

Conclusions:

A Circumscribed Plea for Voluntary Physician-Assisted Suicide

1. Introduction

The concept of “death with dignity” does not automatically imply a desire to die; it certainly does not mean to put someone to death in a dignified way. Organizations that support euthanasia speak of the ‘right to die with dignity’ and this terminology became a euphemism that promotes euthanasia. I believe in the concept of death with dignity and recognize that some prefer death over the continuation of tormented living. Some organizations are so dedicated to the idea, however, that they conceive of themselves as missionaries whose role is to educate and ‘advance’ society in the ‘right’ direction, and sometimes they do not make judgments and decisions carefully.¹ They become too eager and their strong motivation overshadows the need for utmost caution. We cannot be simplistic or ambiguous with this delicate issue.

I recall a discussion with an Israeli attorney who specializes in representing patients who wish to die and who is active in the right-to-die organization in Israel. I asked him about his prime concern. His answer was the patient’s expressed will to die. I further pressed the issue and questioned him about different scenarios: What if your client needs some emotional support? What if he or she is unaware of all the relevant considerations relating to his or her disease? I wanted to understand to what extent the attorney was sensitive and cognizant of the possibility that some of the patients/clients might change their mind if things were explained to them in a different manner. The attorney’s answers clearly

showed that this did not matter to him. For him the client's desire to die was sufficient. His attitude seemed to lack compassion for the clients.

I reiterate: our first obligation is to place the issue in its proper context and to emphasize that most patients seek to preserve life. With this proviso in mind, my opinion supports the right to die with dignity in certain cases, which will be clarified. I will do my best to describe these cases clearly, without being over-zealous, and without offending the people involved. Life should not be seen as a virtue to be preserved at any cost, regardless of the patient's will; at the same time euthanasia should not be supported without reservation. In this context I shall criticize Dr. Jack Kevorkian's campaign for euthanasia and the utilization of his 'Mercitron.' Kevorkian may not be considered seriously by bioethicists, but his deeds deserve serious consideration. From 1990 until his arrest in 1999 Dr. Kevorkian has helped dozens of people to die. Kevorkian recognized the need of people that is not met adequately by society and entered this lacuna with a missionary vigor. His campaign is the result of failures of the medical system in caring for patients with intractable or chronic problems. It forces society to think harder than before about medical mercy and assistance at the end of life, and to find suitable answers so that Kevrkian's ministrations may be made redundant.

The *Eyal* case, which took place in Israel in 1990, serves as an illustration to show that on some occasions physician-assisted suicide may be allowed. I assert that in instances such as this one, the patients' autonomy would be sustained and their dignity better served by helping them to die. It is not always true that keeping a person alive is to treat her as an end. In some incurable situations we respect agonizing patients and their dignity when we help them to cease living. My justification for helping such patients fulfil their request rests on the assumption

that they freely and genuinely expressed their will to die, and that they persist in expressing that desire.

2. The *Benjamin Eyal* Case

In 1990, the magistrate court of Tel Aviv received an appeal made by a patient named Benjamin Eyal. Mr. Eyal suffered from the same disease that attacked Sue Rodriguez in Canada, Amyotrophic Lateral Sclerosis (ALS). Mr. Eyal, aware of the expected process, asked not to be attached to a respiratory machine when he could no longer breathe spontaneously, but to be allowed to die. He expressed this wish in an affidavit, in a videocassette as well as verbally. The specialist who testified before the court said that his commitment to care for Mr. Eyal “does not include a duty to prolong life of unimaginable suffering by committing an intrusive act that could be avoided by following the will of the patient.”²

In considering Mr. Eyal’s motion, Judge Uri Goren emphasized two principles: the “sanctity of life” principle, and the “decent death” principle. As for the “sanctity of life” principle, Judge Goren articulated that this principle should be employed when medical treatment could save life or improve the medical state of patients. (However, Jewish law does recognize the need not to afflict dying people, taking into consideration human suffering and pain.)

Judge Goren explained that in this case, no doubts arose with regard to the wishes of the patient. Mr. Eyal clearly manifested his wish not to be connected to a respirator when the time came and no other alternative was available to keep him alive. In addition, there were no doubts that Mr. Eyal was competent and clear-minded upon voicing his request, knowing its obvious consequences. In his testimony before the court, the Director of Lichtenstaedter Hospital, Dr. Nachman

Wilensky, explained that Mr. Eyal was a senior patient, well known to the hospital officials, and that he was thoroughly convinced that Eyal's intentions were sincere and freely chosen.

Judge Goren decided to accept the appeal. He emphasized that such a decision concerning life and death should be made by a senior director, either by the Director of the Hospital or by the Head of Department. This was because the decision involved expertise, moral values, religion and ethics.³

The *Eyal* case stimulated many debates in Israel. Rabbinical authorities were asked their opinion regarding this situation. I should first reiterate that the major difference between the *halachic* view and the liberal view is that many *halachic* commentators do not endorse the autonomy principle. According to their perspective, persons are not masters of their lives. Life is given to us as a gift from the Creator, and we should not destroy it.⁴ Human life is intrinsically good irrespective of its condition. Rabbi Elyashiv, a well-known *halachic* decider (*Posek Halacha*) said that when medical treatment may only prolong transient life and involved additional suffering, a patient may refuse to accept it. The physicians were allowed to terminate treatment when the last stages of Mr. Eyal's disease were reached. Rabbi Israel Meir Lau, currently the Ashkenazi Chief Rabbi in Israel, also endorsed this view.

In a letter concerning the *Eyal* case, Rabbi Lau wrote that his discretion was limited to the case in hand and to the specific circumstances as described to him. He contended that the *halacha* did not require, and sometimes prohibited, the performance of exceptional treatment that only prolonged the patient's suffering without healing the cause of the pain. Mr. Eyal's disease was said to be incurable and the disputed treatment would not sustain his life in any meaningful sense. So,

when the time came, the attending physicians should be allowed to act upon Mr. Eyal's request and refrain from connecting him to a respirator. Rabbi Lau maintained that, in any event, regular medical treatment should be sustained. That is, Mr. Eyal should be provided with nutrition and all means should be taken to relieve his pain.⁵

Benjamin Eyal died of disease complications before the disease had reached its final stage and before a respirator was necessary. Thus, the physicians at Lichtenstaedter did not have to act upon the court's decision. For the sake of argument, however, let us suppose that the final stage had been reached, and the physicians refrained from connecting Benjamin Eyal to the respirator machine. Would it be humane to witness Mr. Eyal suffocating to death? I asked one of Mr. Eyal's senior doctors if it would be possible for him to stand idly by while his patient was choking to death. The doctor's replied: "I would 'give Eyal something' to shorten his suffering."

I think that this is a humane answer, in harmony with the morals of humane medicine. Any other answer, principally opposed to active intervention, would be inhumane and cruel. Under such circumstances, there are strong reasons to consider physician-assisted suicide. When the patient is obviously suffering and expresses his or her will to die, and the doctors admit that they are unable to cure the illness and all they can do is to ease the physical and not the emotional pain, then there is no substantial difference between voluntary passive euthanasia and voluntary physician-assisted suicide.⁶ The term 'voluntary' refers both to the request of the patient and to the act of the doctor. The patient should have the right to decide for himself about his fate, and the doctor should not be compelled to

abide. The doctor should abide if she feels that physician-assisted suicide is the appropriate, dignified and kind medical measure.

Those who oppose assisted suicide will say that there is no need to reach the stage where we have to consider such termination of life. Benjamin Eyal could have been given medicine to stop him from suffering. The responsibility rests with the doctor to give medicine to patients, even if the medicine shortens their lives. This is allowed because the purpose is to care for the patients and decrease their suffering, not to bring about their death.

I discussed the double effect doctrine in **Chapter 1**. This doctrine serves both spiritual leaders and careful healers as a way out of dealing directly and sincerely with the question of mercy termination of life. Undoubtedly the doctrine provides a better solution than letting people like Benjamin Eyal die slowly in agony does. In the everyday medical practice in hospitals there are many instances in which doctors perform double effect: their intention is to alleviate pain and suffering, not to kill the patient, but the result is the death of the patient. However, I suspect that there are enough cases in which partisan interests rather than the patients' best interests are first and foremost before the doctor's eyes, and the double effect doctrine serves as a convenient guise for pursuing those partisan interests.

The reader should not infer from the ongoing discussion that allowing mercy medical assistance to end life in cases where the patient's condition is irreversible and the patient lacking autonomy seeks assistance to fulfil his or her desire to die entails the killing of patients in other instances. On the above assumptions it might be argued that people in prolonged unawareness (PCU) couldn't possess dignity because they are not autonomous. Thus the argument

might be that in order to safeguard their dignity we might be required to help them cease living. Justice Haim Cohn writes in this context:

In a conflict between human life and human dignity, it is for the human being to make the choice, and, failing his or her declaration to the contrary, he or she is always presumed to choose human life in preference to human dignity: it is only where human life is reduced to a phantom or chimera of human life that human dignity must prevail to bring about at least a dignified death.⁷

But sometimes a patient whose human life is reduced to “a phantom or chimera of human life” might progress and improve in his or her situation. It is only when we are certain that no progress may be made (as in cases of severe, irreversible damage to the brain described as whole-brain-death) that we can speak in definite terms of a shadow of life rather than of a life. Physicians are convinced that, for all practical purposes, the identification of brain death means that the patient is dead. As things stand now, when confronted with brain-dead patients, human dignity must prevail to bring about at least a dignified death. The case is different regarding PCU patients in whom the cerebral hemispheres of the brain are damaged. There are reported cases of PCU patients who showed progress in their condition.⁸

The question becomes more complicated when PCU patients, who are by definition not brain dead, demonstrate no signs of improvement. Then the question of how we can (or should) protect a person’s autonomy becomes one of the major considerations. Among the criteria to be examined are the view of the patient’s loved ones regarding the fate of the patient concerned and whether the

patient has left prior directives regarding treatment in the event that he or she becomes incompetent (for further deliberation see **Chapter 2**).

3. The Doctor's Role

A troubling question is whether or not it is within the doctor's responsibility to terminate life. Obviously, when patients are competent and able to commit suicide they can assist themselves and seek death in various ways without having the need to involve doctors. The case is different when the patients are unable – physically or mentally - to commit suicide. These patients seek the doctors' assistance.

Doctors who are opposed to active euthanasia and physician-assisted suicide find no dignity in killing a patient, and express anxiety about the character of a society in which doctors assume such a responsibility.⁹ Sprung describes doctors' consent to perform euthanasia as 'unethical.'¹⁰ Avraham Steinberg writes in his criticism of this study that the doctor's role does not include killing. If society accepts the need for active euthanasia then any person can commit such an act. The doctor's role is to heal, to help patients and to relieve their suffering. Society must not assign its doctors the additional task of execution.

Although my plea is a circumscribed one in favor of physician-assisted suicide and not active euthanasia, let me first demur and say that I resent the use of the term 'execution' in this context. Support for active euthanasia is not necessarily associated with the acceptance of execution in society. One of the doctor's roles is, indeed, to ease patients' suffering. The daily practice in hospitals demonstrates that sometimes the only way to achieve this objective also shortens the patient's life. We are dealing with a population of patients with reasons, drives, and wills. Failing to listen to those reasons, drives and wills would lead to

gross paternalism: an unjustified action that takes the responsibility from the patient. Such behavior is unjustified because (a) the person for whom the doctor acts paternalistically is competent, and (b) the conduct in question is involuntary and coercive. Is it the task of a doctor to keep a person alive against that person's will? How do we answer that small group of patients who have lost their will to live and plead to their doctors for help? Steinberg and others think that it is not among the doctor's responsibilities to perform mercy killings. The question is whether another professional body exists in society that could take responsibility for this troubling task. Is it conceivable to ask another association (trained paramedics) or social group (the patient's beloved people) to assume this responsibility? My answer is conclusive. It is impossible to act on matters of health without qualified medical opinion. Only a trained physician is qualified to evaluate the patient's condition, is equipped with the data about the particular disease and about the process of dying. As Hardwig contends, the physician could provide a rich source of information about death and about strategies to minimize the trauma, suffering, and agony of death, both for the dying person and for the family.¹¹ Whereas I see no escape from including doctors in the decision-making process, Steinberg wishes, in his words, "to keep the doctor outside the killing circle," and does not want to consider active intervention as an option. Whereas I seek an answer for **all** patients, including those who wish to die, Steinberg ignores those patients who suffer from incurable diseases and express their wish to die. Obviously Dr. Steinberg and others who are opposed to physician-assisted suicide should not be expected to commit an act that contradicts their conscience; that would be as paternalistic as ignoring the patient's will. However, there are doctors

who agree with this line of reasoning and who do not necessarily regard such medical intervention as contrary to their medical and moral conscience.

One major objection to the circumscribed argument evinced here for physician-assisted suicide holds that the action is irreversible in the sense that it curtails the possibility of medical ‘miracles.’ Medicine is not a precise science and doctors do not know all. Often when the body responds differently from what was expected, contrary to the prognoses, contrary to the statistics and to recorded probabilities, explanations are given in a vocabulary that expresses humility regarding human knowledge and ability to comprehend. The popular press often terms such positive responses as ‘miraculous.’ Physician-assisted suicide precludes any chance for such ‘miracles’ and the possibility of re-diagnosing a misdiagnosis. There is also the fear of abuse, of killing patients against their will; thus there is a need for safety valves and for installing mechanisms of control. In the next sections I shall further circumscribe my reasoning in an effort to provide answers to these fair challenges.

4. The Need for Safety Valves

A. Preliminaries

The above warnings are well founded and, therefore, we should strive to minimize the possibility of errors taking place. Because most patients wish to live irrespective of their condition, this discussion is relevant for a small number of cases, like that of Benjamin Eyal and Sue Rodriguez.

To minimize the danger of misdiagnosis, a separate prognosis should be provided by at least two **independent** experts. One should be the patient’s attending physician who is in charge of her treatment and knows her case better

than the other doctors in her surroundings. Where none of the attending doctors really knows the patient well, the decision making process should involve the entire medical team. Competent patients should be advised of the doctors' doubts and hesitations about the nature of their illness, if such doubts exist. The patients should be informed, in language and terms they are able to understand, of the existing knowledge about their illnesses, to what extent it is based on data or speculations, and the margins of error. When the patients are incompetent, their family members and beloved people should be told about the prognoses and thoughts of the doctors.

As to the claim that physician-assisted suicide unnecessarily shortens life we should bear in mind that many of the patients who ask to die do so not because they want to live another day, another week, another month, but because life has become a burden they are better off without. People like Benjamin Eyal no longer wish to explore just how constrained such a life might be. Let me further stress that the circumscribed argument that I am making in favor of physician-assisted suicide relates only to people at the end of their lives, when their medical situation was diagnosed as incurable, and when patients reiterate their request to die several times over a certain period of time. This formulation would exclude physician-assisted suicide for patients who enjoy having helpful medicine that could improve their condition. The argument would also exclude physician-assisted suicide for patients who might suffer depression and who might come to re-enjoy life after the depression period is over.

B. Fear of Sliding Down the Slippery Slope

A serious objection to both active euthanasia and physician-assisted suicide

concerns sliding down the slippery slope toward total disrespect and contempt for human life. The argument holds that it is preferable to keep active euthanasia and physician-assisted suicide illegal so as to raise a clear voice regarding the value and importance of human life and to force physicians to think hard when they assume the responsibility of shortening life. This argument contains several warnings: first, the weak, easy to manipulate populations who are unable to protect themselves could be severely harmed if active euthanasia and physician-assisted suicide were allowed. Sweeping interpretations of allowing active intervention to terminate life could bring about the ending of lives of the poor, the neglected, the unwanted (see the discussion of the *Saikewicz* case in **Chapter 6**). Justice Elon's decision in the *Scheffer* case is germane to this discussion:

When we begin to estimate and to consider the **worth** of human life, these 'evaluations' and 'weightings' will lead firstly to permission to kill people whose minds and bodies are severely defective, then to the killing of those who are defective a bit less, and with time there will be no measure as to how limited the defect would have to be...¹²

Second, there is a danger of applying pressure on patients to die. This pressure could stem from various causes. There might be exploitation of the patient by his or her family members who are after his or her money and consequently welcome his or her death. In fact, this claim raises suspicion about doctors who do not always act in accordance with the best interests of the patient and hence allow room for family exploitation.¹³ There is also a danger of exploitation by the establishment, *i.e.*, by hospitals and medical centers that often operate under circumstances of scarce resources and budget cuts. The argument is

that, in an atmosphere permitting active intervention to end life, human life might become less important, and thus it might be in jeopardy when there are serious budgetary pressures and long lines for beds.

Warnings against a slippery slope process that might result in the deaths of some who wish to continue living are valid. The rationale for creating ethical directives for doctors, from the Hippocratic Oath to hospital ethics committees, arises from the recognition that doctors might abuse the power they possess. Such fears can be avoided by paying careful attention to the fine details when formulating concepts and regulations and by using explicit wording that does not allow abusive interpretations. The fear of abuse and the desire to grant patients with control over their lives until the very last moment were the prime motivation to restrict my plea to physician-assisted suicide and to refrain from advocating active euthanasia as well. From the Netherlands and Oregon we learn that most patients who opted for death were cancer patients. It can be assumed that they were capable of activating a lethal needle administered by a qualified doctor. The claim made by some Dutch physicians that active euthanasia is preferable to physician-assisted suicide can be rebutted.¹⁴ In the Netherlands, unsuccessful physician-assisted suicide happened because physicians administered oral drugs that were not always effective. In the scheme offered here, the lethal medication will be provided by injection, and it is the patient who operates the suicide mechanism.

Fear of the slippery slope should not lead to a *tout court* rejection of active involvement of physicians in the termination of lives, but to a commitment to create clear and definitive guidelines. We must examine the will of the patient, her condition, the extent of her suffering, and the doctors' prognoses regarding the

possibility of improving her condition.¹⁵ At the same time we should punish the abusers to prevent them from committing further wrongdoing and to deter others who might contemplate abuse. But the fear of abuse in itself does not constitute a strong moral ground that overrides the autonomy interests of patients.

Conscientious commentators, while aware of the possibility of the slippery-slope argument, that allowing mercy killing in some cases might lead to allowing this act in other cases, nevertheless argue that in specific circumstances mercy killing and physician-assisted suicide are lumped together) does not go against the patient's interests but conforms with them.¹⁶ Such an act is conceived as not offending against the intrinsic value of human life but rather affirming its convictions, its sense of integrity, and its dignity. Where PCU patients are concerned, their best interests are said to include factors that concern their dignity and the avoidance of 'futile' treatment.

I now turn to the warnings concerning possible negative ramifications for society at large. There are those who claim that licensing mercy killing and physician-assisted suicide in certain cases will lead to an increase in violence and in indifference to human life in general.¹⁷ Note that the slippery slope argument does not state that active euthanasia and physician-assisted suicide are wrong or immoral, but that permitting them might have negative consequences. The argument emphasizes what could happen to society if we indulge a request of a certain patient, but to a certain extent it disregards the **patient**. My claim is that we should not ignore the individual in need and that each case should be considered in its own right. Moreover, the slippery slope argument focuses the attention on what might happen in society as a result of granting a certain patient her wishes, but it ignores the misery of the patient **now**. In the center of the

ensuing analysis lies the individual. I believe that voluntary physician-assisted suicide conducted out of an honest and true motivation to provide relief from suffering is a humane act that respects the patient. There is reason to think that allowing physician-assisted suicide under the specified terms could increase sensitivity to human suffering and dignity, and not contribute to the devaluation of human life. The consequences of voluntary physician-assisted suicide for society may be positive.

Furthermore, we may be sliding down the slippery slope if we allow the present situation to continue. It is my feeling that we have been sliding down the slope. Through the ‘simple’ concepts (discussed in **Chapter 1**) of ‘**terminal**’ patients, life “devoid of **quality**,” ‘**futile**’ treatment, ‘**vegetative**’ patients (or simply ‘**vegetables**’) and the double effect doctrine, shortening of life - not always for sincere motives geared to serve the best interests of the patients - is a common practice in hospitals. As said earlier, the patients will be better off if those key concepts will be replaced by long explanations describing their diseases and by elaborate discussions about their medical prognosis and the available knowledge to help them cope with their illnesses. Single-word vocabulary and obscure Latin words serve the interests of doctors, not of the patients. They facilitate an atmosphere that does not really help to relieve patients’ insecurities and anxieties.¹⁸ In addition, physicians are often hard to reach, not sufficiently attentive to patients and their families, impatient to explain things in detail, and seem rushed to do other things. As Anspach shows, this inattentive attitude leads the medical staff to refrain from using the consent model; rather, they obtained ‘assent,’ or agreement to decisions to terminate life support already made by the staff.¹⁹ Passive euthanasia, practice of the double effect doctrine, and

discrimination against weak groups like aging patients and PCU patients are taking place in hospitals around the globe without sufficient mechanisms of control ascertaining that the patients' best interests are being served.

Many of the fears that are voiced against allowing active euthanasia and physician-assisted suicide are concerned with the possible misbehavior of doctors, yet the people who express these fears are content with the present situation with its 'gray' areas for doctors' maneuvering. Gray areas will apparently always remain. The question is whether we should be content with the present situation or look for ways to reduce these areas. It is time to change the present situation because it does not address the genuine needs of some patients who raise a clear and agonizing voice to die; because we should not consent to the amount of abuse that is already taking place;²⁰ because the responsibility for terminating patients' lives lies with doctors, not with the patients' families,²¹ and because society cannot allow free-riders to terminate patients' lives without proper control (see the discussion *infra* on Kevorkian). What is suggested is a two tier process: (a) to open a public debate about patients' rights and doctors' duties, educate the citizens about the existing state of affairs, put the above mentioned key conceptions on the public agenda, speak openly about the conflicting considerations, and mobilize the media to address these issues; then (b) to ask the public whether the institution of guidelines is preferable to the present situation. It might be the case that the public would feel that clear and specific guidelines would limit the doctors' maneuverability and better serve the interests of all patients, those who wish to live and those who wish to die. Society should address these troubling questions in a common endeavor to specify the roles and duties of doctors, and the rights of patients including their right to ask for a dignified death.

This two-tier process is preferable to leaving the situation as it is where various people around the patient's bed might act in ways that may not coincide with the best interests of the patient.²²

C. Fear of Over Zealousness

Overzealous promoting of medical active termination of life may create the impression that dying with dignity is more important than living with dignity. The guiding rule must be to preserve and maintain life. The termination of life must be the exception. Caution is necessary, both morally and professionally. The prime example of over enthusiasm for the shortening of life concerns the innovation called the 'Mercitron.'

The Mercitron is a suicide machine invented by an American doctor, Dr. Jack Kevorkian, who has led the campaign for assisted suicide and has become a folk hero in the United States and throughout the world.²³ From 1990 until September 1998, Dr. Kevorkian has helped at least sixty-five women and twenty-eight men to die.²⁴ During the 1990s, in a nine-year battle against the medical, legal and religious communities in Michigan, Kevorkian had been acquitted three times by juries in Oakland and Wayne counties in the assisted-suicide deaths of five people. A fourth trial in Ionia County ended in a mistrial. In those trials, Kevorkian relied on evidence about the pain and suffering of people he was charged with helping to die.²⁵

On 4 August 1993, Thomas Hyde, age 30, of Novi, Michigan, who suffered from amyotrophic lateral sclerosis, inhaled carbon monoxide. He was the 17th (some say the 20th) person to die in Kevorkian's presence. In May 1994, Kevorkian stood trial for the first time for his involvement in Hyde's death and

was acquitted. After the trial, a juror commented: “He convinced us he was not a murderer, that he was really trying to help people out.” A second juror said, “Dr. Kevorkian had acted principally to relieve Mr. Hyde’s pain, not to kill him, and that is an action within the law.”²⁶ One month later, Dr. Kevorkian’s medical license was revoked on the grounds that he had been disciplined by the Michigan Board of Medicine, and that he had assisted five patients to commit suicide.²⁷

In March 1996, Kevorkian stood trial for the second time on the charge of causing the deaths of Mrs. Merian Frederick, who suffered from amyotrophic lateral sclerosis, known as Lou Gehrig’s disease, and of Dr. Ali Khalili, who suffered from bone cancer. Kevorkian said that Frederick and Khalili had caused their own deaths by removing the clip on the tubing to allow poisonous gas to flow from a small, black tank into their plastic masks. Kevorkian further claimed that he encouraged both of them to remove the mask if they changed their mind at the last moment. Frederick and Khalili’s relatives testified that they appreciated Dr. Kevorkian’s help and compassion in ending their loved ones’ suffering. The prosecutors suggested that Kevorkian did not fully explore other options with Frederick and Khalili and made hasty decisions about their conditions without consulting their doctors. The jury, however, was not convinced; they felt that Kevorkian’s purpose was merely to relieve the patients’ suffering, not to cause their death, hence he was found not guilty.²⁸

One of the first patients who asked for Dr. Kevorkian’s assistance to die was Janet Adkins, an Alzheimer patient in the first stages of the disease. Aware as she was of the deterioration of human characteristics as a result of this terrible disease, Mrs. Adkins wished to die while she was still competent and able to be in charge of her actions. Dr. Kevorkian assisted her suicide although Mrs. Adkins

apparently had quite a few months left to live during which she could have functioned more or less autonomously. Her private doctor thought that Mrs. Adkins had at least another year before losing her ability to think clearly, and Dr. Kevorkian agreed that she was not a “terminal patient.”²⁹ He estimated that Mrs. Adkins had four to six months before becoming incompetent.³⁰ If Mrs. Adkins’s mental health was intact and she “was not the least depressed over her impending death,” as Dr. Kevorkian testified,³¹ the question arises: Why the rush? The criticism concerns the doctor’s neglecting his obligation to preserve life. Clearly it would have been possible to perform this assisted suicide at a later more advanced stage of the disease. Similar charges were brought against Kevorkian at his second trial.

The case of Janet Adkins exhibits the need to change the legal system to accommodate physician-assisted suicide. If patients would know that physician-assisted suicide would be available to them as an option, they would not need to seek Kevorkian-like physicians to end their lives prematurely. The existing situation brings patients to forgo life earlier than they should in fear of helplessness, degeneration into a prolonged, painful and degrading dying process.

Kevorkian’s third trial was concerned with assisted suicide of Marjorie Wantz and Sherry Miller. Mrs. Wantz (fifty-eight years old) suffered from excruciating pelvic pain; Mrs. Miller (forty-three years old) suffered from multiple sclerosis. Chief prosecutor Larry Buntig characterized Kevorkian as a “reckless agent of death.” Referring to Wantz, whose subsequent autopsy showed she was unlikely to die from her illness, Buntig said she “needed mental health treatment, not a bottle full of poison.”³² Here as in the previous trials the jury remained unconvinced and acquitted Dr. Kevorkian.

In December 1997, Dr. Kevorkian challenged Michigan lawmakers to pass a law banning assisted suicide, declaring at a news conference he will no longer “sneak around” in his assisted suicide campaign, and that he would starve himself to death in prison if convicted of the offense. Kevorkian vowed that “We shall not submit to that tyranny.” At a news conference with his associate to the latest killings, Dr. Georges Reding, a retired psychiatrist, Kevorkian maintained that a ban on “patholysis” (Kevorkian’s term for assisted suicide), “is sorely needed to clear the air... The ban itself o clear the air... The ban itself se we fully intend to challenge it to facilitate a so-called trial -- so-called because any trial mandated by an immoral law is nothing if not a lynching.”³³ Kevorkian also said that the conviction of him and his colleague will help future, more enlightened societies gauge the darkness of our plutocratic and theocratic age.³⁴ When repeatedly pressed by reporters to name the number of people whose suicides he has attended, Kevorkian would not be specific. But he did place the number at “somewhere between 80 and 100.”³⁵

My impression from an examination of Dr. Kevorkian’s deeds is that his acts are tainted with over enthusiasm. In his book, *Prescription: Medicide*, Kevorkian describes in detail his obsession with assisted suicide: how he came to the decision to help patients end their lives; his efforts to convince his colleagues that his conduct is justifiable; the process of building his suicide machine, and the efforts to receive recognition for his newly adopted profession (‘obituary’ in his words, a term derived from the Latin word *obitus* and from the Greek word *iatros*, meaning a doctor who helps patients meet death).³⁶ The efforts to find a place to perform Mrs. Adkins’s suicide were described as ‘Herculean.’³⁷ Dr. Kevorkian states that he does not help patients who are confused and are not of sound and

coherent mind.³⁸ The first patient that Dr. Kevorkian considered treating lost his ability to think clearly before the appointed date for treatment. Kevorkian described what had happened as a “near miss”: “... the patient unexpectedly slipped into babbling incoherence. That eliminated him as the first candidate for my services.”³⁹

Dr. Kevorkian’s acquaintance with most of those patients who sought his help and his suicide machine, which he called ‘Mercitron,’ was superficial. He did not know the patients who approach him, nor did he take pains to study their medical history. He knew Janet Adkins for only two days. The decision to nominate her as his first candidate for his suicide machine was made after a few phone calls and reading through her medical file, without ever having met her face to face.⁴⁰ Mrs. Adkins’s doctor strongly opposed her killing and refused to cooperate with Dr. Kevorkian. Kevorkian himself coldly describes their meeting in a businesslike manner. He writes, “After getting acquainted through a few minutes of conversation, the purpose of the trip was thoroughly discussed.”⁴¹ Kevorkian did not invest effort in convincing those who turn to him to reconsider their situation, and perhaps to opt for life. He did not insist that the request to die be consistent, expressed several times over a certain period of time, so as to make sure that the patients were convinced they reached the right decision. For him, like for the Israeli attorney I mentioned before, the important thing was the expressed will of the autonomous patients to die. The doctor supplied a service that honors their request.

However, the emphasis in Dr. Kevorkian’s book is not on the patient who asks to die but upon the doctor who takes the action. Janet Adkins, Thomas Hyde, Sherry Miller, Marjorie Wantz, Merian Frederick, Ali Khalili, and the other

dozens of patients whom Dr. Kevorkian helped to die are but a means to convey his message to the world. The pioneer to experience the Mercitron, Janet Adkins, serves in his book as no more than a secondary actress in a tragedy he wishes to mount on any possible stage to diffuse his cold ideas, which lack human compassion. I confess: I found it difficult to read his book. The concept of the right to die with dignity which is, in my opinion, a concept worthy of the most serious and painstaking consideration and study, becomes distorted in Dr. Kevorkian's book.⁴² His book is an easy target for those who oppose euthanasia and assisted suicide; a butting tool against those who side with the right to die with dignity.

Dr. Kevorkian's respect for the individual's right to decide autonomously about his or her destiny (for some reason Kevorkian mainly helped women) was extreme. He posed the virtue of respect for the patient's autonomy as the most important consideration, overshadowing other concerns. Because he was unqualified and apparently disinterested to examine his patients and verify their cause of illness, he assisted the suicide of some patients who were misdiagnosed. Kevorkian did not care very much. These people wanted to die and all he did was help them fulfil their desire.

Kevorkian and his attorney, Geoffrey Fieger, insisted that the retired pathologist had assisted in the suicides only of people with terminal illnesses -- including, by Kevorkian's definition, the late stages of Alzheimer's disease and multiple sclerosis -- or severe, chronic pain. But of the 44 people Kevorkian had acknowledged helping die in Oakland County, Dr. Ljubisa J. Dragovic said 11 were terminally ill, 29 had chronic conditions and **four others had no signs of disease**. Dragovic, the coroner who examined the bodies, has classified nearly all

of the 44 deaths linked to Kevorkian as homicides.⁴³ Among the controversial deaths I would mention the death of Margaret Garrish, 72, of Royal Oak (26 November 1994) who suffered from rheumatoid arthritis, and Kevorkian kept his promise to help her die if doctors did not provide better pain medication; Judith Curren, 42, of Pembroke, Mass (15 August 1996) who had chronic fatigue syndrome and suffered from depression;⁴⁴ Loretta Peabody, 54, of Ionia (30 August 1996) who had multiple sclerosis. Her husband remarried shortly after her death; Janet Good who was Kevorkian's assistant (26 August 1997). She had pancreatic cancer, but the coroner said she would have lived at least six months before eventually succumbing to the disease;⁴⁵ Deborah Sickels, 43, of Arlington, Texas (7 September 1997) who suffered from multiple sclerosis and other medical ailments. Her family said she was mentally unstable and accused Kevorkian of being irresponsible for helping her die;⁴⁶ Rebecca Badger, a 39-year-old woman who was diagnosed as suffering from multiple sclerosis but Dragovic says autopsy findings revealed a robust, physically fit young woman,⁴⁷ and Roosevelt Dawson, a 21-year-old quadriplegic college student from Southfield, Michigan (26 February 1998). Dawson was paralyzed from the neck down and relied on a ventilator to breathe since a virus infected his spinal cord.⁴⁸

The assisted suicide of young Dawson has energized Kevorkian's critics. They charged that the retired pathologist has slowly evolved his practice from terminal patients to all comers. Not Dead Yet, a national disabled-rights group fighting the legalization of assisted suicide, contended Kevorkian was slowly conditioning people to view death as the logical alternative to life with a disability. During a August 1990 court proceeding in Oakland County, Kevorkian made the following chilling statement: "The voluntary self-elimination of

individual and mortally diseased or crippled lives, taken collectively, can only enhance the preservation of the public health and welfare.” Dr. Georges Reding, Kevorkian’s associate who attended Dawson’s death, was quoted saying that anyone can choose assisted suicide because “we are all terminal.”⁴⁹

However, this case was not a case of assisted suicide. Dawson was completely incapacitated before his death and could not have operated the Mercitron. No wonder that right-to-die activist groups distanced themselves from Kevorkian. Carol Poenisch of Merian’s Friends, a Northville-based group working to legalize assisted suicide, said that according to Kevorkian “we are cowards because we want to document things and do it in a proper fashion... (Dawson’s) case would need much more careful study before he would qualify under Merian’s Friends’ guidelines. He may not have qualified.”⁵⁰ Indeed, for Kevorkian a person’s choice to live or die should depend on how they view their “quality of life.”

In June 1998, Dr. Kevorkian harvested the kidneys of Joseph Tushkowski, a Nevada man who died with his help. By this act he wanted to attract more media attention and to inflame the debate. The medical authorities refused to accept the organs. The National transplant organizations and area hospitals said that Kevorkian’s conduct did not meet their criteria. Dave Wilkens, a spokesman for the University of Michigan Medical Center in Ann Arbor, commented that Kevorkian’s act was nothing that any kind of responsible institution would participate in. Joel Newman, spokesman of the United Network for Organ Sharing -- a private company in Richmond, Va., with a federal contract to match organ donors with recipients -- said regulations require detailed medical and social histories and that procedures are carried out by surgeons in a hospital setting.⁵¹

In November 1998, Dr. Kevorkian further radicalized his campaign. Throughout his crusade he was dictating the moves, provoking public debate, pressing harder and harder the issue of assisted suicide and the right of people to choose the time of their death, forcing the legal authorities to address the questing and calling upon them to prosecute him. On 22 November 1998, the *Detroit News* reported that Kevorkian actively euthanised Thomas Youk who was suffering the advanced stages of Lou Gehrig's disease and would have been unable to inject himself the lethal dose. By that time, it was estimated that Kevorkian was responsible for more than 130 deaths.⁵² On this occasion, Kevorkian publicly admitted that he administered the lethal poison and, furthermore, submitted videotape to CBS's show "60 Minutes."⁵³ Derek Humphry commented on this development by saying:

I think that Dr. Kevorkian was absolutely right, in human terms, to help Mr. Youk to die by lethal injection. Not to have helped him die just because he could not do it himself would have been the worse kind of discrimination. But I part company with Kevorkian in that active voluntary euthanasia should only take place under a new law, with strong guidelines. He seems to think the medical profession can be trusted, and be willing to hasten deaths in this manner; I think the people should -- if a majority want it -- pass a careful law permitting both physician-assisted suicide and active voluntary euthanasia for a competent, terminally ill adult. But he's made the point very effectively. I have been making the same arguments (accompanied by a plea for a new law) for the past 20 years. Kevorkian -- and CBS TV - - have moved the educational process forward hugely this Sunday

evening.⁵⁴

After the showing of the “60 Minutes” episode which documented Kevorkian administering a lethal injection to Thomas Youk,⁵⁵ a public poll was conducted asking, *inter alia*: “Did the experience of watching tonight’s ‘60 Minutes’ segment on Jack Kevorkian influence you to be more supportive of assisted suicide or more opposed to assisted suicide?” The results were:

6% Much more supportive of assisted suicide

31% Somewhat more supportive of assisted suicide

13% Somewhat more opposed to assisted suicide

38% Much more opposed to assisted suicide

12% Undecided/Don’t know.⁵⁶

The majority of the people in the poll testified that the program made them feel more opposed to assisted suicide. So Kevorkian’s initiative granted him huge publicity and served his interest in provoking public debate, but it did not further public support for his mission.

Ellen Goodman, a *Boston Globe* Columnist, wrote that Thomas Youk was little more than a prop for Kevorkian’s act, a dead body he could use in challenging authority. There is little surprise that Kevorkian upped the ante, moving to active euthanasia. Assisted suicide no longer caught the spotlight. Goodman expressed the opinion that Kevorkian was the wrong role model to cast for the lead in the movement for a more merciful death. Kevorkian forced the issue of assisted suicide and active euthanasia onto the public stage, but he also polarized that public audience. Goodman maintained: “Nor would I wish him at my deathbed offering these last words of comfort: ‘We’re going to inject in your

right arm. OK? Okey-doke.”⁵⁷

In the video, Kevorkian said that he explained to Thomas Youk that euthanasia was preferable to physician-assisted suicide because it provided “better control,” meaning that the physician performing euthanasia had better control over the process of medical killing. It did not occur to him that it is desirable that the **patient**, not the doctor, should have “better control” until the very last moment, a strong claim for physician-assisted suicide denoting the difference from euthanasia. Euthanasia may be allowed only in exceptional cases (see Guideline 11 below).

By videotaping himself giving a man a lethal injection, bringing the tape to the CBS News program “60 Minutes,” and daring prosecutors to charge him with murder, Kevorkian was trying to move the legal system further and faster than most Americans were ready to accept. The Michigan prosecutor could not remain indifferent to this blunt breach of the law. Kevorkian stood trial on charges of first-degree murder and delivering a controlled substance for injecting Youk with lethal drugs. This time, the jury could not ignore the explicit videotape and the language of the law. A “Not Guilty” verdict would have nullified the law on murder and left Kevorkian free to continue his death campaign with a quick-to-inject syringe. Kevorkian was found guilty of second degree murder, and of delivering a controlled substance.⁵⁸ He was given a jail sentence of 10 to 25 years on the 2nd degree murder conviction, and 3 to 7 years on the “controlled substance” conviction. Judge Jessica Cooper emphasized in her verdict that the trial was not about the political or moral correctness of euthanasia. Instead, it was about lawlessness: “It was about disrespect for a society that exists because of the strength of the legal system. No one, sir, is above the law. No one.” Judge Cooper

told Kevorkian: “You had the audacity to go on national television, show the world what you did and dare the legal system to stop you. Well, sir, consider yourself stopped.”⁵⁹

Interestingly, Kevorkian announced that he objected to showing the ‘Final Exit,’ a do-it-yourself suicide video, on television. In this 34-minute video, Derek Humphry lists various drugs that will hasten death, and demonstrates how to crush pills with a spoon and mix them into applesauce. Tea and toast beforehand help the body absorb the drugs, and a shot of vodka wash them down makes them deadlier. If drugs cannot be obtained through a prescription, Humphry demonstrates how to end a life using over-the-counter sleeping pills and a plastic bag over the head to end it all.⁶⁰ Through his lawyer, Kevorkian said that he was appalled at the video and instead urged the ill to seek aid from a doctor. In his opinion, the video is risky because it might get into the hands of teenagers and others who are not as well intentioned as members of the Hemlock society.⁶¹ Humphry responded by saying that the video opens by imploring people to see their doctors first.⁶² Recently it was reported that shortly after the televising of ‘Final Exit’ in Hawaii (for some reason the video was shown twice within four days) two depressed people – a woman in her 40s and a man in his 60s – committed suicide in Honolulu using plastic bags. Both of them were not chronically ill.⁶³ The airing of such a video raises a vexing question in the field of media ethics. The decision makers in the media should think about the consequences of airing such a video and not simply air anything that is likely to attract audience because of the sensational character of the video.⁶⁴

‘Final Exit’ as well as Kevorkian’s deeds put the issue of death with dignity on the public agenda and compel the American authorities to invest efforts

in finding a solution to the problem he poses. If adequate solutions will not be found then, one should not be surprised to find more Kevorkian-like doctors who will come to the help of patients. Indeed, the Reuters Agency in Pontiac, Michigan, reported that Dr. Georges Reding, who began an apprenticeship under Kevorkian in December 1997, helped a 35-year-old woman from San Francisco suffering from AIDS to die.⁶⁵ Reding became an active participant in some other cases of assisted suicide until he was charged with first-degree murder in the August 1998 death of Donna Brennan, a 54-year-old multiple sclerosis patient who died of an overdose of the sedative pentobarbital. In January 2000 it was reported that Reding fled to Europe, and that the authorities do not know for sure where he is.⁶⁶

Kevorkian's missionary vigor, like any unqualified vigor, betrays the best interests of patients and ill-serves the interests of society. The United States as well as other democracies should devise ways to stop Kevorkian like-minded doctors, to think creatively to answer the genuine wills of **all** patients in this modern, technologically advanced era of medicine, and to help doctors who feel that sometimes termination of life is necessary. Doctors need not disguise or hide what they are doing to help their patients in fear of criminal prosecution. It is time to face the existing reality in a sincere and direct way and find adequate answers to pressing moral dilemmas. Openness, clarity and sincerity serve the best interest of all parties concerns: patients, their beloved people, and the medical staff.⁶⁷

5. Conclusions

The right to die with dignity includes the right to live with dignity until the last minute and the right to part from life in a dignified manner. There are competent,

adult patients who feel that the preferable way for them to part from life is through physician-assisted suicide. We must ponder the following considerations on their behalf:

Guideline 1. The physician should not suggest assisted-suicide to the patient. Instead, it is the patient who should have the option to ask for such assistance. Initiation by the physician might undermine trust between the patient and his/her physician, conveying to the patient that the doctor gave up on him/her, and values his/her life only to the extent of offering assistance to die. Such an offer might undermine the will to live and to explore further avenues for livelihood. Many Dutch physicians do not see this issue a significant one. Some of them think it is important for them to raise the issue when it seems that the patient does not dare to raise the issue upon his or her own initiative. However, undoubtedly all people in the Netherlands are aware of the availability of active euthanasia and physician-assisted suicide in their society. The reluctance the patients show with regard to this issue should be honored and respected.

Guideline 2. The request for physician-assisted suicide of an adult,⁶⁸ competent patient who suffers from an intractable, incurable and irreversible disease must be voluntary.⁶⁹ The decision is that of the patient who asks to die without pressures, because life seems the worst alternative in the current situation. The patient should state her wish several times over a period of time.⁷⁰ We must verify that the request for physician-assisted suicide does not stem from a momentary urge, an impulse, a product of passing depression. This emphasis of enduring request was one of the requirements of the abolished Northern Territory law in Australia,⁷¹ is one of the requirements of the Oregon *Death with Dignity Act*,⁷² and of the Dutch Guidelines.⁷³ We must also verify that the request is not the result of external

influences. It should be ascertained with a signed document that the patient is ready to die now, rather than depending solely on directives from the past. Section 2 of the Oregon Act requires that the written request for medication to end one's life be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.⁷⁴

A person can express general attitudes regarding euthanasia, in an informal discussion made in a social setting. She might say that she would not want to live in if she had to rely on the mercy of others, depend on them, and if she were unable to function alone. Such hypothetical observations do not constitute reliable evidence of the patient's current desires once an actual illness is in progress. This is especially true if the wish was stated when young and healthy. The younger people are, and the further they are from serious disease, the more inclined they are to claim that in a hypothetical hopeless state, painful and degrading, they would prefer to end their lives. On the other hand, there is a tendency to come to terms with suffering, to compromise with physical disabilities, to struggle to sustain living, and this tendency grows as the body weakens. Many people change their minds when they confront the unattractive alternatives. Many prefer to remain in what others term the 'cruel' world, and continue the Sisyphean struggle for their lives.

Guideline 3. At times, the patients' decision might be influenced by severe pain.⁷⁵

In this context, the role of palliative care can be crucial. Ganzini and colleagues report that as a result of palliative care some patients in Oregon changed their minds about assisted suicide.⁷⁶ The World health organization defines palliative

care as the “active, total care of patients whose disease is not responsive to curative treatment,” maintaining that control of pain, of other symptoms, and of psychological, social, and spiritual problems, is paramount.⁷⁷ The medical staff must examine whether by means of medication and palliative care it is possible to prevent or to ease the pain.⁷⁸ The Oregon *Death with Dignity Act* requires that the attending physician shall inform the patient of the feasible alternatives including comfort care, hospice care and pain control.⁷⁹ Bill proposals to legislate PAS in Illinois, Hawaii, Maine, Michigan, Vermont, Washington and Wisconsin explicitly required the attending physician to review with the patient options for palliative care including hospice and/or pain control options.⁸⁰ If it is possible to prevent or to ease the patient’s pain, then we may not fulfil the patients’ wish, but instead prescribe the necessary treatment. This is provided that the educated patient (i.e., patient who was advised by the medical staff about the available palliative care options) does not refuse to receive the painkillers, and that when the pain goes so does the motive (or one of the main motives) that caused the patient to ask for assisted suicide. If the patient insists on denying all medication, doctors must try to find first the reasons for this insistence before they comply.

At times, coping with pain and suffering can demand all the patient’s emotional strength, exhausting her ability to deal with other issues. In cases of competent patients, it must be determined that the decision is based on ability to make decisions. The assumption is that the patient understands the meaning of her decision. A psychiatrist assessment of the patient could confirm whether the patient is able to make such a meaningful decision concerning her life. A meeting with a psychiatrist should confirm that the decision is truly that of the patient, expressed consistently and of her own free will. The Northern Territory *Rights of*

Terminally Ill Act required that the patient meet with a qualified psychiatrist to confirm that he or she is not clinically depressed.⁸¹ It is worthwhile to hold several such conversations, separated by a few days. The patient's beloved people and the attending physician should be included in at least one of the conversations.

Guideline 4. The patient must be informed of her situation and the prognoses for both recovery and escalation of the disease and the suffering it may involve. There must be an exchange of information between the doctors and the patient.⁸² Bearing this in mind, we should be careful to use neutral terms and to refrain from terms that might offend patients and their beloved people (see **Chapter 1**).

Guideline 5. It must be ensured that the patient's decision is not a result of familial and environmental pressures. At times, the patient may feel that she constitutes a burden to her beloved people. It is the task of social workers to examine the motives of the patient and to see to what extent they are affected by various external pressures (as opposed to a true free will to die). A situation could exist in which the patient is under no such pressure but still does not wish to be a burden on others. Obviously, we cannot say that the feelings of a patient toward her beloved people are not relevant to the decision making.

Guideline 6. Verification of diagnosis. To minimize misdiagnosis, and to allow the discovery of other medical options, the decision-making process should include a second opinion provided by a specialist who is not dependent on the first doctor, either professionally or otherwise.⁸³ The patient's attending physician, who supposedly knows the patient's case better than any other expert, must be consulted. All reasonable alternative treatments must be explored. The Oregon *Death with Dignity Act* requires that a consulting physician shall examine the patient and his/her relevant medical records and confirm, in writing, the attending

physician's diagnosis that "the patient is suffering from a terminal disease," and verify that the patient is capable, is acting voluntarily and has made an informed decision.⁸⁴ The Dutch Guidelines require that the physician consult a colleague.⁸⁵ The Northern Territory *Rights of Terminally-Ill Act* required that the patient be examined by a physician who specializes in treating terminal illness.⁸⁶

Guideline 7. To avoid the possibility of arranging deals between doctors ("you will consult for me regarding Mr. Jones, approving my decision, and I will consult for you regarding Ms. Smith, approving your decision"), it is advisable that the identity of the consultant will be determined by a small committee of medical specialists (like the "Support and Consultation of Euthanasia in Amsterdam" project⁸⁷) that will review the requests for physician-assisted suicide.

Guideline 8. Some time prior to the performance of physician-assisted suicide, a doctor and a psychiatrist are required to visit the patient, examine her, and verify that this is the genuine wish of a person of sound mind who is not being coerced or influenced by a third party. The conversation between the doctors and the patient should be held without the presence of her family in the room so as to prevent familial pressure. A date for the procedure is then agreed upon.⁸⁸ The patient's beloved people will be notified so they could be present right until the performance of the act, making the day an intimate, family occasion.

Guideline 9. The patient could rescind at any time and in any manner. This was granted under the Australian Northern Territory Act,⁸⁹ and is granted under the Oregon *Death with Dignity Act*.⁹⁰

Guideline 10. Physician-assisted suicide may be performed only by a doctor and in the presence of another doctor. The decision-making team should include at least two doctors and a lawyer, who will examine the legal aspects involved. Insisting

on this demand would serve as a safety valve against possible abuse. Perhaps a public representative should also be present during the entire procedure - the decision making process and the actual performance of the act. This extra caution should ensure that the right to die with dignity does not become a duty. The doctor performing the assisted suicide should be the one who knows the patient best, has been involved in her treatment, taken part in the consultations with her and with her beloved people, and has verified through the help of social workers, nurses and psychologists that PAS is the wish of the patient.

Guideline 11. Physician-assisted suicide may be conducted in one of three ways, all of them discussed openly and decided by the physician and his/her patient: (1) Oral medication; (2) Self-administered, lethal intravenous infusion; (3) Self-administered lethal injection. As said in **Chapter 8**, oral medication may be difficult or impossible for many patients to ingest because of nausea or other side effects of their illnesses. In the event that oral medication was provided and the dying process lingers on for long hours, the physician is allowed to administer a lethal injection by himself/herself.⁹¹ I am also willing to concede the need for euthanasia in the event that the patient who asked for euthanasia is totally paralyzed, from head to toes, unable to move any muscles that could facilitate assisted suicide. These are the only two exceptions for allowing euthanasia.

Guideline 12. Doctors may not demand a *special fee* for the performance of assisted suicide. The motive for physician-assisted suicide is humane, so there must be no financial incentives and no special payment that might cause commercialisation and promotion of the death operation.

Guideline 13. There must be extensive documentation in the patient's medical file including the disease diagnosis and prognosis by the attending and the consulting

physicians; attempted treatments; the patient's reasons for seeking physician-assisted suicide; the patient's request in writing or documented on a video recording; documentation of conversations with the patient; the physician's offer to the patient to rescind his or her request; documentation of discussions with her beloved people, and a psychological report confirming the patient's condition. This meticulous documentation is meant to prevent exploitation of any kind: personal, medical, or institutional.⁹² Each physician-assisted suicide report should be examined by a coroner.⁹³

Guideline 14. Pharmacists should also be required to report all prescriptions for lethal medication, thus providing a further check on physicians' reporting.

Guideline 15. A doctor must not be coerced into taking actions that contradict her conscience and her understanding of her role. This was provided under the Northern Territory Act.⁹⁴

Guideline 16. The local medical association should establish a committee whose role will be not only investigating the underlying facts that were reported, but to investigate whether there are 'mercy' cases which were not reported and/or which did not comply with the Guidelines.

Guideline 17. Licensing sanctions will be taken to punish those healthcare professionals who violated the Guidelines, failed to consult and to file reports or who engaged in involuntary euthanasia without the patient's awareness or consent, or euthanized patients lacking decision-making capacity. Physicians who failed to comply with the above Guidelines will be charged and procedures to sanction them will be opened by the Disciplinary Tribunal of the Medical Association. The maximum penalty for violation of Guidelines should be the revoking of the medical license. In the event that this penalty will prove insufficient in deterring

potential abusers, there will be room to consider further penalties: heavy fines and serving time in prison.⁹⁵

What is presented here is a circumscribed reasoning for physician-assisted suicide to help a designated group of patients who require help in departing from life and who deserve to get such help from the medical profession to meet their wish. The detailed procedure is required to prevent abuse. After all, it is human life on stake. At first I suggest to adopt this reasoning for a trial period of one year and examine whether the consequences justify implementation of the policy for a lengthy period of time. During this one-year trial period, feedbacks between physicians, ethicists and the public at large in reviewing the policy and practice of physician-assisted suicide should be welcomed and encouraged. If the proposal fails (for instance, physicians do not adequately report incidents of physician-assisted suicide), all the data should be brought before a reviewing committee to closely study the policy and practice. Members of the committee will issue a report recommending whether they wish to continue the practice, to amend the Guidelines, or to abolish physician-assisted suicide. Preferably, the final decision should be made through participation of the people.

With regard to more complicated situations which do not satisfy the criteria presented above (free, voluntary, persistent and enduring requests for assisted suicide made by a competent patient who suffers from an incurable and irreversible disease), I urge expanding the circle involved in the decision making process, disthe decision making process, dismmitees and in the courts. The issue is urgent and real and people from different walks of life and with different perspectives: medicine, law, philosophy, psychology, social work, religion -

should take part in the decision making process, enriching the discourse with their insights.

Lastly, although the above Guidelines refer **only** to competent patients, I would like to note that in the case of minors, their parents serve as their guardians. The parents decide on behalf of their child after consulting the attending physicians. We must insist, as Justice Elon did in the *Scheffer* case, that the decision must be made by both parents (assuming that the minor has two parents), and not only by one of them.⁹⁶

¹. Notorious among them are the Hemlock Society in the United States and the corresponding association in Vancouver, British Columbia. Sue Rodriguez disassociated herself from the British Columbia association after she felt they used her and betrayed her trust. For further discussion, see Sue Woodman, *Last Rights* (New York: Plenum Trade, 1998): 17-24, 54-56, 119-137; Derek Humphry and Mary Clement, *Freedom to Die* (New York: St. Martin's Griffin, 2000); <http://www.FinalExit.org/world.fed.html>; E-Mail: <ergo@efn.org>, and Death Net <http://www.island.com/~deathnet/>.

In November 1999, a weekend conference was held in Seattle dealing with methods of self-deliverance from a terminal illness using new equipment. Only those with 'hands-on' experience with assisting death were invited, and the conference location was kept secret. Derek Humphry, whose Euthanasia Research and Guidance Organization sponsored the two-day meeting, explained that they did not want "observers, moralists, philosophers or protesters." See the Seattle Times, http://www.seattletimes.com/news/local/html98/suic_19991115.html <http://www.finalexit.org/practice.html>

In the Netherlands, a website provides a how-to guide of suicide methods. Step-by-step instructions guide the reader through wrist-slashing, sleeping pills, jumping off buildings and the "reasonably painless ... death of carbon monoxide poisoning." The Pink Floyd song, "Goodbye Cruel World," can be heard on the home page, along with verses from the William Butler Yeats poem, "An Irish Airman Foresees His Death." "Suicide Web Site Sparks Controversy," New York Times (31 January 2000). See <http://huizen.dds.nl/~thisbe/> and

<http://huizen.dds.nl/7/8thisbe/verder>

². Opening Motion (Tel-Aviv) 1141/1990. Benjamin Eyal v. Lichtenstaedter Hospital. P.M. 1991 (3), p. 194.

³. Opening Motion (Tel-Aviv) 1141/1990. Benjamin Eyal v. Lichtenstaedter Hospital. P.M. 1991 (3), 187. For further deliberation on similar cases, see 1030/95 Israel Gilad v. Soroka Medical Center and Others, Beer Sheva District Court (23 October 1995); Opening Motion 2339 + 2242/95 A.A. and Y. S. v. Kupat Holim and State of Israel, Tel Aviv District Court (11 January 1996); Opening Motion 2242/95 Eitay Arad v. Kupat Holim and State of Israel, Tel Aviv District Court (1 October 1998). Judge Talgam emphasized in the Arad case that the starting point must be the dignity of the patient, and not of the hesitant doctor.

⁴. See David Novak, Jewish Social Ethics (New York: Oxford University Press, 1992), esp. p. 17; David Novak, Jewish-Christian Dialogue (New York: Oxford University Press, 1989): 8, 142-151. For a contesting view, see Justice Elon in Civil Appeal 506/1988 Yael Scheffer, through Talila Scheffer v. The State of Israel, para. 20.

⁵. I thank Dr. Nachman Wilensky for showing Rabbi Lau's letter to me.

⁶. For an opposing stance, see Avraham Steinberg, "The Terminally Ill- Secular and Jewish Ethical Aspects," Israel J. Med. Sci., Vol. 30, No. 1 (January 1994): 130-135, esp. 134.

⁷. Haim H. Cohn, "On the Meaning of Human Dignity," Israel Yearbook of Human Rights, Vol. 13 (1983): 226-251, at 246.

⁸. Cf. K. Higashi, M. Hatano, S. Abiko et al., "Five-Year Follow Up of Patients with Persistent Vegetative State," J. Neurol Neurosurg Psychiatry, Vol. 44 (1981): 552-554; and W. Arts, H.R. van Dongen, J. van Hof-van Duin, and E. Lammens, "Unexpected Improvement after Prolonged Posttraumatic Vegetative State," J. Neurol Neurosurg Psychiatry, Vol. 48 (1985): 1300-1303. See also B. Steinbock, "Recovery from Persistent Vegetative State?: The Case of Carrie Coons," Hastings Center Report, Vol. 19, No. 4 (1989), p. 14.

⁹. Will Gaylin, Leon Kass, Edmund Pellegrino and Mark Siegler, "Doctors Must Not Kill," J. of the American Medical Assoc., Vol. 259 (1988), 2139; Edmund D. Pellegrino, "Doctors Must Not Kill," in Robert I. Misbin (ed.), Euthanasia: The Good of the Patient, the Good of Society (Frederick, Maryland: University Publishing Group, 1992): 27-41; Charles L. Sprung, Leonid A.

Eidelman, and Avraham Steinberg, "Is the Physician's Duty to the Individual Patient or to Society?," Critical Care Medicine, Vol. 23, No. 4 (1995): 618-620. For a contrasting view, see Fredrick R. Abrams, "The Quality of Mercy: An Examination of The Proposition 'Doctors Must Not Kill,'" in Robert I. Misbin (ed.), Euthanasia: The Good of the Patient, the Good of Society, op. cit.: 43-51.

¹⁰. Charles Sprung, "Changing Attitudes and Practices in Forgoing Life-sustaining Treatments," J. American Med. Assoc., Vol. 263, No. 16 (25 April 1990), p. 2214.

¹¹. John Hardwig, "Dying at the Right Time," in Is There A Duty to Die? (New York and London: Routledge, 2000), p. 95. In the Netherlands, 91 percent of the physicians in the 1990 national study felt that only a physician may perform euthanasia. P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, Euthanasia and other Medical Decisions Concerning the End of Life, Health Policy Monographs (Amsterdam: Elsevier, 1992), p. 108. Faber-Langendoen and Karlawish argue that physician assistance in suicide might be necessary but it is insufficient to ensure that assisted suicide is restricted to appropriate cases and occurs in an appropriate manner. The willingness of other health care professionals – nurses, social workers, and clergy – to participate and even take the lead in assisting suicides is critical, in their opinion, to meet society's interest that assisted suicide should be humane, effective, and confined to appropriate cases. They conclude that as long as legislation and guidelines focus exclusively on the physician's role, laws and regulations will fall short of meeting this assurance. Kathy Faber-Langendoen and Jason T.H. Karlawish, "Should Assisted Suicide Be Only Physician Assisted?," Annals of Internal Medicine, Vol. 132 (21 March 2000): 482-487.

¹². Civil Appeal 506/88 Scheffer v. The State of Israel, P.D. 48 (1) 87, at 172-173.

¹³. Sprung et al. present data showing that doctors see the CPR treatment as 'useless' even when the patients' chances are five-ten percent. They further note that the chances for giving such treatment drop when the patients are black and that many life-and-death decisions are made without the consent of the patients or their family members. See Charles L. Sprung et al., "Changes in Forgoing Life-Sustaining Treatments in the United States: Concern for the Future," Mayo Clinics Proceedings, Vol. 71 (1996): 512-516, at 513-514.

¹⁴. Interviews with Dr. George Beausmans (Maastricht, 26 July 1999), and Dr. Gerrit K. Kimsma

(Koog 'aan de Zaan, 28 July 1999).

¹⁵. Those opposed to my view will say that the Netherlands exemplifies a state in which the defining guiding lines for mercy killings are often crossed, resulting in many patients being killed against their will. See **Chapter 7**. See also David Orentlicher, "The Legalization of Physician Assisted Suicide: A Very Modest Revolution," Boston College L. Rev., Vol. XXXVIII, No. 3 (May 1997): 459-462.

¹⁶. The anxiety over the slippery slope syndrome was probably foremost in the minds of the participants of the 39th World Medical Assembly, held in Madrid in October 1987. In the World Medical Association Declaration on Euthanasia it was contended that euthanasia, "that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness." For critical discussion of the slippery slope syndrome, see R. G. Frey, "The Fear of a Slippery Slope," in Gerald Dworkin, R.G. Frey, and Sissela Bok (eds.), Euthanasia and Physician-Assisted Suicide (New York: Cambridge University Press, 1998): 43-63; Charles F. McKhann, A Time to Die: The Place for Physician Assistance (New Haven, CN: Yale University Press, 1999): 160-196; Ronald Dworkin, "When Is It Right to Die?," The New York Times (17 May 1994), at A19; Bernard Williams, "Which Slopes Are Slippery," in Michael Lockwood (ed.), Moral Dilemmas in Modern Medicine (Oxford: Oxford University Press, 1985): 126-137.

¹⁷. See, for example, Yale Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation," Minnesota Law Review, Vol. 42, No. 6 (1958): 969-1042; Yale Kamisar, "Against Assisted Suicide - Even a Very Limited Form," The University of Detroit Mercy L. Rev., Vol. 72 (Summer 1995): 736-769. URL: <http://www.house.gov/judiciary/2172.htm>; Sissela Bok "Death and Dying: Euthanasia and Sustaining Life: Ethical Views," Encyclopedia of Bioethics, edited by Warren T. Reich (New York: The Free Press, 1978), Vol. 1: 268-277; Sissela Bok, "Euthanasia," in Gerald Dworkin et al (eds.), Euthanasia and Physician-Assisted Suicide, op. cit., esp. pp. 112-118; Peter A. Singer and Mark Siegler, "Euthanasia - A Critique," New England J. of Medicine, Vol. 322 (June 1990): 1881-1883; Charles J. Dougherty, "The Common Good, Terminal Illness, and Euthanasia," Issues in Law and Medicine, Vol. 9, No. 2 (Fall 1993): 151-

166; Carl Elliot, "Philosopher Assisted Suicide and Euthanasia," BMJ, Vol. 313_(26 October 1996), p. 1088.

¹⁸. One of Swigart and colleagues' findings on the role of families in the critical care setting is that explanations should be made in language clearly understandable to family members. They note overuse of medical terms or presentations of medical minutiae that may be overwhelming and confusing for family members. Valerie Swigart, Charles Lidz, Victoria Butterworth and Robert Arnold, "Letting Go: Family Willingness to Forgo Life Support," Heart and Lung, Vol. 25, No. 6 (1996), p. 492.

¹⁹. R. Anspach, Deciding Who Lives (Berkeley: University of California Press, 1993): 85-163. Quoted in Swigart et al., "Letting Go: Family Willingness to Forgo Life Support," p. 484.

²⁰. Every once in a while the media publish stories of alleged killings of patients by medical staff and of patients' deaths in questionable circumstances. "Police Arrest 'Angel of Death' for L.A. Hospital Murders," Reuters (9 January 2001); Lois Rogers, "Police investigate doctor over 50 hospital deaths," The Times (15 October 2000). <http://www.sunday-times.co.uk/news/pages/sti/2000/10/15/stinwenws01030.html>; Joseph B. Frazier, "Grand jury refuses to indict nurse in care center morphine deaths," The Associated Press (13 September 2000); Roy Gibson and Hugh Martin, "Cancer doctor on murder charge," The Age (7 April 2000). <http://www.theage.com.au/news/20000407/A54440-2000Apr7.html>; "Report: Nurses gave too much morphine to at least one patient," The Associated Press (22 March 2000).

²¹. Every once in a while the media publish stories of alleged killings of patients by family members or friends. David Reardon, "Family denies complicity in death," The Age (29 November 2000); Les Kennedy, "Two accused of wilful murder for sister's hospice death," Sydney Morning Herald (13 April 2000). <http://www.smh.com.au/news/0004/13/text/national06.html>; "Elderly man charged in wife's death," The Associated Press (28 February 2000). URL: <http://www10.nytimes.com/aponline/a/AP-BRF-Mercy-Killing.html>; Maxine Bernstein, "Man, 83, in custody in wife's death," The Oregonian (5 March 2000); David Reardon, "Family questioned on mercy killing," The Age (8 April 2000). <http://www.theage.com.au/news/20000408/A56073-2000Apr7.html>; Tracy Wilson, "Man admits killing his ailing spouse," LA Times (15 March 2000). <http://www.latimes.com/editions/valley/sfnews/20000315/t000024869.html>;

²². In March 1998, Justice Antonin Scalia declared that Congress, not the Supreme Court, should decide such vexing questions as abortion rights, the death penalty and physician-assisted suicide. Scalia said: "It is not supposed to be our judgment what the socially desirable answer to all of these questions is. That's supposed to be the judgment of Congress, and we do our job correctly when we apply what Congress has written as basically and honestly as possible". Glen Johnson, "Scalia: Let Congress, not court, decide abortion, assisted suicide," The Associated Press (9 March 1998, 2:14 PM Eastern). <http://www.nytimes.com>

²³. Songs were written about Jack Kevorkian. For instance, Detroit rocker Mitch Ryder dedicated his song "Mercy to 'Dr. Jack' Kevorkian." The lyrics are straightforward:

"Cast your spell, Dr. Jack
I am willing, I can't wait
End my pain
No one else
Seems to understand my fate."

Dr. Kevorkian himself released a CD with 12 songs, 11 of which he wrote. The liner notes say that Kevorkian wants to be remembered as a doctor who helped relieve human suffering.

²⁴. These are the documented cases. See <http://www.finalexit.org/kevorkian.html>
I have checked this site for updates in December 1999 and then the requested URL /kevorkian.htm was not found on this server.

²⁵. Cf. People v. Kevorkian, No. 90003196 (Oakland County, Mich., 14 December 1990); People v. Kevorkian No. 90-390963-A2 (Oakland County, Mich., 5 February 1991); Jim Persels, "Forcing the Issue of Physician-Assisted Suicide," J. of Legal Medicine, Vol. 14 (1993): 95-100.

²⁶. Stephen Vicchio, "Death's logic" (4 April 1999), in URL: <http://www.sunspot.net>

²⁷. Jack Kevorkian and John Doe v. Arnett, No. CV-94-6089 CBM (Kx), 939 F.Supp. 725 (11 September 1996), at 351.

²⁸. State of Michigan v. Kevorkian, Michigan CirCt (Oakland City), verdict 8 March 1996. See <http://www.courtvtv.com/verdicts/kevorkian.html>

²⁹. Jack Kevorkian, Prescription: Medicide (New York: Prometheus Books, 1991), p. 222.

³⁰. Ibid., p. 226.

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- ³¹. Ibid., p.227.
- ³². 2 April 1996: Pontiac, Mich: Kevorkian: Trial or witch-hunt?, from ERGO's electronic mailing list. E-Mail: <ergo@efn.org>
- ³³. Orlando Sentinel Online, "Kevorkian responds to new allegations" (31 December 1997). URL: <http://www.orlandosentinel.com/>
- ³⁴. Brian Harmon, "Kevorkian: I'll put law on trial. Suicide advocate says he'll fight attempts to rein him in," The Detroit News, Metro (1 January 1998). URL: <<http://detnews.com>>
- ³⁵. Orlando Sentinel Online, "Kevorkian responds to new allegations" (31 December 1997). URL: <http://www.orlandosentinel.com/>
- ³⁶. Kevorkian explains his guiding rationale in his book Prescription: Medicide, especially in chapters 13,14.
- ³⁷. Ibid., p. 223.
- ³⁸. Ibid., p. 215.
- ³⁹. Ibid.
- ⁴⁰. Ibid., p. 225.
- ⁴¹. Ibid.
- ⁴². Compare Kevorkian's cold and detached descriptions to Quill's caring and humane train of thought in Death and Dignity, especially his depiction of the stories of Diane, Mark, Wendy and Mrs. J. There are stark differences between the two. See Timothy E. Quill, Death and Dignity (New York: W. W. Norton, 1993), esp. pp. 9-16, 52-56, 84-91, 167-175, 177-179.
- ⁴³. The Detroit News, Metro (6 September 1997). URL: <http://detnews.com/1997/metro/9709/06/09060039.htm>. For further discussion, see Sue Woodman, Last Rights, *op. cit.*: 91-93.
- ⁴⁴. Kevorkian had no training to detect or to treat depression. For further discussion, see Paul R. McHugh, "The Kevorkian Epidemic," The American Scholar (Winter 1997): 15-27.
- ⁴⁵. "Coroner: Janet Good would have lived more than 6 months," The Detroit News, Metro (6 September 1997), URL: <http://detnews.com/1997/metro/9709/06/09060039.htm>
- ⁴⁶. Brian Harmon, "Critics: Kevorkian taking all comers. They claim terminal illness no longer only standard for suicides," The Detroit News (Sunday, 1 March 1998). <http://detnews.com>;

<http://www.oregonian.com>

⁴⁷. Sue Woodman, *Last Rights*, *op. cit.*: 94-95.

⁴⁸. Brian Harmon, "Paralyzed man fulfills death wish: Kevorkian assists 21-year-old hours after leaving hospital," The Detroit News (Friday, 27 February 1998). See <http://detnews.com>; Free Press URL: <http://www.freep.com>; "Kevorkian speaks out against police," The Associated Press (28 February 1998, 4:38 PM Eastern).

⁴⁹. Brian Harmon, "Critics: Kevorkian taking all comers. They claim terminal illness no longer only standard for suicides," The Detroit News (Sunday, 1 March 1998). See also <http://www.oregonian.com>

⁵⁰. Ibid.

⁵¹. David Goodman, "Kevorkian has kidneys available to donate from suicide," Associated Press (7 June 1998). Article is available from URL: <<http://www.nytimes.com>>. See also Joe Swickard and David Crumm, "Kevorkian harvests kidneys," The Free Press (8 June 1998), <http://www.freep.com/news/extra2/index.htm>

⁵². For chronology of events involving Kevorkian, see <http://deathnews.com/TDNHOME/kevo>

⁵³. OPINION Editorial, "Kevorkian's Needle," The Detroit News (Sunday, 22 November 1998).

⁵⁴. Derek Humphry (22 November 1998), e-mail: dhumphry@efn.org, circulated via ergo@efn.org

⁵⁵. 60 Minutes, Death by Doctor (22 November 1998).

⁵⁶. URL: Kevorkian 60 Minutes poll results, http://www.freep.com/news/extra2/kevo_poll.htm (24 November 1998). See also URL: Killing not murder, most say, <http://www.freep.com/news/extra2/qpoll24.htm>

For discussion on the ethics of showing Kevorkian's killing on television, see Fritz Wenzel, "Media are ripped at U of M forum on assisted-suicide coverage" The Toledo Blade (23 February 1999); Brian Murphy, "Wallace rethinks suicide episode" (23 February 1999). URL: <http://www.freep.com/news/metro/qdeath23.htm>. See also

<http://www.freedomforum.org/professional/1998/12/3kevorkian.asp>

⁵⁷. Ellen Goodman, "Kevorkian has punctured the ethical gray zone where most of us live," Boston Globe (3 December 1998). URL: <http://www.boston.com/dailyglobe2/337/oped/>

⁵⁸. See Julie Grace, "Curtains for Dr. Death," Time (5 April 1999), p. 50.

⁵⁹. Associated Press report, “Kevorkian Gets 10 to 25 Years,” Pontiac, Mich. (13 April 1999); New York Times (14 April 1999), p. A23. For further deliberation, see <http://www.freep.com/news/extra2/index.htm>

<http://www.freep.com/news/extra2/qkevo14.htm>

⁶⁰. “Scenes from ‘Final Exit’ Suicide Video,” Associated Press (3 February 2000).

⁶¹. Likewise, Barbara Coombs Lee, executive director of Compassion in Dying and a staunch supporter of Oregon’s Death with Dignity Act opposed the video. She called the video ‘irresponsible,’ saying: “The video’s intended audience, terminally ill individuals, deserves better than hardware store paraphernalia and a secretive death with no family members present.” Deborah Josefsen, “Video Guide to Suicide Is Shown on Television,” BMJ, Vol. 320 (12 February 2000), at 398.

⁶². “Kevorkian Criticizes Suicide Video,” Associated Press (24 February 2000); E-mail sent by Kevorkian’s friend to the Right to Die List right_to_die@efn.org (5 March 2000). See also letter, “‘Final Exit’ aimed at terminally ill,” The Oregonian (4 January 2000).

⁶³. Susan Kreifels, “An Oahu man and woman both choose suffocation just days after the station aired ‘Final Exit’,” Honolulu Star Bulletin (7 March 2000). See also “Coalition seeks to stop showing of suicide video guide,” Associated Press (9 March 2000).

⁶⁴. For further discussion, see R. Cohen-Almagor, Speech, Media and Ethics (Houndmills and New York: Palgrave, 2001).

⁶⁵. “Kevorkian Assistant helps AIDS patient die” (Monday, 19 January 1998, 6:50 AM EST), PONTIAC, Mich. (Reuters).

⁶⁶. “Reding believed hiding in Europe,” The Albuquerque Journal, New Mexico (26 January 2000).

⁶⁷. Magnusson and Ballis reported a research study they conducted into the practice of euthanasia amongst Australian healthcare professionals specializing in HIV/AIDS. Their study shows that illegal euthanasia is currently practiced by the medical profession and suggests that prohibition does not adequately resolve the agonizing dilemmas that health workers face. They maintain that prohibitionism fails to take into account the reality of illegal euthanasia as it is practiced in an unregulated environment and that it is counter-productive because it does not assist in developing a social policy that reflects the reality of current practices while safeguarding patients. Roger S.

Magnusson and Peter H. Ballis, "The Response of Health Care Workers to AIDS Patients' Requests for Euthanasia," Journal of Sociology, No. 35, No. 3 (November 1999): 312-330.

⁶⁸. Most bill proposals to legislate PAS in the United States specify that the age of the consenting patient must be 18 or older to qualify for the procedure. Russell Korobkin, "Physician-assisted Suicide Legislation: Issues and Preliminary Responses," Notre Dame J. of Law, Ethics & Public Policy, Vol. 12, No. 2 (1998), p. 454.

⁶⁹. See the Dutch requirements of careful practice, in John Griffiths, Alex Bood and Heleen Weyers, Euthanasia and Law in the Netherlands (Amsterdam: Amsterdam University Press, 1998), p. 66.

⁷⁰. Many bill proposals to legislate PAS in the United States require a waiting period of 14 or 15 days. Cf. Russell Korobkin, "Physician-assisted Suicide Legislation: Issues and Preliminary Responses," op. cit., p. 468. As explained in **chapter 8**, I would be hesitant to establish a fixed waiting period.

⁷¹. Section 7, Rights of the Terminally Ill Act (1995) (NT).

⁷². In Australia, the law required a 'cooling off' period of nine days. In Oregon, the Act requires a waiting period of fifteen days. I do not wish to suggest an arbitrary time period of waiting, saying instead that the patient should state his or her wish several times "over a period of time." I concur with Miller and colleagues who think that a fifteen days waiting period may be highly burdensome for patients who are suffering intolerably and may preclude access to assisted death for those who request it at the point when they are imminently dying. Franklin G. Miller, Howard Brody and Timothy E. Quill, "Can Physician-Assisted Suicide Be Regulated Effectively?," J. of Law, Medicine & Ethics, Vol. 24 (1996), p. 226. See also Oregon Death with Dignity Act, Oregon Revised Statutes, Vol. 8 (1998 Supplement), at 982.

⁷³. John Griffiths et al., Euthanasia and Law in the Netherlands, op. cit., p. 66.

⁷⁴. Oregon Death with Dignity Act, Oregon Revised Statutes, Vol. 8 (1998 Supplement), at 980.

⁷⁵. For a comparison of physicians' and patients' different conceptions of pain, see William Ruddick, "Do Doctors Undertreat Pain?," Bioethics, Vol. 11, Nos. 3-4 (1997): 246-255.

⁷⁶. Linda Ganzini, Heidi D. Nelson, Terri A. Schmidt, Dale F. Kraemer, Molly A. Delorit, Melinda A. Lee, "Physicians' Experiences with the Oregon Death with Dignity Act," New England Journal

of Medicine, Vol. 342, No. 8 (24 February 2000), p. 563.

⁷⁷. World Health Organization, Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee (Geneva, Switzerland: World Health Organization, 1990), at 11.

⁷⁸. Directive 7 in The General Manager Circular, Israel Ministry of Health, no. 2/96 (31 January 1996) holds: “Doctors must concentrate their efforts on easing the pain, torment, and suffering of the patient, a subject of highest priority in medical treatment, especially where terminal patients are concerned,” p. 12 (Hebrew). For further deliberation on pain control mechanisms and their importance, see Timothy E. Quill, Bernard Lo, and Dan W. Brock, “Palliative Options of Last Resort,” JAMA, Vol. 278, No. 23 (17 December 1997): 2099-2104; P. D. Doyle, G. W. Hanks and N. MacDonald (eds.), Textbook of Palliative Medicine (New York: Oxford University Press, 1998); Christine K. Cassel and Kathleen M. Foley, “Principles for Care of Patients at the End of Life: An Emerging Consensus Among the Specialties of Medicine,” Milbank Memorial Fund Report (New York, 1999), reported by Vida Foubister, “Medical experts agree on guide for end-of-life care,” American Medical News (7 February 2000), http://www.ama-assn.org/sci-pubs/amnews/pick_00/prsa0207.htm; Timothy E. Quill, Barbara Coombs-Lee and Sally Nunn, “Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative,” Annals of Internal Medicine, Vol. 132 (21 March 2000): 488-493. For further discussion on making palliative care decisions for **incompetent** patients, see Jason H.T. Karlawish, Timothy Quill and Diane E. Meier, “A Consensus-Based Approach to Providing Palliative Care to Patients Who Lack Decision-Making Capacity,” Annals of Internal Medicine, Vol. 130 (18 May 1999): 835-840.

⁷⁹. 13 Or. Rev. Stat. § 3.01 (1998).

⁸⁰. Russell Korobkin, “Physician-assisted Suicide Legislation: Issues and Preliminary Responses,” op. cit., p. 469.

⁸¹. Section 7, Rights of the Terminally Ill Act (1995) (NT).

⁸². On this issue, see Oregon Death with Dignity Act, Section 3, Attending physician responsibilities. Many bill proposals to legislate PAS in the United States specify certain information that must be communicated by the physician to the patient before honoring his or her request. Cf. Russell Korobkin, “Physician-assisted Suicide Legislation: Issues and Preliminary Responses,” op. cit., p. 468. See also Section D: Consent to Medical Treatment of The Israel

Patients' Rights Law, 1992, Law Proposal 2132 (16 March 1992); The Patients' Rights Law, 1996, Israel Bk of Laws, 1591 (12 May 1996), at 329-331; and The General Manager Circular, The Ministry of Health, no. 2/96 (31 January 1996), at 10-11 (Hebrew).

⁸³. Most bill proposals to legislate PAS in the United States required that the treating physician refer the patient to a second consulting physician to verify the terminal nature of the disease. The Massachusetts bill required a third confirming opinion. Cf. Russell Korobkin, "Physician-assisted Suicide Legislation: Issues and Preliminary Responses," op. cit., p. 453. The first practical recommendation stated in The General Manager Circular, Israel Ministry of Health, no. 2/96 (31 January 1996), is that the diagnosis and evaluation that a patient's condition is "irreversible and terminal" shall be made by two independent doctors. At least one of them is required to be a head of department, p. 9 (Hebrew).

⁸⁴. Oregon Death with Dignity Act, Oregon Revised Statutes, Vol. 8 (1998 Supplement), at 981-982.

⁸⁵. John Griffiths et al., Euthanasia and Law in the Netherlands, op. cit.: 66, 104. The Dutch guidelines require the doctor to consult an independent colleague, not in order to advise the first doctor on medical treatment, but in order to verify whether the criteria of the guidelines have been satisfied. The consultation is about the patient's condition and life expectancy, the available alternatives and the adequacy of the request. Medical consultation in an earlier stage is part of normal practice. For instance, cancer patients who request euthanasia have invariably been treated in hospitals up to the point at which the doctors and the patient together decided to stop treatment.

⁸⁶. Section 7, Rights of the Terminally Ill Act (1995) (NT).

⁸⁷. Bregje Onwuteaka-Philipsen, Consultation of Another Physician in Cases of Euthanasia and Physician-assisted Suicide (Amsterdam: Department of Social Medicine, Vrije Universiteit, 1999), Doctoral Thesis.

⁸⁸. Proposals to legislate PAS in Illinois, Massachusetts and Maine required that a patient seeking PAS obtain a consultation with a mental health professional in order to insure that the patient can pass the "impaired judgment" standard. Cf. Russell Korobkin, "Physician-assisted Suicide Legislation: Issues and Preliminary Responses," op. cit., p. 456. This Guideline is somewhat similar to the guidelines of the Swiss EXIT protocol. See South Australian Voluntary Euthanasia

Society, DID YOU KNOW ? Assisted Suicide in Switzerland - SAVES Fact Sheet No. 20, issued February 1997. Correspondence with: Hon. Secretary, SAVES, PO Box 2151, Kent Town, SA 5071, Australia - Fax + 61 8 8265 2287. URL: <http://www.finalexit.org/>

⁸⁹. Andrew L. Plattner, "Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It," DePaul J. of Health Care Law, Vol. 1 (Spring 1997), p. 648.

⁹⁰. 13 Or. Rev. Stat. § 3.07 (1998).

⁹¹. In the Netherlands, physicians who intend to provide assisted suicide sometimes end up administering a lethal injection because of the patient's inability to take the medication. Cf. Johanna H. Groenewoud, Agnes van der Heide, Bregje D. Onwuteaka-Philipsen et al., "Clinical Problems with the Performance of Euthanasia and Physician-assisted Suicide in the Netherlands," N. Eng. J. Med., Vol. 342, No. 8 (2000): 551-556.

⁹². For further deliberation, see the Dutch Guidelines in John Griffiths et al., Euthanasia and Law in the Netherlands, op. cit., p. 66; Oregon Death with Dignity Act, Oregon Revised Statutes, Vol. 8 (1998 Supplement), Section 3, at 983. Rebecca Cook pointed out to me that such a bureaucratic procedure might discriminate against minorities who will not find it easy to cope with the described demands. However, the demand for detailed documentation in my proposal is meant to prevent abuse, not to discourage people from getting the help they want. We should be sensitive to cultural differences and strive to meet special needs that arise from cultural norms but not at the expense of leaving the door open for 'eliminating' unwanted people.

⁹³. Directive 6 in The General Manager Circular, Israel Ministry of Health, no. 2/96 (31 January 1996) states: "The decision to respect a patient's objection to a life prolonging treatment shall be documented in the medical statutes, expressing maximum reasons for the decision and the discussions with the patient," p. 12 (Hebrew). See also Israel Patients' Rights Law (1996), 1591, Chapter E: medical documentation and medical information, p. 331.

⁹⁴. Andrew L. Plattner, "Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It," op. cit., p. 648. The Illinois proposed bill to legislate PAS included a "Provider's Freedom of Conscience" clause, which explicitly said that physicians who object to the practice may not be required to participate or aid in PAS. Cf. Russell

Korobkin, "Physician-assisted Suicide Legislation: Issues and Preliminary Responses," op. cit., p. 464.

⁹⁵. For further deliberation, see Arthur L. Caplan, Lois Snyder and Kathy Faber-Langendoen, "The Role of Guidelines in the Practice of Physician-Assisted Suicide," Annals of Internal Medicine, Vol. 132 (21 March 2000): 476-481.

⁹⁶. 506/88 Scheffer v. The State of Israel, Vol. 48 (1) 87, paragraph 65 of Elon J.'s opinion. For further discussion on incompetent patients and minors, see Edmund D. Pellegrino and David C. Thomasma, For the Patient's Good (New York: Oxford University Press, 1988): 148-161; Winifred J. Pinch and Margaret L. Spielman, "The Parents' Perspective: Ethical Decision-Making in Neonatal Intensive Care," J. of Advanced Nursing, Vol. 15 (1990): 712-719; American Academy of Pediatrics Committee on Bioethics, "Guidelines on Forgoing Life-Sustaining Medical Treatment," Pediatrics, Vol. 93, No. 3 (March 1994): 532-536; S. Saigal, B.L. Stoskopf and D. Feeny, "Differences in Preferences for Neonatal Outcomes among Healthcare Professionals, Parents, and Adolescents," JAMA, Vol. 281, No. 21 (2 June 1999): 1991-1997; Norman Fost, "Decisions Regarding Treatment of Seriously Ill Newborns," JAMA, Vol. 281, No. 21 (2 June 1999): 2041-2043.