

**Opting Out:  
An Argument for Physician-Assisted Suicide**

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## Dedication

To Mom and Dad, you are the wind beneath my wings.

And to my new BFF, Amy Eisenberg, thank you for making me do this!

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## INTRODUCTION

In 1913 the average age of death for a man was 50.6; it is currently 76. The average age of death for a woman in 1913 was 55; it is currently 81.<sup>1,2</sup> Therefore, in the last century, the average lifespan for both males and females has increased by an average of twenty-five years. Over these last one hundred years, there have been great advances in medicine and many of these advances have broken new ground. The results have served to increase life span and enhance the quality of life. We have learned so much more about diet and exercise, and the effect it has on our lives. Pacemakers, heart bypass surgery, and transplants have lengthened lives for the better. Often forgotten in the rush to give a person more time, these medical advances have negatively affected our quality of life. Chemotherapy is a good example of this. It has been shown to fight many types of cancer, the side effects such as nausea and vomiting, hair loss, and infection have had a direct negative impact on patients' quality of life. If the prognosis is good, beating the cancer often outweighs the impact of those side effects. If the prognosis is grim, the question becomes, "Does the patient want to suffer any more than what cannot be controlled?" Living wills or advance directives, legal documents which clarify and express a patient's wishes about their own end-of-life-care, are becoming more prevalent today. Physician-assisted-suicide is a choice patients are legally able to make in three US states: Oregon, Washington, and Vermont.

There is an abundant amount of information about physician-assisted suicide through organizations that are pro-physician-assisted suicide such as The Death with

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<sup>1</sup> Data 360, "Life Expectancy-United States." 360Data, [http://www.data360.org/dsg.aspx?Data\\_Set\\_Group\\_Id=195](http://www.data360.org/dsg.aspx?Data_Set_Group_Id=195), (February 2, 2014).

<sup>2</sup> Andrew Noyer, "Life expectancy in the USA, 1900-98," <http://demog.berkeley.edu/~andrew/1918/figure2.html>, (February 2, 2014).

Dignity Organization, available at [www.deathwithdignity.org](http://www.deathwithdignity.org) and Compassion and Choices, available at [www.compassionandchoices.org](http://www.compassionandchoices.org). There are also a multitude of organizations that are anti-physician-assisted suicide such as Not Dead Yet, available at [www.notdeadyet.org](http://www.notdeadyet.org) and Physician's for Compassionate Care, available at [www.pccef.org](http://www.pccef.org). All of these organizations and sites are resolute in their views of physician-assisted suicide. In addition to these organizations, there are a significant number of journal articles advocating a pro or con stance, as well as journal articles which present both sides of the argument, for and against, physician-assisted suicide. The articles and organizations focus primarily on the following issues and how important those issues are to the authors'/members' views: loss of autonomy, loss of dignity, physical pain, and quality of life. The review of the literature on physician-assisted suicide will be discussed in Chapter One.

In 1997, physician-assisted suicide was first legalized in the United States in Oregon. Since then, two other states, Washington and Vermont, have enacted laws. While the state of Montana does not currently have a Death with Dignity act, in 2009 “Montana's Supreme Court ruled nothing in the state law prohibited a physician from honoring a terminally ill, mentally competent patient's request by prescribing medication to hasten the patient's death.”<sup>3</sup> In January 2014, a district judge in New Mexico “ruled terminally ill, mentally competent residents have a constitutional right to request prescribed medication to shorten their suffering.”<sup>4</sup> The New Mexico Attorney General is

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<sup>3</sup> “Death with Dignity Acts,” Death with Dignity National Center, <http://www.deathwithdignity.org/acts>, (January 2, 2014).

<sup>4</sup> Melissa Barber. “NM Judge Rules in Favor of Death with Dignity.” *Living with Dying Blog* (web log), January 14, 2014. Accessed February 10, 2014. <http://www.deathwithdignity.org/2014/01/14/nm-judge-rules-in-favor-of-death-with-dignity>.

looking into that ruling. Chapter Two will provide a more in depth discussion on the relevant laws in participating states.

Chapter Three will address the ethical issues which separate those who believe physician-assisted suicide is a basic human right and those who believe physician-assisted suicide is always wrong and should never be legalized. The ethical discussions surrounding physician-assisted suicide include: a patient's right to choose death over suffering; how laws should be written so there will be no abuse; a physician's obligation to uphold the Hippocratic Oath; the slippery slope or risk-of-abuse arguments questioning whether physician-assisted suicide will evolve into non-voluntary euthanasia; the alternative to physician-assisted suicide which is higher quality palliative care.

Physician-assisted suicide is an emotional topic; most people feel strongly one way or the other with very little middle ground. This paper will discuss an article which advocates vehemently against physician-assisted suicide: "Killing Us Softly: The Dangers of Legalizing Assisted Suicide," by Marilyn Golden and Tyler Zoanni. Some of the arguments presented in this article include: palliative care as the better alternative to physician-assisted suicide; once physician-assisted suicide laws are enacted, there will be a rapid decline towards voluntary euthanasia, spiraling down to non-voluntary euthanasia; physician-assisted suicide is murder; and the fear that the poor, the uninsured, and the disabled will be forced to choose physician-assisted suicide as their only viable option. This paper will argue in support of physician-assisted suicide laws as a human right and against the arguments presented in these three articles.

## CHAPTER ONE

### The Literature

There is a considerable body of information regarding the subject of physician-assisted suicide, both online and in print. One of the frequently addressed topics concerns the terminology used to describe the act: physician-assisted suicide, physician-assisted death, assisted suicide, suicide, aid in dying, euthanasia. In his article in the *New York Times*, Erik Eckholm writes, “Its advocates, who have learned to shun the term ‘assisted suicide,’ believe that as baby boomers watch frail parents suffer, support for what they call the ‘aid in dying’ movement will grow further.”<sup>5</sup> The website, [www.deathwithdignity.org](http://www.deathwithdignity.org), devotes a section to “Inaccurate Terminology and Imagery:”

**Euthanasia:** We don’t advocate for laws which allow euthanasia; in fact, euthanasia is specifically outlawed within the text of Death with Dignity Acts. Euthanasia often refers to the act of painlessly but deliberately causing the death of another who is suffering from an incurable, painful disease or condition. It’s commonly thought of as lethal injection. An injection is never involved under these laws.

**Suicide:** Because the person is in the process of dying and seeking the option to hasten an already inevitable and imminent death, the request to hasten a death isn’t equated with suicide. None of the moral, existential, or religious connotations of suicide apply when the patient’s primary objective is not to end an otherwise open-ended span of life, but to find dignity in an already impending exit from this world. They’re participating in an act to shorten the agony of their final hours, not killing themselves. Cancer (or another underlying condition) is killing them.

**Assisted suicide:** assisted suicide is a biased phrase which opponents often use to scare people about Death with Dignity laws.<sup>6</sup> (Please see Appendix A for a Glossary of Terms)

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<sup>5</sup> Erik Eckholm. “‘Aid in Dying’ Movement Takes Hold in Some States.” *New York Times*, February 7, 2014.

<sup>6</sup> “Terminology,” Death with Dignity National Center, <http://www.deathwithdignity.org/terminology>, (January 2, 2014.).

The movement in favor of physician-assisted suicide recognizes that terminology is a major contributing factor to attitudes and beliefs, and that the term “suicide” has a negative connotation. Euthanasia has a subtext of murder. “Death with Dignity” implies a peaceful, as well as legal, approach. Employing specific terminology is important when trying to rally support for a controversial act.

In 1973, Donald “Dax” Cowart was burned over sixty percent of his body when a propane gas leak exploded. He requested to be killed with a morphine overdose or to be allowed to withhold treatment so that he could die. All of his requests were denied, and while he lived to graduate law school and make a life for himself, he still believes his wishes should have been granted. This case will be discussed in depth in Chapter Three.<sup>7</sup>

In the United Kingdom, a woman named Jean Humphry had been suffering from breast cancer for two years before learning, in 1975, that the cancer had spread throughout her body and into her bones. After discussing it with her husband, she decided that when life became too unbearable, she would take her own life. With the aid of her husband, Derek Humphry, then a British journalist, they created a plan. Derek Humphry found a caring physician who provided him with a lethal medication, which he kept until Jean was ready. When the time came, he mixed the medication into her coffee. They said their good-byes and Jean died an hour later.<sup>8</sup> In 1978, Derek Humphrey published “Jean’s Way,” a book which triggered the controversial discussion about aid in dying and euthanasia. The book was a bestseller in the United Kingdom. A few years later Derek Humphry created The Hemlock Society to assist others who were in

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<sup>7</sup> Alice Steinbach. “Please Let Me Die.” *The Baltimore Sun*, April 26-30, 1998.

<sup>8</sup> Derek Humphry. *Jean’s Way*. New York: Quartet Books, 1978.



situations similar to Jean's. In 1991, he published "The Final Exit," a controversial self-help book for those wanting to end their suffering due to illness. Surprisingly, this was a bestseller for six months, prompting discussions on television, throughout the medical community, as well as among families of the terminally ill. The Hemlock Society, whose inception predated the internet, boasted a staggering twenty thousand members. As time went on, though, the name of the organization became a hindrance, having the opposite of the intended effect. After Derek Humphry retired in 1992, his creation merged and merged again, evolving into a new organization, Compassion and Choices, located in Oregon. In 1993, Humphry founded [www.assistedsuicide.org](http://www.assistedsuicide.org) to promote his views on assisted suicide and euthanasia.<sup>9</sup>

In 1975, in the United States, a twenty-one year old woman named Karen Ann Quinlan became the face of the right-to-die argument. Karen Ann Quinlan arrived home from a party after ingesting prescription pills and alcohol. The doctors revived her but she had sustained massive brain damage, and was in a persistent vegetative state. She was put on a ventilator and a feeding tube was inserted. After months of waiting, the Quinlan family realized there was no hope for Karen, and asked the hospital to remove the ventilator and feeding tube. The hospital, fearing prosecution, refused believing that the only thing keeping Karen Ann alive was the ventilator. Wanting their daughter to die with dignity, the Quinlan's hired an attorney to represent them in their dispute with the hospital. The lower court refused to remove the ventilator and the case was sent to the New Jersey Supreme Court.

The Supreme Court set several legal and medical precedents in its 7-to-0 decision on March 31, 1976.

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<sup>9</sup> Derek Humphry. <http://www.assistedsuicide.org>. (November 22, 2013).

The court held, in a new interpretation of the right of privacy, that Miss Quinlan's interest in having her life-support systems disconnected exceeded the state's interest in preserving life, so long as medical authorities saw "no reasonable possibility" that she would recover.

Because she was in a coma, the court ruled that her father - and not her doctors or a court - was the authority for deciding her fate in her behalf. The court also ruled that no one could be held criminally liable for removing the life-support systems, because the woman's death "would not be homicide, but rather expiration from existing natural causes."<sup>10</sup>

Karen Ann Quinlan lived for ten more years in a nursing home in Morristown, New Jersey. During that time, she received nutrition from a nasogastric tube, and at the time of her death, weighed only sixty-five pounds. This was a landmark case which debated many questions:

- What is the definition of death? Is it when the heart stops or the brain stops working?
- When does a patient's family know when the right time is to turn off the machines keeping their loved one alive?
- Would it be considered murder to shut off a machine that was the only thing keeping the patient alive?

Even in 1985, ten years after the ventilator was removed discussions continued about the moral or ethical dilemma of keeping a patient alive only with the use of a machine. "Technological advances in life-support systems have intensified the problem of prolonging lives, in some cases to a point that some doctors call obscene. Although physicians are sworn to preserve life, many concede privately that they let suffering lives end out of compassion. "Judicious neglect" is believed to be widespread."<sup>11</sup> Had the

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<sup>10</sup>Robert McFadden. "Karen Ann Quinlan, 31, Dies; Focus of '76 Right to Die Case." *New York Times*, June 12, 1985.

<sup>11</sup>Erik Eckholm. "'Aid in Dying' Movement Takes Hold in Some States." *New York Times*, February 7, 2014.

Quinlan's removed the feeding tube as well, Karen Ann's death would have been hastened but her parents did not believe that was right. Their main concern was that the ventilator was painful to her and they wanted to, at least, alleviate that pain.

The Quinlan family fought a courageous, and very public, battle. The case continued for approximately a year. The Quinlan family, which included two other children, was constantly subjected to invasions of privacy by the press at a time when they were trying to grieve. In the end, however, this case resulted in the passage of many good reforms:

The ruling gave patients and families the right to live each stage of life, including the last stage, with dignity and respect, and for medical institutions such as hospitals, hospices and nursing homes that would now be required to establish and maintain ethics committees. In addition, the Quinlan case led to the creation of the "living will," sometimes called an "advanced directive," which outlines the personal wishes of the individual in regard to "extraordinary means" to maintain life.<sup>12</sup>

In the 1990s, Dr. Jack Kevorkian became the person most associated with physician-assisted suicide. The press dubbed him Dr. Death, because he admitted to assisting in the death of approximately 130 people. He was a flamboyant and out-spoken man who created a national debate about assisted suicide and euthanasia. He once arrived in court dressed in colonial clothing to demonstrate that he believed our medical system to be antiquated. He used the press to further the debate about euthanasia and assisted suicide.

He also talked about the "doctrine" he had developed to achieve two goals: ensuring the patient's comfort and protecting himself against criminal conviction. He required patients to express clearly a wish to die. Family physicians and mental health professionals were consulted. Patients were given at least a month to consider their decision and possibly change their

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<sup>12</sup> Robert McFadden. "Karen Ann Quinlan, 31, Dies; Focus of '76 Right to Die Case." *New York Times*, June 12, 1985.

minds. Dr. Kevorkian videotaped interviews with patients, their families and their friends, and he videotaped the suicides, which he called medicides.<sup>13</sup>

In 1999, that all came to an end when he helped in the assisted suicide of a man with ALS (Amyotrophic lateral sclerosis, more commonly known as Lou Gehrig's disease). Kevorkian was arrested and subsequently sent the videotape of the death of that patient to "60 Minutes." In his interview with Mike Wallace, he appeared to be unbalanced, and it took the jury only two days to convict him of second degree murder. "You had the audacity to go on national television, show the world what you did and dare the legal system to stop you," said Judge Jessica R. Cooper, who presided over the trial in Oakland County Circuit Court. "Well, sir, consider yourself stopped."<sup>14</sup> His sentence was ten to twenty-five years in prison, but he was released after eight years after promising he would no longer practice assisted suicide. Dr. Kevorkian died in 2011, unable to use either of the contraptions he created which allowed his patients to administer the lethal medication to end life. The two contraptions, dubbed the Thanatron and the Mercitron, were both built by Kevorkian. Below is a description of those machines:

In the back of the Volkswagon, where Kevorkian had removed some of the seating, the doctor assembled his Mercitron and Thanatron, two machines he built himself. The Thanatron ("death machine"), which Kevorkian showed off during an appearance on the *Donahue* show, was constructed out of household tools and spare parts you might find in any suburban garage. Kevorkian outfitted the patient with an intravenous drip of a saline solution. When the patient pressed a button, the saline would switch to thiopental for sixty seconds. After that strong dose of thiopental, the patient would slip into a deep coma, at which point the Thanatron would inject a lethal dose of potassium chloride, a solution that stops the heart.

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<sup>13</sup> Keith Schneider. "Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives." *The New York Times*, June 3, 2011.

<sup>14</sup> Keith Schneider. "Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives." *The New York Times*, June 3, 2011.

Potassium chloride, a mix of potassium and chlorine, is the same solution that is delivered in the final step of most lethal injection procedures.<sup>15</sup>

While some believe his methods were appalling, Kevorkian left his mark on society, having passionately promoted every person's right to a peaceful and painless death.

Currently, there are two prominent organizations in favor of physician-assisted suicide: Compassion and Choices and The Death with Dignity National Center. The Compassion and Choices organization (formerly the Hemlock Society) describe their organization as "the leading nonprofit organization committed to helping everyone have the best death possible. We offer free consultation, planning resources, referrals and guidance, and across the nation we work to protect and expand options at the end of life."<sup>16</sup> Many people mistakenly believe that Compassion and Choices is only about assisted dying but the goals of this organization are far more reaching. Compassion and Choices provides a multitude of services which enable patients and their families to deal with end of life issues. These services include:

- Navigating the healthcare system
- Contacting hospice or palliative care providers, pain specialists, social services agencies, support groups and other local resource
- Education to help clients receive effective pain and symptom management
- Offering healthcare professionals information about compassionate, patient-centered end-of-life care.<sup>17</sup>

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<sup>15</sup> Nicholas Jackson. "Jack Kevorkian's Death Van and the Tech of Assisted Suicide." The Atlantic.com. June 11, 2011. <http://www.theatlantic.com/technology/print/2011/06/jack-kevorkians-death-van-and-the-tech-of-assisted-suicide/239897/>.

<sup>16</sup> "About Compassion and Choices," Compassion and Choices, <https://www.compassionandchoices.org/who-we-are/about/>, (December 28, 2013).

<sup>17</sup> "What We Do," Compassion and Choices, <https://www.compassionandchoices.org/what-we-do/end-of-life-counseling/>, (December 28, 2013).

The organization believes that, when possible, every patient has the right to die on a particular date and time of his/her choosing, and will advocate on behalf of a patient and his/her family members. Volunteers from the organization assist the majority of those who want to end their lives.

Another well-established organization is the Death with Dignity National Center. Their mission is to “promote Death with Dignity laws based on our model legislation, the Oregon Death with Dignity Act, both to provide an option for dying individuals and to stimulate nationwide improvements in end-of-life care.”<sup>18</sup> This nonprofit organization provides education and legal defense in support of death with dignity.

There are a number of organizations which advocate against physician-assisted suicide. One is called “Not Dead Yet: The Resistance.” This is a disability rights group “that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people. Not Dead Yet helps organize and articulate opposition to these practices based on secular social justice arguments. Not Dead Yet demands the equal protection of the law for the targets of so called “mercy killing” whose lives are seen as worthless.”<sup>19</sup> This group promotes alternatives to physician-assisted suicide, appears publicly when invited to explain the organization’s stance, and lobbies states against enacting Death with Dignity laws. The organization’s principal fear is that physician-assisted suicide will be performed without the patient’s approval and comprehension.

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<sup>18</sup> “About Us,” Death with Dignity National Center, <http://www.deathwithdignity.org/aboutus>, (December 28, 2013).

<sup>19</sup> “Who we are,” Not Dead Yet: The Resistance, <http://www.notdeadyet.org/about>, (February 4, 2014).

Other organizations devoted to preventing the legalization of physician-assisted suicide include [www.Euthanasia.com](http://www.Euthanasia.com), [www.CareNotKilling.com](http://www.CareNotKilling.com), and The Patients Rights Council. All of these organizations have a common goal: to outlaw physician-assisted suicide and promote palliative care as the optimal choice in end-of-life care.

Awareness and education of these issues can be found in a documentary entitled, “How to Die in Oregon.” Winner of the Grand Jury Prize at the Sundance Film Festival in 2011, this documentary tells the story of a number of patients in Oregon who have chosen to end their lives with the aid of a lethal mix of medications. The organization, Compassion and Choices, is prominently portrayed in this documentary, focusing specifically on Sue Porter, a volunteer who supports patients in their end of life choices. She says, “These people have lost so much control, and they’ll tell us repeatedly that they want the medication for control. Whether they take the medication or whether they don’t, at least they can make that decision.”<sup>20</sup> She asks two questions prior to a patient ingesting the lethal medication: do you understand that you can change your mind? And do you know what this medication will do? When the patient answers the questions correctly, s/he drinks the medication, and then dies.

Cody Curtis was also shown in the documentary. She was a woman suffering from liver failure. Her story is interspersed throughout the documentary, revealing her ups and downs throughout her illness, continuing until the night she died. She chose to utilize the Oregon Death with Dignity Act. Her courage and candor greatly contribute to making the documentary more poignant and personal.

It feels a little bit like I’m a dead woman walking. It’s this curious limbo of getting a diagnosis that’s this dire and having this period where you don’t know what’s really going to happen except with Death with Dignity you do have some

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<sup>20</sup> *How to Die in Oregon*. Directed by Peter D. Richardson. United States: HBO Films, 2011. DVD.

control over what's gonna happen. You can offer that to your family. And so it means you can have some good times, and go for a walk, and go back to the coast, and have things be as normal as possible without being focused on "when's she gonna die?" Because you know that.<sup>21</sup>

The documentary is very candid and straightforward, and the filmmakers did an admirable job of choosing a representative cross-section of people utilizing the Oregon Death with Dignity Act, and how it affects the patient as well as their families.

One of the more illuminating articles presented is by Robin Marantz Henig, writing about Margaret Pabst Battin (Peggy) and her husband, Brooke Hopkins. Peggy Battin had been writing about euthanasia, physician-assisted suicide, and death with dignity for years, and was an international leader in bioethics. In one moment all of her philosophies about her writings would be put into question. On November 14, 2008 her husband was riding his bicycle when he ran into another cyclist. He was thrown and landed on his head, his helmet cracked. He had broken his neck and might have died, if someone had not seen the accident and revived him. In the ambulance, they kept him breathing, and when he arrived at the hospital, he was hooked up to a ventilator. If his wife, Peggy, had been there, she may have "urged the rescuers not to revive him. Brooke updated a living will the previous year, specifying that should he suffer a grievous illness or injury leading to a terminal condition or vegetative state, he wanted no procedures done that 'would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process.'"<sup>22</sup> She did not want her husband to die.

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<sup>21</sup> *How to Die in Oregon*. Directed by Peter D. Richardson. United States: HBO Films, 2011. DVD.

<sup>22</sup> Robin Marantz Henig. "A Life-or-Death Situation." *The New York Times Magazine*, July 21, 2013, 28.



Peggy Battin believed the most important aspect to life was a person's autonomy. "The competent patient can, and ought to be accorded the right to, determine what is to be done to him or her, even if...it means he or she will die."<sup>23</sup> But her world had been shattered by Brooke's accident and all of her big ideas were being called into question. This was now a personal journey and she was not sure how it would end. "It is not just about terminally ill people in general in a kind of abstract way now,' she wrote after the accident; 'it's also about my husband, Brooke. I still love him, that's a simple fact. What if he wanted to die? Can I imagine standing by while his ventilator was switched off?'"<sup>24</sup> Fortunately for Brooke he had turned to Buddhism years earlier which helped. His mind was intact, and he hoped that would allow him to accept only an intellectual life rather than the physical life he had enjoyed as well.

About four years after the accident, Robin Marantz Henig visited Peggy and Brooke at their home in Utah. She spoke with Peggy and Brooke together, as well as apart, to see how their lives had progressed with ironic situation. There were times in the article that it appeared that Brooke was happy to still be teaching English literature, albeit from home. And then there were the bad days when he wanted to die.

He's never looked this bad, Peggy whispered to me during the break as students milled around. She went to Brooke and kissed his forehead. 'Are you O.K.?' she asked softly.

'I'm fine,' he said, 'don't worry.'

They have this exchange a lot: Peggy leaning in to ask if he's O.K., Brooke tell her not to worry, Peggy worrying anyway.

Underlying her anxiety was a frightening possibility: that Brooke's inability to teach that day was the start of a progressive decline. Up until then, his occasional

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<sup>23</sup> Margaret Battin. *The Least Worth Death*. New York: Oxford University Press, 1994, 22.

<sup>24</sup> Robin Marantz Henig . "A Life-or-Death Situation." *The New York Times Magazine*, July 21, 2013, 28.

mental fogginess was always explained by something transient, like an infection.<sup>25</sup>

Throughout the article, one can see the good days Brooke has, when he is teaching or when he just being his charming self. But there are days when Brooke is just doing okay and Peggy is trying to keep it together. We can see the impact this has had on both of their lives and it is upsetting to read about. One passage, in particular, was disturbing especially since both people involved strongly believe in the right to a good death.

Brooke suddenly became agitated and started to yell, “Something bad is happening,” he boomed. “I’m not going to make it through the morning.” He had gone the previous two nights without his usual Klonopin, which treats his anxiety....Deciding that Brooke was having a panic attack, Peggy told Jaycee to give him half a dose of Klonopin. She did, but things got worse. Brooke’s eyes flashed with fear, and he yelled to Peggy that he was about to do something terrible to her – meaning, she guessed, that he was going to die and leave her alone. Finally he announced that he wanted to turn off all the machines. Everything. He wanted to be disconnected from all the tubes and hoses that we keeping him alive. He was ready to die.

Peggy and Jaycee did what he asked. They turned off the ventilator and disconnected it from the trach, and placed a cap at the opening in his throat. They turned off the oxygen. They turned off the external battery for the diaphragmatic pacer. They showed Brooke that everything was disconnected.

Two minutes passed. Three minutes passed. He opened his eyes and saw Peggy and Jaycee sitting on stools, one on either side, watching him.

‘Is this a dream?’ he asked.

‘No, it’s not a dream.’

‘I didn’t die?’

To Brooke, it was a kind of miracle – all the machinery had been shut off, just as he asked, but he was still alive.

But it was no miracle. ‘I know what his medical condition is,’ Peggy told me later, out of Brooke’s earshot. ‘The reason he didn’t die is he’s not at the moment fully vent-dependent anymore. He can go without oxygen for a while, and he can go with the pacer turned off for some time.’ She didn’t say any of this to Brooke.

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<sup>25</sup> Robin Marantz Henig . “A Life-or-Death Situation.” *The New York Times Magazine*, July 21, 2013, 31.

‘It seems to have been such an epiphany, such a discovery, when he woke up and discovered he was still alive,’ she said. ‘I don’t really want to puncture his bubble.’

If for some reason Brooke had become unconscious, she and Jaycee would have revived him, Peggy told me, because she didn’t believe he really wanted to die. She thinks what he really wanted was to believe he had a measure of control, that he could ask for an end to his life and be heard.<sup>26</sup>

While Peggy could not keep a secret, she ended up telling Brooke what really had happened and he seemed not to mind. He mimed the entire episode to the reporter over Skype, mugging for the camera. But in June 2011 he had created another farewell letter telling all he would like to die in the Spring of 2014.

This article was disturbing because a person like Peggy, who had written volumes about suicide, the right to die, and physician-assisted suicide, in reality was unable to figure out when her husband was ready to die. Had he been ready to die and she had not seen the signs? Was she in denial about his death? Was she holding onto him when, in fact, he really wanted to go? Throughout the article was see that Brooke wants to make Peggy happy, but at times it seems he does that despite what he thinks is best for him: death.

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<sup>26</sup> Robin Marantz Henig . “A Life-or-Death Situation.” *The New York Times Magazine*, July 21, 2013, 42/50.

## CHAPTER TWO

### Current Laws in the United States

At the time of this writing, there are four states which have legalized physician-assisted suicide: Oregon, Washington, Montana, and Vermont. New Mexico appears to be on the precipice of passing a similar law; it is currently in the hands of the Attorney General.

Derek Humphry tried to get public attention about assisted suicide in the 1970s. In the early 1990s, Dr. Jack assisted terminally ill people to end their lives peacefully. With each arrest, he not only made a bigger name for himself, he created greater awareness of and support for the practice of assisted suicide. In 1994, the State of Oregon passed the Death with Dignity Act by fifty-one percent of the voters, and the Act spent three years tied up in the red tape of a federal injunction. Finally, however, in 1997, the voters were asked once again to support their choice to legalize physician-assisted suicide. Sixty percent of the voters affirmed and the law was passed.

Oregon was the first state to pass a Death with Dignity Act. Patients seeking a request to die with dignity must comply with several stipulations: Patients must be at least 18 years of age, mentally competent to make medical decisions, diagnosed as terminal with less than six months left to live, and be a resident of Oregon. The patient must make two oral requests, separated by fifteen days, for a lethal prescription. There must also be a written request from the patient. The written request must be witnessed by two people, one of whom cannot be a family member, a caregiver, or anyone who may benefit financially from the patient's death. The patient's physician may not be a witness to this written request. The doctor must obtain a consultation from another doctor and

they must agree on both the diagnosis and the competency of the patient. Should either physician question the competency of the patient or feel the patient has been coerced, they are required to refer the patient for psychological counseling. The physician must also discuss alternative treatments such as palliative care or hospice. The physician must wait 48 hours from the time the written request has been submitted to writing the lethal prescription. All of the above must then be reported to the Department of Human Services.<sup>27</sup> Only Medical Doctors (MDs) or Doctors of Osteopathy (DOs) who are licensed in the State of Oregon are permitted to write the lethal prescriptions. Therefore, if a patient's primary care physician is out of state, the patient will need to find a physician in the State of Oregon willing to write the prescription. The physician must request that the patient notify his/her next of kin, although it not required that the patient do so. Patients can change their mind at any time during this process. Physicians report Death with Dignity prescriptions to the Oregon Health Authority. As of 1999, it is communicated to all pharmacists what the prescriptions are actually for. The Oregon Public Health Division is required to issue an annual report.<sup>28</sup>

In 1997, the Oregon Death with Dignity Act came as a surprise to many people. The arguments against this Act mainly emanated from the Republican Party, but there were many Democrats who were uneasy about this act as well. All sides of the political spectrum raised ethical and moral issues. After the first year, the annual report emerged. A major article appeared in *The New England Journal of Medicine* on February 18, 1999

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<sup>27</sup> John Westefeld, etal. "The Oregon Death with Dignity Act: The Right to Live or the Right to Die?" *Journal of Loss and Trauma* 14, no.3 (2009): 156.

<sup>28</sup> Oregon Health Authority, State of Oregon. "Frequently Asked Questions." State of Oregon, Oregon Health Authority, Public Health, accessed August 2012, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx>

entitled, “Legalized Physician-Assisted Suicide in Oregon: The First Year’s Experience” which summarized all of the information provided by the Oregon Health Department’s first annual report. The following details some of the information provided in the annual report:

- The physician must submit specific information to the Oregon Health Department (OHD) which is reviewed thoroughly. Twenty-three people received prescriptions.
- Fifteen patients died from lethal medication prescribed by physicians, and six patients died from their diseases.
- The OHD then does a death certificate review of all those patients that were prescribed the lethal medication and died.
- All patients were white, eleven were male; 20 patients out of the 23 were prescribed either secobarbital or pentobarbital.
- Of the fourteen patients that died from the lethal concoction, on average it took each patient twenty-six minutes to die.<sup>29</sup>

The debate about physician-assisted suicide continued for a year. Unless there was a highly publicized case involving a right to die, such as the Terry Schiavo case in Florida during the 1990s, the debate has abated somewhat. Each year the State of Oregon continues to publish its annual report.

After ten years of being the only state to have a death with dignity act, Oregon was finally joined by the state of Washington when it passed its Death with Dignity Act in 2008. “I-1000, modeled on a decade-old Oregon law, permits terminally ill, competent adult residents of Washington, who are medically predicted to have six months or less to

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<sup>29</sup> Oregon Health Authority, State of Oregon. “Annual Reports.” State of Oregon, Oregon Health Authority, Public Health, accessed December 13 2013.  
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx>

live, to request and self-administer lethal medication prescribed by a physician.”<sup>30</sup> This act followed the model of the Oregon Death with Dignity Act.

In 2009, Robert Baxter, a marine veteran, was suffering from leukemia. He, along with four doctors went to court in Montana to make sure “the right to choose aid in dying is protected by the Montana Constitution’s guarantees of privacy, dignity and equal protection.”<sup>31</sup> It went to the State’s Supreme Court and by a 5-2 ruling the following was issued:

The majority justices wrote:

“We find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The ‘against public policy’ exception to consent has been interpreted by this court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient – not the physician – commits the final death-causing act by self-administering a lethal dose of medicine.”<sup>32</sup>

In April 2013, a bill was introduced in the Montana Senate which “gave a preliminary nod to a House-passed bill that would criminalize physician-assisted suicide.” The bill has since been tabled and no new information is available.

The State of Vermont enacted their Death with Dignity Act much different than the other three states: “Vermont is the first state to pass such a law through the legislative process. Oregon and Washington enacted their laws by referendum; in

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<sup>30</sup> Janet Tu. “‘Death with Dignity’ Act Passes,” *The Seattle Times*. November 5, 2008.

<sup>31</sup> Baxter et al versus Montana, *Compassion and Choices*, <https://www.compassionandchoices.org/what-we-do/in-the-courts/baxter-et-al-v-montana/>, accessed November 12, 2012.

<sup>32</sup> Brad Knickerbocker, “Montana Becomes Third State to Legalize Physician-Assisted Suicide,” *The Christian Science Monitor*, January 2, 2010.

Montana, it was legalized by the courts.”<sup>33</sup> The bill for the Vermont plan mirrors the Oregon platform very closely.

A qualifying patient must be at least 18 years old, a Vermont resident and suffering from an “incurable and irreversible disease,” with less than six months to live. Two physicians, including the prescribing doctor, must make that medical determination. The patient must also be told of other end-of-life services, “including palliative care, comfort care, hospice care, and pain control,” according to the bill.<sup>34</sup>

Oregon has had a Death with Dignity Act for sixteen years. Other states are modeling their laws with Oregon’s in mind.

New Mexico is the latest state to review a death with dignity or aid in dying act. Two physicians have gone to court to obtain permission to prescribe a lethal medication for a forty-nine year old woman, dying of cancer. She told the court during the trial in December 2013 she “did not want suffer needlessly at the end.” The state argued that physicians should be held accountable if they write prescriptions to hasten a patient’s death, and while the judge agreed, said that “the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.” Currently the Attorney General is reviewing the case to see if it should go to the State Supreme Court.<sup>35</sup>

Judge Nash agreed that the law applied, but “This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying,” wrote Judge Nan G. Nash of the Second District Court in Albuquerque.

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<sup>33</sup> Muskal, Michael, “Governor Signs ‘Death with Dignity’ Measure,” *The Los Angeles Times*, May 20, 2013.

<sup>34</sup> Muskal, Michael, “Governor Signs ‘Death with Dignity’ Measure,” *The Los Angeles Times*, May 20, 2013.

<sup>35</sup> Erik Eckholm, “New Mexico Judge Affirms Right to ‘Aid in Dying,’” *The New York Times*, January 13, 2014.



## CHAPTER THREE

### The Ethical Questions

There are numerous ethical and moral questions surrounding physician assisted suicide. When is it acceptable for a patient to choose death over life? Who makes the choice as to what is a quality life? What is a physician's obligation to the Hippocratic Oath in terms of a patient wishing to hasten his/her death? Does the autonomy of the patient asking a physician to hasten his/her death interfere with the autonomy of the physician being asked to write the prescription? How does filling the lethal prescription affect the pharmacist? How likely is it that Death with Dignity laws will slide down the slippery slope toward active euthanasia or non-voluntary euthanasia? (See Appendix A) Is palliative care or continuous sedation the better choice for all concerned? Is there a difference between hastening death with medication, and withholding or withdrawing life-sustaining treatment?

We begin by discussing Donald "Dax" Cowart, a case that encompasses most of the ethical questions surrounding the right to die. On July 25, 1973 Donald Cowart, a twenty five year old man recently discharged from the military, moved back home to Texas to begin working in commercial real estate with his father, Ray. Driving home from work together they decided to stop and look at one last piece of property before heading home for dinner. After checking out the property, they arrived back at the car to find it wouldn't work. Ray fiddled with the engine while Donald turned the key. Unbeknownst to the two men, a propane gas leak was coming from a corroded pipe nearby. Donald turned the key one more time, there was a huge explosion, and flames encompassed the car immediately. Donald got out of the car and ran down the highway looking for his father and looking for help at the same time. A man and his son, walking

their dog along the highway saw Donald running and screaming in pain. The man sent his son for help, ran to Donald. He laid Donald down upon his jacket, telling him it would be alright. But Donald knew better. He asked the man to go and get a gun. Confused, the man asked why? Donald said, “Can’t you see I’m a dead man? I’m going to die anyway. I’ve got to put myself out of this misery.”<sup>36</sup>

When Donald’s mother arrived at the hospital that evening she found her husband had died, and her son was in intensive care, barely hanging on. The medical staff had told Donald to appoint someone as his proxy in case he was unable to make decisions for himself. He asked his mother to be his medical proxy and she agreed. Ada Cowart was a religious woman, recently disappointed in Donald and his hard-partying ways. She wanted Donald to live at least until he had made his peace with God and not suffer eternal damnation.<sup>37</sup>

The treatments at the time were excruciating. At the time physicians were concerned about drug dependency and did not use ample pain medication. “There were routine horrors, too; tortures that formed part of his daily treatment. The one Don most dreaded was the Hubbard tank. Immersed in a solution of water and Clorox, small brushes scrubbing away dead tissue, he felt as though he were being skinned alive.”<sup>38</sup>

Donald was miserable and in pain. He asked doctors to give him an overdose of morphine but the physicians refused. He tried to refuse treatment, but the medical proxy was in the hands of his mother, and she insisted the doctors to keep treating Donald.

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<sup>36</sup> Alice Steinbach. “Please let me die.” *The Baltimore Sun*, April 26, 1998.

<sup>37</sup> Alice Steinbach. “Let Me Fix Your Hands; And Then... You Can Kill Yourself.” *The Baltimore Sun*, April 27, 1998.

<sup>38</sup> Alice Steinbach. “Let Me Fix Your Hands; And Then... You Can Kill Yourself.”

After he was moved to a rehabilitation center, his mother was too far away to make daily decisions. Donald had decided to refuse treatment with the hope that he would get an infection and die. He was moved to a hospital due to his condition. While there he met with by Dr. Robert White, a psychiatrist tasked with evaluating Donald's competence.

Sitting at the bedside of his patient, whose face, body and deformed hands were a patchwork of skin grafts, White gently but firmly drew out Don's feelings during a videotaped interview.

White: "From the very beginning you had some very strong feelings you did not want the doctors to save your life. How do you feel about that at this point?"

Don: "At this point if I thought I could be rehabilitated to where I could walk and do other things normally, I might have a different feeling about it. But being blind is an inordinate factor that influences my thinking. There is no way I want to go on as a blind person and a cripple."

White: "Of course, you're so completely helpless now that you're pretty much at the mercy of all the people around you now. How do you feel about that?"

Don: "It's a really sinking feeling. I've always been really independent and I like to do things for myself. Now I have to rely on someone else to feed me. What really astounds me is that in a country like this, where freedom has been stressed so much, that a competent person can be made to stay, against his wishes, under a doctor's care and be subjected to treatments that are very painful."

White: "But you feel you should have the legal right to not be treated if you don't want to be."

Don: "Yes. I don't see how anyone else could justifiably have this right."

The tape of that 1974 bedside interview -- which White titled "Please Let Me Die" -- went on to become a classic in medical ethics circles, shown at professional meetings around the world and at medical, law and divinity schools.<sup>39</sup>

This was the beginning of Donald's fight to die on his own terms. But it never happened. He was constantly thwarted by physicians or his family or his own fear of death. He had his ups and downs; he changed his name to Cowart, because he needed to start a new chapter in his life. In the early 1980s, a film was made called "Dax's Case" which interviewed everyone involved in Cowart's case. He became a sought-after speaker in the medical and legal communities regarding right to die. And while the film portrayed

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<sup>39</sup> Alice Steinbach. "Let Me Fix Your Hands; And Then... You Can Kill Yourself."

him as hero who had overcome many obstacles to become a successful attorney, his life was falling apart around him. His third marriage had failed, as had his law practice.<sup>40</sup>

That all changed in 1995 after attending a month-long trial college in Wyoming. He met another attorney, Bob Hilliard, and they became close friends immediately. Hilliard offered Cowart a job, and after realizing that traveling around the country going from one speaking engagement to another was lonely, he took the job in Corpus Christi, Texas. In 1997, he won his first case for the firm. The most interesting comment Dax Cowart will always make is the answer to the question, “Do you still wish you had been allowed to die?” His answer is as follows:

The best way I can answer that is that I'm glad to be alive. I've had some happy experiences I wouldn't have had if I had died. But I still believe I should have been the one to make that choice at that time. And my choice was to refuse treatment. If the same thing were to happen today -- even knowing that I could reach this point -- I would still make the same choice.<sup>41</sup>

The Dax Cowart case allows for discussion about many ethical issues regarding the right to die and physician-assisted suicide. When is it acceptable for a patient to choose death over life? In the Cowart case, he asked numerous times to either be killed or be allowed to die, and though he was found competent by two psychiatrists, his wishes were never granted. All of his physicians chose a paternalistic approach by making the decision to keep him alive despite his best efforts to die, or his physicians did not feel that his case warranted a discussion about the right to die.

Who decides what defines a quality of life? Dax Cowart was described by friends and family as a good-looking, charming, ladies' man, who was a daredevil and lived on

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<sup>40</sup> Alice Steinbach. “I've given it everything. I don't think I can make my life work.” *The Baltimore Sun*, April 28, 1998.

<sup>41</sup> Alice Steinbach. “This office needed Dax. The office was drifting, and he has brought us together.” *The Baltimore Sun*. April 29, 1998

the edge. During the years of his rehabilitation, he was constantly in need of assistance because he could not feed himself, he could not dress himself, nor could he go to the bathroom by himself. It felt undignified to him to live a life like this when he had been an independent and physically active man.<sup>42</sup> However, disability rights groups are insulted by anyone who mentions assistance as a hindrance to a good life. “But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance.”<sup>43</sup>

Is the Hippocratic Oath in direct conflict with Death with Dignity laws? The American Medical Association’s definition of physician-assisted suicide is as follows: “Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides the sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.”<sup>44</sup> The Hippocratic Oath specifically states in the original version, “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” It plainly states that a physician will not write a lethal prescription for his/her patient even when requested. In a more recent version, created in 1964 by Louis Lasagna, Dean of Medicine at Tufts University, there is no specific mention of lethal prescriptions. It does state, “Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced

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<sup>42</sup> Alice Steinbach, “Let Me Fix Your Hands; And Then... You Can Kill Yourself.”

<sup>43</sup> Marilyn Golden, Tyler Zoanni, “Killing Us Softly: The Dangers of Legalizing Assisted Suicide,” *Disability and Health Journal*, 3(2010), 18.

<sup>44</sup> “AMA Code of Medical Ethics 2.211,” *American Medical Association – Physicians, Medical Students and Patients (AMA)*, AMA, 01 Nov. 2011 Web. 27-Nov. 2011. <http://www.ama-assn.org/>.

with great humbleness and awareness of my own frailty. Above all, I must not play at God.”<sup>45</sup>

The latter version of the Hippocratic Oath can be interpreted in a couple of ways. The statement, “Above all, I must not play at God” could mean that only God can take a life, and by prescribing a lethal dose of any medication would be taking a life; alternatively, it can be interpreted to mean that the physician must be thoughtful and precise when contemplating a patient’s prognosis, as well as the patient’s prior, present, and future life. If the physician believes the best course of action is to hasten the death of a terminally ill patient, he must do so with humility, and be especially aware of how it will affect him/herself, as well as the patient. Dax Cowart believes that all people have the right to control his or her own body. “The right to control your own body is the right you were born with, and not a right you have to ask anybody else for. Not your government, not your next of kin. It is this ‘right to be left alone’ that Chief Justice Louis Brandeis referred to as the ‘most comprehensive of rights and the right most valued by civilized man.’ Now, if you take away that right, none of the other rights have any meaning at all.”<sup>46</sup>

What happens when there is a conflict between the patient’s autonomy and that of the physician? Should one prevail over the other? In the Cowart case, the views of the physicians were the only views considered. The physicians believed that all the procedures were necessary to keep Cowart alive. Cowart tried to check himself out of the

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<sup>45</sup> Ludwig Edelstein, Louis Lasagna. “Hippocratic Oath Definition – Medical Dictionary Definitions of Popular Medical Terms Easily Defined on MedTerms.” *MedicineNet.com*, <http://www.medterms.com/script/main/art.asp?articlekey=20909>>.

<sup>46</sup> Alice Steinbach. “This office needed Dax. The office was drifting, and he has brought us together.” *The Baltimore Sun*. April 29, 1998.

hospital, but the physicians believed that allowing him to go home was akin to allowing him to commit suicide with their knowledge. He even tried to find an attorney to take on his right to die case, but no one would help him make a telephone call.<sup>47</sup> He felt like a man incarcerated and the hospital was doing everything they deemed necessary to force him to live.

For physician-assisted suicide, the doctor writes the lethal prescription for a patient to self-administer the dose when the patient is ready. There is also another party involved in this scenario, the pharmacist. In the states that have death with dignity laws, the patient can ask for a prescription to hasten his/her death if that patient has a prognosis of six months or less left to live. Once the request has been approved, the patient can have the prescription filled at any time, keeping it tucked away until needed. In 1999, the Oregon legislature added a requirement that pharmacists must be informed of the intended use of the prescribed medication. On the Compassion and Choices website, there are instructions for pharmacists:

The pharmacist's role is to dispense the life-ending medication and to ensure the patient understands how to take it. It is essential the patient understand how to take the life-ending medication. It is common for patients to request that the pharmacist hold the prescription until the patient is ready to have it on hand. Because patients are terminally ill, many are not able to get their own prescriptions. The Oregon Death with Dignity Act permits the patient to designate someone else to pick up the medication. Do Not:

- Accept the prescription from the patient. (The Attending Physician is required to deliver or mail it to you.)
  
- Dispense the prescription until you receive the original prescription from the patient's Attending Physician. (Faxes are not permissible.)<sup>48</sup>

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<sup>47</sup> Alice Steinbach, "Let Me Fix Your Hands; And Then... You Can Kill Yourself."

<sup>48</sup> "Oregon Pharmacist: Death with Dignity Act Overview." Compassion Choices of Oregon. Accessed January 12, 2014. doi:<http://www.compassionoforegon.org/services/for-pharmacists/>.

The pharmacist must have the original prescription on hand prior to dispensing the medication. Pharmacists may refuse to participate in the Death with Dignity Acts and not accept these types of prescriptions.

Many people believe that palliative care or continuous sedation is the proper course of action for patients rather than choosing physician-assisted suicide. The “do no harm” portion of the Hippocratic Oath would not be questioned. A pharmacist would never need to question whether the dispensing of a medication is assisting someone in suicide. Family members may feel more comfortable with a loved one slipping into death, rather than asking for a physician to hasten it. For those groups of people bound by religious teachings which prohibit any type of artificial death, palliative care or continuous sedation would be considered acceptable.

A predominant concern regarding the ethics of legalizing physician-assisted suicide is whether it will metamorphose into voluntary euthanasia, and then slide down the slippery slope into involuntary euthanasia. As discussed, physician-assisted suicide occurs when a medical doctor prescribes a lethal medication to hasten a patient’s death, which is then self-administered only by the patient. The only role of the physician in the actual death is the writing of the prescription. The concern of those opposed to this practice is that the next step will be to allow physicians to hasten the death of patients who are unable to administer the lethal injections on their own. For example, amyotrophic lateral sclerosis (ALS), more commonly known as Lou Gehrig’s disease, is a progressive disease that weakens and then paralyzes a person. “As the weakening and paralysis continue to spread to the muscles of the trunk of the body, the disease eventually affects speech, swallowing, chewing and breathing. When the breathing



muscles become affected, ultimately the patient will need permanent ventilator support in order to survive.”<sup>49</sup> A patient with ALS may want to live until the quality of life is gone; however, that time may come too late to administer a lethal dose of medication on his or her own. That is when the patient may opt for voluntary euthanasia, which is currently legal in the Netherlands. Non-voluntary euthanasia occurs when a patient cannot make a decision on his/her own such as in the case of coma, mental incompetence, or severe brain damage. The patient’s proxy then makes the decision on behalf of the patient. Finally, involuntary euthanasia occurs when a patient wants to live but is killed anyway. This is most often considered murder but there are rare instances when the death is questionable: for example, “a soldier has their stomach blown open by a shell burst. They are in great pain and screaming in agony. They beg the army doctor to save their life. The doctor knows that they will die in ten minutes whatever happens. As he has no painkilling drugs with him he decides to spare the soldier further pain and shoots them dead.”<sup>50</sup> Although the last ten minutes of that soldier’s life may have been in agony, s/he may have wanted to get a message to someone, or consider his/her life, or just pray until death came. This is why society generally looks upon involuntary euthanasia as murder.

The apprehension of the slippery slope is that society will become comfortable with people hastening their own deaths, and take the next step that would allow a physician to administer the medication to hasten death. In Dax Cowart’s case, he would have been happy to kill himself but he was physically unable to do so. He even asked many physician’s to hasten his death with pain medications too, because he very much

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<sup>49</sup> “Symptoms,” ALS Association, [www.als.org](http://www.als.org), accessed February 1, 2014.

<sup>50</sup> BBC Ethics Guide, *Voluntary and Involuntary Euthanasia*, [www.bbc.co.uk/ethics/euthanasia](http://www.bbc.co.uk/ethics/euthanasia), accessed February 22, 2014.

wanted to die. However the final concern is that some people will become so relaxed about voluntary euthanasia that deciding who should live and who should die for the good of society becomes less complex

Is there a difference between hastening a patient's death with drugs and a patient refusing treatment or sustenance? In the first scenario, the physician prescribes a lethal dose of medication which the patient takes on his/her own since it is illegal for a physician to administer the medication. But what about the patient who is unable to administer that medication on his/her own? The patient is unable to ask someone else to administer the drugs, because it is against the law everywhere in the United States. The patient's only alternative would be to stop eating and drinking. For example, Christina Symanski was a beautiful, fun-loving girl who, at the age of twenty-four, dove into a swimming pool, broke her neck, rendering her a quadriplegic. For years she lived with pain, depression, and loss of independence. But in early December, 2011, after making the decision to die, she passed away in her mother's arms at the age of thirty-one. On her blog, she posted a goodbye to friends and family.

Unfortunately, there is no cure for me. There aren't many options or relief. Life itself has become torture. I have felt like a prisoner within my own body. I'm tired of suffering. I'm tired of fighting to live, only be sick and miserable. This is not a quality life for me. I never wanted to disappoint, or hurt my loved ones, but I have reached my limit. I have tried my hardest for six long, painful years and now I just want to rest in peace. I hope my book will help people understand me better, and open people's eyes and minds to what things matter most in life. I hope it helps to broaden people's perceptions on right to die issues and the importance of quality of life. I leave this life with the comfort of knowing I will be surrounded by those closest to me. I leave behind my friends and family with a heavy heart, but feel I'm ready to embrace death and hopefully move on to a better, peaceful place.<sup>51</sup>

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<sup>51</sup> Symanski, Christina. *Life Paralyzed* (web log), April 19, 2011. Accessed May 25, 2012. [www.lifeparalyzed.blogspot.com](http://www.lifeparalyzed.blogspot.com).

Symanski had researched her options and found that starving herself was the only way to die. The question is whether this woman was suffering from depression, and would she have chosen to starve herself to death if she had more effective palliative care? Her view of a quality life was not the one she was living.

These questions and so many others surround the right to die movement in the United States. If everyone has the right to die, how is that right going to be afforded to each individual? Every story is different, each life and each death different from the last. How does a government make laws general enough for every situation and specific enough to make a difference?

## CHAPTER FOUR

### The Arguments for Physician-assisted Suicide

In an effort to put forth an argument for physician-assisted suicide, presented below is an article by Golden and Zoanni entitled, “Killing Us Softly: The Dangers of Legalizing Assisted Suicide.” The authors vehemently oppose physician-assisted suicide for anyone, especially for those people with disabilities. This paper argues in favor of physician-assisted suicide being made available to anyone, including those people with disabilities, and that all states should have Death with Dignity laws similar to those in Oregon, Washington, and Vermont.

Golden And Zoanni state, “It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn. It is legal to receive sufficient painkillers to be comfortable, and we now know this will not hasten death.”<sup>52</sup> While pain management medicine may slowly be improving, and those improvements may help some patients live a better quality of life, there are others who will never benefit from the comfort of painkillers. For example, someone with severe pain from cancer would need to take so many painkillers the quality of the patient’s life would be diminished. Golden and Zoanni add, “And perhaps last understood, for anyone who is dying in discomfort, it is legal in a U.S. state to receive palliative sedation, wherein the dying person is sedated so discomfort is relieved during the dying process.”<sup>53</sup> The idea of palliative sedation is just a longer version of physician-

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<sup>52</sup> Marilyn Golden and Tyler Zoanni, “Killing Us Softly: The Dangers of Legalizing Assisted Suicide,” *Disability and Health Journal*, 3 (2010), 17.

<sup>53</sup> Golden and Zoanni, 17.

assisted suicide. ‘Palliative sedation is defined as the monitored use of medications to relieve refractory and unendurable symptoms by inducing varying degrees of unconsciousness-but not death-in patients who, given their disease state, progression, and symptom constellation, are expected to die within hours or days.’<sup>54</sup> This is another example of the double effect doctrine: the physician sedates the patient to relieve their suffering, not wanting to hasten death, but in the end the patient dies and whether it is from the medication or the patient’s underlying condition becomes a moot point. This is the acceptable version of voluntary euthanasia – the physician’s unintended effect of death. While palliative sedation may seem preferable to some, it really just prolongs the dying process.

“Fear, bias, and prejudice against disability play a significant role in assisted suicide....But the overwhelming majority of the people in Oregon who have reportedly used that state’s assisted suicide law wanted to die not because of pain, but for reasons associated with disability, including the loss of dignity and the loss of control of bodily functions.”<sup>55</sup> This is true. The top three reasons given for requested assisted suicide in Oregon, based on the most recent annual report included on the State’s website, are loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and loss of dignity.<sup>56</sup> However it is the reason of loss of dignity which seems to upset Golden and Zoanni. They claim that “as many thousands of people with disabilities who rely on

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<sup>54</sup> Susan Bruce, Cristina Hendrix, Jennifer Gentry, “Palliative Sedation in End of Life Care,” *Journal of Hospice and Palliative Nursing*, 8(6) 2006; 320.

<sup>55</sup> Golden and Zoanni, 18.

<sup>56</sup> Oregon.gov, Death with Dignity Annual Reports, [www.oregon.gov, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx](http://www.oregon.gov/public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx).

personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance.”<sup>57</sup> This is just their opinion. As for the many who rely on personal assistance and find it dignified, how long have they lived in their current condition? The average age of those using the Death with Dignity Act in Oregon for the last sixteen years is seventy years old, and the majority of those patients have cancer. This is not the same as a person who was born with a disability deciding to use the Death with Dignity Act. This is a person who was disabled at the latter part of life, with no hope for recovery. The patient would have had no time to acclimate to needing assistance for daily activities.

Golden and Zoanni’s next argument is that legalizing physician-assisted suicide would impact disadvantaged people:

The deadly impact of legalizing assisted suicide would fall hardest, whether directly or indirectly, on socially and economically disadvantaged people who have less access to medical resources and who already find themselves discriminated against the health care system. Particularly at risk are individuals in poverty, people of color, older adults, people with progressive or chronic conditions.<sup>58</sup>

The last sixteen years, from 1998 to 2013, data show that the following statistics:

Since the law was passed in 1997, a total of 1,173 people have had Death with Dignity Acts (DWDA) prescriptions written and 752 patients have died from ingesting medications prescribed under the DWDA.

- 396 males and 356 females used the Act
- Median age range was 71
- Race - 729-White, 1-African-America, 2-American Indian, 8-Asian, 1-Pacific Islander, 5-Hispanic, 2-two or more races, 1-other, 3-unknown
- Education – 44 had less than high school diploma, 164 high school graduates, 198 had some college, 341 had Baccalaureate or higher, 5 unknown.

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<sup>57</sup> Golden and Zoanni, 18.

<sup>58</sup> Golden and Zoanni, 18.

- 653 enrolled in hospice, 451 had private insurance, 254 had Medicare, Medicaid or other Governmental insurance, 12 had no insurance, 35 were unknown
- Deaths - 591 died of malignant neoplasms, 54 of ALS, 34 of chronic respiratory disease, 14 of heart disease, 9 of HIV/AIDS
- Other information - 44 were referred for psychiatric evaluation, 632 informed family, 714 died at home
- End of life concerns – 684 losing autonomy, 665 less able to engage in activities, 504 loss of dignity, 376 losing control of bodily functions, 299 burden on family and friends, 177 inadequate pain control, 22 financial implications.<sup>59</sup>

It is obvious from these statistics that the concerns presented by Golden and Zoanni are currently unsupported by the facts. The Oregon Death with Dignity Act has been in effect for sixteen years, with transparent reports posted on the website, as well as in The New England Journal of Medicine each year.

Another argument presented by Golden and Zoanni is that physicians feel hastening a patient's death defies the "do no harm" portion of the Hippocratic Oath. In 2007, two associates of oncologists in California said,

That legalization 'strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship.' Legalization, they concluded, undermines the 'physician's primary directive...to *first, do no harm*'; 'destroys the trust between the patient and doctor'; and, '[u]nder the pretense of providing compassion,' relieves a physician 'of his or her primary responsibility...to safeguard [patients' lives] and to provide comfort to the suffering. It is the ultimate patient abandonment'.<sup>60</sup>

"First, do no harm" can be interpreted in two ways: that hastening a death is doing harm; or conversely, that hastening a death is showing that patient mercy. The Oregon Death with Dignity Act allows for a patient to request a prescription to hasten his/her death. Should the physician wish to participate in the Death with Dignity Act, s/he will write the prescription for the patient. However, the physician is under no obligation to

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<sup>59</sup> Public Health of Oregon, "Death with Dignity Act," [www.oregon.gov](http://www.oregon.gov), Accessed December 12, 2013.

<sup>60</sup> Golden and Zoanni, 19.

participate. Also, a physician is not writing these prescriptions without the knowledge, request, and/or consent of the patient. These prescriptions are written as a last resort for a patient who wants to choose a good death, knowing that there is no justifiable reason for a bad death.

Golden and Zoanni discuss the failure of safeguards in the current Death with Dignity Acts and what they consider to be the myths surrounding the legitimacy of those Acts. First discussed is the myth of free choice and self-determination. Margaret Dore, a law specialist, asserts that the assisted suicide laws “dramatically undermine patient control.” She claims that those in favor of the Act printed “glossy brochures” telling people that only the patient can administer the lethal dose, and yet nowhere in the Act itself does it say this. She claims that heirs of the patient are able to sign the patient up for assisted suicide, as well as speak on behalf of the patient during the process, inviting coercion. Also, Dore believes there is no oversight once the prescription has been filled. She claims that “The Act does not state that ‘only’ the patient may administer the lethal dose; it provides that the patient ‘self-administer’ the dose.”<sup>61</sup> She claims that someone else giving the patient the lethal medication is allowed: “Someone else putting the lethal dose in the patient’s mouth qualifies as ‘self-administration.’” This is not in the spirit of the laws enacted currently. The patient is the only person allowed to request the medication and the only person allowed to administer the medication. If there is suspicious activity, that is for the police to decide.

Golden and Zoanni claim that “The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear distinction between those who are

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<sup>61</sup> Dore M, “Death with Dignity”: what do we advise our clients? *King County Bar Bulletin*, 2009; May. Available at <http://www.kcba.org/80.newsevents/barbulletinarchive/2009/09-05/article5.aspx>.



terminally ill with six months to live and everyone else.”<sup>62</sup> Obviously medical doctors can be wrong about a prognosis. However the Acts state that when a physician tells a patient s/he has six months left, that is when the prescription can be written. That does not mean that the patient takes the medication immediately upon getting that information. Each patient is different: some will spiral down toward death faster than others. Having the prescription and taking it are two different things.

“Doctor shopping” is the next argument made for not legalizing assisted suicide. It is argued that patients, whose doctors are unwilling to write the lethal prescription, will try to find a physician who will. That is certainly the right of every patient’s right. The fear is that a non-terminal patient will find a physician who will write him/her a lethal prescription under the Death with Dignity Act. “When the first physician a patient approached refused to comply with the request for lethal drugs...the patient sought out a second physician, and in some cases, a third and fourth, until someone finally agreed. In fact, in the first three years assisted suicide was legal in Oregon, patients had to ask at least two physicians before receiving lethal drugs in 59% of cases.”<sup>63</sup> When a physician feels a patient is under duress, depressed, or being coerced, he will refer the patient for psychiatric counseling. This is normal procedure which can be the reason the patient had to “ask at least two physicians” for the prescription.

Compassion and Choices, a patient advocacy group, helps patients and families navigate the options associated with end-of-life care. Golden and Zoanni believe that physicians who are affiliated with this group will write prescriptions based on requests

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<sup>62</sup> Golden and Zoanni, 21.

<sup>63</sup> Golden and Zoanni, 21.

from Compassion and Choices. Again, the patient is the one making the request, not the family nor an advocacy group. While Compassion and Choices does fund causes in relation to assisted suicide, the organization is much more than that. The organization offers end-of-life counseling which includes:

- completing advanced directives
- navigating the healthcare system
- contacting hospice or palliative care providers, pain specialists, social services agencies, support groups, and other local resources
- educating family and friends on how to advocate for their loved ones
- education to help clients receive effective pain and symptom management
- advocating for residents of long-term care facilities or other healthcare institutions
- providing information about aid in dying if suffering becomes unbearable for terminally ill, mentally capable adults
- consultation regarding other considerations for obtaining a peaceful death such as voluntary stopping of eating and drinking, refusing unwanted medical treatment, or discontinuing life sustaining treatment under the care of a physician
- offering healthcare professionals information about compassionate, patient centered end-of-life care.<sup>64</sup>

Golden and Zoanni cite the case of Kate Cheney to support some of their claims. Kate Cheney was an 85 year old woman who spent a week in a nursing home to give her family a rest in caregiving. Cheney felt she was a burden to her family. She saw two physicians because her daughter thought the first one was dismissive. The second physician wanted a psychiatric evaluation which reported that Cheney was unable to understand the options about assisted suicide, and therefore her request for assisted suicide was denied. Apparently her daughter became “angry” and requested another evaluation. “Disturbingly, the psychologist deemed Cheney competent while still noting that her ‘choices may be influenced by her family’s wishes and her daughter, Erika, may

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<sup>64</sup> Compassion and Choices, *End of Life Consultation*, [www.compassionandchoices.org](http://www.compassionandchoices.org).

be somewhat coercive.’ Cheney soon took the drugs and died.”<sup>65</sup> There are safeguards in place for these types of situations. The physician who wrote the prescription after receiving a psychiatric evaluation deeming Kate Cheney unfit to truly make the choice of physician-assisted suicide, should have been investigated for malpractice.

Golden and Zoanni cite the Demoralization Syndrome as the reason most patients opt for physician-assisted suicide. This is “very common in chronic, . . . life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon’s law . . . but request [assisted suicide] because of fears of . . . the future: helplessness, dependence, becoming a burden.” As previously stated the number one reason for requesting the Act is loss of autonomy. Golden and Zoanni believe that a person requesting physician-assisted suicide are depressed and this author concurs. The patient cannot only be depressed to receive a lethal dose of medication. The patient must also have a terminal illness, and have less than six months to live. If a patient knows unconditionally that his/her life will be filled with endless pain, indignities, loss of independence, and nothing joyful to look forward to, then it would be fair to believe the patient is depressed, and why not? However there is a difference between being depressed and being mentally competent to understand the ramifications of physician-assisted suicide through a cloud of situational depression.

An example used regarding the above is as follows:

A woman in her mid-50s with heart disease, but otherwise with no significant pain or mobility limitations, requested a lethal prescription from her cardiologist. The cardiologist, in turn, referred her to another physician who was willing to write lethal prescriptions. This physician determined she was not terminally ill. But rather than ask about the origins of her suicidal wishes and give her a psychiatric referral, the physician

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<sup>65</sup> Golden and Zoanni, 22.

simply told her to see her cardiologist again. Her cry for help unanswered, she committed suicide the following day.”<sup>66</sup>

While the story is sad, no one saw this woman for what she was: suicidal. Only those involved can know how this woman presented herself. We do not know how she committed suicide. Was she trying to get the medication because she thought it was the easiest way to die? We do not know why her cardiologist sent her to another physician because of her request for assisted suicide. The referring physician did the right thing by not prescribing this patient medication, but that is all we know. The referring physician may have encouraged her to talk to her cardiologist about her feelings; we just do not know. Believing she committed suicide because she had access to the Death with Dignity Act cannot be concluded in this case.

Another argument given by Golden and Zoanni is “there is no monitoring or control once the prescription for lethal drugs is written.”<sup>67</sup> There is a question as to what happens to the medication if the patient dies from his/her underlying condition. Why is that a question? No one asks what happens to other medications. Secobarbital and pentobarbital are two of the medications often prescribed in physician-assisted suicide, but another of its uses is for insomnia. If a patient who takes either drug for insomnia dies, no one asks what happened to the medication provided. “The drugs could be stored over time in private homes or workplaces, with no oversight to protect public safety.”<sup>68</sup> People are prescribed many medications that are dangerous if used improperly, but there

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<sup>66</sup> Golden and Zoanni, 24.

<sup>67</sup> Golden and Zoanni, 25.

<sup>68</sup> Golden and Zoanni, 25.

is information provided with all prescriptions from pharmacies about how to store the medication, when the medication expires, and often to keep out of the hands of children.

Golden and Zoanni use the laws of the Netherlands to demonstrate how the United States could become another nation to permit euthanasia. “Although it remained technically illegal until 2002, the Netherlands first began to legally tolerate assisted suicide in the early 1970s, providing the longest experience with assisted suicide in any country. Today, active euthanasia – physicians giving lethal injections – has almost completely replaced assisted suicide.”<sup>69</sup> The Death with Dignity laws have been enacted for a patient’s right to choose death over suffering. The laws do not state in any way that anyone else can administer the lethal medication. If there comes a time when the United States considers broadening the definition of assisted suicide to include the permissibility of a person other than the patient to administer the lethal drug to the patient, the ultimate decision will be settled through the legal system. Is it possible that the U.S. will ever tolerate involuntary euthanasia? Anything is possible, but this author believes the laws in place are sufficient and will mostly likely not go further.

This author believes the arguments put forth by Golden and Zoanni are easily refuted. The Death with Dignity Acts are laws to which all citizen deserve access, but having access does not mean that everyone will use the it. Nor does it mean that the Acts will be used only for nefarious reasons, such as insurance companies using it to decrease costs, or for greedy relatives to gain their inheritance earlier rather than later.

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<sup>69</sup> Golden and Zoanni, 27.

## CONCLUSION

This author strongly advocates that physician-assisted suicide, or aid in dying, should be a constitutional right; that each state should afford this opportunity to each of its citizens; and, since it appears that the Oregon Death with Dignity Act has worked well for the last sixteen years, each state should use Oregon's practice as its model. Granting patients the autonomy to choose how and when to die is a fundamental right to which all citizens are entitled, especially at a time in life when the belief is that there are no other choices. Surely if a patient determines that his or her quality of life is extremely poor, and that determination is supported by the standards set forth by the medical community (as judged by a medically licensed professional), and that patient is suffering, living with intractable pain, and has little or no hope of recovery, the patient should be afforded the right to choose to die with dignity.

It is very clear, however, that this issue may never be easily characterized as black or white. There are several contributing factors which, if not satisfactorily addressed, could serve to cloud this argument. For example, many believe that allowing physician-assisted suicide tarnishes the medical profession. To many, the medical profession is tasked with sustaining life, rather than ending it because that is their goal – to prolong life. Alternatively, however, this could be interpreted positively by the medical profession because the physician is providing assistance to the patient by alleviating terminal suffering, as is the charge of a physician. Because the physician cannot administer the medication but can only write the prescription for the lethal dose, the decision to end his/her life is entirely up to the patient. While the physician supplies the patient with a

mechanism for committing suicide, it is ultimately up to the patient to make that choice, that final decision.

To ensure the success of all future states' legislation it is imperative to clearly identify and outline the credentials, scope, and overall responsibility of the physicians who decide to practice legally physician-assisted suicide. In order for state approved physician-assisted suicide to work there needs to be appropriately funded programs to support the families, physicians, and state agencies in order to ensure that everything from training to vital record keeping is available. Detractors will point to the slippery slope argument, the concern that by allowing physicians to assist in hastening death, the medical profession will now become God-like and begin coercing people to kill themselves because: a) the patient is considered less human than the majority of the population; b) the patient is considered a drain upon society, or c) greedy family members will want their inheritance earlier rather than later. To that argument, point to the well-kept records of the state of Oregon where there are sixteen years of documentation, reports, and statistics from the Oregon Department of Human Services demonstrating that the Act has had minimal, if any, abuses. This reinforces the notion that states using a physician-assisted suicide model like that of Oregon could prove to be successful if implemented with care and precision.

Another reason in support of widespread availability of physician-assisted suicide is that the suffering, terminally ill are not confined to only a handful of states. Affording this option to so few such patients is morally wrong. Moving to a state which legally sanctions physician-assisted suicide is usually prohibitive for such patients as their illness renders them physically, and frequently financially, restricted. Additionally, one of the

stipulations is that patients must establish residency in these states and most patients simply do not have that kind of time left. In fact, Oregon specifically added the residency stipulation so that detractors could not argue that people will move to Oregon just to die. That act was passed two decades ago and only four states have legalized this act.

According to the Oregon Department of Human Services, the patients who have chosen to participate in the Death with Dignity Act had three primary reasons for doing so: the patient was losing autonomy, losing independence; the patient was less engaged in activities that made life enjoyable; and the patient's loss of dignity. Physician-assisted suicide allows a doctor to prescribe a lethal dose of a particular medication specifically for the patient, regardless of the reason, to hasten his/her own life. The physician is not allowed to administer the lethal dose, the patient must do it alone. Physicians have a choice, as well – each physician can decide for her/himself whether to participate by writing a lethal prescription. No one can force a physician to participate.

It is acknowledged that killing is wrong, indeed we have many laws that support that belief. A discussion of physician-assisted suicide, however, is not about the act of killing or cold blooded murder. It is about dying with dignity by choice, the patient is going to die with or without that intervention, and it is up to the patient to choose how and when that will occur. There are those whose religious beliefs support the notion that there is great nobility in suffering. Cody Curtis in “How to Die in Oregon” mentions this when discussing her choice of death with her Compassion and Choices case worker:

Cody: I'm coming to think maybe it's not being able to take care of myself and not worrying my family. And I feel like I want to model for my children a kind of, um, grace and acceptance, 'cause I'm really scared of being a coward at the end.

Case Worker: Well, we call it death with dignity, not death from cowardice. Do you think it's cowardice to not wanna suffer? That's a message that our society



gives over and over again that only the...if you're...the truly courageous are the ones that are willing to suffer the most.

Cody: Yeah, you're right.

Case worker – it's an absolutely totally erroneous and completely flawed philosophy and logic – there's no logic to that.

Cody: You're right and I don't want to put my children through that. It's a very human thing to die. We're all gonna die.

Case worker: Yeah.

Cody: And I'm just lucky to know that more about how and when I'll die and have more control about that than most people do.

Case Worker – Right.<sup>70</sup>

With the extraordinary medical advances which have developed over the past century it is baffling that any one should have to endure pain when there are clear options for its alleviation. Even animals are treated humanely as they are put to death. Many people used the argument that if criminals convicted of atrocious acts of violence upon other people are afforded the right to die with some dignity by our legal system, then someone who chooses to end their life because it is not, in fact, any longer their own ought to be afforded the same privilege.

The role of the medical professional is evolving. The argument that the profession will be undermined by a physician helping to hasten a terminally ill patient's death needs to be re-evaluated and re-examined. There are doctors who truly believe assisting a patient in death is helping the patient. All of the discussions and actions pertaining to a doctor's assistance in hastening death are private and protected by doctor/patient confidentiality. It is the patient who requests the assistance to carry out the act; the doctor is only there to facilitate the patient's wishes.

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<sup>70</sup> Peter D. Richardson, *How to Die in Oregon*, HBO, 2011.

Concerns over the slippery slope aspect of legalizing euthanasia are certainly valid. Government oversight of these laws can be daunting as well. If the government has difficulty effectively managing the Department of Motor Vehicles, how might they navigate the sensitive waters of physician-assisted suicide?

Twenty years have passed since Oregon voted this law into its constitution and, to date, there have been no noted negative effects of a slippery slope. It would be naïve to think that euthanasia does not exist in our society today, but it is illegal and those who participate in that act are subject to negative consequences if discovered. Certainly, there are abuses of all laws and these cannot be completely eliminated. One should never stop doing the *right* thing in an individual case because of the *possibility* of abuse in the aggregate. The law must be written with as much attention to detail as possible, and those it serves must hope for the best while handling abuses swiftly and decisively.

Another concern of those in opposition to Death with Dignity laws is the potential for coercion from family members to hasten death, whether for financial reasons or because the patient was made to feel a burden to the family. It is for this reason that the doctor and his consulting physician must be diligent about guiding the patient through the process. Even one hint at coercion must bring the process to a halt. The law is written in such a way as to either preclude the coercion or to illuminate it during the process.

Another concern expressed by opposing entities is that the disenfranchised or vulnerable members of the population – generally defined as women, racial and ethnic minorities, the disabled, the poor, or some combination of these groups – would be adversely affected in disproportionate numbers by legalization.<sup>71</sup> In Oregon, this

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<sup>71</sup> Ronald Lindsay, “Oregon’s Experience: Evaluating the Record,” *The American Journal of Bioethics* 9.2 (2009): 19-27.

potentiality has not materialized. Indeed, a recent report from the Oregon Human Services Department indicates that almost all of those who have utilized the Death with Dignity Act were white, educated, and male. In addition, most also had medical insurance and were financially stable.<sup>72</sup>

In addition to the above listed concerns, opponents bring up the concern that opting for palliative care will decline because physicians will use the Death with Dignity Act more frequently for those patients who are considered terminal. The guidelines, however, specifically state that physicians must discuss alternative treatments, including palliative care. While insurance companies might be more inclined to hasten a patient's death in favor of financial interest, that interest should never enter into a physician's decision. The physician takes an oath to do no harm, and hastening a patient's death for financial reasons only, would certainly amount to harm to that patient.

Terminally ill patients often fear loss of autonomy but one must also consider the autonomy of the physician. Since the Oregon Death with Dignity Act specifically states that a physician cannot administer the lethal dose to assist in dying, the ultimate decision rests with the patient. In the sixteen years since the inception of Oregon's Death with Dignity Act, there are a number of cases which indicate that prescriptions had been written for patients who never used the lethal medication. In these cases, the patients died from the disease. No one can truly know why the patient chose not to hasten death given the opportunity, but does it matter to the physician who wrote the prescription? Does he breathe a sigh of relief that the patient died of "natural causes" rather than by the

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<sup>72</sup> Death with Dignity Act, Annual Reports, accessed December 13, 2013, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx>

doctor's contribution? We may never know. We can hope, however, that the physician who writes the prescription is comfortable in knowing the possibility is there should the patient choose.

Because Oregon controls secobarbital, the most popular drug chosen for physician-assisted suicide prescribed by physicians, it is unavailable to the general public. The only legal way to get the drug is from a doctor's prescription. Some believe that just by writing the prescription, the physician is culpable in the death of the patient if the patient dies as a result of ingesting the drug. If that is the case, should we not blame the pharmacist for filling the prescription, or the pharmaceutical company that manufactures the drug, or the scientists who synthesize the chemical to create the compound? The doctor writes, on a piece of paper, the drug to be prescribed, but it is the pharmacist who actually provides the medication to the patient. And still, the final decision rests with the patient. The drug is not being forced into the patient's mouth. The vial of pills sits in a drawer until the patient chooses to exercise the option.

Opponents of Death with Dignity laws often say doctors are healers, and by giving them the ability to prescribe a lethal dose of a drug to assist in hastening the death of a terminally ill patient, the public will begin to think of physicians as Doctors of Death, rather than healers. Frequent references name Dr. Jack Kevorkian when raising this argument against physician-assisted suicide. The fear is that all physicians writing these prescriptions will be tagged with the "Dr. Death" persona. Dr. Kevorkian was an eccentric man, this is acknowledged, but he was eagerly trying to raise awareness of this issue. He was passionate about his cause, always wanting to do the right thing for those who sought his aid.

It is interesting to note that many people use the Death with Dignity Acts in Oregon and Washington but do not actually ingest the medication. Whether these patients wait until it is too late rendering the patient unable to administer the medication alone, we may never know. It was apparent to viewers of the HBO documentary, “How to Die in Oregon” that all of the patients filmed who had picked up the medication, felt a sense of relief, just knowing the medication was available.

Some people fear that physicians will become indifferent to the plight of their patients. People are concerned that doctors will easily slip into allowing family members or insurance companies to coerce patients into choosing death over more expensive and lengthier palliative care. People worry that just having the power to write the prescription, will turn the physicians into God-like beings who will decide which patients should live and which should die.

Continuous Sedation is what some consider an appropriate alternative to physician-assisted suicide. However it appears that continuous sedation and euthanasia are similar to each other. The difference is that euthanized patients will die quickly. With continuous sedation, the patient will die a slower death. What is the point of living if one is continuously sedated until his last breath? The patient spends the remainder of his days dying, not living.

## APPENDIX A

### Glossary of Terms<sup>73</sup>

Discussion about death with dignity and assisted dying is often made difficult because of confusion surrounding various terms. "Mercy killing," "euthanasia," and "suicide" for example. This page aims to help clarify several terms and increase understanding of the death with dignity movement.

#### **Advance Directive**

A general term describing two kinds of legal documents [See [Living Will](#) and [Durable Powers of Attorney](#)]. Such documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity. Each state has its own regulations concerning the use of advance directives.

#### **Assisted Death**

Also known as "physician-assisted suicide," "physician-assisted dying," or "aid in dying" and is legal in the United States in Oregon and Washington. It permits mentally competent, terminally-ill adult patients to request a prescription for life-ending medication from their physician. The Oregon and Washington laws mandate that the medication must be self-administered.

#### **Autonomy**

The exercise of self-determination and choice among alternatives, based on the individual's values and beliefs.

#### **Continuum of Care**

Relates to a course of therapy during which a patient's needs for comfort care and symptom relief is managed comprehensively and seamlessly. Hospice provides a continuum of care to terminally-ill patients, and aid-in-dying is assumed as the option of last resort at the end of that continuum.

#### **Coma**

The National Institute of Neurological Disorders and Stroke defines coma as "a profound or deep state of unconsciousness. An individual in a state of coma is alive but unable to move or respond to his or her environment." Comas can result from chronic illness or severe injury/trauma.

#### **Comfort Care**

An approach to end-of-life care that emphasizes the relief of discomfort rather than the cure of illness or prolonging life. Physical, social and emotional needs are the first priority, even when treatment such as high dose pain medication may hasten death.

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<sup>73</sup> Death with Dignity National Center, "Glossary of Terms," <http://www.deathwithdignity.org/acts>, (January 2, 2014).

## **DNR / DNI**

DNR/DNI are acronyms for Do Not Resuscitate and Do Not Intubate and are specific physician orders. Do Not Resuscitate means that in the event of cardiac arrest, no CPR or electric shock will be performed to re-start the heart. Do Not Intubate means that no breathing tube will be placed in the throat in the event of breathing difficulty or respiratory arrest. Each of these orders may be given separately and are generally prominently noted in the patient's medical chart. The patient can change a DNR and DNI order at any time, and experts urge such orders be reviewed regularly. In a DNR/DNI situation, a patient is provided comfort care. Without such an order, emergency medical technicians are legally required to perform CPR.

## **Double Effect**

This is the doctrine established by St. Thomas Aquinas in the 13th century in which an action that has two effects—one that is intended and positive and one that is foreseen but negative—is ethically acceptable if the actor intends only the positive effect. The doctrine is often used to describe the impact of administering high doses of morphine or terminal sedation—treatments intended to relieve suffering but that often hasten death. Since the intention is comfort care, this is not considered euthanasia and is legal and generally practiced throughout the United States and around the world—generally in private and without publicity.

## **Durable Power of Attorney**

A document appointing a surrogate to make medical decisions in the event that an individual becomes unable to make those decisions on their own. It is also sometimes referred to as a "health care proxy."

## **Euthanasia**

Translated literally as "good death" and refers to the act of painlessly but deliberately causing the death of another who is suffering from an incurable, painful disease or condition. It is commonly thought of as lethal injection and it is sometimes referred to as "mercy killing." *All forms of euthanasia are illegal in the United States.*

- **Active Euthanasia:** Generally understood as the deliberate action of a medical professional or layperson to hasten a patient's death.
- **Passive Euthanasia:** Generally understood as a patient's death due to actions *not taken* by a medical professional or layperson—actions that would normally keep the patient alive.
- **Voluntary Euthanasia:** Occurs at the request of the person who dies.
- **Non-Voluntary Euthanasia:** When a patient is unconscious or otherwise mentally unable to make a meaningful choice between living and dying, a legal surrogate makes the decision on the patient's behalf.
- **Involuntary Euthanasia:** Occurs when a patient's death is hastened without the patient's consent. While generally viewed as murder, there are some instances in which the death may be viewed as a "mercy killing."

**Futile Measures**

generally refers to the medical care of patients in which the care will have little or no effect on the patient's outcome or prognosis.

***Guardian Ad Litem***

A Latin term for a court-appointed representative who makes decisions in a legal proceeding on behalf of a minor or an incompetent or otherwise impaired person.

**Hospice**

An organization or institution that provides comfort (a.k.a. palliative) care for dying individuals when medical treatment is no longer expected to cure the disease or prolong life. Hospice sometimes also applies to an insurance benefit that pays the costs of comfort care usually at home for patients with a prognosis or life expectancy of six months or less.

**Intent**

A concept used to draw a moral distinction between aid-in-dying and other acts/omissions that cause death—such as terminal sedation and withdrawing life-sustaining therapy. "Intent" assumes the ability to draw a clear distinction between *knowledge* of a certain outcome and an *intention* to produce that outcome.

**Life-Sustaining Treatment**

Any treatment, the discontinuation of which would result in death. Such treatments include technological interventions like dialysis and ventilators. They also include such simpler treatments as feeding tubes and antibiotics.

**Living Will**

A type of advance directive containing instructions about future medical treatment in the event the individual is unable to communicate specific wishes due to illness or injury. Each state has its own regulations concerning the use of living wills.

**Minimally Conscious**

A state of being which was described in the February 12, 2002 edition of *Neurology* as qualitatively distinct from coma and vegetative states. For example, patients who are "minimally conscious" are impaired but have some capabilities, such as the ability to reach for and grasp objects, track moving objects, locate sounds, and process and respond to words. Patients may inconsistently verbalize or gesture to communicate, and patients may regain full consciousness. However, minimal consciousness may also be permanent.

**Palliative Care**

Care and treatment that focuses on relieving pain and discomfort rather than on curing the disease or prolonging life. [See also [comfort care](#)]

**Patient Self-Determination Act of 1991**

A federal law which requires health care facilities that receive Medicare and Medicaid



funds to inform patients of their right to execute advance directives regarding end-of-life care.

### **Persistent Vegetative State**

Some comatose patients lapse into a persistent vegetative state. According to the National Institute of Neurological Disorders and Stroke, patients in such a state "have lost their thinking abilities and awareness of their surroundings, but retain non-cognitive function and normal sleep patterns. Even though those in a persistent vegetative state lose their higher brain functions, other key functions such as breathing and circulation remain relatively intact. Spontaneous movements may occur, and the eyes may open in response to external stimuli. They may even occasionally grimace, cry or laugh. Although individuals in a persistent vegetative state may appear somewhat normal, they do not speak and they are unable to respond to commands."

### **Refusal of Medication/Treatment and Nutrition/Hydration**

Terminally-ill patients who feel they are near the end of life may legally and consciously refuse medication, life-sustaining treatments, nutrition and/or hydration. Published [studies](#) indicate that "within the context of adequate palliative care, the refusal of food and fluids does not contribute to suffering among the terminally ill", and might actually contribute to a comfortable passage from life. "At least for some persons, starvation does correlate with reported euphoria."

### **Studied Neutrality**

Various medical organizations' recognition of and respect for the diversity of members' personal and religious views and choices -- as well as those of their patients -- in order to encourage open discussion about all end-of-life options.

### **Suicide**

Generally defined as the act of taking one's own life voluntarily and intentionally -- usually as the result of an individual's self-destructive impulse and mental illness and often independent of a terminal illness. Because a terminally-ill adult patient who is deemed mentally competent chooses to hasten his or her death through a physician's assistance, "physician-assisted dying" is more accurate than "physician-assisted suicide."

### **Surrogate Decision Making**

A procedure that allows a loved one to make medical-care decisions on a patient's behalf, in accordance with a patient's known wishes. If the patient's wishes are not known, the decisions are generally said to be made in the patient's "best interests."

### **Terminal Sedation**

Generally practiced during the final days or hours of a dying patient's life, this coma-like state is medically induced through medication when symptoms such as pain, nausea, breathlessness or delirium cannot be controlled while the patient is conscious. Patients generally die after of the sedation's secondary effects of dehydration or other intervening complications.

**Withholding/Withdrawing Treatment**

Omitting or ending life sustaining treatments such as ventilators, feeding tubes, kidney dialysis, or medication that would otherwise prolong the patient's life. This legal act may be upon the patient's request, as the result of an advance directive or based upon the medical determination of futility.

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