

PHILOSOPHICAL FOUNDATIONS OF PHYSICIAN-ASSISTED DEATH AND
EUTHANASIA LEGISLATION IN OREGON AND THE NETHERLANDS:
A COMPARATIVE ANALYSIS

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I. Introduction

The issue of physician-assisted death (PAD) lies at the intersection of a number of distinct areas of thought. Between the philosophical foundations of the arguments in favor of and against the practice, the political and economic implications of its legalization, and the medical intricacies of PAD and related acts, there are numerous interacting components that must be considered when discussing the debate over physician-assisted death and the related act of euthanasia. Against this interdisciplinary backdrop, no single angle can provide a complete understanding of the manifold issues that surround the end-of-life decision-making of the medically ill.

Because an exploration of every relevant angle is far beyond the scope of this paper, my focus will be narrowed to the philosophical foundations of particular laws concerning physician-assisted death and euthanasia. Understanding the ethical motivations behind these specific legalized end-of-life practices is not only enlightening, but we can also use an analysis of these motivations to craft future policies with solid philosophical underpinnings. In this paper, I will explore the distinct philosophical positions that serve as the bases of the Oregon Death with Dignity Act (DWDA) and the Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act, also referred to as the Dutch Euthanasia Act.

In particular, I will focus on the value of respecting patient autonomy, which appears as a central theme throughout the Oregon Death with Dignity Act, and I will compare this autonomy basis with the Dutch Euthanasia Act's central value of avoiding patient suffering. I will weigh the advantages and drawbacks of these two ethical foundations of autonomy and suffering, and ultimately argue for a hybrid philosophical approach to the issues of PAD and euthanasia, a framework that might serve as the basis for an ideal policy formulation.

In Section II, I establish definitions for the terminology that I will be using throughout the paper. In Sections III and IV, I review the debates over physician-assisted death and euthanasia as they have unfolded in both Oregon and the Netherlands, and introduce the current policies and practices of PAD and euthanasia in each of those places. In Section V, I begin my philosophical analysis by exploring the distinct motivations that lie beneath the Oregon Death with Dignity Act and the Dutch Euthanasia Act, namely Oregon's emphasis on a respect for patient autonomy, and the Dutch emphasis on avoiding suffering. In Section VI, I characterize these distinct philosophical motivations, and in Section VII, I explore the philosophical support that exists for each of these ethical foundations. I weigh the advantages and drawbacks of both the autonomy-based and suffering-based accounts of PAD and euthanasia in Sections VIII and IX. In section X, I propose a hybrid philosophical approach to PAD that incorporates important elements of both the autonomy-based and suffering-based accounts. I examine how such a hybrid approach would be reflected in my suggested PAD and euthanasia policy. Finally, in Section XI, I summarize my analysis and present areas for further discussion.

II. Terminology

When discussing the controversy over physician-assisted death and euthanasia, the issue of terminology is of critical importance. Before delving into the debates over PAD and euthanasia, it will be important to establish the terms that are crucial to our discussion of the issue. Namely, the distinction between active and passive euthanasia must be established, as well as the distinction between the practices of active euthanasia and physician-assisted death.

Active Versus Passive Euthanasia:

Active euthanasia is described as the case in which an individual¹ deliberately administers an agent to his patient that will end the patient's life. The American Medical Association considers this sort of active euthanasia to be equivalent to the more general term "euthanasia," which they define as "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering."² In line with the AMA's definition, when referring to "euthanasia" throughout this paper, I am referencing the philosophical notion of active euthanasia, in which a medical professional directly administers the lethal drug to a patient.

In contrast with active euthanasia, which many thinkers philosophically equate with the act of killing, passive euthanasia is ethically comparable to letting die. Passive euthanasia is described as the case in which a medical professional discontinues an action that was previously keeping his patient alive, or simply fails to take an action that would have kept him alive. This might involve the removal of a patient's life-support, the discontinuation of nutrition and

¹ The question of who in particular this individual ought to be is a debate in itself. In general, we will be focusing on active euthanasia administered by medical professionals such as physicians, or more particularly end-of-life specialists.

² American Medical Association, "Opinion 2.21 – Euthanasia."
<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page?>

hydration, or the failure to use “extraordinary means” to keep a patient alive. The distinction between passive and active euthanasia is a debate in itself, and in general, American law has been willing to permit passive, but not active, euthanasia under certain circumstances.³ The key point of controversy at this point in time, and the debate that will be our focus throughout this paper, is the controversy surrounding the permissibility of active euthanasia and the closely related act of physician-assisted death.

Physician-Assisted Death:

Physician-assisted death would typically involve a physician prescribing a patient with a lethal agent for the patient to ultimately administer to herself. Physician-assisted death would then fall somewhere in between active and passive euthanasia. For, the physician is the one who prescribes the lethal dose, but it is the patient who takes the medication on her own volition, at the time of her choosing. The American Medical Association, which officially disapproves of the act, defines “physician-assisted suicide” as occurring 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.”⁴ The means that enable this life-ending act typically involve the prescription of some sort of lethal drug that the patient can then choose to take to end her life. Despite the AMA’s use of the term physician-assisted suicide, for the purposes of this paper I will refer to that act as physician-assisted death, as proponents of Death with Dignity generally do.⁵ Similarly, although many of the philosophers and theorists discussed in this paper use physician-

³ For more on the U.S. Passive Euthanasia discussion, see the Supreme Court case *Cruzan v. Director, Missouri Department of Health*.

⁴ American Medical Association. “Opinion 2.211 - Physician-Assisted Suicide,” <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page?>

⁵ The debates over the terms physician-assisted suicide and physician-assisted death are part of a larger discussion that will be expanded upon later on in the paper.

assisted suicide terminology, I will consider their notions of physician-assisted suicide to fall within my established definition of physician-assisted death.

III. The Debates over Physician-assisted Death and Euthanasia

The debate over physician-assisted death has arisen as a highly controversial issue only in the past few decades. In the United States, debates over PAD have generally revolved around the question of a right to die, and to what extent individuals have the Constitutional right to determine the times and manners of their deaths. Those who argue in favor of such a Constitutionally protected right generally base their views on the liberty interest that is included in the Due Process Clause, claiming that individuals should have the freedom to make important end-of-life decisions, such as the decision to request physician-assisted death. Opponents of a legalized right to physician-assisted death and euthanasia have used a variety of arguments, including claims about the sanctity of life and the Constitutional protection of life. In this manner, these counter-arguments might be comparable to pro-life advocates in the abortion debates, who base their arguments upon the presumed Constitutional protection of life.

Although there is not a clearly established right to die under the Federal Constitution, many U.S. states have implemented legislation related to the practice of physician-assisted death, both permissive and prohibitive. With no Constitutional rule against the general practice of physician-assisted death, these state-level laws related to the practice have been at the core of many conflicts that have risen to the Supreme Court level. In recent history, several cases surrounding the issue of PAD have been brought forth to the U.S. Supreme Court, and in general, the Court has been unwilling to support physician-assisted death, mainly by maintaining that a right to die is not included in the Constitution.

In 1997, in the cases of *Washington v. Glucksberg* and *Vacco v. Quill*, the Supreme Court made two important rulings affirming state prohibitions against physician-assisted death. In the *Washington v. Glucksberg* case, the Court held that the Constitution's Due Process Clause does

not protect the right to physician-assisted death, as supporters of the practice claim. The same year, in *Vacco v. Quill*, the Court upheld New York State's prohibition against physician-assisted death. Despite these two Supreme Court cases affirming prohibitions against the practice, state-level laws granting patients the right to die through PAD are currently in place in Oregon, Washington, and Vermont, with related discussions in place in other states such as New Mexico and Montana. As the first U.S. state to implement physician-assisted death legislation with the adoption of the 1994 Oregon Death with Dignity Act, the state of Oregon has led the rest of the country's Death with Dignity initiatives, with Washington and Vermont adopting similar versions of the Oregon policy.⁶

Discussions regarding physician-assisted death and euthanasia have also played out extensively across Europe. As opposed to the closely related Death with Dignity laws that are in place in America, there are major differences amongst the various physician-assisted death and euthanasia laws that have been implemented throughout Europe. For the purposes of this paper, I will be examining physician-assisted death and euthanasia laws in the Netherlands, and in particular, how the basis of the Dutch legislation contrasts with that of the Oregon Death with Dignity Act. Of course, there are many more examples of physician-assisted death and active euthanasia legislation that I will not be discussing in this paper. I have selected Oregon and the Netherlands as samples to compare because of the long-established histories of their respective euthanasia and physician-assisted death legislations, and the strong contrasts that are present between these two policies.

⁶ Howard Ball, "The Pioneering PAD States," In *At Liberty to Die the Battle for Death with Dignity in America* (New York: New York University Press, 2012), 131.

The Oregon Debates

The Oregon debates over physician-assisted death began in the late 1980's, when Hemlock Society USA founder Derek Humphry began campaigning in favor of the practice. Humphry's efforts were aided by the Oregon Compassionate Choices group in the early 1990's, and in 1994 voters approved the Oregon Death with Dignity Act. The Oregon DWDA went into effect in 1997, in response to the aforementioned *Washington v. Glucksberg* ruling that the Due Process Clause does not protect the right to assisted-death. Between its approval and implementation, the Oregon Death with Dignity Act was fiercely challenged by groups such as the Roman Catholic Church and various Oregon health care organizations.

Many other challenges against the act were posed following its implementation, including a notable attempt by the U.S. Attorney General to punish Oregon physicians who prescribed lethal drugs to their patients. In the 2006 *Gonzales v. Oregon* decision, the Supreme Court ruled against the Attorney General's attempts to enforce the Controlled Substances Act against physicians prescribing life-ending drugs to their terminally ill patients. The *Gonzales* case was heard in response to an Interpretive Rule issued by Attorney General John Ashcroft in 2001, stating that physicians prescribing lethal agents to their patients for the purpose of physician-assisted death were in violation of the Controlled Substances Act. Ashcroft claimed that physician-assisted death was not a legitimate medical purpose, and that it therefore violated the

Act. Aschcroft's rule was successfully challenged by the state of Oregon, backed by a group of terminally ill patients, a doctor, and a pharmacist.

Since the 2006 *Gonzales* case, the Death with Dignity law in Oregon has been upheld despite the many debates that surround the issue. The law has continued to withstand the numerous challenges that have been raised against it, and is still in place almost 20 years after its implementation. The issue of PAD gained America's attention in November of 2014 when 29-year-old Brittany Maynard published an article about her decision to move to Oregon to use the state's Death with Dignity law to end her battle with terminal brain cancer.⁷ The American PAD debates continue to gain national press coverage, even as recently as March 2015, when the *New York Times* publicized an article dedicated to the topic that features a detailed examination of the Oregon Death with Dignity Act.⁸ We will be looking at Oregon's Death with Dignity Act in greater detail in Section IV.

The Dutch Debates

The euthanasia⁹ debates in the Netherlands began gaining their force with the 1973 "Postma Case," when a physician was convicted for murder after euthanizing her dying mother. Although this was not a "win" for legalized euthanasia, this case opened up the country's

⁷ Brittany Maynard, "My Right to Death with Dignity at 29," CNN, November 2, 2014, <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/>.

⁸ Clyde Haberman, "Stigma Around Physician-Assisted Dying Lingers," *The New York Times*, March 22, 2015, http://www.nytimes.com/2015/03/23/us/stigma-around-physician-assisted-dying-lingers.html?_r=0.

⁹ In the Netherlands, the debates are framed around euthanasia, a category which includes the less extreme act of physician-assisted death.

euthanasia debates, a discussion which has now been evolving for decades. In the 1980's, the Royal Dutch Medical Association worked to try to encourage physicians to report their cases of euthanasia. This attempt to manage the country's use of Euthanasia marked a step toward the country's favorable stance on the issue.

In 1982 a State Commission was put in place to address the issue of euthanasia in the Netherlands, eventually creating a set of criteria that would need to be met in cases of physician-administered euthanasia. During the State Commission's work, the 1984 Schoonheim case became the first euthanasia case to be judged by the Dutch Supreme Court. In this case, the Court acquitted a physician who euthanized his 95-year-old patient who was facing severely deteriorating health and dignity. Raphael Cohen-Almagor explains the court's reasoning for the Schoonheim case saying, "The Court accepted the doctor's defense that he faced a conflict of responsibilities between preserving the patient's life and alleviating suffering."¹⁰ Schoonheim's acquittal marked a major step toward the Netherland's acceptance of physician-administered euthanasia in cases of patients facing severe and interminable suffering.

Following the famous Schoonheim case, measures were continually taken through the 1990's to encourage increased transparency and reporting of euthanasia in the Netherlands, until 1998 when an official reporting procedure involving review committees was established. Euthanasia was officially legalized in the Netherlands in 2002 with the implementation of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which allows a physician to end a severely suffering patient's life upon request, or to prescribe such a patient with a life-ending agent. More information on the details of the Dutch law will be presented in the next section.

¹⁰ Raphael Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing*, Springer Science & Business Media (2008), 41.

IV. Current Policies and Usage

Having provided the context of the physician-assisted death and euthanasia debates that have unfolded in Oregon and the Netherlands, we can now delve into the policies that are currently in place in each of these locations. In this section, I will detail both the Oregon Death with Dignity Act and the Dutch Euthanasia Act, outlining the eligibility standards that each of these policies require, and the processes that they call for when it comes to an eligible patient going about ending her life. We will also take a brief glimpse at how widely these policies have been utilized in their respective regions since the times of their implementation.

The Oregon Death with Dignity Act

According to the Oregon Death with Dignity Act, any competent Oregon resident aged 18 or older who is suffering from a terminal illness with a life expectancy of six months or less has the right to voluntarily request a prescription for life-ending medication that the patient will administer to himself. The law requires that such a request be initiated by the patient himself, and followed by a second oral request that is made at least fifteen days after the initial request. The patient must also be informed about all alternative treatment options. After a patient's request for physician-assisted death is made, a second physician must confirm the patient's condition and diagnosis, and two witnesses must confirm his request. If the physicians believe that a patient's judgment might be impaired by depression, the patient must be referred to a psychiatrist to be evaluated.

If the patient meets the aforementioned criteria outlined by the Oregon DWDA, the primary physician can then write a prescription for lethal medication, and when doing so she must confirm that she has fulfilled the requirements of the act through a report that is submitted

to the health division.¹¹ As of 2014, a total of 1,327 people have had lethal prescriptions written through the Death with Dignity Act, with 859 patients dying by taking the lethal drug prescribed through the act.¹²

The Dutch Euthanasia Act

The 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act regulates both physician-administered euthanasia and physician-assisted death in the Netherlands. It is important to note that the Dutch laws treat PAD and euthanasia as morally equivalent, and require nearly identical conditions for both acts. The law in the Netherlands applies to patients of at least 12 years of age, with patients under 16 requiring parental consent, and patients between 16 and 18 requiring parental consultation. It makes euthanasia and PAD not punishable as long as the attending physician acts in line with a number of criteria: 1) The patient must be experiencing unbearable suffering with no hope of improvement. 2) The patient must make a voluntary and persistent request. 3) The patient must fully understand his condition and options. 4) A second physician must be consulted to confirm that the preceding three conditions have been met. 5) The doctor or patient must execute the death in a manner that is medically appropriate, and if the patient takes his life on his own, a physician must be present.

It is also worth noting that although there is no residency requirement within the Netherlands policy, the act does require the existence of a close and well-established relationship

¹¹ Death with Dignity Requirements, Oregon Public Health Division, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/requirements.pdf>.

¹² Oregon Public Health Division, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>.

between the physician and the patient.¹³ Unlike the Oregon Death with Dignity Act, the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act does not require that the patient be terminally ill with a required life expectancy in order to be eligible for PAD, but instead states that the patient must be facing interminable suffering, a category which might include mental and physical suffering with a long or even unknown life expectancy.

Under the Dutch Euthanasia Act, there are also significant requirements detailing reports that the physician must submit to one of five regional review committees. In fact, much of the text of the Dutch legislation is dedicated to the details of the required reporting practices, with physicians using PAD and euthanasia viewed as violating the Criminal Code until the case has successfully passed through the extensive review process that the law puts in place. The review committees—each of which must include at least one legal specialist, one physician, and one ethicist—are tasked with reviewing every euthanasia and PAD case to ensure that the attending physician has acted in line with the due care criteria outlined in the Act.¹⁴ As of a 2012 report from CBS StatLine, the country saw close to 4,000 deaths by euthanasia, and almost 200 physician-assisted death cases.¹⁵

¹³ G. K. Kimsma, “Death By Request In The Netherlands: Facts, The Legal Context And Effects On Physicians, Patients And Families,” *Medicine, Health Care and Philosophy*, 355-61.

¹⁴ “Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act),” Online.

http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/05/Dutch_law_04_12.pdf

¹⁵ CBS StatLine, Statistics Netherlands, “Deaths by medical end-of-life decision; age, cause of death,” <http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLen&PA=81655ENG&LA=en>.

V. Philosophical Motivations

Having laid the groundwork for these distinct euthanasia and physician-assisted death policies in Oregon and the Netherlands, I will now examine the apparent motivations that underlie each of these important pieces of legislation. In looking at the text¹⁶ of the Oregon Death with Dignity Act in comparison with the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, it becomes clear that each of these policies is a product of particular interests and points of emphasis, revealing the distinct philosophical foundations that underlie these two laws.

Oregon's Autonomy Basis

In assessing the motivations that underlie Oregon's Death with Dignity Act, which has served as the basis of related laws in several other states in America, it will be necessary to take a close look at the specific set of circumstances under which the Oregon DWDA permits a physician to assist his patient in dying. Furthermore, I will examine the discussions that took place in Oregon during the time of the law's passage to find the points of emphasis that were used in the debate.

In my discussion of the Oregon legislation, I will be arguing that the value of patient autonomy stands at the forefront of the Oregon Death with Dignity Act. Before doing so, I will need to outline the characteristics that comprise my understanding of autonomy. The Stanford Encyclopedia of Philosophy defines individual autonomy as "an idea that is generally understood to refer to the capacity to be one's own person, to live one's life according to reasons and motives

¹⁶ In this paper, I will use the details of the legislative texts themselves as the key points of comparison, although there is certainly a comparison that can be made between the distinct legal and political debates about the issue that took place in Oregon and the Netherlands.

that are taken as one's own and not the product of manipulative or distorting external forces."¹⁷ I will accept this general definition of autonomy, and expand on characteristics that are important to autonomy in the context of medical decision-making. In particular, I will consider a patient's autonomous treatment decision to be one that is in line with a patient's own "reasons and motives," cited in the definition. I might refer to these reasons and motives as an individual's core or fundamental values, which remain consistent over time. In cases of clinical decision-making, the "manipulative or distorting external forces" referred to in the definition would be any forces that could influence an individual's decision to be out of line with that individual's fundamental values. Such forces could be the influence of medical professionals or family members, or a patient's distorted mental state, which might lead the patient to make a treatment decision that is misaligned with the values that would normally guide that patient.

Upon a detailed reading of the Oregon Death with Dignity Act, it appears that a leading motivation behind the legislation is a desire to respect patient autonomy. This is clear throughout the text of the statute, where it is emphasized that the patient must be deemed "capable" and that the patient's request for a life-ending agent must be "voluntary."¹⁸ This emphasis on the decision-making capability of the patient and the voluntary nature of the request seems to stem from a desire to ensure that no force—be it depression or coercion by some other party—can infringe on the autonomous nature of the patient's decision. And thus, much of the motivation behind many features of the Oregon Death with Dignity Act seems to be a philosophical valuing of patient autonomy when it comes to end-of-life decision-making. This autonomy emphasis was apparent in the local news at the time of the 1994 Oregon decision, with *The Oregonian*

¹⁷ John Christman, "Autonomy in Moral and Political Philosophy", *The Stanford Encyclopedia of Philosophy* (Spring 2015 Edition), Edward N. Zalta (ed.), <http://plato.stanford.edu/archives/spr2015/entries/autonomy-moral/>.

¹⁸ Oregon Death with Dignity Act revised Statute, Chapter 127, https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors127.html.

quoting legal expert Arthur LaFrance saying that the statute “acknowledges the autonomy of the individual, and that autonomy is a centrally protected constitutional concept.”¹⁹

Throughout the text of the Oregon legislation, there appear many examples of safeguards that the law puts in place in order to protect patient autonomy. Firstly, the statute requires that eligible patients be 18 years or older, which might be based upon the belief that a person lacks some degree of decision-making capability before the age of 18. In requiring that the patient be 18 or older, the Oregon legislation is limited to only those patients who have reached an age at which they are capable of autonomous decision-making. Although it is difficult to measure the formation of individuals’ value systems, it is certainly reasonable to claim that an individual does not have a fully formed set of values until reaching adulthood, at which point it is generally believed that peoples’ core principles and motives are cemented. Therefore, this age requirement incorporates the value of autonomy, as we couldn’t expect an individual to make an autonomous decision that is in line with the “reasons and motives that are taken as ones own,” as Stanford’s definition puts it, if that individual has not yet reached the age at which those values are crystallized.

According to the Oregon DWDA, a patient must also make two requests for physician-assisted death spaced no less than 15 days apart, which ensures the certainty of the patient’s request by requiring that the patient take due time to fully reflect on the decision and evaluate whether he still chooses PAD even after the passage of some time. This requirement seems to be based on the value of patient autonomy, because the required 15-day gap between requests reflects how autonomy, by definition, does not just value an individual’s temporary preferences. Rather, the value of autonomy concerns the idea of an individual making choices that are

¹⁹ Patrick O’Neill, “Physician-Assisted Suicide Law Has It’s Day in Court,” *The Oregonian*, December 19, 1994.

consistent over time, in that they are in line with that individual's fundamental values, which are more firmly established than his ever-changing momentary preferences. Together, the age minimum and the two-request requirement emphasize the Oregon lawmakers' apparent intentions of ensuring that a patient who chooses PAD not only be fully capable of making intelligent decisions for himself, but also that the decisions he makes are well-thought-out over an extended period of time. These requirements can therefore be viewed as protecting patient autonomy, as they ensure that the patient is old enough to make an autonomous decision, and that such decisions with this autonomous quality can withstand the passage of time and still remain in line with that patient's core beliefs or fundamental values.

Further protecting patient autonomy is the Oregon DWDA's requirement that a patient's depression is not influencing his decision to die. The Oregon law requires that a patient be evaluated psychiatrically if the physician fears that depression or any other mental impairment may be impacting his decision-making capabilities. Therefore, according to the law, a patient's depressed state is a possible interference on a patient's autonomy, and a safeguard must be put in place in order to avoid this potential infringement. Depression is viewed as a threat to autonomy, in that it may cause an individual to act in a manner that is out of line with his fundamental values. This view of depression as a condition that undermines autonomy is generally held in the bioethics community, as outlined by Paul Biegler.²⁰ Therefore, Oregon's requirement that the patient requesting physician-assisted death not be influenced by depression is a reflection of the value of patient autonomy, in that it secures a patient's autonomy from the potential threat of depression.

Beyond outlining these details of the characteristics that PAD-eligible patients must possess, the Oregon law also requires witnesses to ensure that the patient is fully autonomous in

²⁰ Paul Biegler, "Autonomy And Ethical Treatment In Depression," *Bioethics* 24, no. 4 (2010), 181.

making his decision to die. Witnesses are required to make sure the patient is “capable, acting voluntarily, and is not being coerced,” three qualities which are repeated throughout the text of the legislation.²¹ It is interesting to also note that the law protects not only the patient’s autonomy, but the physician’s autonomy as well. The law reveals this respect for physician autonomy when it states that no physician may be forced to assist his patient in dying. Just as a patient may not be coerced by another person or by a skewed psychological state to engage in PAD, a physician, too, can only assist in his patient’s suicide if he independently wills to do so. This protection of the physician’s autonomy further emphasizes the important role that autonomy plays throughout the Oregon legislation, as it ensures that all parties of every PAD decision are acting out of their own volitions.

Beyond this respect for patient autonomy, there are certainly other significant motivations behind the Oregon legislation, namely, an attempt to distinguish physician-assisted death as it is laid out in the Oregon legislation from typical cases of suicide. In particular, the requirement that the patient be suffering from a disease that will kill him in six months or less reveals the lawmakers’ attempt to separate the cases of physician-assisted death made possible by this law from the characteristics that are generally associated with suicide. When compared with the form of physician-assisted death that is legalized by the Oregon DWDA, most cases of suicide are associated with people who would have lived average lifespans bringing about their own deaths earlier than would have been natural.²² Suicide is therefore viewed as something irrational or

²¹ Oregon Death with Dignity Act revised Statute, Chapter 127, https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors127.html.

²² According to the CDC, in 2013 the U.S. suicide rate is highest for people aged 25 to 64 (16.25 deaths per 100,000 people), an age group whose members, we can assume, would have otherwise lived to the average U.S. life expectancy of about 79 years. The suicide rate in this 25-64 age group surpassed the 65+ age group in 2004 and 2006, and has been increasing since. See the CDC’s “Trends in Suicide Rates Among Both Sexes, by Age Group, United States, 1991-2009.” <http://www.cdc.gov/violenceprevention/suicide/statistics/trends02.html>.

unreasonable, as the act would significantly shorten a person's otherwise long and physically healthy life. On the other hand, the physician-aided deaths of people with terminal illnesses who will die within a short amount of time seems like more of a rational and well-reasoned decision, given the futile and miserable nature of the patient's condition. This six-month requirement ensures that physician-assisted death only be permitted for patients who will soon die anyway, thereby separating these permissible cases with general cases of suicide that involve notably early deaths. This important distinction between PAD and suicide can therefore counter the potential argument that the Oregon Death with Dignity Act is just a way for people to kill themselves. Instead, PAD is portrayed in the Oregon DWDA as allowing the rational and well-reasoned hastening of an inevitable and otherwise painful death.

It is interesting to note that the motivations behind this six-month life expectancy requirement might also be the reason that proponents of PAD use the term "physician-assisted death" instead of the widely used "physician-assisted suicide" terminology. Because the act of PAD hastens the patient's death, which will inevitably occur soon, rather than ending the patient's life long before his death would have naturally occurred, "death" seems to be a more fitting term for the act than "suicide," which is often viewed as an irrational end to an otherwise long life. As explained in the University of Washington School of Medicine's *Ethics in Medicine* journal, the physician-assisted death terminology "is meant to reflect the requirement that eligible persons must be decisionally competent and have a limited life expectancy of about 6 months or less." And furthermore, "the term is meant to reflect that physicians provide assistance to patients who are otherwise going to die, and who seek help to control the timing and circumstances of their death in the face of end-of-life suffering they deem intolerable."²³

²³ Clarence H. Braddock III and Mark R. Tonelli, "Physician Aid-in-Dying," *Ethical Topics in Medicine* (1998), <https://depts.washington.edu/bioethx/topics/pad.html>.

This requirement that the patient have a life expectancy of six months or less is also particularly telling because it reveals that mere suffering is not the top criteria that is considered in these cases of physician-assisted death. For, two patients might be experiencing equivalent amounts of interminable suffering, one with a short life expectancy (say, a pancreatic cancer patient) and the other with many years ahead of her (an ALS patient for example), but only the pancreatic cancer patient would be permitted to request this life-ending prescription under the Oregon DWDA. Therefore, even if a person is suffering from an illness that is irreversible, if the disease will not kill the patient imminently, then physician-assisted death is not a permissible option under the Oregon law. In contrast, in the cases of physician-assisted death that *would* be permissible by the Oregon Death with Dignity Act, the patient's forthcoming death is an unavoidable element of his condition. The six-month life expectancy qualification therefore indicates that regardless of the level of suffering that a patient is experiencing, precautions must be taken to avoid physician-assisted death from entering into the realm of the act of suicide as committed by someone with a normal life expectancy.

A final element of the Oregon Death with Dignity Act that reveals the ethical motivations underlying the legislation is the requirement that PAD-eligible patients must be proven residents of Oregon. The reasoning behind this requirement might be an attempt by the lawmakers to keep the state Oregon from becoming a destination for death by making it difficult for people to come to Oregon for the sole purpose of dying.²⁴ Such a provision might serve to quell possible concerns raised by the federal government about individuals from other states entering Oregon to take advantage of this state-level law.²⁵ The residency requirement responds to these concerns by

²⁴ Of course, the law cannot completely avoid this, as it is possible for people to resettle in Oregon with the intention of using physician-assisted death soon after.

²⁵ Kathy T. Graham, "Last Rights: Oregon's New Death With Dignity Act," *Willamette Law Review* 31, no. 3 (1995), 614.

acting as a logistical barrier. For, even if individuals from other states were to move to Oregon and establish residency there, it is clear that establishing residency somewhere is a decision that takes more time, thought, and planning than the decision to briefly visit a particular place. As David S. Ford, spokesman for the San Francisco AIDS Foundation said in a 1994 interview with *The Oregonian*, “I can't imagine that someone would want to pack up their belongings, close up their apartment, leave their friends and move up to Oregon in order to establish residency and find two doctors who will pronounce them as having six months to live – all in order to have a doctor-assisted suicide.”²⁶

Therefore, in putting the residency limitation in place, the Oregon legislation emphasizes that the decision to request PAD ought not be made on a whim, and it also acts as a hurdle that ensures that aside from Oregon residents who will face a number of other safeguards and filters down the line, the only people who may begin the process of requesting PAD are those who have put significant thought and effort into the decision to die. This residency requirement therefore limits PAD eligibility to a small group of Oregon residents (whether they've already been established residents or they've made the decision to become residents) who meet the specific set of criteria that are outlined throughout the legislation—most significantly, the numerous autonomy safeguards that I have detailed above.

The Dutch Suffering Basis

When considering the motivations behind the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, it is important to first mention that the requirements included in the legislation apply for both the act of physician-assisted death (which the legislation calls assisted-suicide), and euthanasia performed by a doctor. The Netherlands law

²⁶ Spencer Heinz, “End Game,” *The Oregonian*, December 5, 1994.

makes no moral distinction between euthanasia and physician-assisted death, grouping them together within the same piece of legislation. As I assess the Netherlands' euthanasia law, I will be arguing that the primary basis of the Dutch legislation is an attempt to avoid patient suffering, which strongly contrasts with the Oregon autonomy-basis that we have just seen.

With regards to the characteristics that an eligible patient must have, according to the Dutch law, any patient aged 12 years or older can be eligible for physician-assisted death or euthanasia, although there are more safeguards for patients on the younger end of the spectrum. In order to receive physician-assisted death or euthanasia by the Dutch Euthanasia Act, patients ages 12 through 16 must have a consenting parent or guardian, and patients between 16 and 18 years of age must have a parent or guardian at least consulted. Philosophically, it seems that if the law states that a parent ought to be consulted, this would imply that a patient under the age of 18 is viewed as incapable of making a fully autonomous decision that carries legal weight. For, even in the case of a patient between 16 and 18, if no guardian is available for consultation, there is no weight given to her decision to die.

The details of this age requirement imply that in the view of the Dutch law, a legal minor's decision, absent of parental consultation, is not enough to make PAD or euthanasia permissible. It might therefore be inferred that so long as parental consent or consultation is required, a patient is not viewed as autonomous enough to make a decision independently. This is an interesting point of distinction, because whereas the Oregon statute would never permit a less-than-capable patient to make the decision to undergo PAD, the Dutch law does permit such a decision, as long as it is bolstered by parental consent or consultation.

Another important note on the Dutch legislation is the strong emphasis that the law places on the suffering that the patient is undergoing. Interestingly, the Dutch law makes no distinction

between short-term and long-term suffering as the Oregon law does. Regardless of the patient's life expectancy, as long as there is no chance for the patient's condition to improve, a hopelessly suffering patient can be legally eligible for physician-assisted death or euthanasia. This detail reveals the essential role that patient suffering plays in the Netherlands law. For, an eligible patient's suffering does not necessarily have to be accompanied by imminent death, but even prolonged suffering with no chance of improvement makes one eligible for PAD or euthanasia in the Netherlands. The Netherlands is therefore more concerned with the patient's degree of suffering than with the patient's particular physical condition and the life expectancy that is associated with such a condition.²⁷ This focus on the degree of patient suffering is revealing of the motivations behind the Dutch law. In particular, it seems as though according to the Netherlands legislation, a key philosophical basis of euthanasia and physician-assisted death is the avoidance of patient suffering, even if this means ending a patient's life at a point much earlier than death would have naturally occurred.

With regards to the type of suffering that a patient must be experiencing in order to be eligible for physician-assisted death or euthanasia in the Netherlands, the Dutch legislation has an expansive definition of suffering that extends beyond just physical suffering. The Netherlands euthanasia law doesn't include a depression or mental illness safeguard as the Oregon law does. In this way, the Dutch legislation does not limit eligibility for physician-assisted death and euthanasia to only those people who are experiencing physical suffering. Rather, it expands its definition of suffering to include mental suffering as well. A 1994 Oregon newspaper references the Netherlands' wide definition of suffering, mentioning the 1993 Dutch case in which "a court of three judges acquitted a psychiatrist in the assisted suicide of a physically [sic] healthy but

²⁷ The avoidance of patient suffering is consistently mentioned as a key element of the Dutch debate over PAD and euthanasia. See Raphael Cohen-Almagor's article "Why the Netherlands?"

emotionally disturbed woman grieving over the death of her two sons.”²⁸ This broad definition of suffering further reveals the Netherlands’ strong emphasis on the value of avoiding patient suffering of all types.

Although suffering seems to be the key basis of the Netherlands legislation, the law does not fail to mention patient autonomy. The Dutch law requires that the patient fully understand her condition and prospects, which ensures that the patient is knowledgeable enough to make an autonomous decision that is also informed. This requirement, however, may not reveal a significant value of autonomy, but is rather in line with general consent requirements for medical procedures in the Netherlands, which are outlined in the Dutch Medical Contract Act.²⁹ Buiting et al. mention the common Dutch requirement that the patient fully understand her situation and prognosis, which is part of the country’s normal medical practice.³⁰ Therefore, although the Netherlands legislation does incorporate the value of autonomy, it does not emphasize this value any more significantly for cases of PAD and euthanasia than it does with most other medical procedures, where informed consent rules require some degree of patient autonomy, in that they similarly demand that the patient fully understand her condition and prospects.

Another important requirement of the Netherlands legislation is the requirement that the patient initiate the request to die on her own, which seems to be an attempt to keep other forces from interfering with the patient’s autonomous decision to die. It is, however, difficult to place this requirement as definably autonomy valuing or suffering valuing. Given the important decision-making role that this requirement gives to the patient, it appears as though this

²⁸ Mark O’Keefe, “Dutch Courts Provide Loophole for Doctors,” *The Oregonian*, December 19th, 1994.

²⁹ Ewoud Hondius and Annet Van Hooft, “The New Dutch Law on Medical Services,” *Netherlands International Law Review* (1996).

³⁰ Hilde Buiting, Johannes Van Delden, Bregje Onwuteaka-Philipsen, Judith Rietjens, Mette Rurup, Donald Van Tol, Joseph Gevers, Paul Van Der Maas, and Agnes Van Der Heide, “Reporting Of Euthanasia And Physician-assisted Suicide In The Netherlands: Descriptive Study,” *BMC Medical Ethics* 10, 8.

requirement reflects the value of patient autonomy, but it very well may be that this actually shows a valuing prioritization of patient suffering. For, this patient-initiated request requirement emphasizes the fact only the patient can know and evaluate the degree of her own suffering, and such an important evaluation should not be tainted by other opinions.

A final important element of the Dutch euthanasia legislation is that although the law does not have a residency requirement like Oregon does, it does require that there be a well-established doctor-patient relationship in cases of physician-assisted death and euthanasia.³¹ This requirement is believed by the legislatures to similarly keep the Netherlands from becoming a death destination, as many opponents of physician-assisted death fear. It therefore seems that in outlining the due care requirements that imply a close and well-established doctor-patient relationship, the Netherlands legislation is crafted for a specific group of physician-patient pairs with preexisting clinical relationships. Thus, the Netherlands puts safeguards in place to avoid abuse of the euthanasia act, but the act's overall motivations seem closely tied to an avoidance of pain and suffering, all within the boundaries that the act puts in place.

Comparison: Oregon's Autonomy Basis Versus the Dutch Suffering Basis

In comparing the motivations behind the Oregon Death with Dignity Act and the Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act, a few major points of distinction arise. In particular, it seems as though the key motivation behind the details of Oregon's physician-assisted death laws are an intention to protect patient autonomy, a motivation which is more secondary in the Netherlands legislation. Oregon's

³¹ Netherlands Ministry of Foreign Affairs: FAQ – Euthanasia 2010: The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice. http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/03/Netherlands_Ministry_of_Justice_FAQ_Euthanasia_2010.pdf.

autonomy emphasis can be seen through the requirement that the patient make multiple requests for a lethal prescription over an extended period of time. This autonomy basis is also revealed through the requirement that a patient's depression not be influencing his decision to die, and the repeated insistence that a patient be "capable" and that his request is "voluntary." Furthermore, the many technical safeguards that the Oregon DWDA puts in place—such as the age minimum of 18 years and the residency requirement—reveal the Oregon legislation's significant emphasis on the protection of patient autonomy.

The requirements surrounding the type of pain and suffering that the patient is undergoing seem, in the case of the Oregon laws, to be secondary to the requirements related to the patient's level of autonomy. For, the Oregon legislation does not include suffering from depression as a type of suffering that could necessitate PAD, and it instead views it as a possible interference with autonomy, prioritizing this possible interference over the possibility that mental suffering might warrant a need for PAD. Thus, this fear that mental illness might interfere with autonomy reveals that a respect for patient autonomy is the driving force of the Oregon physician-assisted death legislation.

On the other hand, an avoidance of suffering seems to be the key motivation underlying the Netherlands PAD and euthanasia legislation. This can be seen by the fact that whereas the Oregon legislation requires that a patient be suffering from an illness that will kill him within six months, the Netherlands' Euthanasia Act permits physician-assisted death or euthanasia for people who will be experiencing irreversible suffering, regardless of the life-expectancy associated with the condition. It seems to be that the primary goal of the Dutch euthanasia legislation is to provide an opportunity for relief for those who are experiencing suffering, be it near-death suffering or a more extended span of suffering.

Further revealing that suffering is the leading basis for the Netherlands legislation is the fact that the Netherlands doesn't set up any safeguards for depressed or otherwise mentally impaired patients as the Oregon law does. Rather, the Netherlands defines suffering as widely as possible, not limiting the eligibility standards to only those undergoing physical suffering. The Netherlands' lack of these two safeguards—on mentally ill patients and on patients who will be suffering indefinitely—reveal its expansive definition of suffering and its valuing of an avoidance of suffering over other values such as autonomy.

Another strong point of distinction between the Netherlands euthanasia and PAD laws and the Oregon physician-assisted death legislation are their contrasting treatments of the ages of eligible patients. For the Netherlands, there are age windows at which the patient is not legally able to make the decision to die without parental consultation or consent, and this implies that the Netherlands law recognizes a lack of decision-making autonomy for patients between the ages of 12 and 18, and for this reason requires parental involvement. In permitting these decisions to be made with parental consent, the Dutch legislation permits patients who are not viewed as fully autonomous to request PAD or euthanasia. In contrast, the Oregon legislation only allows an individual to request a life-ending prescription once he is at an age where parental consent would not be required for legal decision-making. This point of distinction might suggest that the Oregon legislation takes greater measures to ensure that a fully autonomous decision to end one's life is being made, avoiding any possibility of PAD for someone who has not reached the age of full autonomy, even with parental consent.

Thus, in assessing each piece of legislation, as well as some of the surrounding public debates, it is clear that these two distinct themes arise in each policy. Whereas the Oregon Death with Dignity Act is ultimately focused on a respect for patient autonomy, the Netherlands

Termination of Life on Request and Assisted Suicide (Review Procedures) Act is driven by an attempt to avoid patient suffering at all costs. Hilde Buiting et al. point out this important distinction in their study on the physician-assisted death reporting practices in the Netherlands. In comparing the American model with the legislation in selected European countries, the authors note, “for the Dutch, Belgian and Luxembourg Acts, addressing the patient's suffering is the most important principle underlying the Act. The Oregon and Washington Acts, on the other hand, put emphasis on patients' rights and on helping patients to maintain control and independence.”³² Having provided evidence for these two ethical motivations, we will see that there is strong philosophical support for each of the distinct foundations that seem to drive the Netherlands and Oregon legislations.

³² Buiting, et al., “Reporting of euthanasia and physician-assisted suicide in the Netherlands: descriptive study,” 3.

VI. Autonomy Versus Suffering: Characterizing the Accounts

Thus far, I have shown that the Oregon and Netherlands physician-assisted death and euthanasia legislations are based in these two distinct philosophical foundations: Oregon, on a respect for patient autonomy, and the Netherlands, on an avoidance of patient suffering. Having identified these contrasting bases, I will now begin expanding upon the details of these two philosophical values, and exploring their uses as ethical foundations for opinions on the issue of physician-assisted death. In approaching this comparative philosophical examination, it will be necessary to briefly distinguish between the autonomy basis for physician-assisted death and what I will call the suffering basis for physician-assisted death. Before characterizing these two accounts, it is important to note that both the suffering-based account and autonomy-based account contain philosophical motivations that could be used to argue in support of a whole set of life-ending acts beyond just physician-assisted death. However, because my ultimate policy discussion is framed around PAD³³, this is the practice that I will refer to in characterizing the autonomy-based and suffering-based accounts.

On the autonomy-based account of physician-assisted death, PAD should be legally permissible if and only if doing so furthers or respects autonomy better than a prohibition on PAD. As we've previously seen, when it comes to clinical decision-making, a respect for autonomy can be characterized by the attempt to ensure that treatment decisions made by an individual patient are in line with that person's fundamental values, uncoerced and undistorted by external forces. Proponents of PAD who use an autonomy-based argument generally base their arguments on the idea that an individual should have the right to determine the time and manner of his own death, and therefore that prohibiting a person to make the decision to die

³³ In my policy formation, I do suggest permitting euthanasia under some specific circumstances, but in most cases, physician-assisted death is the treatment that my policy permits.

through physician-assisted death is an interference with that individual's autonomy. This argument is based on the idea that part of an individual's self-determination and autonomy are decisions related to the course of that individual's own life and to the treatment of his body, and thus a right to determine the time and manner of one's death is a necessary part of autonomy, included in the right to bodily self-determination.³⁴

On the suffering-based account of physician-assisted death, PAD should be legally permissible if and only if it is done as a means of avoiding patient pain and suffering in a manner that other treatments could not. Those who argue in favor of physician-assisted death with a suffering basis would claim that when a person is suffering with no relief, it is more compassionate to let the patient end her life and put an immediate end to her pain than to force the patient to continue suffering hopelessly. Therefore, as opposed to a respect for autonomy, the driving force of these suffering-based accounts is the prioritization of an avoidance of misery and pain. In valuing the avoidance of suffering above all, these suffering-based accounts are generally founded in the philosophical principle of beneficence, which is described by the Stanford Encyclopedia of Philosophy as the "moral obligation to act for the others' benefit, helping them to further their important and legitimate interests, often by preventing or removing possible harms."³⁵ Proponents of this view might argue about the human responsibility to reduce the harm experienced by other humans by acting with compassion toward those who are experiencing pain. In addition, proponents of a suffering-based view of PAD might base their

³⁴ Monika Ardel, "Physician-Assisted Death," C. D. Bryant et al. (eds.): *Handbook of Death and Dying, Volume One: The Presence of Death*, Thousand Oaks, CA: Sage Publications, 425.

³⁵ Tom Beauchamp, "The Principle of Beneficence in Applied Ethics." Stanford University, January 2, 2008, <http://plato.stanford.edu/entries/principle-beneficence/>.

positions on beliefs about the physician's responsibility to protect patients from experiencing unnecessary pain and discomfort.³⁶

³⁶ Ardelt, "Physician-Assisted Death," 425.

VII. Autonomy Versus Suffering: Two Philosophical Camps

Having provided the basic definitions of these two distinct ethical justifications of physician-assisted death, I will now present in more detail some of the philosophical arguments that have been used to support the autonomy-based and suffering-based accounts of PAD. It is important to mention that some of these theorists place a value on both respecting patient autonomy and avoiding patient suffering. But generally speaking, the primary foundations of the particular arguments we will be discussing are either suffering or autonomy, and in this section I will attempt to distinguish between these ethical approaches.

Furthermore, before delving into these philosophical accounts, I must mention that the authors discussed in the following sections are not necessarily arguing in favor of the particular policies of physician-assisted death and euthanasia that the Oregon and Netherlands legislations permit. Nevertheless, the following accounts present arguments—based in either the value of patient autonomy or the value of avoiding suffering—that serve as examples for possible philosophical arguments that might be extended to support the treatments permitted in the pieces of legislation that I address in this paper. Therefore, we will look at these philosophical approaches to gain an understanding of what sorts of arguments can be made in support of the autonomy-based and suffering-based accounts of physician-assisted death.

Autonomy-Based Accounts

From the start of the debates, a respect for patient autonomy has been a key value to back arguments in favor of policies permitting physician-assisted suicide and euthanasia. As the argument generally goes, an individual should have the right to autonomy and self-determination, and with this right comes the freedom to make decisions about one's own life and body. According to this argument, a respect for an individual's autonomy and self-determination

must therefore include a protection of the right to bodily self-determination and the included right to determine the manner and time of one's death.

In "Assisted Suicide: The Philosophers' Brief," which was submitted to the Supreme Court before its rulings of the 1997 *Vacco v. Quill* and *Washington v. Glucksberg* cases, six moral philosophers—Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, and Judith Jarvis Thomson—put forth an argument in favor of physician-assisted death. This argument is a strong example of the autonomy-centered argument for permitting physician-assisted death. In the Brief, the philosophers convey their autonomy-based account of the issue in their fundamental claim that each individual has a right to make the "most intimate and personal choices central to personal dignity and autonomy."³⁷ According to the Brief, this right to make such choices encompasses the right to exercise some control over the time and manner of one's death. Although the Court did not rule in accordance with the views set forth by the "Philosophers' Brief," many thinkers who have written on the issue of physician-assisted death and euthanasia provide autonomy-based accounts similar to the one presented in the Brief. These philosophers make arguments along similar lines about the importance of a respect for autonomy, which includes the right to make individual end-of-life decisions.

In his essay, "Voluntary Active Euthanasia," the philosopher Dan Brock provides an autonomy-based account of end-of-life decision-making. Although in this case, Brock is arguing about voluntary active euthanasia rather than the particular act of physician-assisted death, he emphasizes the necessity of respect for the self-determination of individuals, allowing us to categorize his argument as autonomy-based. According to Brock, the granting of a competent patient's request to die is required by the duty to respect self-determination and autonomy. Brock

³⁷ Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, and Judith Jarvis Thomson, "Assisted Suicide: The Philosophers' Brief," <http://www.nybooks.com/articles/archives/1997/mar/27/assisted-suicide-the-philosophers-brief/>.

stresses the importance of “people’s interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life, and in being left free to act on those decisions.”³⁸ Given this importance of self-determination, Brock argues about the necessity that “individuals control the manner, circumstances, and timing of their dying and death.”³⁹ Therefore, Brock sees a respect for patient autonomy as central to the permissibility of the euthanasia of competent patients who request it. This view might be more extreme than autonomy-based arguments for the act of physician-assisted death as I have defined it, but if Brock finds an autonomy basis for euthanasia, then we could certainly infer that this argument would apply to the less contested act of physician-assisted death, which he views as morally equivalent to both passive and active euthanasia.

It is important to mention that in his argument in favor of voluntary active euthanasia, Brock also takes suffering into account, as he sees the relief of pain and suffering as an important “good consequence” of permitting euthanasia. However, respecting autonomy takes on a much more prominent role on Brock’s list of good consequences of permitting voluntary active euthanasia, with the avoidance of suffering being emphasized less. As Brock says, the respect for autonomy, coupled with the value of individual well-being, is “the central ethical argument for euthanasia.”⁴⁰ Thus, a respect for patient autonomy is the dominant ethical foundation of Brock’s argument in favor of euthanasia, which he views as morally equivalent to passive euthanasia and physician-assisted death.

Similar to Brock, Dr. Helga Kuhse argues for the permissibility of active voluntary euthanasia, with a respect for the autonomy of a competent patient serving as the basis of her

³⁸ Dan W. Brock, “Voluntary Active Euthanasia,” *The Hastings Center Report*, Vol. 22 (2); Mar-Apr 1992, 11.

³⁹ *Ibid.*

⁴⁰ *Ibid.*

argument. Kuhse proves the moral equivalence of killing and letting die, and in turn makes an argument for the permissibility of both passive and active euthanasia for competent patients. Kuhse's argument for passive euthanasia, which she extends to apply to active euthanasia, is tied with her belief in the importance of bodily self-determination with respect to the value of autonomy.

A competent patient has an overriding interest in autonomy or self-determination. This important interest is linked to an important legal right: the right to bodily self-determination in health care. This involves the right to make the ultimate decision about what will or will not be done to one's body, and includes the right to accept or refuse treatment—even life-sustaining treatment.⁴¹

This argument that Kuhse brings forth is a strong example of the common autonomy-based arguments made in support of physician-assisted death and euthanasia. Based on the premise of the importance of the individual's right to self-determination and autonomy, these thinkers argue for the importance of bodily self-determination, which should include the right to make decisions about the time and manner of one's death. On this basis, these philosophers argue that competent patients should have the right to request physician-assisted death and euthanasia. Thus we can see that the Philosophers' Brief, along with the arguments made by Brock and Kuhse, reveal the widely held view that a respect for patient autonomy should include a respect for a patient's decision to die. There are many other thinkers who would fall within this autonomy-based school of thought, but these three examples can serve to present the arguments that are central to this account of physician-assisted suicide.

Suffering-Based Accounts

In contrast with the autonomy-based account of physician-assisted death, there are a number of thinkers who argue that avoidance of suffering is the primary rationale behind

⁴¹ Helga Kuhse, "The Case for Active Voluntary Euthanasia," *The Journal of Law, Medicine & Ethics*, 146.

granting patients the right to choose to die. These philosophers generally focus on cases in which a patient's quick death would involve less suffering than the continuation of life in that patient's current state of agony. Therefore, rather than focusing on an individual's rights, these arguments generally focus on the details of a patient's current condition, and the differing consequences of living and dying in light of this condition. These arguments generally find that if a patient's death would involve less suffering than the continuation of that patient's life, then it is reasonable and most reflective of the philosophical principle of beneficence to permit the patient at hand to choose death over a continued life of misery.

The philosopher James Rachels emphasizes the supreme value of avoiding patient suffering in his paper "Active and Passive Euthanasia." Although the primary goal of Rachels's piece is to argue that killing is morally indistinguishable from letting die, in making this argument, Rachels reveals his prioritization of the value of protecting patients from excessive suffering. In making his argument for the moral equivalence of killing and letting die, Rachels claims that there are cases in which the act of killing and letting die might both involve the benevolent intention of putting a person out of his misery. Rachels argues that in many of these cases involving benevolent motives, killing is morally better than letting die because it may reduce a person's suffering. Rachels brings the example of a patient dying of incurable throat cancer, where withholding medical treatment would yield a slower and more painful death than would active euthanasia. In cases like this one, he says, "the process of being 'allowed to die' can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless."⁴²

⁴² James Rachels, "Active and Passive Euthanasia," *Killing and Letting Die*, Bonnie Steinbock and Alastair Norcross Ed., (New York: Fordham University Press: 1994), 113.

Although Rachels is making an argument here about active euthanasia being preferred to passive euthanasia, we can apply his logic to the use of physician-assisted death, as it would have the same benevolent motive, and would similarly be a means of putting a quick end to a person's misery. Rachels's argument therefore implies that when compared to passive euthanasia, active euthanasia and physician-assisted death show a greater respect for the qualities that make life worth living, in that these acts often avoid unnecessary suffering, which no one should be forced to undergo. Thus, in putting forth this deontological argument about the benevolent intentions of avoiding suffering that drive these life-ending acts, Rachels conveys that an avoidance of suffering is the main value to consider when it comes to end-of-life decision-making.

In addition to Rachels, doctors Timothy Quill and Robert Brody make a suffering-based argument about a physician's occasional obligation to aid patients' deaths. Although this argument is focused on a narrow set of death-causing acts—namely barbiturate sedation and the refusal of life-sustaining treatment—the argument for these treatments is based on the principle of avoiding patients pain and suffering. Therefore, it can be claimed that this suffering-based account could extend to an argument for physician-assisted death, if we view PAD as morally equivalent to the acts of barbiturate sedation and passive euthanasia, as many philosophers do. Quill and Brody discuss their idea of a “good death,” which is defined in contrast with a death that is filled with intolerable pain and suffering. The authors make arguments for two treatment options which can serve to facilitate “good deaths,” namely the prescription of a pain relieving medication at a high enough dosage to cause eventual death, and a patient's decision to refuse life-sustaining treatment. The authors' argument in favor of these two treatments is largely based on their assumption that an avoidance of patient suffering is the primary interest to consider when making end-of-life decisions. In their conception of suffering, the authors take on

a wide definition that includes the emotional and existential pain that patients may face as they approach death.

If we define suffering broadly enough, as we must, then we have to include the care provider's commitment to join the patient in confronting the existential, emotional, and spiritual as well as the physical elements of suffering. It would be presumptuous and absurd to believe that physicians or hospice staff members have the ability to resolve all such issues. Many times, one of two dimensions of suffering dominate the patient's experience. Practitioners have an obligation to address each patient's unique form of agony, and to respond as best they can.⁴³

Thus, although Quill and Brody do not explicitly argue in favor of the types of physician-assisted death and euthanasia that we have described in relation to the legislation at hand, these authors stand firmly in the school of thought that places an avoidance of suffering as the main value to consider when making determinations about patients' end-of-life decisions.

Another thinker who stands in opposition to the autonomy-based philosophers and conveys something closer to a suffering-based account is J. David Velleman. Velleman makes a strong argument against the typical autonomy-based justification for physician-assisted suicide, claiming that giving a patient additional treatment options might have the effect of restricting patient autonomy. Velleman's main argument is that policies that allow for the possibility of physician-assisted death or euthanasia actually interfere with patient autonomy because they introduce an option that the patient may not have otherwise considered on her own. In Velleman's view, if a policy offers patients the option to die via euthanasia, then the patient staying alive is no longer the default, and instead it is just one of a set of treatment options that a patient may choose. In turn, according to Velleman, offering a patient the option to die not only

⁴³ Timothy Quill and Robert Brody, "'You Promised Me I wouldn't die like this!' A Bad Death as a Medical Emergency," *Arch Intern Med*, Volume 155 (June 26th, 1995), 1252.

shifts the choice to live away from being the default status, but to Velleman, “to offer the option of dying may be to give people new reasons for dying.”⁴⁴

Based on this argument against an autonomy-basis for a patient’s right to die, it might seem that Velleman is completely opposed to any sort of right to die. But an important element of Velleman’s argument is his claim that even after dismissing the autonomy-based account of physician-assisted death policies, there might be a strong suffering basis for a patient’s right to die. Velleman does not go as far as to argue for a legal protection of such a right, but he sees a suffering basis as much more sound than an autonomy-based argument for a patient’s right to request to die. He says: “A moral entitlement to be allowed to or helped to die is less likely to flow from principles of autonomy or respect, in my opinion, than from principles of simple benevolence. I strongly believe that a person’s life can sometimes be made worse by being prolonged, and that a swift and painless death can then be a benefit.”⁴⁵ Thus, although Velleman does not argue in favor of a legal right to die, he does see a strong suffering basis for such an argument, and he rejects the autonomy basis that many thinkers use.

I have therefore established that there is strong support for both the autonomy-based and suffering-based accounts of physician-assisted death and euthanasia, as I have defined them. These distinct sets of philosophical arguments can each provide ethical foundations for the respective policies with which they align. We can place the writers of the “Philosophers’ Brief,” Kuhse, and Brock in a set of voices that might back an argument in favor of Oregon’s autonomy-based physician-assisted death legislation, and conversely we can place Rachels and Quill and Brody in the school of thought that would support the Netherlands’ suffering-based physician-assisted death and euthanasia policy. Although Velleman would likely oppose any sort of

⁴⁴ J. David Velleman, “Against the Right to Die,” *The Journal of Medicine and Philosophy*. Volume 17 No. 6. (December 1992), 676.

⁴⁵ *Ibid.*, 667.

physician-assisted death or euthanasia legislation, it seems as though based on his fears about an autonomy-basis and his emphasis on the importance of benevolence and avoiding pain, Velleman would have a greater respect for the Dutch suffering-based account of PAD and euthanasia than he would have for Oregon's autonomy-based account of PAD.

VIII. Assessing the Autonomy Account

With the arguments of these thinkers in mind, I will now assess the autonomy and suffering bases for physician-assisted death legislation in greater detail. I will examine the advantages and disadvantages of each of these accounts in order to ultimately formulate a hybrid approach that draws from elements of both the autonomy-based and suffering-based accounts of physician-assisted death. I will ultimately argue that this hybrid approach provides a philosophical framework for physician-assisted death and euthanasia legislation, which is superior to either the autonomy foundation or the suffering foundation on its own.

Advantages of an Autonomy-based Account

A key advantage of an autonomy-based approach to physician-assisted death is that a respect for autonomy with competency requirements protects vulnerable patients who are not suited to make autonomous decisions. In Section V, I defined autonomy as a capacity to make one's own decisions according to one's own fundamental values and uncoerced by any manipulating external forces. In line with this definition, we might claim that an argument for PAD that is based on the value of patient autonomy would likely call for PAD legislation that only qualifies capable decision makers as eligible to request PAD, excluding those with unsatisfactory levels of autonomy. In this manner, such an autonomy requirement would protect groups such as infants or mentally incompetent patients, as they would not be considered capable enough to be legally permitted to request PAD. If we were to instead use suffering as the sole framework, then babies or mentally incompetent patients might have an easier time being permitted to use PAD, despite their lack of decision-making capabilities.⁴⁶ As we will soon see,

⁴⁶ Of course, infants would not reasonably be able to request and utilize PAD, but we use infants as an example of a group that would theoretically be protected by autonomy requirements. This argument could

there might be cases in which there is a strong enough suffering basis for permitting infants or mentally incompetent patients to use PAD or euthanasia, but my focus right now is on the protective advantage of an autonomy basis. With an autonomy basis in place, we would ensure that these life and death decisions are only made by patients who are fully capable of making them, thereby protecting those individuals who are unable to make autonomous decisions about the courses of their lives.

There are certainly points of difficulty that can be raised against this argument for an autonomy-based approach to physician-assisted death. Firstly, one might question the role of the parent or guardian in decision-making, and whether they should be making decisions based on thoughts about the present or future autonomy of the currently incapable or incompetent individual. In response to this argument, we might return to a point that was made about the Netherlands' age requirement, which allows patients below the age of 18 to request PAD or euthanasia with parental consent or consultation (depending on the specific age). I showed in Section V that any such parental consent requirement affirms the fact that the patient at hand is not autonomous enough to make a given decision on her own. Although there are certainly cases in which a parent should be able to assist with a child's treatment decision, the decision of when to end one's life is so entwined with that individual's own self, that in general the highest degree of respect for autonomy must be met in legalizing such a decision.⁴⁷ There might be cases in

extend for small children or adolescents who are below the age at which we consider patients to be autonomous.

⁴⁷ There are also cases in which patients have signed advanced directives to inform future treatment decisions. For instance, consider a case in which a previously competent adult loses mental competency and therefore loses her status as an autonomous decision maker. With an advance directive in place, we might allow the patient's family member to consent to the treatment indicated in the directive, because the treatment at hand had been chosen by the patient at a time when that patient was autonomous. However, here we are only referring to cases in which advanced directives have not been issued, in which a patient is incapable, and the parent or guardian would be the sole decision maker, with no assurance that the medical decision is one that the patient would have made autonomously.

which suffering is so severe that we would leave these decisions to a parent or guardian, on a suffering basis, but such assessments should be made on an individual basis, depending on the patient's degree of suffering, as I will soon discuss.

Another point of difficulty with this advantage of the autonomy-based account is the question of borderline cases, in which it is difficult to determine whether an individual has the level of autonomy that is required for medical decision-making. This concern is particularly relevant in the case of adolescents, an age group whose degree of autonomy might be debatable. This issue was recently disputed with regards to Belgium, when the country extended its euthanasia laws to include terminally ill and suffering children.⁴⁸ In response to this point of difficulty, it can be argued that for cases in which levels of autonomy are difficult to establish, an ideal policy should require that the patient meet a high standard of suffering, to ensure that physician-assisted death is a reasonable treatment option, given the undisputable degree of suffering that the patient is experiencing. Perhaps such a policy should require even higher standards of suffering levels for patients who are clearly not autonomous, like infants and individuals with severe mental disabilities, two groups that I have previously mentioned. For, a simple autonomy-based account would discriminate against these borderline autonomous and non-autonomous patients by disqualifying them from the option of PAD, and it is therefore important to incorporate the value of avoiding suffering in order to include these patients whose levels of suffering might reasonably necessitate PAD. In Section X, I expand upon the manner in which I incorporate the value of suffering in these cases where patients are lacking in autonomy.

A second key advantage of the autonomy-based argument for physician-assisted death is the importance of patient autonomy to the physician-patient relationship. If we were to disregard

⁴⁸ Damien Carrick, "Euthanasia for children expands legal debate in Belgium," February 19th, 2014, <http://www.abc.net.au/radionational/programs/lawreport/5269980>.

patient autonomy in cases of PAD, then this could certainly open the door for a more paternalistic model of the doctor-patient relationship. Allen Buchanan and Dan Brock argue about the need for patient decision-making autonomy, claiming that the views of a capacitated patient who has the reasoning capabilities to make a rational choice ought to be respected by physicians. As a basis for their argument, Buchanan and Brock emphasize that permitting capacitated patients to make autonomous treatment decisions is required by the values of individual self-determination and well-being. They argue against a more paternalistic model in which a physician is the sole medical decision maker, claiming that such a model infringes on these values.

Whether a certain treatment would be in the best interest of the patient depends not only upon the medical effects of treatment but also upon the relationship between those effects and the interests and previously expressed values of the patient. Physicians' professional expertise makes them more knowledgeable about the former, but not about the latter.⁴⁹

In this manner, because the physician's knowledge is limited in the realm of moral decision-making, a non-paternalistic model of the physician-patient relationship that values patient autonomy is required in order to protect patients' self-determination and well-being.

Disadvantages of an Autonomy-Based Account

Despite the benefits I have just laid out, there are significant drawbacks that might come along with a PAD legislation that is solely based on a respect for patient autonomy. One key disadvantage of the autonomy-based account is the slippery slope concern, which a person might use to argue that if we hold autonomy as the central value of the physician-patient relationship, then this might pave the way for physicians to permit patients to make other, unwise treatment decisions, out of respect for patient autonomy. As we saw earlier, the decision to request

⁴⁹ Allen Buchanan and Dan Brock, *Deciding for Others: The Ethics of Surrogate Decision Making*, 1 edition, (New York: Cambridge University Press, 1990), 140.

physician-assisted death in the case of unbearable and interminable suffering cases is generally viewed as well reasoned and rational. However, a patient might make a similarly autonomous request for treatments that are viewed as less rational, despite being in line with his fundamental values. Dan Brock and Steven Wartman explore this issue of competent patients making irrational decisions.

When the physician properly judges a patient's treatment choice to be irrational, attempts to change that choice through persuasion are common and proper. Noncoercive and nonmanipulative attempts to persuade patients of the irrational and harmful nature of their choices do not violate their right of self-determination. Instead, they reflect an appropriate responsibility and concern for the patient's well-being.⁵⁰

As Brock and Wartman explain, there are certainly cases in which a respect for patient autonomy might lead a physician to permit a patient to make an unwise treatment decision, and for this reason we might argue that it is difficult to claim that a respect for autonomy should be *the* only value to inform medical decision making. Other values brought forth by these authors—like the doctor's responsibility to ensure that patients are acting in their best interests—must also come into play, even as we hold patient autonomy to be a core value.

Another disadvantage of a PAD legislation based only on the philosophical foundation of a respect for patient autonomy is the difficulty that might come along with attempting to classify a patient's decision as fully autonomous. Although a patient's decision might appear to be autonomous if it seems to be in line with the patient's said values and appears to have been arrived at with no overt third party coercion, there might certainly be concerns that a patient has been indirectly coerced to a certain extent. Many authors who have written about physician-assisted death, especially those who argue against it, fear that individuals undergoing interminable suffering might choose PAD because of fears of becoming financial or emotional

⁵⁰ Dan W. Brock and Steven A. Wartman, "When Competent Patients Make Irrational Choices," *The New England Journal of Medicine*, Vol. 322 No. 22 (1990), 1596.

burdens on their families. Coercion is certainly difficult to measure, and many thinkers fear that irreversibly ill patients might feel obligated to choose death, with such a felt obligation being a possible interference with patient autonomy. Yale Kamisar, an opponent of legalized physician-assisted death and euthanasia, brings forth this type of argument against euthanasia legalization, asking about the potentially coercive consequences of such legislation. “Will not some feel an obligation to have themselves ‘eliminated’ in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?”⁵¹ Thus, some might object to an autonomy-based argument in favor of PAD by claiming that it is difficult to determine whether a decision is fully autonomous, when other, less directly coercive factors—such as the fear of emotionally or financially burdening one’s family—might affect a patient’s clinical decision-making process.

This disadvantage related to the possibility of indirect coercion is one of the many reasons to call for a hybrid philosophical approach to PAD that values both a respect for patient autonomy and an avoidance of suffering. For, if in these cases we value suffering in addition to autonomy, we would be able to ensure that the patient has significant reasons for requesting to die, aside from not wanting to be a burden. Such reasons would likely be tied to the patient’s condition of intense physical or emotional suffering, which would take into account the quality of the patient’s life, as opposed to just a respect for his bodily self-determination. A hybrid approach might then yield a policy that permits PAD for severely suffering patients, despite their lower autonomy levels (for instance, infants and mentally incompetent individuals). With this in mind, in the following section I will discuss the advantages of valuing the avoidance of suffering when it comes to PAD decisions.

⁵¹ Yale Kamisar, “Some Non-Religious Views against Proposed ‘Mercy-Killing’ Legislation Part 1,” University of Michigan Law School Scholarship Repository (1976), 80. <http://repository.law.umich.edu/cgi/viewcontent.cgi?article=2065&context=articles>.

IX. Assessing the Suffering Account

An alternative to the autonomy-based account of physician-assisted death, the suffering-based account that supports the Netherlands' euthanasia act has advantages and disadvantages of its own. These benefits and downsides of the suffering-based account can be helpful in assessing the possible consequences of an argument for PAD based purely on the philosophical principle of beneficence, or an avoidance of patient suffering.

Advantages of a Suffering-based Account

An important advantage of the suffering-based account of physician-assisted death is the argument that in many cases, allowing a patient to die through physician-assisted death or euthanasia is far more compassionate, and involves much less pain, than letting the patient die of an excruciating terminal illness. Many thinkers use this compassion-based argument to lend philosophical support to the acts of physician-assisted death and euthanasia. James Rachels, a thinker who I have previously established as a proponent of the suffering-based account, summarizes this beneficence-based argument by saying, "If a person prefers—and even begs for—death as the only alternative to lingering on *in this kind of torment*, only to die anyway after a while, then surely it is not immoral to help this person die sooner." Rachels then quotes journalist Stewart Alsop, who died of a rare type of cancer and wrote extensively about his experience with terminal illness. Alsop, as quoted by Rachels, argues about the compassion required in these futile cases, saying, "No human being with a spark of pity could let a living thing suffer so, to no good end."⁵² Rachels brings forth these suffering-based arguments in presenting his justification for active euthanasia, and we might therefore conclude that this sort

⁵² James Rachels, "More Impertinent Distinctions and Defense of Active Euthanasia," *Killing and Letting Die*, Bonnie Steinbock and Alastair Norcross Ed., (New York: Fordham University Press: 1994), 148.

of argument for euthanasia—backed by the value of compassion for humans—can certainly be used as an argument for the less extreme act of PAD.

I might also add to the compassion-based argument by discussing the role of a physician as someone who is tasked not only to heal patients and attempt to extend their lives, but also to protect patients from experiencing unnecessary pain and discomfort. An argument for PAD based on an avoidance of patient suffering would remain in line with the view of the physician as someone who works not simply to make patients live long lives, but also to avoid patients' unnecessary agony. David Velleman brings forth this type of argument about the role of medicine, saying "I believe that the proper goal of medical science is, not to prolong human life *per se*, but rather to make human life better – often by prolonging it, of course, but also by relieving pain, restoring function, or facilitating natural processes."⁵³ In many cases, this pain relief and facilitation of natural processes might involve a quickened death assisted by a physician, and therefore PAD can certainly be seen as a practice that is in-line with this view of a physician's role as a pain reliever.

Another advantage to the suffering-based account of physician-assisted death is that such a basis can serve to avoid the fears about coercion that I have previously mentioned as a disadvantage of the autonomy-based account of PAD. As discussed in the previous section, it is difficult to assess whether a patient's decision is truly autonomous and uncoerced, when fears of becoming an emotional and financial burden on one's family may very well be influencing a patient's decision to die. With suffering as a basis for PAD, we can avoid these concerns by confirming that given a patient's physician condition, it is reasonable to believe that suffering—rather than the possible burden she is placing on her family—is the key factor informing the patient's decision to die. If the medical team can confirm that a patient is in a state of severe

⁵³ Velleman, "Against the Right to Die," 667.

suffering that can't be relieved, then we would be able to ensure that a patient is choosing PAD as a result of *her* condition, rather than out of fear of becoming a burden on her family.

Disadvantages of a Suffering-based Account

Along the lines of this advantage, and the possibility of ensuring that a patient is undergoing a degree of suffering that would cause him to want to die, we might come across a significant disadvantage of the suffering-based account. In particular, there might be great difficulty that comes along with attempting to measure the extent of an individual's suffering. Suffering is subjective by nature, as it is a physical feeling experienced by an individual that can manifest itself in an individual's emotional state as well. It might therefore be difficult to distinguish between and weigh the relative importance of a patient's physical and emotional suffering. This disadvantage might certainly bring about questions about whose view of suffering should govern the decision to use PAD—an individual's view about his own suffering, or a more "objective" third party view of that individual's degree of suffering. When it comes to forming a PAD policy, perhaps this disadvantage is one place where I will need to introduce the value of autonomy in cases where suffering is difficult to determine. Therefore, the proper procedure would be something similar to what the Netherlands uses, where the patient must autonomously initiate the request for PAD or euthanasia, given the degree of suffering that he is personally experiencing, and only afterwards is his level of suffering assessed and confirmed by outside parties. I also suggest the use of existing assessments in order to determine patients' levels of both physical and emotional suffering, as I will mention in Section X.

Another disadvantage of the suffering-based account of physician-assisted death is that an account based solely on an avoidance of suffering might open the door to an argument in favor of allowing the deaths of *any* suffering patients. For instance, if suffering is the primary

value informing decisions about PAD, then some might argue that this could lead to justifying the deaths of all patients experiencing suffering, a group which might include terminally suffering infants and mentally incompetent patients. These two groups would be particularly vulnerable when it comes to this disadvantage, as their degrees of suffering would be difficult to determine due to a lack of communicative abilities in the case of infants, and a general lack of decision-making capacity in the case of mentally incompetent patients. We might fear that in permitting death for members of these vulnerable groups who are unable to reliably convey their levels of suffering, we would open the door for the deaths of individuals in these groups who would not have desired to die, but are incapable of understanding and communicating their desires. For this reason, I will require a narrowly defined, high standard of suffering for these vulnerable patients, to ensure that even without meeting certain autonomy standards, these patients can use PAD or euthanasia in cases of extreme degrees of suffering. In this manner, this concern can be alleviated by the introduction of a hybrid philosophical approach that values not only an avoidance of suffering, but the autonomy of the patient as well, requiring higher suffering standards when autonomy is lacking. We will explore the details of such an approach in the next section.

A final point of difficulty that is worth mentioning when it comes to the suffering-based account of PAD is the question of suffering in the context of temporary or potentially treatable conditions. If we consider an avoidance of suffering to be our only basis for PAD, some might fear that a patient undergoing temporary suffering might be permitted to use PAD. It is important to note that for this reason, we must not only consider that the patient is suffering, but that a patient is undergoing unrelenting—not temporary—suffering. Therefore, the full rationale that must be included in this suffering-based account is not just suffering, but unavoidable suffering

with no hope of relief. This is the type of language that we see in the Netherland's, and certainly in Oregon's legislation, and it seems as though this qualification would be necessary in order to avoid wrongful uses of PAD that disrespect autonomy. This last point of difficulty is therefore another one of the many concerns that can be avoided through the introduction of autonomy. For, in line with my original definition of the term, the value of autonomy requires that the decision to die is not a momentary preference, but rather, a long-standing decision that remains aligned with an individual's core values over an extended period of time. Thus, in cases where the highest standards of suffering are not met, I will suggest relying on the strictest autonomy requirements to ensure that a patient's decision is truly in line with his values, and not clouded by severe, yet temporary suffering.⁵⁴

⁵⁴ There are certainly difficult cases in which patients might be severely suffering for a long—yet temporary—period of time, such as the case of Dax Cowart, but these cases require further discussion that is beyond the scope of this paper. Cowart was forced to undergo excruciating treatments for severe burn injuries, despite insisting that he wanted to die and refusing to consent to these treatments, all while he was deemed competent. Cowart later healed, but has remained outspoken about his right to die, which he felt was undermined by his medical staff. See Dax Cowart and Robert Burt. "Confronting Death: Who Chooses, Who Controls?" *Hastings Center Report*, Vol. 28, No. 1 (1998), 14-17.

X. Towards a Hybrid Philosophical Approach

Against the backdrop of the advantages and disadvantages that would come along with creating a physician-assisted death policy based in either an autonomy-based or suffering-based philosophical foundation, there is significant reason to argue that ideal PAD legislation should be grounded in a hybrid philosophical approach, one that gives both autonomy and suffering significant weight. In crafting my hybrid approach to PAD, I will attempt to incorporate the advantageous elements of both the Netherlands' suffering-based account of PAD and euthanasia, and Oregon's autonomy-based account of PAD. For, given that each of these policies are based in the sound philosophical motivations of either suffering or autonomy, it is reasonable to draw from both pieces of legislation in order to incorporate elements of both the autonomy-based and suffering-based accounts. My suggested policy permits physician-assisted death, and in some cases euthanasia, depending on the individual's level of autonomy and the severity and form of his suffering.

Before introducing my suggested policy, it will be important to return to the main features that comprise the two policies upon which mine is based: the Oregon Death with Dignity Act and the Dutch Euthanasia Act. The Oregon DWDA allows competent, proven Oregon residents (18 years or older) to initiate requests for lethal prescriptions if they are suffering from a terminal disease that will kill them within six months. The patient must make two voluntary requests spaced at least 15 days apart, and a second physician must also confirm the patient's condition and diagnosis. In addition, the physician must fully inform the patient of his current condition and of every possible alternative treatment option. Furthermore, two witnesses must confirm the patient's request, and if the patient is suffering from a mental

disorder that might be impairing his decision, he must be referred to a psychiatrist for further evaluation.

According to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures Act), physicians can not be punished for providing patients with euthanasia or PAD prescription as long as they have submitted reports proving that the patient (1) is experiencing unbearable suffering with no hope of improvement, (2) has made voluntary and persistent requests, and (3) fully understands her condition. Furthermore, according to the Dutch law, the patient must be at least 12 years old, with parental consent being required for patients ages 12 through 16, and parental consultation required for patients between 16 and 18. The acting physician must also consult a second physician to confirm that all of the criteria have been met, and the patient's death must be executed in a medically appropriate manner, with the physician required to be present if the patient ends her life on her own. On the following page, I outline the criteria which comprise my suggested policy, most of which are based on elements of the Oregon DWDA and the Dutch Euthanasia Act.

Suggested PAD and Euthanasia Criteria

Figure 1 presents my suggested criteria for three distinct patient groups, which are distinguished based on levels of decision-making competence.

Figure 1.

	Category A Patients	Category B Patients	Category C Patients
1. Competence Level	Fully Competent	Borderline Competent	Incapable of Medical Decision Making
2. Competence Assessor	Attending physician and psychiatrist	Attending physician and psychiatrist	Attending physician and psychiatrist (in cases of mental illness)
3. Requesting Agent	Patient	Patient with parent/guardian consent	Surrogate and Advanced Directive (if possible)
4. Treatment(s) Permitted	Physician-Assisted Death	Physician-Assisted Death	Physician-Assisted Death or Euthanasia
5. Suffering Type	Irreversible and interminable mental or physical suffering with no hope of significant relief	Irreversible and interminable physical suffering with no hope of significant relief	Irreversible and interminable physical suffering with no hope of significant relief
6. Suffering Assessment	Self-assessed through MSAS and MQOL scales; confirmed by a physician and a psychiatrist	Self-assessed through MSAS and MQOL scales; confirmed by two physicians and a psychiatrist; agreed to by a parent/guardian	Assessed by two physicians; agreed to by surrogate
7. Request Timeline	Two oral requests made at least 15 days apart, plus a written request if possible	Two oral requests made at least 15 days apart, plus a written request if possible	Two oral requests made at least 15 days apart, plus a written request if possible (in cases where surrogate is requesting agent)
8. Physician Requirements	Physician must voluntarily agree to provide the requested treatment	Physician must voluntarily agree to provide the requested treatment	Physician must voluntarily agree to provide the requested treatment
9. Physician-Patient Relationship Requirements	Well-established and long-standing	Well-established and long-standing	Well-established and long-standing

As shown in *Figure 1*, I begin crafting my suggested policy by grouping eligible patients into three categories, which are dependent on the individual patient's level of autonomy. I separate them in this manner so that in cases where autonomy is lacking, we can heighten suffering requirements to ensure that the treatment decision is reasonable—even with lesser levels of autonomy—given the patient's extreme level of suffering. Therefore, although the policy is framed around these patient categories that are established based on autonomy levels, suffering is an essential part of my PAD and physician-assisted death requirements, as it is required for all patient types. Furthermore, suffering is an essential requirement in cases of patients with the lowest levels of autonomy, in which the value of avoiding suffering can compensate for a lack of autonomy. I will begin explaining my recommended policy by detailing the requirements that apply to all patient categories.

Requirement 7 / Request Timeline:

I adopt the timeline laid out in the Oregon Death with Dignity Act, which is reasonable in requiring that the patient or decision-making agent must make two separate oral requests with a significant amount of time between them, to ensure that the decision is not just a momentary preference, but an autonomous decision that is in line with the patient's firmly rooted values. For cases of Category C patients, it is important to keep this request timeline in place to ensure that in cases where the surrogate decision maker is requesting euthanasia, the surrogate's decision is not hindered by any momentary emotional stress that might come along with watching a loved one suffer. Rather, I require that a surrogate's decision remain consistent over time to ensure that it is well reasoned and rational, and not a momentary preference distorted by emotional stress.⁵⁵

To make review procedures simpler, I will also require a written request if possible. This request

⁵⁵ Of course, the emotional stress that a surrogate decision maker undergoes might be affecting this decision maker over time, but the request timeline requirement can ensure that no momentary heightening in emotions would cause a lapse in judgment.

timeline requirement, on top of the physician-patient relationship requirements, both serve to ensure that patients' decisions are consistent over time and not just temporary.

Requirement 8 / Physician Requirements:

It is important that for all three patient categories, no physician can be forced to write a prescription for a lethal agent (or in some Category C cases, to administer euthanasia). This requirement, which draws from the text of the Oregon DWDA, is necessary in order to respect the autonomy of the physician. I make the assumption that the existing medical regulations would guarantee that physicians have the competence levels required to make these important clinical decisions.

Requirement 9 / Physician-Patient Relationship Requirements:

Instead of using a residency requirement like the Oregon legislation has in place, I adopt the Dutch requirement that the physician and patient have a long-standing and well-established treatment relationship. This way, my policy can ensure that the attending physician knows the patient well enough to understand the details of the patient's physical and emotional condition, and to confirm that the patient's request is in line with his core values and his medical history, ensuring that it is a truly autonomous request. For Category C patients, it is similarly important that the physician know about the patient's condition and the fundamental values at hand, whether those are the values that the patient had at a time when he was autonomous, or the surrogate decision maker's views about what the patient might have wanted or what would be best for the patient. In requiring this deeply rooted relationship, this feature establishes a more thorough safeguard than a simple residency requirement would provide.

Having gone over the requirements that apply across the board for all three of the patient categories that I've established, I will now detail the distinctions that I make between the required PAD and euthanasia requesting processes for the three categories of patients.

Requirements for Category A Patients:

Patients in Category A, who are considered to have full competence, are adults aged 18 and older who have been deemed capable of making end-of-life treatment decisions on their own, having been evaluated by an attending physician along with a psychiatrist in order to confirm that these patients have met the necessary competence level. In order to make such assessments, psychiatrists might follow the Oregon guidelines of ensuring that requests patients are "capable," and that their requests are "voluntary." In terms of suffering types, the PAD requests initiated by Category A patients may be approved if the patient at hand is undergoing interminable and irreversible suffering with no hope of significant relief. This might include mental or physical suffering that the physician and psychiatrist have confirmed to be irreversible and interminable. This would mean that if a Category A patient was suffering from a potentially treatable mental disorder like depression, the psychiatrist must first attempt treatment and only permit PAD requests once it has been confirmed that the patient's condition can't be improved with treatment.

Because patients in Category A have the highest levels of competence and autonomy, I incorporate the expansive and inclusive view of suffering that is utilized by the Netherlands legislation. In assessing the suffering of these patients, I suggest weighing both mental and physical suffering. I distinguish between these suffering types depending on how the patient experiences this suffering, with mental suffering causing trauma to a patient's emotional and

mental state, and physical suffering being experienced primarily through bodily pain.⁵⁶ I suggest using assessments such as the Memorial Symptom Assessment Scale (MSAS) and McGill Quality of Life Questionnaire (MQAL)⁵⁷, which can allow patients to report their levels of physical and mental suffering. I trust that with well-established physician-patient relationships, the physician would be able to confirm the validity of a patient's self-reported suffering, given his knowledge about the patient's history and current condition. If the patient's suffering is of the mental or emotional form, then the psychiatric evaluation, combined with the physician's intensive knowledge of the patient, would similarly ensure that physician-assisted death is a reasonable treatment option for the requesting Category A patient.

Requirements for Category B Patients:

Patients in Category B are considered to have moderate or borderline levels of autonomy, and for these patients, I adjust my suffering requirements to make sure that even with lesser autonomy levels, PAD can still be a reasonable treatment decision, given the degree of the patient's suffering. Examples of Category B patients might be adolescents suffering from terminal illnesses, or individuals with mental disorders that are not severe enough to deem them incompetent. Of course, when it comes to mental disabilities, it is difficult to determine which cases fall into this "borderline" category, but I believe that this should be left to the discretion of the treating psychiatrist and physicians (one of whom would know the patient quite well). I will allow these patients in Category B to assess their own suffering with the MSAS and MQAL scales after initiating their requests for PAD.

⁵⁶ Of course, these suffering types are closely linked. For, pain with a bodily source can often cause serious emotional trauma. However, in classifying a patient's suffering, I suggest attempting to determine whether a patient's pain is experienced more strongly as a physical or mental phenomenon.

⁵⁷ See appendices for more information on these assessments.

In addition, because of fears about the lesser levels of patient autonomy, I suggest relying on the opinions of two physicians (one of whom has a well-established treatment relationship with the patient) and one psychiatrist, as a way of confirming that given the patient's condition, the patient's suffering is severe and irreversible to the extent that physician-assisted death is the most reasonable treatment option. Furthermore, similar to the Dutch legislation, I will require the written consent of a parent or guardian when it comes to Category B patients in order to recognize and compensate for the fact that these patients are not fully autonomous medical decision makers. These extra safeguards of an additional physician and parental consent requirement are attempts to distinguish between the management of cases of clearly competent patients and those cases of patients whose competence levels might be questionable.

Of course, there might be cases in which there are conflicts between the opinions of the physicians, psychiatrist, and parent or guardian. These cases are especially difficult, and I would argue that they should not go forward due to the inconsistencies between the opinions of the decision makers, whose opinions should all hold significant value. There might certainly be cases in which not bringing these cases forward could mean a patient's continued suffering, but out of respect for all of the decision-making parties, I can't reasonably conclude that one of these opinions should be given more weight than another. There is certainly room for further discussion on this question, but in crafting a policy, it is of utmost importance to maintain a respect for all of the decision-making parties for which the policy applies.

I also require that at least some part of the suffering experienced by patients in Category B be interminable physical suffering, because the medical team might not be able to fully rely on these patients' self-reported mental states due to their lack of competence. Physical suffering would hopefully be more easily assessed and confirmed by third parties (physicians, a

psychiatrist, and a guardian), as opposed to mental suffering, which might be difficult to assess when it comes to patients who are lacking in competence. Of course, many of these patients would be experiencing both mental and physical suffering, given their agonizing conditions, but I require that some element of the suffering be physical in order to make the assessment more reliable. This higher suffering standard can quell fears about these patients' lack of decision-making autonomy, in order to ensure that even with lower levels of autonomy, these patients are suffering to a degree so extreme that physician-assisted death is a reasonable and rational treatment option.

Requirements for Category C Patients:

Category C patients possess the lowest level of autonomy, and therefore their end-of-life decisions are made by legally appointed surrogate decision makers, or by the instructions of an advanced directive if one was put in place at a time when the patient was fully autonomous (for instance, a previously competent patient who has severe brain damage that has made him mentally incompetent). Because this category includes patients who would likely be unable to administer their own lethal medication, I include euthanasia as a possible treatment for patients in this category in order to provide relief for these patients' suffering. For instance, a severely suffering infant might be eligible for euthanasia if the surrogate decision maker requests it, and an extreme level of irreversible suffering is being experienced, as confirmed by two physicians.

In terms of confirming the suffering-levels of patients in Category C, I leave this assessment to the discretion of two physicians (one of whom must have the required well-established relationship with the patient and surrogate decision maker). The type of suffering in this case would therefore be purely physical, since for incompetent patients, it is difficult—if not impossible—to assess levels of mental suffering. I require that the physicians and surrogate

decision maker have agreed that euthanasia or physician-assisted death is the only reasonable treatment option, given the extreme severity and irreversibility of the patient's suffering. Like in contested cases of Category B patients, Category C cases where the surrogate and the physicians disagree may not be brought forward, out of respect for the opinions of all decision-making entities.

Thus, Category C patients face the most limiting suffering requirements, because these patients are lacking in competence to the degree that they are unable to make any treatment decisions for themselves. For even without decision-making capabilities, it is clear—especially in the context of my philosophical assessment of the suffering-based account of PAD and euthanasia—that there would be many cases in which suffering could be so severe and futile that causing death is far more compassionate than leaving these patients to live in their agonizing states. It should be noted that my suggested treatment of Category C patients is where my policy most strongly differs from both the Netherlands and Oregon legislations, which would not allow physician-assisted death or euthanasia of patients below the age of 18 (in Oregon) or 12 (in the Netherlands). But if I am to truly value an avoidance of suffering and the philosophical principle of beneficence in creating this policy, then there is certainly reason for me to extend PAD and euthanasia to Category C patients, who might be experiencing suffering even more extreme than patients in Categories A and B.

Policy Review

Thus, I have set out requirements that would apply for these patient groups that reflect three different levels of autonomy. My policy permits physician-assisted death, and in some cases euthanasia, with no residency requirement and no life-expectancy requirement. Instead, my proposed policy values a well-established physician-patient relationship, to ensure that for every

case of PAD or euthanasia, the physician has an extensive knowledge of the patient's medical history, current condition, and fundamental values. Like the Netherlands law, my policy asserts that as long as a patient is undergoing suffering that is irreversible and interminable, she may be eligible for physician-assisted death or euthanasia, depending on her category of autonomy (self-reported physical or mental suffering for Category A patients, and higher physical suffering standards for patients in categories B and C).

Regarding the terminology used in my suggested policy framework, I continue to use the term physician-assisted death, despite the fact that in many of the cases in which my policy would permit PAD, patients would be significantly shortening their lives. If we recall from Section V, some believe that the six-month life expectancy requirement distinguishes Oregon-legalized PAD with physician-assisted "suicide," because the former represents hastening deaths that would inevitably occur soon. However, even without a short life-expectancy requirement, I still refer to my suggested policy as one permitting "physician-assisted death" and not "physician-assisted suicide," because I feel that death under the agonizing circumstances outlined above is a reasonable and rational decision, as opposed to more general cases of suicide, which are viewed as irrationally life-shortening.

In order to be implemented, the suggested framework I have laid out in this section would need to be further expanded upon into a formal policy. But the goals of this paper are to suggest a possible legislative framework, based in the ethical foundations that I've shown to be necessary for a philosophically sound PAD and euthanasia policy. Having provided this philosophical account and the type of policy that a hybrid philosophical approach might generate, perhaps further discussion could flesh out this framework into a more formal piece of legislation that could eventually be implemented.

XI. Summary & Conclusion

In this paper, I have argued about the notable distinction between the philosophical foundations of the Oregon Death with Dignity Act and the Dutch Euthanasia Act. In particular, I have argued that the Oregon legislation is primarily based on an attempt to protect patient autonomy, while the Netherlands policy is mainly based on an avoidance of patient suffering. I have explored existing philosophical support for these distinct foundations for permitting physician-assisted death and euthanasia, and discussed the benefits and drawbacks that come along with legislation built upon each of these bases. With these advantages and drawbacks in mind, I have argued that an ideal policy would incorporate philosophical elements of both the Oregon and Netherlands legislation, by showing a respect for patient autonomy coupled with an attempt to avoid suffering.

In the policy I have formulated, I distinguish between patients based on their levels of autonomy and competence, and argue that for patients with lower levels of competence, a higher standard of suffering severity should be required. These established categories of autonomy, and the different levels of suffering required for each of them, reflect the importance of weighing both a respect for autonomy and an avoidance of suffering when it comes to decisions about physician-assisted death and euthanasia. My suggested policy represents an attempt to ensure that such decisions are always founded in a strong basis that combines autonomy and suffering, giving these values different weights depending on the individual characteristics of the patient at hand.

With this in mind, it is clear that PAD legislation and other similar policies would be improved by increased international discussions about these issues. For, when using an international framework to discuss the issue of physician-assisted death and euthanasia, we can

draw from the profound advantages that come along with these regions' respective ethical foundations. There are certainly more questions to be answered when it comes to my suggested policy and its implementation. As I mentioned in Section X, my suggested legislative framework would have to be expanded upon as a formal policy in order to be implemented. In addition, although I suggest using the MSAS and MQOL assessments, there is always room for improvement when it comes to the scales that we use to determine levels of emotional and physical suffering, and the weight that should be given to these forms of suffering when it comes to making treatment decisions. Lastly, I am aware that we are in need of a discussion of the reporting requirements that should be implemented along with any piece of PAD and euthanasia legislation, but this too is a large topic that requires further discussion. Even with these areas for further discussion in mind, this suggested hybrid philosophical approach can serve as a model for a philosophically sound account of physician-assisted death and euthanasia that draws from these two necessary ethical foundations of respect for patient autonomy and avoidance of suffering.

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Appendix I. Memorial Symptom Assessment Scale

MEMORIAL SYMPTOM ASSESSMENT SCALE														
Name							Date							
Section 1														
Instructions: We have listed 24 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how <u>OFTEN</u> you had it, how <u>SEVERE</u> it was usually and how much it <u>DISTRESSED</u> or <u>BOTHERED</u> you by circling the appropriate number. If you <u>DID NOT HAVE</u> the symptom, make an "X" in the box marked " <u>DID NOT HAVE</u> ."														
DURING THE PAST WEEK Did you have any of the following symptoms?	D I D N O T H A V E	IF YES				IF YES				IF YES				
		How OFTEN did you have it?				How SEVERE was it usually				How much did it DISTRESS or BOTHER you?				
		Rarely	Occasionally	Frequently	Almost Constantly	Slight	Moderate	Severe	Very Severe	Not at all	A Little Bit	Somewhat	Quite a Bit	Very Much
Difficulty concentrating		1	2	3	4	1	2	3	4	0	1	2	3	4
Pain		1	2	3	4	1	2	3	4	0	1	2	3	4
Lack of energy		1	2	3	4	1	2	3	4	0	1	2	3	4
Cough		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling nervous		1	2	3	4	1	2	3	4	0	1	2	3	4
Dry mouth		1	2	3	4	1	2	3	4	0	1	2	3	4
Nausea		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling drowsy		1	2	3	4	1	2	3	4	0	1	2	3	4
Numbness/tingling in hands/feet		1	2	3	4	1	2	3	4	0	1	2	3	4
Difficulty sleeping		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling bloated		1	2	3	4	1	2	3	4	0	1	2	3	4
Problems with urination		1	2	3	4	1	2	3	4	0	1	2	3	4
Vomiting		1	2	3	4	1	2	3	4	0	1	2	3	4
Shortness of breath		1	2	3	4	1	2	3	4	0	1	2	3	4
Diarrhea		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling sad		1	2	3	4	1	2	3	4	0	1	2	3	4
Sweats		1	2	3	4	1	2	3	4	0	1	2	3	4
Worrying		1	2	3	4	1	2	3	4	0	1	2	3	4
Problems with sexual interest or activity		1	2	3	4	1	2	3	4	0	1	2	3	4
Itching		1	2	3	4	1	2	3	4	0	1	2	3	4
Lack of appetite		1	2	3	4	1	2	3	4	0	1	2	3	4
Dizziness		1	2	3	4	1	2	3	4	0	1	2	3	4
Difficulty swallowing		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling irritable		1	2	3	4	1	2	3	4	0	1	2	3	4

Section 2										
INSTRUCTIONS: We have listed 8 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how SEVERE it was usually and how much it DISTRESSED or BOTHERED you by circling the appropriate number. If you DID NOT HAVE the symptom, make an "X" in the box marked "DID NOT HAVE."										
DURING THE PAST WEEK. Did you have any of the following symptoms?	D I D N O T H A V E	IF YES How SEVERE was it usually?				IF YES How much did it DISTRESS or BOTHER you?				
		Slight	Moderate	Severe	Very Severe	Not at all	A little bit	Somewhat	Quite a bit	Very much
Mouth sores		1	2	3	4	0	1	2	3	4
Change in the way food tastes		1	2	3	4	0	1	2	3	4
Weight loss		1	2	3	4	0	1	2	3	4
Hair loss		1	2	3	4	0	1	2	3	4
Constipation		1	2	3	4	0	1	2	3	4
Swelling of arms or legs		1	2	3	4	0	1	2	3	4
"I don't look like myself"		1	2	3	4	0	1	2	3	4
Changes in skin		1	2	3	4	0	1	2	3	4
IF YOU HAD ANY OTHER SYMPTOMS DURING THE PAST WEEK, PLEASE LIST BELOW AND INDICATE HOW MUCH THE SYMPTOM HAS DISTRESSED OR BOTHERED YOU.										
Other:						0	1	2	3	4
Other:						0	1	2	3	4
Other:						0	1	2	3	4

Source: National Palliative Care Research Center

Appendix II. McGill Quality of Life Questionnaire

McGILL QUALITY OF LIFE QUESTIONNAIRE

STUDY IDENTIFICATION #: _____ DATE: _____

Instructions

The questions in this questionnaire begin with a statement followed by two opposite answers. Numbers extend from one extreme answer to its opposite. Please circle the number between 0 and 10 which is most true for you. There are no right or wrong answers. Completely honest answers will be most helpful.

EXAMPLE:

I am hungry:

not at all 0 1 2 3 4 5 6 7 8 9 10 **extremely**

- If you are not even a little bit hungry, you would circle 0.
- If you are a little hungry (you just finished a meal but still have room for dessert), you might circle a 1, 2, or 3.
- If you are feeling moderately hungry (because mealtime is approaching), you might circle a 4, 5, or 6.
- If you are very hungry (because you haven't eaten all day), you might circle a 7, 8, or 9.
- If you are extremely hungry, you would circle 10.

BEGIN HERE:

IT IS VERY IMPORTANT THAT YOU ANSWER ALL QUESTIONS FOR HOW YOU HAVE BEEN FEELING JUST IN THE PAST TWO (2) DAYS.

PART A

Considering all parts of my life - physical, emotional, social, spiritual, and financial - over the past two (2) days the quality of my life has been:

very bad 0 1 2 3 4 5 6 7 8 9 10 **excellent**

Please continue on the next page...

PART B: Physical Symptoms or Physical Problems

- (1) For the questions in Part "B", please list the **PHYSICAL SYMPTOMS OR PROBLEMS** which have been the biggest problem for you over the past **two (2) days**. (Some examples are: pain, tiredness, weakness, nausea, vomiting, constipation, diarrhea, trouble sleeping, shortness of breath, lack of appetite, sweating, immobility. Feel free to refer to others if necessary).
- (2) Circle the number which best shows how big a problem each one has been for you **OVER THE PAST TWO (2) DAYS**.
- (3) If, over the past two (2) days, you had **NO** physical symptoms or problems, or only one or two, answer for each of the ones you have had and write "none" for the extra questions in Part B, then continue with Part C.

1. Over the past two (2) days,
one troublesome symptom has been: _____
(write symptom)

no problem 0 1 2 3 4 5 6 7 8 9 10 **tremendous problem**

2. Over the past two (2) days,
another troublesome symptom has been: _____
(write symptom)

no problem 0 1 2 3 4 5 6 7 8 9 10 **tremendous problem**

3. Over the past two (2) days,
a third troublesome symptom has been: _____
(write symptom)

no problem 0 1 2 3 4 5 6 7 8 9 10 **tremendous problem**

Please continue on the next page...

4. Over the past two (2) days I have felt:

physically 0 1 2 3 4 5 6 7 8 9 10 **physically**
terrible **well**

*PART C Please choose the number which best describes your feelings and thoughts
OVER THE PAST TWO (2) DAYS.*

5. Over the past two (2) days, I have been depressed:

not at all 0 1 2 3 4 5 6 7 8 9 10 **extremely**

6. Over the past two (2) days, I have been nervous or worried:

not at all 0 1 2 3 4 5 6 7 8 9 10 **extremely**

7. Over the past two (2) days, how much of the time did you feel sad?

never 0 1 2 3 4 5 6 7 8 9 10 **always**

8. Over the past two (2) days, when I thought of the future, I was:

not afraid 0 1 2 3 4 5 6 7 8 9 10 **terrified**

9. Over the past two (2) days, my life has been:

utterly 0 1 2 3 4 5 6 7 8 9 10 **very**
meaningless **purposeful**
and without **and**
purpose **meaningful**

10. Over the past two (2) days, when I thought about my whole life, I felt that in achieving life goals I have:

made no 0 1 2 3 4 5 6 7 8 9 10 **progressed to**
progress **complete**
whatsoever **fulfillment**

Please continue on the next page...

11. Over the past two (2) days, when I thought about my life, I felt that my life to this point has been:

completely worthless 0 1 2 3 4 5 6 7 8 9 10 **very worthwhile**

12. Over the past two (2) days, I have felt that I have:

no control over my life 0 1 2 3 4 5 6 7 8 9 10 **complete control over my life**

13. Over the past two (2) days, I felt good about myself as a person.

completely disagree 0 1 2 3 4 5 6 7 8 9 10 **completely agree**

14. To me, the past two (2) days were:

a burden 0 1 2 3 4 5 6 7 8 9 10 **a gift**

15. Over the past two (2) days, the world has been:

an impersonal unfeeling place 0 1 2 3 4 5 6 7 8 9 10 **caring and responsive to my needs**

16. Over the past two (2) days, I have felt supported:

not at all 0 1 2 3 4 5 6 7 8 9 10 **completely**

Please continue on the next page...

