law allowing assisted suicide and euthanasia for terminally ill adults in 2009.⁵⁴

The U.S. states of Washington (2009), Vermont (2013), California (2016), Colorado (2016), Hawaii (2019), New Jersey (2019), and Maine (2019), and the District of Columbia (2017) have legalized assisted suicide for adults with incurable conditions, and Montana's state supreme court decriminalized assisting suicide in 2009, although its legislature has not passed implementing legislation.⁵⁵ Colombia's Constitutional Court definitely established a constitutional right to "death with dignity" in 2014⁵⁶ and extended this to minors, potentially as young as six, in 2017.⁵⁷

Canada's Supreme Court also found a right to assisted suicide within its Charter of Rights and Freedoms in 2015,⁵⁸ and the government adopted a law allowing assisted suicide and euthanasia for suffering adults whose deaths are reasonably foreseeable.⁵⁹ The law also requiring the government to investigate the possibility of providing assisted suicide to "mature minors" and those suffering from mental illness.⁶⁰ Australia does not have national assisted suicide legislation, but the parliament of the state of Victoria passed "voluntary assistance in dying" legislation in 2017,⁶¹ with the law taking effect in 2019.⁶²

⁵⁴ Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide], Memorial A No. 46 Journal Officiel du Grand-Duché de Luxembourg 615 [Official Gazette of Luxembourg] available at <http://legilux.public.lu/eli/etat/leg/memorial/2009/46>.

⁵⁵ Catharine Paddock, *Washington State Legalizes Assisted Suicide*, MED. NEWS TODAY (Mar. 6, 2009), <https://www.medicalnewstoday.com/articles/141318.php>; Terri Hallenbeck, *Vermont governor signs end-of-life bill*, USA TODAY (May 20, 2013), <https://www.usatoday.com/story/news/politics/2013/05/20/vermont-physician-assisted-death-bill/2343481/>; Brakkton Booker, *California Governor Signs Physician-Assisted Suicide Bill Into Law*, NPR (Oct. 5, 2015), <https://www.npr.org/sections/thetwo-way/2015/10/05/446115171/california-governor-signs-physician-assisted-suicide-bill-into-law>; Jennifer Brown, *Colorado passes medical aid in dying, joining five other states*, DENVER POST (Nov. 8, 2016), <https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/>; Wayne Yoshioka, *"Death with Dignity" Signed Into Law*, HAWAII PUB. RADIO (April 5, 2018), <http://www.hawaiipublicradio.org/post/death-dignity-signed-law>; Nicholas Pugliese, *NJ legalizes assisted suicide as Gov. Phil Murphy signs contentious bill into law*, NorthJersey.com (Apr. 12, 2019), <https://www.northjersey.com/story/news/new-jersey/2019/04/12/nj-legalizes-assisted-suicide-murphy-signs-contentious-bill-into-law/3446698002/>; Marina Villeneuve, *Maine becomes 8th state to legalize assisted suicide*, AP (June 12, 2019), <https://www.apnews.com/7f0fe9d789294a02852c1669c892f382>; *Baxter v. State*, 2009 MT 449, ¶¶ 5-6, 354 Mont. 234, 224 P.3d 1211; Fenit Nirappil, *A year after D.C. passed its controversial assisted suicide law, not a single patient has used it*, The Washington Post (Apr. 10, 2018), https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html?utm_term=.2de5d8f8d809; Mike Dennison, *House passes bill to outlaw physician-assisted suicide in Montana*, MISSOULIAN (Mar. 16, 2015), https://missoulian.com/news/state-and-regional/montana-legislature/house-passes-bill-to-outlaw-physician-assisted-suicide-in-montana/article_c6facb27-78c0-59be-a5fa-a8686ac7964f.html; *Montana Lawmakers Reject Criminalizing Physician-Assisted Suicide*, MTPR NEWS (Mar. 1, 2017), <http://www.mtpr.org/post/montana-lawmakers-reject-criminalizing-physician-assisted-suicide>.

⁵⁶ Corte Constitucional [C.C.], diciembre 15, 2014, Sentencia T-1970/14, § II(5), available at <http://www.corteconstitucional.gov.co/relatoria/2014/t%2D970%2D14.htm>.

⁵⁷ Ministerio de Salud y Protección Social, Res. No. 0825 de 2018, arts. 2(2.4)-(2.6), 3 paragrafo, 10.

⁵⁸ *Carter v. Canada* (Attorney General), [2015] S.C.R. 331, 335-36 (Can.).

⁵⁹ An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016, c. 3 §§ 2(227), 3(241.1), 3(241.2)(1)-(2) (Can.).

⁶⁰ *Id.* § 8(9.1).

⁶¹ *Voluntary Assisted Dying Act 2017*, no. 61 of 2017 (Austl., Vic.)

⁶² Jean Edwards, *Euthanasia: Victoria becomes the first Australian state to legalise voluntary assisted dying*, ABC NEWS (Nov. 29, 2017, 4:19AM), available at <https://www.abc.net.au/news/2017-11-29/euthanasia-passes-parliament-in-victoria/9205472>.

The modern euthanasia movement often utilizes “rights” argumentation, asserting that there should be a “right to die” or a “right to die with dignity” recognized by international law. According to some authors, this right stems from the right of the human person to choose what he or she considers to be a good life, and consequently also what constitutes a good death. The advocates argue that the respect for individual autonomy also implies the right to choose how one wants to die.⁶³ Besides respect for the autonomy of dying patients, advocates for the legalization of euthanasia and assisted suicide usually present them as acts of compassion for persons who are suffering and nearing death. As many countries and regions have campaigns promoting the adoption or judicial imposition of assisted suicide,⁶⁴ claims that it is a right and various arguments used to support it warrant further attention. A discussion of those issues, as well as risks inherent in the practices and dignity-centered solutions to end-of-life care, follows.

III. “Death with Dignity”: Common rationales for permitting assisted suicide and euthanasia

Within human rights law, “dignity” has a precise meaning: the value an individual human being has simply by virtue of being human.⁶⁵ This value is intrinsic, inherent, and universal;⁶⁶ it does not decrease or increase in proportion to any personal characteristic, experience, or action. That includes manners of dying: no one loses his dignity because he has become reliant on others

No one loses his dignity because he has become reliant on others for care, or experiences suffering. To suggest otherwise suggests that human life does not have objective value, which would undermine not only laws banning assisted suicide, but the foundation of human rights itself.

for care, or experiences suffering. To suggest otherwise suggests that human life does not have objective value, which would undermine not only laws banning assisted suicide, but the foundation of human rights itself.

“Death with dignity” and its variations are popular slogans among PAS advocates, even though the terms are inherently vague.⁶⁷ This phrase pits autonomy against an unknown hour and manner of death, and suggest that the suffering and pain experienced by many at

the end of life is undignified and therefore should be avoided. Numerous PAS advocacy organizations have framed this as a “right to die with dignity,” suggesting a legal obligation despite most courts finding that no right to die, in any manner, exists.⁶⁸

⁶³ GORSUCH, *supra* note 8, at 99.

⁶⁴ See, e.g., Sibilla Bondolfi, *Death by Choice: The global fight for assisted suicide*, SWI SWISSINFO.CH (Nov. 14, 2018), https://www.swissinfo.ch/eng/business/death-by-choice_the-global-fight-for-assisted-suicide/44543634; *Noticias Internacional*, DERECHO A MORIR DIGNAMENTE, <https://derechoamorir.org/category/noticias-internacional/>; *Take Action*, COMPASSION & CHOICES, <https://compassionandchoices.org/take-action>.

⁶⁵ See Universal Declaration of Human Rights, G.A. Res. 217A, Preamble, art. 1, U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (Dec. 12, 1948).

⁶⁶ *Id.* at Preamble (“Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family...”).

⁶⁷ KEVIN YUILL, ASSISTED SUICIDE: THE LIBERAL, HUMANIST CASE AGAINST LEGALIZATION 13-15 (2015).

⁶⁸ GORSUCH, *supra* note 8, at 45 (2006).

This concept is inherently problematic, regardless of whether euthanasia is included in the concept of “dying with dignity” or not. It suggests that there could equally be a situation in which a person could die “without dignity”. One scholar summarizes it thus: “Death with dignity, either alone or with others, is certainly preferable to death without dignity, whether it be lingering or rather sudden.”⁶⁹ This view is radically mistaken, because a human person is never “without” his or her dignity. This confusion in semantics suggests that the elderly, suffering, disabled or terminally ill may be deprived of their dignity, which undermines the fundamental equality of all persons. No matter how difficult the end of life may be, no manner of death can be without dignity because no person is ever without dignity. That dignity must be respected throughout life, including in the provision of care for the dying.

Equally wrong are the terms of “dignified death” and “dignity of death.” Death is the moment in which human life ends. Death itself, considered biologically, is “the degradation of the biological dimension of the human being, nothing dignified.”⁷⁰ In all the other aspects (psychological, emotional, social and mental) death also indicates the disintegration of the human being. Since life is a fundamental value for a person (there can be no non-living person; a dead body is a corpse and not a dead person) and death signifies the moment in which this fundamental value ceases to exist, there is nothing of dignity in the death *per se*.

Thus, concepts of “dignified death” and the “dignity of death” should be abandoned. Rather, the focus should be on respect for dignity in end-of-life care. The process of dying can be more or less in accordance with human dignity, and thus can be more or less respectful of human dignity. Society should aim for end-of-life care which respects human dignity for those who are dying, so that this care is understood as a process of dying in accordance with human dignity—a process of dying worthy of the human person.

“Death with dignity” arguments typically present as arguments related to choosing the manner of one’s own death (autonomy) and avoiding suffering. Deeper examinations of each aspect of arguments for “death with dignity” follow.

A. Autonomy

One of the most common arguments in favor of legalizing euthanasia and assisted suicide is the argument from autonomy and self-determination. According to this argument, the mentally competent and terminally ill adults should have the right to decide how and when to end their lives. This argument suggests that the State should protect that right by not interfering with and prohibiting others from interfering with one’s autonomous decision.

However, what the argument essentially misses is that legalizing euthanasia and assisted suicide is not a solitary action, but one that requires a doctor’s participation in the suicide *and* social acceptance of the act. “Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable.”⁷¹ Self-determination in the case of euthanasia can only be achieved “by the moral and physical assistance of another. Euthanasia is thus no longer a matter only of self-determination, but of a mutual, social decision between two people.”⁷²

⁶⁹ Jordan J. Paust, *The Human Right to Die With Dignity: A Policy-Oriented Essay*, 17 HUM. RTS. Q. 463 (1995).

⁷⁰ Valentin Pozaić, *Palliative care and the human dignity of patients*, 5 GLAS. PUL. BOLN. 153, 154 (2009).

⁷¹ Daniel Callahan, *When Self-Determination Runs Amok*, 22 THE HASTINGS CENTER REP. 52, 53 (1992).

⁷² *Id.* at 52.

The autonomy argument is clearly expressed in the decision of the United States Supreme Court in *Planned Parenthood v. Casey*: “At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.”⁷³ Applying this principle in *Compassion in Dying v. Washington*, the federal district court for the state of Washington reasoned that “the decision of a terminally ill person to end his or her life involves the most intimate and personal choices a person may make in a lifetime and constitutes a choice central to personal dignity and autonomy.”⁷⁴

Individual autonomy, however important it may be, is always limited by the protection of the fundamental goods of society. One such good is the life of a human being, which should be always protected; therefore, the intentional taking of the life of another should be always prohibited. The principle of the inviolability of life is a fundamental principle of common law,⁷⁵ and this principle has been enshrined in numerous human rights conventions.⁷⁶ It is grounded in an “understanding of each human being as having an intrinsic and inviolable dignity. The essence of the principle is the prohibition on the intentional taking of human life, intention used in its ordinary sense of aim or purpose.”⁷⁷ The Canadian House of Lords Select Committee on Medical Ethics described the prohibition on intentional killing as “the cornerstone of law and of social relationships” which “protects each one of us impartially, embodying the belief that all are equal.”⁷⁸ As numerous court decisions indicate, the State has a legitimate interest in preserving life.⁷⁹

England’s Court of Appeal has observed that some cases present an apparent conflict between the patient’s interest in “self-determination” and society’s interest in “upholding the concept that all human life is sacred.”⁸⁰ While acknowledging that the right of self-determination is of “paramount” importance, the court held that in cases where doubt exists about whether the individual is actually exercising that right, “that doubt fails to be resolved in favour of the preservation of life for if the individual is to override the public interest, [she] must do so in clear terms.”⁸¹ Similarly, the European Court of Human Rights stressed that “the concept that ‘everyone’s life shall be protected by law’ enjoins the state not only to refrain from taking life ‘intentionally’ but, further, to take appropriate steps to safeguard life.”⁸² In the Case *Pretty v. United Kingdom*, the court underlined that it has always placed “consistent emphasis . . . [on] the obligation of the State to protect life.”⁸³

Moreover, the patient’s autonomy, which proponents of the legalization of euthanasia and PAS claim these practices protect, is in fact illusory, because the final decision rests in the hands of the doctor, not the patient. “The physician decides when the patient is suffering intolerably

⁷³ *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)

⁷⁴ *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459-60 (Wash. 1994).

⁷⁵ John Keown, *A Right to Voluntary Euthanasia? Confusion in Canada in Carter*, 28 NOTRE DAME J.L. ETHICS & PUB. POL’Y 1, 5 (2014) [hereinafter Keown, *Voluntary Euthanasia*]

⁷⁶ See ICCPR, *supra* note 11, art. 6; European Convention on Human Rights art. 2, *opened for signature* Nov. 4, 1950, E.T.S. No. 5, 213 U.N.T.S. 221; American Convention on Human Rights art. 4, Nov. 21, 1969, 1144 U.N.T.S. 143; African Charter on Human and Peoples’ Rights art. 4, *opened for signature* June 27, 1981, 1520 U.N.T.S. 217.

⁷⁷ Keown, *Voluntary Euthanasia*, *supra* note 75, at 5.

⁷⁸ *Id.* at 6.

⁷⁹ GORSUCH, *supra* note 8, at 10.

⁸⁰ *Id.* at 187.

⁸¹ *Id.*

⁸² *L.C.B. v. United Kingdom*, App. No. 23413/94 § 36, Eur. Ct. H.R., June 9, 1998; *see generally* Ass’n of Parents v. United Kingdom, No. 7154/75, Eur. Ct. H.R., July 12, 1978.

⁸³ *Pretty*, No. 2346/02 § 39.

enough to use the last resort. The physician controls the availability of the medication and its dose. The physician makes a judgment about the quality of the patient's life and suffering and what is good for the patient."⁸⁴ Thus, as some authors have argued, making physicians the arbiters of assisted suicide and euthanasia is a return to one of the most severe forms of paternalism, not a victory for patient autonomy.⁸⁵ Therefore, the justification of voluntary euthanasia rests

Making physicians the arbiters of assisted suicide and euthanasia is a return to one of the most severe forms of paternalism, not a victory for patient autonomy.

fundamentally not on the patient's autonomous request *but on the doctor's judgment that the request is justified because the patient no longer has a life "worth" living.* If a doctor can make this judgment in relation to an autonomous patient, he can, logically, make it in relation to an incompetent patient. Moreover, if death is a 'benefit' for competent patients suffering certain conditions, why should it be denied incompetent patients suffering from the same conditions?⁸⁶

Numerous cases of non-voluntary and involuntary euthanasia worldwide testify to this. In the Netherlands by 1990, there were 1,000 cases (0.8% of all deaths) where physicians administered a drug hastening the end of life "without an explicit request of the patient,"⁸⁷ and in 4,000 cases physicians "withdrew or withheld treatment without request" with the explicit intent to shorten life.⁸⁸ The number remained high in 1995, with 900 cases of *active* euthanasia without the explicit request of the patient.⁸⁹ Replication studies in Australia and Belgium both found incidence of ending life without the explicit request of the patient to be over 3%.⁹⁰ Dutch studies show that in 8% of the cases in which "a life-terminating act was performed without explicit request of the patient," other treatment alternatives still existed.⁹¹ Physicians justified their actions on the grounds that the suffering was considered unbearable, standard medical care failed to help, and death would occur most likely within a week.⁹²

The numbers are even more alarming when they include death by deliberate act of omission. Dutch numbers show that there were 15,528 cases (59%) of intentionally terminating life without any explicit request in 1995.⁹³ The numbers for the United States show that 54% of

⁸⁴ Edmund D. Pellegrino, *Compassion Is Not Enough*, in *THE CASE AGAINST ASSISTED SUICIDE* 48 (Kathleen Foley & Herbert Hendin, eds., 2002).

⁸⁵ *Id.*

⁸⁶ John Keown, *Euthanasia in the Netherlands: Sliding down the Slippery Slope*, 9 *NOTRE DAME J. L., ETHICS & PUB. POL'Y* 407, 408 (2002) (emphasis in original).

⁸⁷ *Id.* at 417.

⁸⁸ *Id.* at 418.

⁸⁹ Gerrit van der Wal & P. J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, in *ASKING TO DIE* 171 (David C. Thomasma, et al., eds., 1998).

⁹⁰ Raphael Cohen-Almagor, *Non-voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives*, 18 *ISSUES IN LAW & MED.* 239, 241 (2003).

⁹¹ *Id.* at 242.

⁹² *Id.*

⁹³ John Finnis, *Euthanasia, Morality and Law*, 31 *LOY. L. A. L. REV.* 1123, 1128 (1998).

the patients who received a lethal injection did not make the request for euthanasia themselves.⁹⁴ According to a Dutch study from 2001, 16% of patients whose lives were ended without request were fully competent, raising the question of why a request to die was not obtained.⁹⁵ A previously-made request is now acceptable without restatement in the Netherlands: in the first trial of a doctor who performed euthanasia since legalization,⁹⁶ a Dutch court found that doctors do “not have to verify the current desire to die” for patients who have previously requested euthanasia but due to dementia are no longer mentally competent to make the request.⁹⁷

One survey of critical care nurses calculated that at least 7% of the nurses interviewed had at least once carried out euthanasia without a request from either the patient or a surrogate.⁹⁸ Another 4% had hastened a patient’s death by only pretending to provide the life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without a request or advance knowledge of physicians.⁹⁹ In another Dutch study, the researchers went so far as to suggest that “the person responsible for avoiding involuntary termination of life is the patient” and that “the person who does not wish to have his or her life terminated should declare this clearly, in advance, orally and in writing, preferably in the form of a living will.”¹⁰⁰

Finally, euthanasia for mentally competent terminally ill persons raises the problem of diagnosing and estimating how much time people have left until the end of life. Doctors often report problems with determining whether the disease is terminal and how much time is left for the person. One study from 2011 conducted on 1622 patients found that physicians accurately estimated the duration of the patient’s survival in only 34% of the cases.¹⁰¹ In a 1996 survey approximately half of Oregon physicians acknowledged a lack of confidence in their own ability to predict whether patients have more or less than six months to live.¹⁰² A 1999 survey of Oregon physicians showed that “one in six were not confident about finding reliable lethal prescribing information, and one in four were not confident in determining six-month life expectancy.”¹⁰³ The problem with medical prognoses is that they are based on statistical averages, which are nearly useless in determining what will happen to an individual patient.¹⁰⁴

⁹⁴ Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia*, 338 NEW ENG. J. MED. 1193, 1200 (1998).

⁹⁵ ANTONIA GRUNDMANN, DAS NIEDERLÄNDISCHE GESETZ ÜBER DIE PRÜFUNG VON LEBENSBEENDIGUNG 210 (2004).

⁹⁶ Raf Casert & Aleksandar Furtula, “Landmark euthanasia trial opens in the Netherlands,” MED. XPRESS (Aug. 26, 2019), <https://medicalxpress.com/news/2019-08-landmark-euthanasia-trial-netherlands.html>.

⁹⁷ Mike Corder & Maria Cheng, “Dutch court clears doctor in landmark euthanasia trial,” MED. XPRESS (Sept. 11, 2019), <https://medicalxpress.com/news/2019-09-dutch-court-doctor-landmark-euthanasia.html>.

⁹⁸ David A. Asch, *The Role Of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 NEW ENG. J. MED. 1374 (1996).

⁹⁹ *Id.*

¹⁰⁰ Herbert Hendin, *The Dutch Experience*, in THE CASE AGAINST ASSISTED SUICIDE 117 (Kathleen Foley & Herbert Hendin, eds., 2002) [hereinafter Hendin, *The Dutch Experience*].

¹⁰¹ Debbie Selby et al., *Clinician Accuracy When Estimating Survival Duration: The Role of the Patient’s Performance Status and Time-Based Prognostic Categories*, 42 J. PAIN & SYMPTOM MGMT. 578 (2011).

¹⁰² Melinda A. Lee, et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 334 (1996).

¹⁰³ Linda Ganzini, et al., *Oregon physicians’ attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act*, 285 JAMA 2363, 2368 (2001).

¹⁰⁴ Marilyn Golden & Tyler Zoanni, *Killing us softly: the dangers of legalizing assisted suicide*, 2 DISABILITY & HEALTH J. 16, 21 (2010).

B. Pain and Suffering

One common and persuasive argument for PAS is that laws banning the practice force people to suffer. This argument draws on the feeling of empathy experienced in response to suffering, as well as fears of future suffering among supporters. It raises challenging questions of what compassion means and whether society meets the needs of those in grave pain or distress. For proponents of PAS, a desire for suicide is a reasonable response to grave suffering, and compassion for those suffering requires us to aid them in ending their lives.

Pain and fear of pain are a major concern at the end of life, even though concerns about autonomy or being a burden may rank more highly among those seeking assisted suicide.¹⁰⁵ There is evidence to suggest that many patients have inadequate pain management¹⁰⁶ (which some healthcare providers may “treat” with euthanasia¹⁰⁷). The most vulnerable patients, such as members of minority groups and the elderly, may receive less pain treatment than other groups.¹⁰⁸ Many physicians report that they lack necessary knowledge to control pain effectively.¹⁰⁹

Assisted suicide is a final and unchangeable response to suffering which may well be poorly managed or under treated. It may also be less a request for help ending one’s own life as much as a call for meaningful assistance at the end of life. A program at Memorial Sloan Kettering Cancer Hospital, a leading New York City hospital, found that patients expressing a desire for suicide were notably more fatigued than those who did not, and often used their request to “ensure that the listener understood the depth of their suffering.”¹¹⁰ When these conversations took place, healthcare providers were able to address key concerns and ensure better patient care, with the result that none of the patients in that report ended their lives.¹¹¹ Reports from Oregon and the Netherlands suggest that effective palliative care interventions can lead to a significant number of patients changing their minds about assisted suicide.¹¹² Addressing these gaps through physician education, improved pain management, and holistic palliative care should take priority over acts that deliberately end lives.

Physical suffering can also cause or contribute to mental and emotional distress. Patients’ desires to live can fluctuate over time, impacted by factors like depression, anxiety, and physical symptoms.¹¹³ Patients requesting PAS often cite loss of autonomy and fear of being a

¹⁰⁵ See, e.g., OREGON PUBLIC HEALTH DIVISION, OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY 12 (2019) [hereinafter OREGON 2018 DATA SUMMARY].

¹⁰⁶ Kathleen Foley, *Compassionate Care, Not Assisted Suicide*, in THE CASE AGAINST ASSISTED SUICIDE at 298 (Kathleen Foley & Herbert Hendin, eds. 2002) [hereinafter Foley, *Compassionate Care*]

¹⁰⁷ Dutch physician Zbigniew Zylicz recounts instances of referrals to his palliative care clinic of patients whose doctors had or would have euthanized patients for pain and discomfort which they did not realize could be ameliorated. Zbigniew Zylicz, *Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician*, in THE CASE AGAINST ASSISTED SUICIDE at 127, 139-40 (Kathleen Foley & Herbert Hendin, eds. 2002).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 300.

¹¹¹ *Id.* at 300-01.

¹¹² Linda Ganzini et al., *Physicians’ Experiences with the Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 560, 562 (2000). In Oregon, nearly half of patients who received substantive interventions changed their minds. *Id.* at 560.

¹¹³ Harvey M. Chochinov & Leonard Schwartz, *Depression and the Will to Live in the Psychological Landscape of Terminally Ill Patients*, in THE CASE AGAINST ASSISTED SUICIDE at 267 (Kathleen Foley & Herbert Hendin, eds. 2002).

burden, not only physical pain,¹¹⁴ which be reflect or intensify their psycho-social concerns. Depression, rather than pain, is related to patients stockpiling medications to end their lives.¹¹⁵ Older patients and patients with serious illnesses experience depression and anxiety, which can affect their medical decision-making.¹¹⁶ And clinical depression and psychological distress in patients correlates with their support for PAS.¹¹⁷

Although symptoms of serious illness and serious depression can overlap, research has shown that there are ways to evaluate patient depression, including simply asking if they often felt depressed.¹¹⁸ These conditions can sometimes be organic in nature (caused by injury or disease), but even those that are purely psychiatric suggest that the issue of competent decision-making deserves additional scrutiny.¹¹⁹ Researchers also found a stronger correlation between hopelessness and a desire for suicide than even depression and suicide.¹²⁰

Proponents of assisted suicide often portray it as compassionate towards those experiencing suffering.¹²¹ This reflects an emotivist ethic: that emotions and sympathy are the key factor in determining whether an action is moral.¹²² Suffering can provoke feelings of empathy—and a desire to end that suffering, even if it means helping to end the life of the sufferer.¹²³ Yet emotions can provoke both good and bad responses, and varied responses among different people; they do not prove themselves morally correct simply by virtue of being a natural response, but must be examined with reason.¹²⁴

The compassion offered by PAS collapses under deeper examination. The word “compassion” comes from the Latin verb meaning “to suffer with.”¹²⁵ Yet assisted suicide requires little of society, least of all sharing in the suffering of our most vulnerable at the final moments, when they end their lives by themselves.¹²⁶

Assisted suicide requires little of society, least of all sharing in the suffering of our most vulnerable at the final moments, when they end their lives by themselves.

This in turn points to a more fundamental problem with using this supposed compassion for suffering as a guide: its resistance to limits.¹²⁷ If feeling compassion for suffering is a reasonable basis to permit assisted suicide, why should it only apply to physical pain among mentally competent, terminally ill adults?¹²⁸ If ending suffering is inherently a moral good, should euthanasia be allowed? Does it even

¹¹⁴ OREGON 2018 DATA SUMMARY, *supra* note 105, at 10; DISEASE CONTROL & HEALTH STATISTICS DIVISION, WASH. STATE DEPT. HEALTH 2017 DEATH WITH DIGNITY ACT REPORT 8 (2018) [hereinafter WASH. 2017 REPORT], available at <https://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf>; GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 33-34 (2017).

¹¹⁵ Chochinov & Schwartz, *supra* note 113, at 269.

¹¹⁶ Foley, *Compassionate Care*, *supra* note 106, at 299.

¹¹⁷ Chochinov & Schwartz, *supra* note 113, at 263.

¹¹⁸ *Id.* at 265-66.

¹¹⁹ *Id.* at 266.

¹²⁰ *Id.* at 268.

¹²¹ YUILL, *supra* note 67, at 41.

¹²² Pellegrino, *supra* note 84, at 43.

¹²³ *Id.* at 43-44.

¹²⁴ *Id.* at 44-45.

¹²⁵ *Id.* at 42.

¹²⁶ YUILL, *supra* note 67, at 41. Yuill calls this “a compassion of the most cowardly variety that prefers to hand the gun to the suffering individual rather than take responsibility for the action itself.” *Id.*

¹²⁷ YUILL, *supra* note 67, at 46; Pellegrino, *supra* note 84, at 46.

¹²⁸ YUILL, *supra* note 67, at 46; Pellegrino, *supra* note 84, at 46.

need to be requested? At least one assisted suicide critic has characterized the argument for PAS from compassion as essentially a projection of supporters' future fears onto those suffering now, and one that lacks courage, because if it were true it would tend to support euthanasia, even without request, not assisted suicide.¹²⁹ As he writes, "What kind of compassionate person refuses to take action herself and instead simply says to the suffering person: 'It's your choice'? An act of compassion is an action waiting around to see what a suffering person wants."¹³⁰

Though advocates deride the "slippery slope," or simply refuse to engage it,¹³¹ there is cause for concern. The Netherlands now euthanizes disabled and severely ill infants on the grounds that ending their lives is more compassionate than the speculated suffering they will endure.¹³² Middle-aged deaf twin brothers in Belgium requested and received assisted suicide upon learning that they were going blind, rather than be unable to see each other or placed in institutional care.¹³³ Colombia issued rules for euthanasia for adults, and, within two years, for children, even as young as six.¹³⁴ In a case that made headlines, a rape victim suffering mental health effects from her trauma ended her life with a lethal prescription in the Netherlands.¹³⁵ If ending suffering is a moral imperative, it becomes difficult to limit it, or draw a bright line between which forms of suffering are bad enough to warrant helping someone end his life and which are not.

Compassion alone cannot justify an action; it must be evaluated by reason with the good of the person in mind.¹³⁶ It also demands something, both of individuals and society: actions to alleviate suffering where it can be alleviated, and to accompany the suffering. Legalizing assisted suicide will not meet the deepest needs, medical or psycho-social, of those suffering. Despite its emotional appeal, PAS represents at its most basic level the abandonment of the vulnerable to their suffering, not compassion for it, and must therefore be rejected.

¹²⁹ YUILL, *supra* note 67, at 46.

¹³⁰ *Id.*

¹³¹ Benjamin T. Jones, *Singer and Fisher preach to their flocks in euthanasia debate*, THE CONVERSATION (Boston), Aug. 13, 2015, available at <https://theconversation.com/singer-and-fisher-preach-to-their-flocks-in-euthanasia-debate-45880> ("For much of the debate, the two did not address the other's arguments. Singer kept a small target, advocating voluntary euthanasia only for competent adults with a terminal illness."). Singer's decision not to engage the argument that assisted suicide laws tend to loosen over time could be considered, as the article puts it, remaining focused on what he supports, or as a failure to engage a central claim of assisted suicide opponents: that the narrow circumstances he expressed his support for assisted suicide are where the laws begin, but not where they end. The entire debate may be viewed online on the YouTube channel of the Sydney University Catholic Society, which co-sponsored the event (https://www.youtube.com/watch?v=kZLs5L_Iknc).

¹³² *Netherlands grapples with euthanasia of babies*, NBC NEWS, Nov. 20, 2004, available at http://www.nbcnews.com/id/6621588/ns/health-childrens_health/t/netherlands-grapples-euthanasia-babies/#.W_I_yi3MywA.

¹³³ Michelle Castillo, *Report: Twin deaf brothers going blind undergo euthanasia*, CBS NEWS, Jan. 14, 2013, available at <https://www.cbsnews.com/news/report-twin-deaf-brothers-going-blind-undergo-euthanasia/>.

¹³⁴ Ministerio de Salud y Protección Social, Res. No. 0825 de 2018, art. 3 *paragrafo*.

¹³⁵ Matt Payton, *Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to 'incurable' PTSD*, INDEPENDENT (London), May 11, 2016, available at <https://www.independent.co.uk/news/world/europe/sex-abuse-victim-in-her-20s-allowed-by-dutch-doctors-to-undergo-euthanasia-due-to-severe-ptsd-a7023666.html>.

¹³⁶ Pellegrino, *supra* note 84, at 45.

IV. Assisted Suicide and Euthanasia: Concerns and Risks

A. Assisted suicide and disability discrimination

Disability rights groups have actively opposed assisted suicide.¹³⁷ Some, such as Not Dead Yet and local affiliates, focus specifically on opposing assisted suicide from a disability rights perspective.¹³⁸ For these activists, assisted suicide is a clear threat to their health and lives. They raise compelling concerns about the influence of disability prejudice on medical care, how quality of life is assessed, and the problem in resisting “help” dying when help living is hard to get.

Advocates for PAS argue that laws contain sufficient safeguards and that disability concerns should not limit what options are available to those who do want to end their lives.¹³⁹ Yet, as disability advocates point out, legalization of assisted suicide creates a system where “some people who say they want to die will receive suicide intervention, and others will receive suicide assistance.”¹⁴⁰ A powerful cartoon by Amy Hasbrouck, Director of Toujours Vivant/Not Dead Yet Canada, illustrates this: it features a wheelchair user between two doors, one requiring stairs to enter and labeled “Suicide Prevention Program” and one at the top of a ramp, labeled “Assisted Suicide.”¹⁴¹ A doctor’s perceptions of quality of life, suffering, and likely prognosis can funnel patients to one door or the other, without necessarily engaging conscious bias. The use of euthanasia under the Groningen Protocol and several cases where parents and doctors opted to starve infants with disabilities, including non-life-threatening conditions, underline the very real danger these attitudes pose to the life and well-being of persons with disabilities.¹⁴²

There is reason to believe that medical providers and patients with disabilities perceive problems related to care differently. People with disabilities tend to rate their quality of life much higher than their healthcare providers do, and similar to how people without disabilities assess their own quality of life.¹⁴³ In one survey, medical providers tended to identify barriers to care for people with disabilities in terms of finances, booking and attending appointments, and difficulty explaining to and understanding staff.¹⁴⁴ On the other hand, patients with disabilities in focus groups identified other concerns: “lack of preventative care, financial barriers, and dissatisfaction with the care they received.”¹⁴⁵ They expressed concern about poor communication, inattentiveness, negative attitudes and lack of training, which could have negative health outcomes, especially if they have complex medical needs.¹⁴⁶

¹³⁷ Coleman, *Not Dead Yet*, in *THE CASE AGAINST ASSISTED SUICIDE* 213 (Kathleen Foley & Herbert Hendin, eds., 2002).

¹³⁸ *See Who We Are, NOT DEAD YET*, <http://notdeadyet.org/about> (last visited Nov. 18, 2018).

¹³⁹ Coleman, *supra* note 137, at 222; Alicia Ouellette, *Barriers to Physician Aid in Dying for People with Disabilities*, 6 *LAWS* no. 23, at 3 (2017) (articles are individually paginated in this journal).

¹⁴⁰ Coleman, *supra* note 137, at 221.

¹⁴¹ TOUJOURS VIVANT/NOT DEAD YET CANADA, <https://tvndy.ca/en/> (last visited Nov. 18, 2018). (Scroll down on main page to view cartoon.)

¹⁴² *See* Verhagen & Sauer, *supra* note 50, at 959; GORSUCH, *supra* note 8, at 191-94.

¹⁴³ Nancy Sharby et al., *Decreasing Health Disparities for People with Disabilities through Improved Communication Strategies and Awareness*, 12 *INT’L J. ENVTL. RES. & PUB. HEALTH* 3301, 3313 (2015).

¹⁴⁴ *Id.* at 3310-11.

¹⁴⁵ *Id.* at 3311.

¹⁴⁶ *Id.*

PAS does not resolve those problems, which take an investment of time, money, and training, but it might push already vulnerable people towards ending their lives. Surveys of those ending their lives under assisted suicide legislation reflect fears of loss of function, autonomy, and being a burden—in short, fears about living with a disability.¹⁴⁷ Similarly, safeguards are often much more limited than they seem, with few checks on doctors' reports, filed after patients' deaths by PAS, that no abuses occurred.¹⁴⁸ Moreover, at least one jurisdiction, Oregon, has taken such an expansive view of what constitutes a terminal illness for the purposes of the assisted suicide law that it includes conditions which with treatment would be manageable and chronic rather than terminal.¹⁴⁹

Disability activists also raise concerns that assisted suicide may create a duty to die. Accessibility, assistive devices, medical care, and other things people with disabilities need to live their lives fully can become extremely costly. Although couched in language of choice, some assisted suicide advocates have identified the expenses of care as a path forward for their movement.¹⁵⁰ Roger Foley, a chronically ill Canadian man who needs extensive assistance, has filed suit against a hospital, healthcare officials, and the government after claiming that he was refused the quality care he needed to live at home, but advised of his options related to a “medically assisted death.”¹⁵¹ Sean Tagert, a forty-one year old father with amyotrophic lateral sclerosis (also known as motor neuron disease), was offered insufficient hours of care at the home where he had partial custody of his son.¹⁵² Without support from health authorities to receive the medically-indicated twenty-four hour care, and believing that the care he could receive in a facility would shorten his life and remove him from his son, Tagert ended his life under Canada's medically assisted dying process.¹⁵³

¹⁴⁷ Coleman, *supra* note 137, at 225. See also OREGON 2018 DATA SUMMARY, *supra* note 105, at 12; WASH. 2017 REPORT, *supra* note 114, at 8.

¹⁴⁸ See, e.g., REGIONAL EUTHANASIA REVIEW COMMITTEES, REGIONAL EUTHANASIA REVIEW COMMITTEES RTE: ANNUAL REPORT 2017 at 8, 17, 19 (English version), available at <https://english.euthanasiacommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> (reporting only twelve findings of a doctor “not acting in accordance with due care criteria” out of 6,585 reports filed by doctors, and 80% of cases found to be “straightforward” on initial review from reports submitted by doctors); Xavier Symons, *Dutch authorities to prosecute euthanasia doctor*, BIOEDGE (Nov. 11, 2018), <https://www.bioedge.org/bioethics/dutch-authorities-to-prosecute-euthanasia-doctor/12889> (reporting on the first prosecution of a doctor in the Netherlands, who euthanized a patient with advanced dementia in 2016). This is also troubling in light of the way that civil authorities and the general public seem to take abuse of people with disabilities less seriously, as evidenced by much lighter sentences for caregivers who commit murder than for those who murder able-bodied people. Coleman, *supra* note 137, at 232.

¹⁴⁹ See generally FABIAN STAHL, OREGON HEALTH AUTHORITY REVEALS HIDDEN PROBLEMS WITH THE OREGON ASSISTED SUICIDE MODEL 1-2 (Jan. 2018), available at <https://drive.google.com/file/d/1xOZfLFrVuQcaZfFudEncp2b18NrUo/view>. Mr. Stahl is an independent researcher in Sweden whose report quotes correspondence between him and state health officials.

¹⁵⁰ Coleman, *supra* note 137, at 227.

¹⁵¹ *Chronically ill man releases audio of hospital staff offering assisted death*, CTV NEWS (Aug. 2, 2018), <https://www.ctvnews.ca/health/chronically-ill-man-releases-audio-of-hospital-staff-offering-assisted-death-1.4038841?cache=yes%3FautoPlay%3Dtrue%3FautoPlay%3Dtrue>. Foley also alleged that his condition had deteriorated due to substandard care provided by his assigned caregivers.

¹⁵² *B.C. man with ALS chooses medically assisted death after years of struggling to fund 24-hour care*, CBC NEWS (Aug. 13, 2019), <https://www.msn.com/en-ca/news/canada/bc-man-with-als-chooses-medically-assisted-death-after-years-of-struggling-to-fund-24-hour-care/ar-AAFKuYa?li=AAgNb9&%253Bsrcref=rss>.

¹⁵³ *Id.*

Improvements in medicine have led to more people living longer who might otherwise have died, all at an increased financial and even emotional burden on society.¹⁵⁴ An already vulnerable person may “internalize the social oppression that declares severe disability to be undignified” and decide that suicide will restore their worth.¹⁵⁵ The twentieth century witnessed several efforts to limit the burden imposed on society by the poor and people with disabilities, both through proactive euthanasia and sterilization programs, and through failing to treat them, even if conditions were treatable.¹⁵⁶ The veneer of choice cannot erase this disturbing history, nor alter the context of unmet medical needs, lack of resources, and social stigma in which such “choices” will be made.

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B. Vulnerable groups and coercion

Legalizing euthanasia and assisted suicide requires physicians to determine which lives can be considered unworthy of living, and inevitably leads to increased pressure on members of vulnerable groups. A right-to-die mentality has been shown to exert psychological pressure upon vulnerable persons,¹⁵⁷ and this pressure raises the question of whether any real autonomy can be exercised in these conditions.

The case of Kate Cheney, as described by both Cheney and members of her family, illustrates this point.¹⁵⁸ Kate was an eighty-five-year-old widow diagnosed with terminal stomach cancer. She wanted the option of assisted suicide “in case she was in pain or if the indignities of losing control of her bodily functions became unbearable.”¹⁵⁹ Her daughter Erika went with Kate when she made the request to her physician. Erika described the physician as “dismissive” and requested a referral to a second physician. He arranged for a psychiatric consultation, which was a standard procedure. The psychiatrist, who visited Kate at her home, found that Kate did not “seem to be explicitly pushing for [assisted suicide]” and that she lacked the “level of capacity ... to weigh options about [it].”¹⁶⁰

Although Kate seemed to accept the assessment, her daughter became very angry. The hospital then suggested that the family obtain a second assessment from an outside consultant. The second psychologist noted that Kate had memory defects and that her “choices [might have been] influenced by her family's wishes and [that] her daughter, Erika, [might have been] somewhat coercive,” but felt Kate had the ability to make her own decision. A hospital administrator then saw Kate and decided that she was competent and was making the decision on her own. Kate received the lethal drugs, which were put under Erika's care. As time passed, Erika

¹⁵⁴ *Id.* at 228.

¹⁵⁵ *Id.* at 228.

¹⁵⁶ *Id.* at 228-29.

¹⁵⁷ LEWY, *supra* note 114, at 153.

¹⁵⁸ See Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1624 (2008) [hereinafter Hendin & Foley, *Oregon*].

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

and her husband sent Kate to a nursing home for a week. When Erika visited, Kate always asked “when she would be going home.” On the day she returned from the nursing home, she told Erika and her husband that “she had considered going permanently into a nursing home but had decided to use the pills instead and asked for their help.”¹⁶¹ Within a short time, Kate took the pills and died.

Several cases suggest that family expectations can exert pressure, not only on the patients, but also on physicians to assist in suicide even where it may not be warranted. Helen was a patient who performed aerobic exercises up until two weeks before she contacted the physician to request PAS.¹⁶² She told the physician she could not do them anymore, and she was also unable to continue to garden, which had been one of her favorite activities. Apart from that she was not bedridden, was not in great pain, and was still able to look after her own house. Helen's own physician had refused to assist in her suicide, and a second physician refused too on the grounds that Helen was depressed.

Helen's husband then called the advocacy group Compassion in Dying and was referred to a physician who would assist her. The third doctor finally approved the request. He later regretted his decision and the fact that he didn't personally discuss the case with her regular physician and had only cursory contact with Helen. He also explained the reasons behind his decisions: “The thought of Helen dying so soon was almost too much to bear.... On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.”¹⁶³

Some studies have shown that in the Netherlands “families request euthanasia more often than patients themselves” and “the family, the doctors, and the nurses often pressured the patient to request euthanasia.”¹⁶⁴ “The relatives’ inability to cope” was also cited by physicians as a major reason (32% of cases) for terminating life without patients consent.¹⁶⁵ In 2001, Dutch doctor Wilfrid van Oijen ended the life of an 84-year-old woman at her daughters’ request, and not her own.¹⁶⁶ The woman had heart problems and was increasingly bedridden, but was not in pain and had even said that she did not want to die, but could not care for herself. She expressed the desire to be with her daughters who cared for her at home, but the care became burdensome to the daughters, so van Oijen gave her medication to hasten the process of dying.¹⁶⁷

The legalization of PAS can also foster economic coercion, both due to financial burdens on families and in savings to society as a whole. Recently, a study was published in Canada which tried to argue that legalizing “medical assistance in dying could reduce annual health care spending across Canada by between \$34.7 million and \$138.8 million.”¹⁶⁸ Legalizing euthanasia sends a message that **legalizing euthanasia sends a message that some groups are a burden for a society and that society would be better off without them.**

¹⁶¹ *Id.* at 1625.

¹⁶² *Id.* at 1616.

¹⁶³ Peter Reagan, *Helen*, 353 LANCET 1265, 1266 (1999), quoted in Hendin & Foley, *Oregon*, *supra* note 158, at 1619.

¹⁶⁴ Cohen-Almagor, *supra* note 90, at 249.

¹⁶⁵ GORSUCH, *supra* note 8, at 110.

¹⁶⁶ Herbert Hendin, *The Dutch Experience*, *supra* note 100, at 115.

¹⁶⁷ *Id.*

¹⁶⁸ Aaron J. Trachtenberg & Braden Manns, *Cost analysis of medical assistance in dying in Canada*, 189 CAN. MED. ASS'N J. E101, E101 (2017).

some groups are a burden for a society and that society would be better off without them. This inevitably leads to a utilitarian view of human persons, which allows the “sacrifice” of certain groups for the benefit of other groups who aren’t too costly to care for. As the New York State Task Force on Life and the Law, established in the early 1990s to consider the possibility of legalizing PAS, observed: “Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians' decisions at the bedside... Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process.”¹⁶⁹

In 2008, Randy Stroup was diagnosed with prostate cancer and he turned to the Oregon state-run health plan for coverage of his chemotherapy treatments.¹⁷⁰ Since chemotherapy is expensive, Stroup received a letter that stated his request was denied, but the State would pay for physician-assisted suicide.¹⁷¹ Stroup had such a low chance of recovery that the state of Oregon decided he was no longer worth treating.¹⁷² In another case in Oregon, a dying patient was euthanized to free a hospital bed.¹⁷³ As euthanasia advocate Derek Humphry predicted, “one must look at the realities of the increasing cost of health care in an aging society, because in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice.”¹⁷⁴

This is not a fringe position; in fact, a number of officials around the world have endorsed it more or less openly. A former governor of Colorado has openly and repeatedly defended the view that the elderly have a duty to die to make room (and save resources for) the young.¹⁷⁵ In 2014 a Lithuanian Health Minister suggested euthanasia could be a solution for poor people,¹⁷⁶ and a Japanese finance minister said that the elderly should be allowed to “hurry up and die” to relieve pressure on the state to pay for their medical care.¹⁷⁷ Baroness Warnock, a leading ethicist in the U.K., similarly suggested that dementia sufferers may have a “duty to die.”¹⁷⁸ It shouldn’t surprise us then, as one poll in Ohio found that “those most likely to oppose the practice [of PAS] were black, people 65 and older, and those with low levels of income and education.”¹⁷⁹

¹⁶⁹ NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 123 (1994) [hereinafter NYS TASK FORCE ON LIFE AND THE LAW], available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought.

¹⁷⁰ Zachary D. Smoll, *Physician-Assisted Suicide Tells People Like Me That Our Lives Are No Longer Worth Living*, THE PUB. DISCOURSE (May 8, 2017), available at <http://www.thepublicdiscourse.com/2017/05/19163/>.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ R.J.D. George, et al., *Legalised euthanasia will violate the rights of vulnerable patients*, 331 BRIT. MED. J. 684, 685 (2005).

¹⁷⁴ DEREK HUMPHRY & MARY CLEMENT, FREEDOM TO DIE: PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT 313 (1998).

¹⁷⁵ GORSUCH, *supra* note 8, at 131.

¹⁷⁶ *Euthanasia could be option for poor, says Lithuanian health minister*, BIOEDGE (Jul 26, 2014), available at https://www.bioedge.org/bioethics/euthanasia_could_be_option_for_poor_says_lithuanian_health_minister/11071.

¹⁷⁷ *Let elderly people 'hurry up and die', says Japanese minister*, GUARDIAN (Jan 22, 2013), available at <https://www.theguardian.com/world/2013/jan/22/elderly-hurry-up-die-japanese>.

¹⁷⁸ *Baroness Warnock: Dementia sufferers may have a 'duty to die'*, TELEGRAPH (Sept 18, 2008), available at <https://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html>.

¹⁷⁹ GORSUCH, *supra* note 8, at 126.

It is for this reason that numerous bodies have rejected the legalization of assisted suicide. The British House of Lords concluded in 2001 that a prohibition against the practice was justified precisely because of the possibility that “vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, real or imagined, to request early death . . . [and] the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.”¹⁸⁰ The New York State Task Force similarly explained in 1992 that they had “unanimously concluded that legalizing assisted suicide and euthanasia... will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.”¹⁸¹ Similarly, an Australian euthanasia bill from 1996 was repealed by the Commonwealth Parliament in 1997, with the consideration that it “had an unacceptable impact on the attitudes of the Aboriginal community towards health services,”¹⁸² and that “evidence was received that hospitals had become feared as places in which Aborigines could be killed without their consent.”¹⁸³ The poor, elderly, sick, members of minority groups, and people with disabilities already face barriers to healthcare without further undermining their trust that medical providers will provide the same quality of care to them as to everyone else.

C. Assisted suicide changes the role of the doctor

Legalizing euthanasia and assisted suicide creates a new set of problems for the medical profession, by distorting the doctor-patient relationship and undermining the integrity of medicine. Medicine always operated under the ethical framework expressed in the Hippocratic Oath. In its original form, the Hippocratic Oath stated: “I will give no deadly medicine to any one if asked, nor suggest any such counsel.”¹⁸⁴ Today’s version of the oath, called the Declaration of Geneva, also says: “I will maintain the utmost respect for human life... I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”¹⁸⁵

Medicine has always operated under the basic principles that life should be preserved and that promoting and restoring health is a natural goal of medicine.¹⁸⁶ Whenever possible, the disease should be cured and pain relieved: “Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business.”¹⁸⁷ Any society that legalizes euthanasia or assisted suicide undermines these basic principles and necessarily endangers the integrity of the medical profession. As the American Geriatric Society states,

Legalization of physician-assisted suicide would create a moral dilemma for geriatricians. Most elderly persons experience serious and progressive illness for extended periods before death and need

¹⁸⁰ Regina v. Director of Public Prosecutors & Sec’y of State for the Home Dept., [2001] 1 A.C. 800 (H.L.) § 29 (U.K.), quoted in GORSUCH, *supra* note 8, at 46.

¹⁸¹ NYS TASK FORCE ON LIFE AND THE LAW, *supra* note 169, at 120.

¹⁸² David W. Kissane, *Deadly Days in Darwin*, in THE CASE AGAINST ASSISTED SUICIDE 206 (Kathleen Foley & Herbert Hendin, eds., 2002).

¹⁸³ *Id.* at 205.

¹⁸⁴ *Hippocratic Oath*, ENCYCLOPAEDIA BRITANNICA, available at <https://www.britannica.com/topic/Hippocratic-oath>.

¹⁸⁵ World Medical Association Declaration of Geneva, adopted Sept. 1948, available at <https://www.wma.net/policies-post/wma-declaration-of-geneva/>.

¹⁸⁶ Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 95 PUB. INT. 25, 29 (1989).

¹⁸⁷ *Id.* at 39.

significant social, financial and medical supports. These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs. By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because a patient's relative poverty and disadvantaged social situation is seen as coercive, geriatricians would condemn their patients, and themselves, to live through the patient's undesired difficulties for the time remaining.¹⁸⁸

Legalizing euthanasia or assisted suicide also undermines the trust between patients and the doctor, as discussed above. The Court in *Washington v. Glucksberg* found that "Physician assisted suicide could . . . undermine the trust that is essential to the doctor-patient relationship by blurring the time honored line between healing and harming."¹⁸⁹ Medical ethicist Dr. Leon Kass illustrates this vividly:

Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.¹⁹⁰

The majority of medical associations worldwide have consistently opposed the practice, including the World Health Organization, the American Medical Association (AMA), the American College of Physicians, the Canadian Medical Association, the British Medical Association, the Royal College of Physicians, the German Medical Association, and over 20 others.¹⁹¹ The World Medical Association (WMA) has repeatedly highlighted its "strong belief that euthanasia is in conflict with basic ethical principles of medical practice," even though it is allowed by law in some countries. The WMA's Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, October 1987, states: "Euthanasia, that is the act of deliberately ending the life of a patient, even at

"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical."

-WMA Declaration on Euthanasia

¹⁸⁸ Felicia Cohn & Joanne Lynn, *Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide*, in THE CASE AGAINST ASSISTED SUICIDE 250 (Kathleen Foley & Herbert Hendin, eds., 2002), quoting Joanne Lynn et al., *American Geriatrics Society on Physician-Assisted Suicide: Brief to the United States Supreme Court*, 45 J. AM. GERIATRICS SOC'Y. 489 (1997).

¹⁸⁹ *Glucksberg*, 521 U.S. at 731.

¹⁹⁰ Kass, *supra* note 186, at 35.

¹⁹¹ Carter Snead, *Carter Snead lecture "Physician Assisted Suicide: Objections in Principle and in Prudence"*, FACULTY LECTURES & PRESENTATIONS Paper 26, at 46-48 (2014). available at http://scholarship.law.nd.edu/law_faculty_lectures/26.

the patient’s own request or at the request of close relatives, is unethical.”¹⁹²

The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992, likewise states: “Physicians-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.”¹⁹³ At the same time, the AMA recognizes that “withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and non-maleficence,” while assisting suicide always is, because the latter involves intentionally using the tools of medicine to kill.¹⁹⁴

The final question raised by the legalization of euthanasia or assisted suicide is the threat to the rights of conscience of the doctors who would refuse to participate in such practices. If there is a right to assisted suicide, then a doctor will have to take actions to ensure that right can be exercised. Many contemporary advocates of legalization of euthanasia and assisted suicide are, in fact, openly discussing putative professional and legal “duties” for doctors to perform those acts.¹⁹⁵ Under a legal regime which grants a right to assisted suicide, “what would happen to the medical care professionals who fail to act? Might they open themselves up to suits in negligence by families upset that their relatives suffered needlessly because a doctor or nurse did not advocate their death? Might we eventually have a ‘wrongful life’ cause of action?”¹⁹⁶ Even though some courts have noted that “a patient has no right to compel a health-care provider to violate generally accepted professional standards,”¹⁹⁷ there is no obvious reason why the patients and the courts would not have the right to compel a doctor to perform a certain practice contrary to his conscience, if the “professional standards” change in such a way to make these practices a part of a standard medical care.

V. Dignity-respecting healthcare at the end of life

Physician-assisted suicide and euthanasia do not address the needs their proponents claim they do. Ending a life does not resolve inadequate pain management, distress, anguish, or loss of meaning. Moreover, both practices, even with patient request, carry a significant risk of coercion and abuse, alter the practice of medicine away from its purpose, and undermine the relationship between doctor and patient. When deliberately taking life is considered a valid avenue of treatment, other, less drastic options become costly in time and resources by comparison.

Banning assisted suicide and euthanasia may, therefore, call out greater creativity in, and commitment to, the care of those suffering at the end of life. But prohibitions alone are not

¹⁹² World Medical Association Declaration on Euthanasia (Oct. 1987), available at <https://www.wma.net/policies-post/wma-declaration-on-euthanasia>.

¹⁹³ World Medical Association Statement on Physician-Assisted Suicide (Sept. 1992), available at <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/>.

¹⁹⁴ American Med. Ass’n, Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2230, 2233 (1992). In June 2019, the AMA adopted a report from its Council on Ethical and Juridical Affairs which recommended maintaining opposition to assisted suicide, following a request from Oregon physician members to adopt a neutral position on assisted suicide. Joyce Frieden, *Physician-Assisted Suicide Once Again Divides AMA Members*, MEDPAGE TODAY (June 11, 2019), <https://www.medpagetoday.com/meetingcoverage/ama/80384>.

¹⁹⁵ GORSUCH, *supra* note 8, at 130.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.* at 184.

sufficient. With many parts of the world experiencing population ageing,¹⁹⁸ improvements in care cannot wait. Healthcare providers, families, and society as a whole must ensure that no one nearing the end of their life's path walks alone. This includes the provision of the basic necessities of life for those who are not in danger of death due to their condition, but rely on others to provide them with food and water.

To offer technical guidance on specific treatments is beyond the scope of this paper, particularly as medicine continues to advance. Different interventions may be considered more or less invasive based on the advancement of medical technology, the nature and progression of the condition, how the intervention works, and other factors.¹⁹⁹ This approach recognizes life as

Care grounded in the dignity of the person requires a commitment to meet the physical, psychosocial, and palliative needs of all terminally ill patients.

a basic good, while also understanding that other considerations should be taken into account.²⁰⁰ Life need not be prolonged under all circumstances or for as long as possible, but it should not be intentionally ended.²⁰¹ This is particularly important where the patient cannot make her own decisions, and in the care and options presented to members of other

vulnerable groups. Care grounded in the dignity of the person requires a commitment to meet the physical, psychosocial, and palliative needs of all terminally ill patients.

A. The physician-patient relationship and goals for end-of-life care

Unlike previous eras which lacked the ability to treat illnesses ranging from infection to cancer, most people today will live longer than those a century before. Healthcare providers can solve many problems, but not the last one: while death may be delayed, it cannot be avoided forever. Each patient will have to decide what matters to him or her about his or her own death, whether to prolong life, or accept its progression. Yet the patient is in a vulnerable position due to illness, factors associated with old age, and potentially, disability. Ensuring that patients receive care in line with their goals requires a doctor-patient relationship of trust and good communication.

Patients who know they are terminally ill are more likely to discuss end-of-life care with doctors than those who do not know that their condition is terminal.²⁰² Terminal patients are also more likely to direct their care towards symptom management than prolongation of life.²⁰³ A patient's desires can shift due to changes in their healthcare, and non-medical factors, such as

¹⁹⁸ WORLD HEALTH ORGANIZATION, WORLD REPORT ON AGEING AND HEALTH 43-45 (2015).

¹⁹⁹ For example, seriously ill people may wish to avoid or prolong use of a ventilator based on their perceptions of their likelihood of recovery, Kwon Ivo et al., *A survey of the perspectives of patients who are seriously ill regarding end-of-life decisions in some medical institutions of Korea, China, and Japan*, 38 J. Med. Ethics 310, 312 (2012), indicating that some see it as an intensive, extraordinary means of life support, where in fact increasing numbers of people with chronic respiratory failure use respirators at home, Sarah Masefield et al., *Attitudes and preferences of home mechanical ventilation users from four European countries: an ERS/ELF survey*, 3 EUR. RESPIRATORY J. OPEN ACCESS No. 2 at 2 (2017).

²⁰⁰ GORSUCH, *supra* note 8, at 157-58.

²⁰¹ *See generally* GORSUCH, *supra* note 8, 157-180 (Chapter 9).

²⁰² Jennifer W. Mack et al., *End-of-Life Discussions, Goal Attainment, and Distress at the End of Life: Predictors and Outcomes of Receipt of Care Consistent with Preferences*, 28 J. CLINICAL ONCOLOGY 1203, 1205 (2010).

²⁰³ *Id.* at 1205, 1208.

relative youth or having young children, can also affect how a patient wants to direct his or her care.²⁰⁴ Evidence suggests that patients who discuss their wishes with their doctors are more likely to receive care in line with what they want.²⁰⁵

There is also reason to believe that many patients who receive life-extending care prefer symptom-directed care.²⁰⁶ One study found that patients tended to choose default options when presented with different versions of advance directives,²⁰⁷ highlighting the risk of inadvertent influence. That same study notes that a common end-of-life care questionnaire in the U.S. has life-extending options as a default,²⁰⁸ potentially influencing patient decisions towards unwanted medical interventions. Communication should be ongoing and personal to avoid losing sight of patients' wishes.

Yet goals of care discussions may not happen when patients do not understand that their health is declining, or because both sides find such conversations difficult,²⁰⁹ or expect each other to bring up various elements, such as pain, depression, or other symptoms.²¹⁰ A survey of American hematologic oncologists found that many believed the timing of their end-of-life care conversations with patients was often "too late," and the discussions themselves were held at less than ideal times.²¹¹

Some interventions and innovations to promote goals of care conversations have been tested with promising results.²¹² Holding these conversations early can increase quality of life, including through referrals to other services, such as palliative care for those whose conditions often cause great suffering.²¹³ Palliative care can be started early, even concurrently with life-prolonging treatments, to ensure quality of life.²¹⁴

Doctors who elicit patients' goals may be surprised to learn that what matters to them is not necessarily directly related to death at all. American doctor Mitch Kaminski recalled his surprise when a patient's goal was simply to walk without falling, and to stay at home rather than receive inpatient care.²¹⁵ By taking the time to find out what the patient wanted, he was able improve his patient's quality of life in a meaningful way. This care made such an impression on the family that the man's widow, herself approaching the end of life, later sought Kaminski out

²⁰⁴ *Id.* at 1207, 1203.

²⁰⁵ *Id.* at 1205.

²⁰⁶ *Id.* at 1208.

²⁰⁷ Scott D. Halpern et al., *Default Options In Advance Directives Influence How Patients Set Goals for End-Of-Life Care*, 32 HEALTH AFFAIRS 408, 412-13 (2013).

²⁰⁸ *Id.* at 408.

²⁰⁹ Ardith Z. Doorenbos et al., *An Intervention to Enhance Goals-of-Care Communication Between Heart Failure Patients and Heart Failure Providers*, 52 J. PAIN & SYMPTOM MGMT. 353, 354 (2016); Foley, *Compassionate Care*, *supra* note 106, at 300.

²¹⁰ Kurt Kroenke et al., *The Association of Depression and Pain with Health-Related Quality of Life, Disability, and Health Care Use in Cancer Patients*, 40 J. PAIN & SYMPTOM MGMT. 327, 335 (2010).

²¹¹ Oreofe O. Odejide et al., *Timeliness of End-of-Life Discussions for Blood Cancers: A National Survey of Hematologic Oncologists*, 176 JAMA 263, 263 (2016).

²¹² *See, e.g.*, Doorenbos, *supra* note 209, at 357.

²¹³ *Id.* at 358. The study also notes that "[m]any patients for whom palliative care could significantly improve quality of life do not have access to such care services. Instead of palliative care, patients at end-of-life often receive intensive and costly care even when it may not contribute significantly to prolonging life." *Id.* at 354 (citations omitted).

²¹⁴ *See, e.g.*, Thomas W. LeBlanc, *Addressing End-of-Life Quality Gaps in Hematologic Cancers: The Importance of Early Concurrent Palliative Care*, 176 JAMA INTERNAL MED. 265, 265-66 (2016).

²¹⁵ Mitch Kaminski, *What one patient taught a physician*, WASH. POST, Mar. 10, 2015, at E1.

for her own care.²¹⁶ In both cases, a proper understanding of patient autonomy led to patient-centered care that led to better quality of life and a better experience of dying for the patient and his family.

It is worth noting that some patients may express a desire for hastened death. Within jurisdictions that allow PAS and/or euthanasia, that desire may be taken as normal. However, there are varying reasons why someone might want to hasten their death. These have been categorized as reflecting an exit plan (and therefore control over one's fate), an expression of despair (a state of psychosocial distress), or letting go (not so much a desire to hasten one's death as an acceptance of approaching death).²¹⁷

For patients whose desire to hasten their death reflects despair, this despair may not be a constant state, but may vary related to pain and adaptation to the circumstances of illness.²¹⁸ Those wanting to exercise control over their death may do so out of a desire to avoid experiences they expect will be painful and undignified,²¹⁹ potentially reflecting and reinforcing stigma about disability. This underlines the need for society to promote an understanding of dignity as distinct from a feeling of being dignified, as discussed above. More practically, however, in addition to discussions about care, there are options available which can help address these concerns, and what is driving them, without the irrevocable step of ending the patient's life.

B. Palliative care

Palliative care seeks to alleviate pain and suffering in a way that is respectful of human dignity. Dame Cicely Saunders created the palliative care approach in 1967 in the United Kingdom.²²⁰ She argued for the approach of "total care" which aims to address all aspects of the pain a patient is experiencing. The term palliative care refers to the "medical skill of an optimized expert use of drugs intended to remove or diminish pain, or to put it simple [*sic*] to improve the life quality. The combination of medical palliative care and human hospice care produces a complete human care and love for the sick and the dying."²²¹ It is generally understood that while curative medicine seeks to cure disease, palliative medicine seeks to alleviate pain and suffering.²²² Palliative care has an essential role to play in end-of-life care; cancer, a leading cause of death worldwide,²²³ often causes pain for patients, but that pain is largely treatable.²²⁴

The World Health Organization defines palliative care as

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early

²¹⁶ *Id.*

²¹⁷ Rinat Nissim et al., *The desire for hastened death in individuals with advanced cancer: A longitudinal qualitative study*, 69 SOC. SCIENCE & MED. 165, 168-69 (2009).

²¹⁸ *Id.*

²¹⁹ *Id.* at 168.

²²⁰ Anica Jušić, *Eutanazija*, 9 REV. SOC. POLIT. 301, 307 (2002).

²²¹ Pozaić, *supra* note 70, at 153.

²²² See generally Morana Brkljačić, *Bioetika i bioetički aspekti palijativne medicine*, 44 MEDICINA 149 (2008).

²²³ *Cancer*, WORLD HEALTH ORGANIZATION, <https://www.who.int/news-room/fact-sheets/detail/cancer> (Sept. 12, 2018).

²²⁴ Kroenke et al., *supra* note 210, at 328.

identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.²²⁵

Palliative care is always interdisciplinary in its approach and includes the patient, the family, and the community within its scope. It tends to the patient at the most basic level: that of providing for the needs of the patient wherever he or she is cared for, either at home or in the hospital.²²⁶ Among its core principles are respect for the patient's autonomy, good communication with the patient, collaboration with and support of family and caregivers, respect for personal, cultural, and religious beliefs and values, and an understanding that its purpose is

neither to hasten nor postpone death.²²⁷

The fundamental difference in purpose reflects the basic difference in the approach: palliative care seeks to relieve suffering at the end of life; euthanasia seeks to end life itself.

Some authors have introduced a model of “*integral* palliative care, in which euthanasia is considered as another option at the end of a palliative care pathway,”²²⁸ since neither seeks to cure the disease, and, they suggest, both seek to alleviate pain. This view does not hold up in light of the difference in intent. Euthanasia has the “intent to cause or hasten patient's death.”²²⁹ On the other hand, palliative care “intends neither to hasten or postpone death.”²³⁰ The

²²⁵ *Palliative Care*, WORLD HEALTH ORGANIZATION, available at <http://www.who.int/cancer/palliative/definition/en/>.

²²⁶ Lukas Radbruch et al., *White Paper on standards and norms for hospice and palliative care in Europe: part 1. Recommendations from the European Association for Palliative Care*, 17 EUR. J. PALLIATIVE CARE 278, 280 (2009).
²²⁷ *Id.* at 283.

²²⁸ Jan L. Bernheim, et al., *Development of palliative care and legalisation of euthanasia: antagonism or synergy?* 336 Brit. Med. J. 864, 867 (2008) (emphasis added).

²²⁹ PERICO, *supra* note 3, at 138.

²³⁰ Tania Pastrana et al., *A matter of definition: key elements identified in a discourse analysis of definitions of palliative care*, 22 PALLIATIVE MED. 222, 223 (2008).

fundamental difference in purpose reflects the basic difference in the approach: palliative care seeks to relieve suffering at the end of life; euthanasia seeks to end life itself.

For this reason, most palliative care organizations, such as the European Association for Palliative Care (EAPC), reject euthanasia as a part of the palliative care approach. Rather, they “stress the importance of refocusing attention onto the responsibility of all societies to provide care for their older, dying and vulnerable citizens. A major component in achieving this is the establishment of palliative care within the mainstream healthcare systems... supported by appropriate finance, education and research.”²³¹

C. Psychosocial care

The commitment to the whole person and easing suffering must go beyond the management of physical pain. Depression in seriously ill patients has been connected with an increased desire for hastened death.²³² Physical pain and psychological wellbeing are interconnected: they often overlap both in cancer patients and those with other medical conditions, and have “reciprocal adverse effects on one another and on quality of life and functioning.”²³³ Depression is known to impact quality of life among sufferers in the general population, and a 2017 study found a strong association between depression and quality of life in patients with advanced cancer.²³⁴ “Depression is prevalent among people with advanced cancer,”²³⁵ but is often under-diagnosed and therefore left untreated.²³⁶

For those suffering from mental distress, other interventions are needed. One study found that depression had stronger effects on quality of life and function in cancer patients than pain did.²³⁷ Yet studies have found that it often goes undetected in palliative care settings, which may be due to lack of training, but probably at least partly due to the similarities between depressive symptoms and disease symptoms.²³⁸ Moreover, given perceptions of despair as a natural reaction to a challenging diagnosis, and their prevalence, medical caregivers “often underestimate the level of depressive symptoms in patients,” and are “more likely to make false-negative than false-positive errors in detecting depression.”²³⁹

Simple screening tools which are easily incorporated into palliative practice can be highly effective in signalling the need for more in depth diagnosis, but they are rarely used in practice.²⁴⁰ Doctors, nurses, and other palliative caregivers can find it difficult to bring up depression and mental anguish with patients, which contributes to low rates of mental

²³¹ Lukas Radbruch et al., *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care*, 30 PALLIATIVE MED. 1, 11 (2016).

²³² William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA. 2907, 2909 (2000).

²³³ Kroenke et al., *supra* note 210, at 334. See also David J. Hallford et al., *Depression in palliative care settings: The need for training for nurses and other health professionals to improve patients’ pathways to care*, 32 NURSE ED. TODAY 556 (2012).

²³⁴ Kjersti S. Grotmol et al., *Depression—A Major Contributor to Poor Quality of Life in Patients With Advanced Cancer*, 54 J. PAIN & SYMPTOM MGMT. 889, 893 (2017).

²³⁵ *Id.*

²³⁶ Kroenke et al., *supra* note 210, at 328.

²³⁷ *Id.* at 336.

²³⁸ Hallford et al., *supra* note 233 at 556-57.

²³⁹ *Id.* at 557.

²⁴⁰ *Id.*

intervention.²⁴¹ However, additional training can help nurses and other professional caregivers build the knowledge and confidence to incorporate depression screening into their regular practice.²⁴² Patients experiencing depression at the end of life must be screened for depression and receive appropriate interventions.

Similarly, demoralization, a form of existential distress associated with a loss of meaning and purpose, has also “been associated with a desire for hastened death.”²⁴³ Demoralization can be associated with depression, but patients can experience it without meeting criteria for depression.²⁴⁴ Depending on the assessment tool used, studies have found rates of demoralization ranging from 13-33% of patients experiencing cancer or another progressive illness.²⁴⁵ As with depression, demoralization is linked with physical symptoms and quality of life concerns.²⁴⁶

Meaning and purpose are key factors in seriously ill patients’ ability to cope with their illness and approaching death. “[H]opelessness, worthlessness, meaninglessness, and shame are the potential mediators of suicidal thinking.”²⁴⁷ Conversely, a sense of meaning and purpose helps patients to deal with their illness.²⁴⁸ One study observed that a lack of meaning and purpose was more strongly correlated with a desire for hastened death than physical symptoms, loss of function, or even other psychological factors.²⁴⁹ Therefore, interventions designed to foster a sense of meaning and purpose can lead to reducing patients’ desire for hastened death.²⁵⁰

Therefore, interventions designed to foster a sense of meaning and purpose can lead to reducing patients’ desire for hastened death.

One such intervention which has been being developed is meaning-centered psychotherapy based on the work of psychiatrist (and Holocaust survivor) Viktor Frankl, who wrote *Man’s Search for Meaning*.²⁵¹ Studies have targeted spiritual wellbeing²⁵² through both

²⁴¹ *Id.* at 557-58.

²⁴² *Id.* at 558-59; Kroenke et al., *supra* note 210, at 335.

²⁴³ Sophie Robinson et al., *A Systematic Review of the Demoralization Syndrome in Individuals With Progressive Disease and Cancer: A Decade of Research*, 49 J. PAIN & SYMPTOM MGMT. 595, 595-96, 604 (2015). The study argues for demoralization as an adjustment disorder. *Id.* at 606. It also notes that due to different assessment tools the definition is not completely established, *id.* at 608, but was able to draw some conclusions about demoralization via systematic review despite a split in which assessment tool was used.

²⁴⁴ *Id.* at 605. The fifth edition of *The Diagnostic and Statistic Manual of Mental Disorders (DSM-5)* does not include meaning and purpose in its discussion of depressive disorders. *Id.* at 606.

²⁴⁵ *Id.* at 606. Studies focused on measuring dimensions of “clinically significant” demoralization found smaller proportions, in the range of 13-18% of patients. *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ Mariona Guerrero-Torrelles et al., *Meaning in Life as a Mediator Between Physical Impairment and the Wish to Hasten Death in Patients With Advanced Cancer*, 56 J. PAIN & SYMPTOM MGMT. 826, 827 (2017).

²⁴⁹ *Id.* at 830.

²⁵⁰ *Id.* at 830-31.

²⁵¹ William Breitbart et al., *Individual Meaning-Centered Psychotherapy for the Treatment of Psychological and Existential Distress: A Randomized Controlled Trial in Patients with Advanced Cancer*, 124 CANCER 3231, 3232 (2018) [hereinafter Breitbart et al., *IMCP*].

²⁵² “Spiritual wellbeing” in this context reflects existential elements of wellbeing, such as meaning and purpose. William Breitbart, et al., *Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial*, 19 PSYCHO-ONCOLOGY 21, 21-22 (2010) [hereinafter Breitbart et al., *Meaning-centered group psychotherapy*].

group and individual therapy.²⁵³ Although these interventions are still in development, they have shown promise as a treatment avenue.

A pilot study comparing meaning-centered group psychotherapy (MCGP) with supportive group psychotherapy found higher rates of attendance and a greater impact on spiritual wellbeing among those undergoing MCGP than those receiving supportive group therapy.²⁵⁴ A more recent study focused on individuals divided into groups receiving enhanced usual care (EUC), supportive psychotherapy (SP), and individual meaning-centered psychotherapy (IMCP).²⁵⁵ Although overall IMCP's efficacy compared to SP was not significantly greater, the impact was higher when comparing those who had attended more sessions, suggesting overall that IMCP is an effective invention.²⁵⁶ These and other interventions testify to the treatability of despair and hopelessness which many experience at the end of life.

VI. Conclusion

Physician-assisted suicide and euthanasia may seem like an answer to the possibility of a painful or difficult death, loss of function, or poor quality of life. There is no right under international law to assistance in ending one's life, and most countries and jurisdictions ban the practice. Such bans have been upheld in most national and international courts. Places which allow the practices have adopted expansive interpretations of rules that go far beyond the common refrain that assistance in ending their lives should be allowed for terminally ill, mentally competent adults.

Permitting these practices also corrupts the practice of medicine, fundamentally changing the doctor-patient relationship. They offer less social and legal protection to those with disabilities or experiencing serious illness, which is particularly troubling in light of patient vulnerability and the risk of coercion. Society must resist these practices, which may well exacerbate existing gaps in care and place the already vulnerable at greater risk.

The ultimate answer to pain, suffering, and dependency at the end of life is to accompany the dying person. This requires adequate treatments, such as those discussed above, to be available to all, but it also requires that caregivers, healthcare providers, and society as a whole affirm the value of every person. No one goes through life entirely autonomous or without difficulties. A culture that cherishes human dignity eases that suffering through affirming that we care about people for *who they are*, not for what they can or cannot do. That care and concern must then direct our efforts towards ensuring medical and psychosocial care that upholds the fundamental dignity of each person at the end of life without exception.

²⁵³ See generally Breitbart et al., *IMCP*, *supra* note 251; Breitbart et al., *Meaning-centered group psychotherapy*, *supra* note 252.

²⁵⁴ Breitbart et al., *Meaning-centered group psychotherapy*, *supra* note 252, at 24-25.

²⁵⁵ See generally Breitbart et al., *IMCP*, *supra* note 251.

²⁵⁶ *Id.* at 3236-37.