

Physician Assisted Suicide: An Exploration of the Dying Process

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Abstract

Up until about two decades ago, the practice of physician-assisted suicide was prohibited in the United States. However, the issues surrounding the legalization of physician-assisted suicide have long been the topic of debate as proponents seek to change public policy. Just as keenly, though, the opposition seeks to alienate any ideas that may even remotely resemble physician aid in dying. With such a rigorous ongoing debate, it becomes necessary to step back and examine, once again, the underlying cause for the emanation of such a request in the first place. A shared belief by both sides is that the groups of people most susceptible to the outcome of this debate are terminally ill adults and terminally ill children. Consequently, it is crucial to ask the question, how exactly does having the option to request physician-assisted suicide influence the dying process of a terminally ill patient? The mere option of requesting physician-assisted suicide in the unfortunate event of a debilitating terminal illness shows promise in effectively eliminating suffering, demedicalizing the ever so medicalized death, promoting patient autonomy, and encouraging physician nonabandonment. Physician-assisted suicide, therefore, offers a wide scope of improvement to a terminal patient's dying process.

Introduction

Perhaps the most vulnerable time in a person's life emerges first when the person is born, and then again when the person readies to leave this world. Approaching death can spark numerous emotions; inevitably fear being the most powerful. This fear can often interfere with, perhaps even manipulate, the decisions one makes pertaining to his final moments. An affiliate with Yale and Harvard University, Daniel Callahan is a leading bioethicist and President Emeritus of the Hastings Center, one of the first centers in the US devoted to research in the field of biomedical ethics. His essay, "Reason, Self-determination, and Physician-Assisted Suicide," will help form part of the theoretical frame for this research as Callahan argues that achieving death with dignity and surmounting the fear that an impending death instills are the two fundamental reasons that explain why terminally ill patients may request deviant end of life solutions such as physician-assisted suicide (Callahan 53). However, Callahan firmly believes that a turn to physician-assisted suicide is resorting to curing one evil with another and is an utter mistake that carries the potential of devaluing one's dying process (Callahan 68).

Nevertheless, Callahan represents just one aspect of the debate about end of life experiences. Professor Stephen Ziegler, a former Mayday Pain scholar and an associate professor in the Division of Public & Environmental Affairs at Indiana University-Purdue University, discusses a different point of view. His research article "Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance

Oversight and Demedicalize the Dying Process” will help form the other part of the theoretical frame for this paper. In this article, Professor Ziegler emphasizes that PAS models allow patients to dodge unnecessary medical interference during their most vulnerable and meaningful chapters in life. He stresses that with the advent of modern medical technology, prolonging life and thus, the dying process, is a lot more feasible nowadays. However, sustaining a life simply to burden it with endless medical interference and more suffering is quite contrary to the purpose of medicine (Ziegler 318). How exactly does having the option of physician-assisted suicide (PAS) influence the dying process of a terminally ill patient? This question aims to inspect the very root of the debate. All debaters, proponents and opponents alike, deliberate this question before shaping their views on the subject of PAS. Having the option of physician-assisted suicide indeed helps obviate an otherwise unwanted, burdensome death, and thus improves the dying process.

Historical Context

Although the infamous Dr. Jack Kevorkian, better known as Doctor Death, is the first figure to come to mind upon the discussion of assisted suicide, PAS has been the subject of public discourse since the fourth century B.C. (Pickert). This debate of whether physicians have the right to help their patients end their lives stems from the original Hippocratic Oath, which includes the explicit statement: *I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan* (Pickert). Dr. Jack Kevorkian was the first to openly employ physician-assisted suicide in the United States in 1990 after his medical license had been revoked in the state of Michigan. He claimed to have helped 130 civilians end their lives and served a seven-year sentence in prison beginning in the year 2000 (Pickert).

Arguably, Kevorkian’s doings serve as the basis of modern day opposition to physician-assisted suicide, which fears uncontrollable and illegitimate ending of lives under the title of assisted suicide. According to Dr. Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, much of the opposition to PAS fears the emergence of another Doctor Death (“The Kevorkian Verdict”). Caplan comments, “proponents said the biggest obstacle they faced [in legalizing PAS] was Kevorkian and what he had done” (Caplan). Despite this obstacle and Kevorkian’s influence on the debate of PAS, however, the citizens of Oregon decriminalized PAS in 1997 (Caplan). Soon after, Washington joined the effort and sought to legalize PAS. Today, the select few places known for employing PAS include the Netherlands, Switzerland, and

Belgium, and the states of Oregon, Washington, and Montana (Pickert). Nonetheless, PAS fails to be a widely exercised practice because due to Kevorkian's actions, many refuse to even consider the benefits PAS may demonstrate during a terminal patient's dying process.

Key Words

The study of medical ethics addressing the ongoing debate of PAS often encounters an interesting trend. There exists a constant quarrel amongst ethicists, in which many theoretical or technical arguments are often combated with moral and emotional sentiments, and surely vice versa. Because of this ambiguous tendency and the delicacy of the debate itself, it becomes critical to define certain terms and then strongly adhere to those definitions. Physician assisted suicide refers to physician prescription of a lethal drug that the patient willingly self-administers. For the sake of this research, hastened death in medical context is the same as physician assisted suicide, with the exception of who administers the lethal drug. Also, the term demedicalization refers to lessening all medical interference during the dying process of an individual, including life sustaining machinery and medicinal drive to prolong life.

Aspects of the PAS debate that consider legality in terms of regulation are not directly relevant to a patient's dying process. Therefore, in order to avoid transforming this exploration of the dying process into yet another discussion of legalizing PAS, legal issues regarding the law and regulation are omitted. The scope of this research paper focuses primarily on a few crucial elements of a complex dying process: suffering, both physical and psychological, the demedicalization of death, a patient's desire for control, and medical obligation. The actual event, death itself, is inclusive and is considered a part of the dying process. A proper and thorough address of the posed research question is only achievable if all these aspects and the various viewpoints pertaining to these aspects are reflected upon. Although death and the dying process are hardly universal, this research paper assumes the dying process as an event in the life of a human being of any descent.

Demedicalization of the Dying Process

Having the option to request physician assisted suicide in the face of a terminal illness can avoid prolonging a painful death. Professor Ziegler asserts, "Modern medicine, in its zeal to conquer death, has become obsessed with its curative function and the ability to extend the lives of the dying. To many in the medical community, death represents failure and is something to be avoided at all costs, and like many other social

problems in the United States, has become medicalized” (Ziegler 319). Death portrays an enemy that physicians seek to defeat by any means necessary. But in this fight against death, do the patient’s best interests remain top priority? The dying process has become excessively medicalized over the years and not only does the patient live longer, he dies longer as well. In such circumstances, the dying patient is kept alive simply to celebrate a medical triumph, one that undermines the patient’s well being and the practice of medicine itself. When the patient, subject to life prolonging medical intervention, agonizes in a purely medical setting rid of comfort and friendly faces, his dying process in fact takes on the role of an enemy - an invincible enemy that not even traditional medicine can overcome. Ziegler points out that the practice of PAS can help end this agony and can put an end to further, meaningless prolongation of death, reversing this trend of medicalized dying (Ziegler 324). PAS offers a solution to rectify such a situation, one that a terminal patient’s dying process may often elicit. In doing so, the option of PAS can improve one’s dying process.

In a 2009 study published in the *Archives of Internal Medicine*, Zhang et al. sought to analyze the relationship between end of life costs and the extent of physician involvement. They found that patients utilizing life sustaining and enhancing equipment were not only subject to higher medical bills, but also died a prolonged death with more “physical distress and a worse quality of death” (Zhang et al). It is true that medicinal intervention undoubtedly possesses the ability to prolong life. However, is a sustained life always in the best interest of the terminal patient during his dying process? This study suggests that a medicalized setting does not always prove to be beneficial, and can even intensify a deteriorating patient’s dying process. In a 2010 study published in the *Archives of Pediatric and Adolescent Medicine*, Dussel et al. found that “on average, the children [with terminal cancer] who died of a treatment-related complication suffered from more symptoms than those who died of progressive disease” (327). This discovery reflects that those who let nature take its course not only died a more “natural” death, but suffered less as well. It also supports the idea that death has indeed become overly medicalized and for all the wrong reasons. PAS not only serves as an instrument to demedicalize the way we die, but also helps prevent unrestrained use of medical technology that may result in an unpleasant dying process.

PAS Medicalizes Suicide

Opponents of PAS can easily argue that physician-assisted suicide is indeed a medical procedure, thereby invalidating Ziegler’s argument that PAS can demedicalize

the way we die. Here is an instance where a morally driven argument of demedicalization is confuted with a technical argument, expressing the medicalizing effects of PAS on suicide. In his essay, Callahan endorses the argument that unlike unassisted suicide, PAS is a social act, requiring the assistance of a physician (Callahan 60). In a *Hastings Center Report* article entitled “Physician-Assisted Suicide: Promoting Autonomy or Medicalizing Suicide?” Tania Salem also argues “that physician-assisted suicide does not demedicalize death; rather, it medicalizes suicide” (Salem 30). For Callahan, Salem, and other opponents, PAS ultimately takes the very private action of suicide and transforms it into a medical event. Salem even goes as far as claiming that “physician-assisted suicide implies not a resistance to but an extension of medical power over life and death” (Salem 30). She suggests that the medical nature of the procedure prevents PAS from effectively demedicalizing death and instead increases medical involvement during one’s dying process. The quality of the dying process, with this reasoning, declines with the option of PAS.

This argument holds some merit. However, is it appropriate to equate a suicidal act to physician-assisted suicide? In a letter response to Salem’s article published in *The Hastings Center Report*, Dr. Thomas Preston, a pediatric neuropsychologist and professor at University of Washington, argues that Salem “refuses to recognize the difference between ordinary suicide and physician-assisted suicide” (Preston 4). Regular suicide is often outside of medical context in terms of dying; it can revolve around a mentally unbalanced, yet otherwise healthy individual (Preston 4). Without a distinction between the two acts, Salem quite callously ignores the conditions in which one seeks PAS: a painful, terminal illness. This blatant disregard is sufficient to discredit Salem’s argument and once again endorse Ziegler’s view that PAS demedicalizes death and thus improves the dying process.

The Suffering Patient

The original debate for the legalization of PAS revolves around two central issues. The first is a patient’s right to end his suffering and medical obligation to ensure this endeavor succeeds. It is unmistakable that intense suffering can interfere with a person’s dying process, often compelling the patient to eagerly await death. Doctor Eric Cassell in his essay “When Suffering Patients Seek Death” insists, “Patients who are terminally ill look forward to death not because they want to die but because their suffering has made living intolerable” (Cassell 76). The anguish of a constantly deteriorating health, both physical and psychological, can leave the patient imploring for a hastened death. That

patients want to end this suffering is no surprise and with terminal cases, extinguishing the agony often implies extinguishing life. In a 2003 study conducted to determine patient characteristics related to requests for PAS, Meier et al. concluded that all patients requesting and receiving aid in death were immensely burdened with physical and psychological suffering. Meier et al. comment, “patients receiving a physician’s assistance in hastening their death are making specific requests due to a substantial burden of physical pain and distress, and are expected to die of their illness within a short time” (1541). This suggests that with a prospect of recovery and without intolerable suffering, a patient himself wants to live and battle his disease. However, those that do plead for hastened death do so because of the great suffering their illness brings about. Awarding credibility to a patient’s request for PAS, these findings lead one to believe that the plea for PAS stems from an earnest desire to achieve a dying process free of suffering. Therefore, having the option to make this request shows promise in improving one’s dying process.

Every aspect of the PAS debate, or any medical debate for that matter, intensifies when the focus shifts from terminally ill adult patients to terminally ill children. Deeming a child’s illness terminal and incurable is far more disconcerting than accepting the terminal nature of an elderly patient’s illness. Although delivering PAS in a case involving terminally ill children is an incredibly lamentable idea, it is difficult to ignore the shocking similarities between the physical and psychological suffering of adults versus that of children. In an article published in the *New England Journal of Medicine* entitled “Symptoms and Suffering at the End of Life for Children with Cancer”, Wolfe et al. concluded that “overall, 89 percent of the children [diagnosed with terminal cancer] experienced a lot or a great deal of suffering” during their terminal moments (330). This suggests that the dying process of these unfortunate children consisted of unbearable suffering, a suffering so severe that no child should ever have to bear. Could the option of PAS offer these children a better, less painful dying process? Perhaps, yes. In the article “Considerations About Hastening Death Among Parents of Children Who Die of Cancer,” Dussel et al. report the results of their study conducted to estimate the frequency of hastening death and PAS discussions in cases of terminally ill children. The results suggest that “more than 1 of every 8 parents report considering [hastened death] during their child’s illness, and they tended to do so if their child was in pain” (Dussel et al. 236). Although this means that 7 out of 8 parents do not contemplate PAS, to elicit such a response from even a single parent is utterly inconceivable. However, could one even

begin to envision the suffering a parent must witness his child experience before resorting to such a miserable notion? In the end, the truth is very bitter. It is likely that the option of PAS, although very permanent, can eliminate suffering from one's dying process and allow these children to achieve a more peaceful death.

Hospice and Palliative Care

An opposing point of view to the idea that PAS can eliminate suffering may entail the argument that PAS is an unnecessary course of action in the presence of good palliative care, that palliative care is a sufficient means of ending patient suffering. This opposition firmly believes that with today's medicine, "virtually all suffering can be relieved, that in the presence of good hospice care suffering is much less common, that pain, which is a frequent source of suffering can almost always be controlled" (Cassell 78). According to this belief, with compassionate physicians and proper use of medicinal facilities, all pain and suffering is curable. In her article "Competent Care for the Dying Instead of Physician-Assisted Suicide, Katherine Foley, a known neurologist and advocate of palliative care, insists that "palliative medicine has developed guidelines for aggressive pharmacologic management of intractable symptoms in dying patients, including sedation for those near death" (54). She is confident in modern palliative medicine and believes that with proper execution, palliative care can replace the option of PAS and its morbid endeavor to improve the process of dying by hastening death.

However, what Foley fails to realize is that despite employment of exceptional hospice care, terminal patients still suffer during their dying process. Ziegler points out that "just because one is enrolled in hospice does not necessarily mean that they would not want PAS" (325). According to the tenth annual report on Oregon's Death with Dignity Act, "88% of those who requested PAS were currently enrolled in hospice care" ("Tenth Annual Report" 2). Therefore, it is obvious that palliative care fails to satisfy the needs of terminal patients who then seek PAS to relieve their suffering. Now the question that remains is whether this outcome is a product of poor physician training or an inability to palliate a suffering so intense. Research suggests that both of these reasons are responsible for the shortcomings of palliative care. A 2002 study published in *Palliative Medicine* sought to investigate the failure of palliative care to achieve adequate symptom control. Grande et al. discovered that "there was generally low agreement between patients' and [general practitioners'] reports of patients' symptoms" and that "[general practitioners] were most likely to miss symptoms which were perceived to be difficult to control and which were less prevalent in the patient sample" (405). This study

suggests that because of the rarity of cases requiring palliative care, physicians are unable to accurately identify terminal patient symptoms, without which it is impossible to make patients feel comfortable during their dying process. The suffering lingers.

Another point the opposition fails to acknowledge is that suffering is not always physical. In fact, physical symptoms lead to suffering, which is “an afflicted state of being” (Cassell 76). Unconsciously therefore, the hallmark of medicine, to relieve one’s suffering, is often substituted with pain relief. Pain medication may succeed in numbing the physical agony, however, fails to cure the patient’s suffering. Cassell argues, “the belief that suffering can be relieved in all or ‘virtually all’ cases displays ignorance of what suffering is and how it comes about” (79). Suffering is not only the loss of bodily functions and debilitating health; it is more psychological in that it entails the helplessness brought upon by the terminal illness or the burden of dying a painful death. Certainly, palliative care, or any other form of care for that matter, fails to cure such a suffering during one’s dying process.

Even when the suffering is merely physical pain, studies show that the patient is not made as comfortable as possible. This occurs perhaps because all physicians are “not of one mind on the link between physical pain and request for hastened death” (Ziegler and Lovrich). In *And a Time to Die: How American Hospitals Shape the End of Life*, author Sharon Kaufman explores the internal aspects of the modern American hospital system and with the help of the interviewing process, reports the protocol when dealing with a terminally ill patient. She reports a case study in which, “...the hospitalist physician doesn’t believe in intravenous morphine drips, commonly used with dying hospitalized patients. He feels that drips are all too close to assisted suicide, so as a personal policy he just doesn’t use them...As a result, the patient is not really made comfortable” (Kaufman 135). This is shocking support for the idea that even when physicians can alleviate the patient’s pain, their fear of engaging in an illegal act of PAS, or something that remotely resembles it, keeps them from effectively providing palliative care. Not only is this account suggestive of the failures in palliative medicine, but also supportive of the idea that the option of PAS, if legalized, would allow physicians to practice better palliative care and thus, effectively improve one’s dying process.

Acceptance of the Suffering

Other criticism of the idea that having the option of PAS can help eliminate suffering from one’s dying process revolves around the concept of necessary suffering. Callahan’s introduction of this concept challenges PAS, however, in a completely

different manner. He explains, “No moral impulse seems more deeply ingrained than the need to relieve human suffering” (Callahan 54). He agrees that lessening one’s discomfort and suffering is the very basic tenet of all medicinal approaches and humanity itself. However, Callahan points out that in order to learn the value of life it is important to “discern when suffering cannot, or should not, be wholly overcome, when our duty may be to accept the suffering of another, just as the person whose suffering it is must accept it” (Callahan 55). That is, one must not dismiss significant aspects of life simply because they bear a possibility of suffering and should instead embrace the causal lesson taught by it. With these ideals, the escape PAS offers runs the risk of devaluing the dying process, deeming the natural condition that may sometimes entail suffering, unnecessary suffering. In fact, he argues, suffering needs to be evident. It is interesting to note that once again, the ambiguity of the debate here is evident – the very objective reality of suffering is combated with a moral argument addressing the necessity of existential suffering. In any case, Callahan worries “if we make the avoidance or relief of suffering itself the highest goal, we run the severe risk of sacrificing, or minimizing, other human purposes” (56). He points out that when a person above all aims to reduce suffering, he may inadvertently neglect significant goals in life. Dismissing PAS, Callahan’s views nurture this concept of necessary suffering – suffering that no one should seek to overcome, but grow to accept. With this suffering, or more appropriately, sacrifice, one’s death gains meaning and further enriches the dying process.

Although it is acceptable to say suffering in the light of achieving a human purpose is a necessary component of life, is it appropriate to deem a terminal patient’s excruciating pain and suffering necessary? Cassell points out, “[Physicians] know that nothing can make [death] any less what it is. Nothing diminishes its profound importance in and to life, the sadness, pain, grief, and loss that may precede and almost inevitably follow death” (Cassell 77). A peaceful death does not necessarily devalue its meaning. Instead, a death without prolonged suffering achieves the comfort and closure a dying man seeks. Suffering, in this case, is indeed unnecessary. Perhaps even avoidable. Moreover, in an article published in the *New England Journal of Medicine*, Cassell insists that without proper understanding of the patient’s suffering, “the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself,” which worsens the patient’s quality of death (639). This suggests that acknowledging a patient’s suffering and understanding its nature are significant steps to effectively provide relief and prevent

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the agony from worsening. Thus, when opponents like Callahan dismiss the belief that suffering should always be eliminated, they compel one to believe that they are incapable of fully understanding the patient's suffering. More explicitly, they convince a proponent that because they believe suffering is essential, their attention to a patient's suffering and motivation to reduce it may be inadequate. Therefore, one can conclude that terminally ill, dying patients under the supervision of physicians that carry Callahan's beliefs will suffer, and for no reason at that. This sustains the belief that PAS can eliminate a dying patient's suffering, which is in fact unnecessary, and thus, grant the patient a better dying process.

The Right to Waive the Right to Live

As discussed, the right to end one's suffering frames one major aspect of the PAS debate. The other pillar of this debate consists of the right to patient autonomy and the control a terminal individual seeks during his dying process. During the course of a terminal illness that virtually determines all aspects of a patient's dying process, the patient can desire to at least have control over his decisions. In their essay "The Role of Autonomy in Choosing Physician Aid in Dying," Drs. Preston, Gunderson, and Mayo stress that "an autonomous decision to hasten one's death is a profoundly important decision for a terminally ill person that involves his or her most significant values" (40-41). Suffering from a constantly deteriorating illness, patients seek to incorporate their values and practice some control with their dying process. In a 2000 study, published in the *Archives of Internal Medicine*, to explore the attitudes of the terminally ill towards physician-assisted suicide, Wilson et al. found that 75% of the patients "believed that they had the right to exercise choice and control over the manner of their deaths" (2457). This study suggests that terminally ill patients indeed feel that they should have the right to waive their right to live. Often in terminal cases, this right and quest of control amount to having the option to request PAS. Therefore, if having the option of PAS awards terminally ill patients with a much sought after sense of control and autonomy, then it makes their dying a more comfortable process.

Critics of this view may argue that the option of PAS does the exact opposite. It restricts patient autonomy. This criticism emphasizes that a respect for the patient's right to self-determination and the acceptance of PAS are contradicting ideas that proponents always seek to link. John Safranek expresses this contradiction in his article, "Autonomy and Assisted Suicide: The Execution of Freedom," published in the *Hastings Center Report*. He claims, "autonomous acts of assisted suicide annihilate the basis of autonomy

and thereby undermine the very ground of their justification” (Safranek 35). Safranek suggests that empowering a physician to aid in dying results in a loss of autonomy for the patient who must now submit to physician oversight. This claim, largely shared amongst the opposition, emanates from the idea that the very action of requesting medical assistance undermines the principle of self-determination. Furthermore, Callahan stresses that the requirements that render PAS necessary also undermine self-determination. He questions, “...why must the person be suffering? Does not this stipulation already compromise the right of self-determination? How can self-determination have any limits” (Callahan 62)? Callahan points out that because the administration of PAS requires that the patient demonstrate unbearable suffering, patient autonomy is already undermined. Accordingly, if patient autonomy is undermined, how can PAS improve the dying process, a process that strongly summons autonomy? This ridicule of PAS for decreasing a patient’s self-determination renders having this option oppressive to one’s dying process.

Safranek and Callahan’s echoing concerns are plausible. Their argument that PAS increases physician involvement ties in with Salem’s earlier argument addressing the medicalizing effects PAS exerts on suicide. This counter argument, therefore, calls for a similar rebuttal. Although it is possible that increasing physician authority undermines patient autonomy, is it reasonable to overlook the increase in patient choice that the availability of the option to request PAS results in? Preston points out that “even though the autonomy in choosing physician-assisted suicide may be limited by physicians, it represents a net gain in autonomy because patients previously had no autonomy over the matter” (4). Clearly, allowing patients to choose PAS in attempts to improve their dying process is one more alternative in addition to the list of end of life care possibilities. Therefore, the scope of patient choice increases, awarding the patient with a larger sense of self-determination. Contrary to Safranek’s declaration, having this option in fact increases patient autonomy by allowing the patient to exhibit control and choose PAS in light of a terminal illness.

Nonabandonment and Fear

Approaching death can introduce a great deal of fear. The inevitability of this fear is expressed in numerous studies conducted to evaluate the effects of PAS on the dying process. In the study mentioned earlier published in the *Archives of Internal Medicine*, Wilson et al. also found that the majority (73%) of the terminal cancer patients believed that a system of PAS should be implemented and be used (2454). When asked why,

these patients used the fear of unbearable pain as the primary reason to validate the practice (Wilson et al. 2456). This study suggests that terminally ill patients are indeed subject to tremendous amounts of fear during their dying process. This fear includes the fear of the experience of dying, fear of being a burden to one's loved ones, and above all, the fear of dying a painful death with an utter loss of control (Angell 15). To mitigate this fear would be a substantial improvement to one's dying process.

However, achieving this goal requires an understanding of the profound effects physician involvement can have on one's near death experience. Drs. Timothy Quill and Christine Cassel introduce the idea of nonabandonment – a principle that “acknowledges and reinforces the centrality of an ongoing personal commitment to caring and problem solving between physician and patient” (24). With this commitment, physicians promise to pacify their patients' fears and continue patient care up until the patient's very last breath. Well, sometimes this promise requires that a physician respect and deliver a patient's request for PAS. Hastening one's death is indeed a very delicate matter and its discussion is only possible when a patient and physician establish a comfortable relationship under the principles of nonabandonment (Quill and Cassel 33). With that in mind, having the option of PAS requires that a physician commit to not abandon his patient and further enforces the principles of nonabandonment. Transitively, therefore, having the option of PAS, which encourages nonabandonment, lessens a patient's fears about approaching death. Although quite complex, the effectiveness of this linear relationship between fear, nonabandonment, and having the option to request PAS can help protect and improve one's dying process.

The discussion of abandonment is highly subjective. Opposition argues that PAS is a form of abandoning the patient; whereas proponents of PAS may argue that not employing PAS at the request of the patient is abandonment. Critics of the idea that PAS promotes the doctor-patient relationship and the promise of nonabandonment argue that “aiding a patient in dying [is in fact] a form of abandonment, because a physician needs to walk the last mile with the patient, as a witness, not as an executioner” (Foley 55). Foley argues that ultimately, by hastening the patient's death, the physician forsakes his patient's side and simply gives up. On the other hand, Ziegler argues that “outside of the PAS context, some doctors already abandon their dying patients” (324). He suggests that without respecting a patient's request for PAS, the physician abandons his patient in a desperate time of need. Again, it all comes down to the wishes of the patient. However, considering both sides, one cannot ignore the profound effects merely having the option

to request PAS can have on the doctor-patient relationship. If the alternative to make this request exists, then physicians become obligated to develop a close relationship with their patients simply in anticipation of the possibility that their patient makes that request. This connection more or less ties in with idea that by providing the option to request PAS, the number of choices increases and so does patient autonomy. Similarly, if the option is available, it encourages physicians to adhere to the principles of nonabandonment – an encouragement that can be lacking otherwise. By promoting nonabandonment in a time of need, having the option to request PAS betters the dying process.

Conclusion

The dying process is a very complex event in a person's life full of confusion, fear, and the desire for meaning. In the largely discussed debate on PAS, many seem to forget the very foundation of its birth; they seem to overlook the pleading nature of the request that one only makes when he is terminally ill and experiencing a very poor quality of dying. PAS offers an alternative for this kind of patient when medicine has failed him and shows promise to improve, or rather salvage, a person's dying process. The findings of this exploration of the dying process reveal that the mere availability of the option to request PAS has the potential to considerably improve one's dying process. Studies reported in scholarly journals suggest that many of those suffering on their deathbed make requests for hastened death and PAS, as a whole, allows a physician to eliminate this suffering, demedicalize and make one's dying process more comfortable. Also, findings of this paper suggest that the mere option of PAS encourages patient autonomy and medical nonabandonment, not to mention better palliative care. Overall, therefore, the conclusions drawn from this exploration of the dying process suggest that PAS has the potential to better one's dying experience.

Whereas Ziegler outlines the various improvements PAS can implement on the dying process, Callahan refutes them. With this kind of theoretical set up, conducting a thorough exploration is achievable since both authors provide arguments and counter arguments in anticipation to those arguments. The findings of this research paper are in complete accordance with Ziegler's theory advocating that PAS demedicalizes death. However, Callahan's theories of the negative effects of PAS on both the dying process and society are not supported by the conclusions drawn in this exploration.

Traditional medicine conflicts with the idea of physician-assisted suicide. The Hippocratic Oath, from the beginning of its institution, forbids all physicians from

intentionally allowing a patient to die. Unfortunately, however, adhering to this tradition would resemble an impediment to the growth and value of medicine and society. Kevoorkian and regulation issues have allowed digression from the original purpose of PAS, which could be a part of good medical care. With a consideration of the dying process, perhaps one day all states will realize that the opposition does not honor the wishes of those that it most likely applies to and recognize a public policy in support of physician-assisted suicide.

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