his doctor that he is exhausted, cannot tolerate the pain, and simply wants to be "put to sleep." A plan for terminal sedation is proposed to him and he accepts. A barbiturate infusion is begun. The dosage is increased until Mr. Care is deeply sedated and his pain appears to be controlled. No orders for fluids and nutrition are written.

CASE II. Mr. Care is in the late stages of multiple sclerosis. He is still living at home but is admitted to the hospital for aspiration pneumonia. His physician is confident that he will recover and return home. However, Mr. Care tells his wife and the physician that he is tired of living with his deteriorating condition. He refuses treatment for his pneumonia and refuses to eat, saying he intends to starve himself to death. He asks to be sedated in order to die comfortably.

COMMENT. In both cases, a person with decisional capacity refuses care (see Section 2.2.7). However, in Case I the patient is terminal, and the sedation is a response to intractable pain and recurring pneumonia. In Case II, the patient is not terminal and is not asking for pain relief but for death to be hastened. In the first case, palliative sedation is an acceptable example of double effect reasoning; in the second, palliative sedation, although not the cause of death, accelerates it. This is not ethically acceptable.

Palliative sedation in the setting of competent request and imminent death is clearly ethical. In other cases, it is ethically problematic. As a clinical practice, it should be approached cautiously. It has potential for abuse. It can become a means of enabling death of the nonterminally ill, as in Case II, or a routine clinical practice for patients who are terminal and whose wishes are not known.

3.5 MEDICALLY ASSISTED DYING

Some persons may conclude that the quality of their life is so diminished that life is no longer worth living. This conclusion may be the result of unrelieved pain or suffering, or because they consider the prospect of deterioration, or because they believe that their lives are a burden on others. Persons who come to this conclusion are often terminally ill and under the care of a physician. It may occur to them to ask their physician to help them die quickly and painlessly. In the previous sections of this book, we have discussed situations in which some form of medical treatment, such as dialysis, mechanical ventilation, or chemotherapy, was sustaining the life of the patient. We have analyzed the situations in which patients and

physicians may decide to forgo these forms of medical intervention. In this section, we envision a situation in which termination of treatment will not itself cause the death of the patient; some additional action must be taken to do so. We here ask what physicians may ethically do to respond to patients' request to help them end their lives.

3.5.1 Euthanasia

The term *euthanasia*, meaning "a good death" has been used for centuries to describe this moral question. In its original medical use, "euthanasia" implied the duty of a doctor to assure that his patients died as peacefully and comfortably as the medicine of the time could provide. Direct killing was repudiated. Later, the term was used as a synonym for *mercy killing*, that is, deliberately and directly killing a sufferer to relieve pain, either by a physician or by some other compassionate party. Then, distinctions were made between voluntary, nonvoluntary, and involuntary euthanasia. Voluntary euthanasia described situations in which the patient consciously and deliberately requested death. Nonvoluntary euthanasia described situations in which the patient was decisionally incapacitated and made no request. Involuntary euthanasia described situations in which the patients were killed against their wishes. Involuntary euthanasia (practiced as a policy in Nazi medicine) has been condemned by all commentators. Nonvoluntary euthanasia, that is, causing death, usually of persons without decisional capacity, without their expressed wish, has been criticized by most commentators. Voluntary euthanasia, though very controversial, has been defended by a few commentators as ethically permissible on the basis of patient autonomy.

The contemporary debate in the United States has moved away from these distinctions and now focuses on the more precise question of whether physicians may respond to a request from a competent and terminally ill patient for assistance in dying. This question itself requires clarification. It may refer either to a situation in which a patient requests a physician to administer a lethal drug, or to a situation in which the patient asks a physician to prescribe potentially lethal medications that the patient can self-administer to bring about death. The patient makes the final decision about whether his or her quality of life is too low to continue to live. This patient performs the action that will end his or her life. By comparing this issue to the discussion about forgoing life support, it is possible to clarify similarities and differences.

EXAMPLE. Ms. Comfort is dying from widely disseminated cancer and is suffering intense pain, even though she is receiving high doses of morphine. She is conscious and capable of communication. She begs her doctor "to put her to sleep forever." The physician administers a lethal dose of a short-acting barbiturate and morphine sulfate intravenously.

COMMENT. This is an example of voluntary euthanasia: the patient requests death and the physician administers a lethal drug. The debate over the physician's role was long posed in these terms. It is obvious, in this case, that the physician is the agent and cause of the death of the patient, even though the patient voluntarily requested him to do so. However, in American law, this scenario would constitute an illegal taking of human life. In all ethics statements of medical organizations, it is considered unethical behavior. In the bioethical literature, it remains highly debatable. Today, the discussion of physician involvement in aiding the death of a patient has shifted to the formulation commonly called "physician-assisted dying," as explained later.

Beauchamp TL, Childress JF. The justification of intentionally arranged death. In: Beauchamp TL, Childress JF, eds. *Principles of Biomedical Ethics*. 6th ed. New York, NY: Oxford University Press; 2009:176–186.

Dickens BM, Boyle JM, Ganzini L. Euthansia and assisted suicide. In: Singer PA, ed. *The Cambridge Textbook of Biomedical Ethics*. New York, NY: Cambridge University Press; 2008:72–78.

Dworkin G. Physician assisted death: the state of the debate. In: Steinbock B, ed. *The Oxford Handbook of Bioethics*. New York, NY: Oxford University Press; 2009:375–393.

Lo B. Physician-assisted suicide and active euthanasia. In: Lo B, ed. *Resolving Ethical Dilemmas: A Guide for Clinicians*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2009:151–161.

3.5.2 Physician-Assisted Dying

In traditional discussions of euthanasia, the physician's role was generally described as administration of a lethal drug, usually by injection. In the more recent debates, the physician's role has been more precisely defined as the legalization of the physician's prescription of a drug that the patient may take to bring about death.

EXAMPLE. Ms. Comfort is dying from widely disseminated cancer and is suffering intense and implacable pain because of bone metastases, even with optimum pain management. She requests her physician to prescribe a

supply of barbiturates sufficient for her to end her life, to give her instructions about appropriate dosage and administration, and to be present when she takes the prescribed medication to end her life.

COMMENT.

(a) Proponents of physician-assisted dying offer the following argument in its favor. It is correct, they say, that direct administration of a lethal drug constitutes an act of homicide. However, prescription of drugs that the terminally ill patient can take at will removes the physician as the agent of the patient's death. The decision and the action of ending life remain in the patient's control. The patient, then, hastens his or her own dying process, which is quite different from a suicide by a person who is not terminally ill (see Section 3.6.1). These advocates propose that the physician's participation by providing the means should be explicitly exempted from statutes that prohibit aiding a suicide. Physician participation, they claim, is a proper medical response of respect for patient autonomy and of their patient's evaluation of their quality of life.

(b) Physicians opposed to assisting patients in hastening their death in this manner regard participation as unprofessional and unethical. The American Medical Association rejects physician-assisted dying as "fundamentally incompatible with the physician's role as healer." The American College of Physicians does not support the legalization of physician-assisted dying because "the practice might undermine patient trust and distract from reform in end-of-life care" and because of the risk of discrimination against vulnerable populations, including the elderly and the disabled.

AMA Council on Ethical and Judicial Affairs, *Curr Opin.* 1996;2:211.
American College of Physicians. *American College of Physicians Ethics Manual.* 5th ed. Philadelphia, PA: American College of Physicians; 2005.

(c) The states of Oregon and of Washington are the only American jurisdictions that allow physician-assisted dying. Their statutes state that physicians may prescribe, but not administer, a lethal drug for a competently requesting patient who is terminally ill. A 2-week waiting period between request and prescription is required. The physician must be confident that the patient is making a competent and informed request, and psychiatric consultation is required if the physician suspects that

the requesting patient suffers from mental illness. It is the patient rather than the physician who is in control of the process, from its initiation to its completion. This feature of assisted dying differentiates it ethically and legally from other legalized forms of euthanasia, such as in the Netherlands and Belgium, where physicians are permitted to be the agents of the patient's death.

Since 1997, when physician-assisted suicide was legalized in Oregon, approximately 0.1% of Oregon deaths (about 30–60 out of approximately 38,000 annually) have resulted from physician-assisted dying. Also, some patients who obtain a prescription never make use of it. Only a small number of physicians and patients participate in physician-assisted dying. Any physician may decline to participate. The reasons most commonly offered for requests are controlling the timing of death, not becoming dependent, and avoiding future pain (rather than actual pain in the present).

3.5.3 Ethical Arguments

The public, the medical community, and medical ethicists are divided about the ethical propriety of physician-assisted dying. The opponents offer the following arguments:

(a) Prohibition of direct taking of human life has been a central tenet of many religious traditions and has been equally strong in the secular ethic. An ancient maxim of the Western legal tradition states that even the consent of the victim is not a defense against homicide. These opponents consider the "indirect" involvement of the physician as only a prescriber, not an administrator, of the lethal intervention as equally objectionable.
(b) Medical ethics has traditionally emphasized the saving and preservation of life and has repudiated the direct taking of life. The Hippocratic Oath states: "I will not administer a deadly poison to anyone when asked to do so nor suggest such a course." This ancient prohibition seems directly aimed at physician-assisted dying. Contemporary organized medicine reaffirms this tradition.
(c) The dedication of the medical profession to the welfare of patients and to the promotion of health might be seriously undermined in the eyes of the public and of patients by the participation of physicians in the death of the very ill, even of those who request it.
(d) Requests for swift death are often made in circumstances of extreme distress, which may be alleviated by skillful pain management and

other positive interventions such as those employed in hospice care. Similarly, such requests may manifest a treatable depression.

(e) Even if approval is limited to voluntary assisted dying, it is possible that, once established, the practice might become tolerated for nonvoluntary patients whom others assume "would have requested it" if they had been able. Similarly, the availability of quick death may bring subtle coercion on persons who feel that their compromised state is a burden to others. Therefore, even when effecting a swift death at the request of a suffering patient seems merciful and benevolent, the acceptance of the practice as ethical may bear the seeds of dangerous social consequences. This is the so-called slippery-slope argument, namely, that tolerance for a practice on the grounds that it is harmless in one situation will gradually lead to tolerance of similar but more dangerous practices. In the Netherlands, where euthanasia is legal, some commentators claim there is such a slide; no similar slide has appeared in the state of Oregon.

Proponents of physician-assisted dying counter with the following arguments:

(a) The termination of treatment in many cases hastens a patient's death, such as discontinuing artifical nutrition and hydration for a patient in a vegetative state, who is not even terminally ill. Permitting competent and conscious but terminally ill patients to decide to hasten their death is less ethically problematic.

(b) Autonomous individuals have moral authority over their lives; patients who are dying should be allowed the means to control the time and manner of their death with assistance from competent clinicians.

(c) No person should be required to bear disproportionate burdens of pain and suffering, and those who relieve them of such burdens, at their request, are acting ethically, that is, out of compassion and respect for autonomy. Physicians do not have a duty to prescribe lethal drugs; they are ethically permitted to accept or reject the terminally ill patient's request.

(d) Often the burdens of pain and disability are the result of the "success" of medical intervention that has extended life of unacceptable quality. Those who have effected this result should be permitted to respect the patient's desire no longer to bear so unrewarding a result. Just as patients may refuse artificial nutrition and hydration to hasten their death, one might argue that physician-assisted dying accomplishes the same goal.

(e) The maxim of the Hippocratic Oath prohibiting the "giving of poisons" is outdated, because medicine could never have anticipated the ability to prolong dying that it has today.
(f) Some voices within the medical profession, which has been traditionally opposed to euthanasia, have recently expressed support for the carefully circumscribed forms of assistance in dying that have been legalized in Oregon and Washington State.

COMMENT. These arguments are vigorously debated by proponents and opponents of physician-assisted dying. During the 1990s, efforts were made, by legislation and by judicial decision, to make physician-assisted dying legal. Oregon and Washington states have done so. The United States Supreme Court has ruled that, while there is no constitutional right to physician-assisted dying, states may legislate either to prohibit or to permit it (*Washington v Glucksberg* and *Vacco v Quill* 1997).

3.5.4 Physician Response to Request for Assistance in Dying

Even though physician-assisted dying may be widely legalized in the future, debates about its ethical propriety will continue. Physicians will have to make conscientious decisions about whether to provide assistance to patients to hasten their deaths. The practice of physician-assisted dying requires difficult decisions about what constitutes terminal illness, and whether all means of relieving physical and psychological pain have been exhausted. In particular, legal authorization limited to only competent patients in terminal illness leaves unanswered questions about patients in equally distressing circumstances who are unable to self-administer lethal medication and also about persons who are not terminal but who anticipate slow death from degenerative disease. In addition, the question of how vigorously to pursue diagnosis of mental illness, especially depression, remains unsettled.

A request from a patient for assistance in dying should be met in the following manner:

(a) A physician who is unpersuaded by the arguments supporting physician-assisted dying must inform the patient that he or she cannot in conscience cooperate. This physician should offer to discuss the issue in depth with the patient, in hope of finding mutually acceptable options. If the patient continues to request assistance, the physician may offer to resign from the case or to provide only palliative care.

(b) A physician who is persuaded by the arguments favoring assisted dying must recognize that assisting is illegal except in Oregon and Washington. Different jurisdictions have somewhat differing laws and different ways of dealing with the issue, but, in general, assisting a patient to die by prescribing a lethal drug is a criminal act. A physician may choose to take the risk of legal liability, but should do so in full knowledge of the possible consequences.

(c) If a physician chooses to take the legal risk, he or she should be confident that the patient has decisional capacity and is suffering from a condition that can realistically be characterized as terminal. Consultation on these matters is advisable.

(d) The physician should explore the issue with the patient very carefully and sympathetically. The patient's medical situation, options for treatment, alternatives ways to hasten death, palliative care, relief of pain, social supports, values, and attitudes should be discussed. The discussion should take place over time and might include others, such as the patient's spouse and children, closest friends, and religious and ethical counselors.

3.6 CARE OF THE DYING PATIENT

Quality end-of-life care requires a combination of the judgment of clinicians and the preferences of patients in three particular areas, namely, achieving appropriate control of pain and symptoms, avoiding inappropriate prolongation of dying, and enhancing the control of patients over their care. Other aspects of quality care rest primarily with patient and family, supported by physicians, nurses, and social workers. Spiritual concerns of the patient should be met in ways congenial to the patient.

A decision to terminate some specific form of treatment or not to resuscitate does not imply the termination of other forms of care for the patient. It is frequently noted that after a DNR order is written, attention to the patient's needs diminishes. This is unethical for two reasons. First, more than 50% of patients for whom DNR orders have been written survive to be discharged. These patients require continued appropriate care. Second, when the goals of curing are exhausted, the goals of caring must be reinforced. In hospice care, life-support technology and life-saving interventions are avoided in favor of comfort care. Attention to relief of pain and discomfort and enhancement of the patient's ability to interact with family and friends become predominant goals. Hospice care and palliative