

Autonomy, Euthanasia and the Common Good

A Brief submitted to the Select Committee on Dying with Dignity.

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INTRODUCTION

I find it unsettling that the select committee has chosen as its title, *Dying With Dignity*, a slogan of the right-to-die movement.¹ That choice, along with many of the stories in the committee's consultation document concerning people facing end of life issues, seems to indicate to me that the committee has a bias toward assisted suicide as a viable end of life option. Nevertheless, I will attempt to make the case (using as examples, the most commonly identified forms of life-ending practices, i.e., voluntary active euthanasia² and physician assisted suicide³) that the intentional taking of human life should not be permitted as a legal medical option in Quebec. Though my position on assisted suicide is shaped by my religious faith, for the most part I will attempt to restrict my position to secular arguments.

THE IDEOLOGY OF AUTONOMY

In my view, there is a presumption in the *Dying With Dignity* movement that the only way one can die “with dignity” is if he/she has total control over the manner and timing of his/her death. Consequently, this pro-euthanasia movement pushes the principle of autonomy as grounds for an individual's “right” to end his/her life by either voluntary-active euthanasia (VAE) or physician-assisted suicide (PAS). The case for autonomy as a rationalization for the legalization of VAE/PAS usually revolves around the patient's wish to avoid unnecessary and inevitable physical suffering and/or to preserve the patient's “dignity” in the dying process. How one defines “dignity” in the dying process is uncertain.⁴ But an indication of how the forces pushing for euthanasia / assisted suicide understand it may lie, in part, in their rejecting the “sanctity of life” tradition (i.e. human life has intrinsic value and thus should be respected and protected) to embrace of the “quality of life” ethic which attaches instrumental value to human

life (i.e., human persons are valued for their usefulness, their productivity, their ability to be of some use to society. They are not valued for their own sake, but for the sake of what they can do for society as a whole).

This “quality of life” ethic attaches human dignity to the principle of autonomy. However, autonomy as used by VAE/PAS activists is rooted more in the ideology of *ethical liberalism* than in medical practice. Those who advocate for legalized VAE/PAS tend to view the principle of autonomy from a perspective which attributes ultimate value to the principle of self-determination.⁵ Indeed, Derek Humphrey, founder of the pro-euthanasia, *Hemlock Society*, (currently renamed, “*End of Life Choices*”) insists that the principle of autonomy endows the individual with the “incontestable right to humankind’s *ultimate civil and personal liberty*--the right to die in a manner and at a time of their own choosing.”⁶ (Italics added)

According to Professor Luke Gormally of Britain’s *Linacre Centre for Health Care Ethics*, the significance of views like Humphrey’s is that they impart to autonomy a radical individualism concerning what constitutes human worth or dignity. He contends that if autonomy is the essential issue in end of life decision-making, a patient who says his/her life is no longer worthwhile, removes all grounds for overriding that judgment since it is down to the patient to determine what counts as the value of his or her life.⁷ Gormally concludes that:

(Autonomy) appears to lend a unique authority to a patient's own view of the value of his life. On what basis could a doctor question a patient's judgment that his life is no longer worthwhile if the worth of that life is wholly determined by the patient's idiosyncratic choices? If it is true that the value of a person's life is uniquely determined by the choices that person makes, then, if he or she says that under certain conditions their life would not be worthwhile and they would be better off dead, does that not make out the case for saying that death would be a benefit to the patient? And if a benefit, then surely a doctor (would feel) justified in assisting in suicide or executing euthanasia.⁸

Dr Hubert Marcoux, associate professor in the Department of Family Medicine and Emergency Medicine of the Faculty of Medicine at Laval University, considers the ideological use of autonomy in end of life care as a “tyranny” Writing in the publication, *Canadian Family Physician*, Marcoux states:

The ideology of autonomy has placed responsibility for decision making in the area of health in the hands of patients, who see it as a right, not a duty. With this shift in responsibility has come a sense of entitlement, including the right to die upon request. The right to choose has become the right to demand. When a patient says, “this is what I want; this is what I demand”, all other balancing values are thrown out. A physician who refuses to comply with a technically achievable demand is accused of imposing his or her own personal values. Sound medical practice and equitable access to care are among the values being driven out. Euthanasia becomes a matter purely of personal conscience, not a matter of ethics for an entire profession.⁹

Gormally’s and Marcoux’s observations regarding the grounding of VAE/PAS in the principle of autonomy, point to serious consequences for the medical profession. An obvious consequence to medicine is the destruction of the profession’s ethical center--to heal and *not* to kill. By making doctors, nurses, hospital technicians, and pharmacists complicit in dealing death, society’s trust of medical practitioners would be seriously harmed. Moreover, the VAE/PAS death dealing web of complicity would stretch even wider to ensnare the government, which must approve the practice VAE/PAS, and, ultimately, the people of Quebec, who would be made complicit once VAE/PAS is accepted as part of our social policy.¹⁰ (I find the latter ironic given that in the death penalty debate a few decades ago, we made a decision as a society, not to take human life.. VAE/PAS are not on the level of executions, but the end result is the same.)

One must accept that the VAE/PAS debate is not just about the individual. To have end of life choices founded primarily on the principle of individual autonomy pretends that VAE/PAS are essentially private acts. But as noted above, in that these measures involve the participation of other individuals, they become a form of public action, *communal acts*. Moral

theologian, Richard Gula, states that the principle of autonomy is directed toward self-determination, “apart from any concern of how one’s personal desires or striving *contributes to the good of society as a whole.*” (Italics added) ¹¹ Thus, he asserts, the principle of patient autonomy, as used by the advocates of VAE/PAS, runs counter to the principle of the common good which promotes those actions and policies that would contribute to the total well being of society while respecting and serving the interests of individual persons.¹² Gula argues that VAE/PAS must be assessed under the light of the principle of the common good to determine the *social impact* of these acts.

AUTONOMY AND THE COMMON GOOD

Admittedly, the principle of the common good stands in constant tension with the principle of autonomy because it holds that the well-being of the individual will best be served insofar as the well-being of society, as a whole, is served.¹³ Quebec society is not unfamiliar with this tension. For example, the principle of the common good is understood to be one of the pillars supporting the province’s language legislation. It is generally accepted in Quebec that, for the well-being and flourishing of Quebec society, French is to be our dominant language. Consequently, the principle of the common good, as applied to language in Quebec, trumps all claims regarding *individual* “language rights.”

In writing on euthanasia and the common good, Charles Dougherty, former Director of the Creighton Center for Health and Ethics at Creighton University in the United States defines the relationship between the two as “a dual vision of persons in society... The common good is a good for all, not a good for each. The common good is something collective, not simply the sum of what is good for each member of the society in a distributive sense. It is a *good* that pertains to

the general social relationships in which individuals seek specific goods. Because the common good is a general good, it may frustrate acquisition of specific goods for individuals.”¹⁴

Dougherty states that legalizing VAE/PAS as acceptable medical practice would adversely affect the common good because it “would change our collective moral psychology, making what was previously prohibited more and more socially acceptable, even expected.”¹⁵ He predicts that if VAE/PAS becomes acceptable social policy, its advocates will not be satisfied with only making the practice acceptable but will strive to make it the right or obligatory thing to do in order to reassure our “therapy-oriented culture” that it need not feel guilty about abiding VAE/PAS as end of life options.¹⁶ Thus,” Dougherty submits, acceptance and recourse to euthanasia would likely grow over time to see VAE/PAS as the only way to die with dignity. Dougherty sees nothing in the proponents' case for legalization that is” inconsistent with this future.”¹⁷

In considering the implications of VAE/PAS in the light of the principle of the common good, ethicist Richard Gula poses some necessary questions:

If we introduce (VAE)/PAS as a legal, medical option, would we risk discriminating against vulnerable groups -- such as those with AIDS, Alzheimer's or spinal cord injuries -- that are perceived as burdens on the system and on society? Would legalizing euthanasia/PAS affect the way we think about mental and physical decline, about suffering, about the obligations of adult children to their parents or of how parents needing care feel toward their children? How would this practice affect the self-understanding of the disabled and their relation to society? How would it affect physicians' attitudes toward their failing patients? How would it affect the way we distribute our resources? Would those who did not choose euthanasia/PAS be forced to justify their refusal?¹⁸

Daniel Callahan, Director of International Programs at the Hastings Center and a Fellow of the Institution for Social and Policy Studies at Yale University, echoes the concerns of Gula

and Dougherty that the grounding of VAE/PAS in autonomy at the expense of the common good opens the door for abuses which could have considerable *social* impact:

(T)here are no good moral reasons to limit euthanasia once the principle of taking life for that purpose has been legitimated. If we really believe in self-determination, then any competent person should have a right to be killed by a doctor for any reason that suits him. If we believe in the relief of suffering, then it seems cruel and capricious to deny it to the incompetent. There is, in short, no reasonable or logical stopping point once the turn has been made down the road to euthanasia, which could soon turn into a convenient and commodious expressway.¹⁹

The above may seem to go the way of the “slippery slope argument which the advocates for the legalization of VAE/PAS reject as fear-mongering and worthless speculation. I do not intend to restate all the slippery-slope arguments in this paper. They are well known to those who have followed this debate. Yet I cannot help noticing that some in the pro-VAE/PAS camp have, themselves, not shied away from making the slippery slope even slipperier.

Consider the following remarks of Britain's leading moral philosopher, Mary Warnock, who helped to shape British law governing human fertilisation and embryology. As reported in the on-line version of the British newspaper the *Telegraph*, Warnock, who the article identified as a prominent supporter of euthanasia, “suggested that pensioners who do not want to become a burden on their care-givers should be helped to die.” Dementia sufferers, she added:

should consider ending their lives through euthanasia because of the strain they put on their families and public services. I'm absolutely, fully in agreement with the argument that if pain is insufferable, then someone should be given help to die, but I feel there's a wider argument that if somebody absolutely, desperately wants to die because they're a burden to their family, or the state, then I think they too should be allowed to die. Actually I've just written an article called 'A Duty to Die?' for a Norwegian periodical. I wrote it really suggesting that there's nothing wrong with feeling you ought to do so for the sake of others as well as yourself.”²⁰

Warnock, who is also a consultant to the British government, was quoted in another paper as favoring the euthanizing of sick and premature babies.²¹

As Britain's leading moral philosopher, Warnock's has some influence in Britain's assisted suicide debate. Her comments seem to support the `slippery slope` contention, that once out of the box, VAS/PAS will seek to expand its reach to a broader segment of society than just those suffering unbearable pain.

Then there is the proposal of Professor Julian Savulescu of the Oxford Uehiro Centre for Practical Ethics, University of Oxford. He and his associate, Dominic Wilkinson, argue for "Organ Donation Euthanasia" which the two describe as euthanizing "permanently unconscious" patients in order to remove their organs for transplant. Savulescu defends ODE as follows:

(W)hy should surgeons have to wait until the patient has died as a result of withdrawal of advanced life support or even simple life prolonging medical treatment? An alternative would be to anaesthetize the patient and remove organs, including the heart and lungs. Brain death would follow removal of the heart (call this Organ Donation Euthanasia (ODE)). The process of death would be less likely to be associated with suffering for the patient than death following withdrawal of LST (which is not usually accompanied by full anaesthetic doses of drugs). If there were a careful and appropriate process for selection, no patient would die who would not otherwise have died.²²

Savulescu admits that

Technically, this would be a form of killing – active euthanasia... (but) the broader justification for ODE includes not merely those who no longer have interests, but those who will inevitably shortly die. The argument for removing organs from this group is even stronger. It does not rely on controversial judgments of quality of life, wellbeing or interests. These patients will die because they are on life sustaining treatment and it will be withdrawn. Indeed we would suggest that, although most arguments for euthanasia are distinguished from questions of organ donation, it may be that the benefits of donation, for the individual and for others, provide the strongest case for euthanasia.²³

Positions like that of Warnock and Savulescu may be downplayed by the pro-VAE/PAS activists as "extreme." Undoubtedly, they will insist that scenarios like those above can be contained by strict controls on the VAE/PAS process. Yet, Daniel Callahan warns that authorities can regulate the process as strictly as they wish, but, abuses will be "inevitable". He explains that

“all laws on delicate, controversial matters” will eventually be abused by those who disagree with them. Moreover, if the regulations governing VAE/PAS have a “low enforcement priority” in a society’s criminal justice system, violations will undoubtedly be tolerated, thus, further encouraging abuses.²⁴

Dr. Gonzalo Herranz, Professor of Pathology and Medical Ethics at the University of Navarra in Spain shares Callahan’s disquiet about the effectiveness of restrictions on VAE/PAS practice. After studying physician behaviour in the Netherlands and in Belgium, two countries that have legalized PAS, Herranz concluded that:

... once euthanasia is legally authorized, there is no way to stop it. There are two reliable grounds to support this assumption. One is the individual behavior of doctors, as observed in physicians who succumb to the notion that euthanasia is professionally acceptable, even if it is seldom required. The other is related to society in general, as shown in the increasing pressure of the pro-euthanasia movement to legalize “compassionate” death, even within strict limitations... My first proposition can be formulated as follows: If a physician sincerely accepts the idea that it is right, from a professional and ethical perspective, to end the life of one of his patients, he will not stop there. It will be difficult for him, and also unjust, not to offer euthanasia to other patients who suffer in a similar way or are approaching a similar level of pain or anguish. He will find more reasons to offer “merciful” death to other patients, earlier, and with more zealous compassion.²⁵

Apprehension over abuses is given added support in the June 15th issue of the journal of the *Canadian Medical Association*. According to researchers, despite the stipulation in Belgium’s euthanasia law that only physicians are to administer life-ending drugs on a patient’s explicit request, this regulation is almost routinely flouted. The article reports that in some cases the act of administering lethal injections has been performed by nurses, not doctors. Furthermore, in its coverage of the CMA study, the digital edition of the *Vancouver Sun* reported that (1) “a fifth of Belgian nurses interviewed by researchers admitted that they had been involved in euthanizing patients based on the “assumption” that the patients would “want to die” and (2) nearly

half of the nurses - 120 of 248 - admitted they had taken part in "terminations without request or consent".²⁶

The CMA report concluded that “by administering the life-ending drugs in some of the cases of euthanasia, and in almost half of the cases without an explicit request from the patient, the nurses in our study *operated beyond the legal margins of their profession.*”(Italics added)²⁷

Wesley J. Smith, a Senior Fellow in Human Rights and Bioethics at the Discovery Institute, a consultant to the International Task Force on Euthanasia and Assisted Suicide, and a special consultant for the Center for Bioethics and Culture, writes in an article on legalized VAE /PAS in Europe that “(e)uthanasia has been around long enough and practiced sufficiently enough for us to detect a pattern. Killing is sold to the public as a last resort justified only in cases where nothing else can be done to alleviate suffering. But once the reaper is allowed through the door, the categories of killable people expand steadily toward the acceptance of death on demand.”²⁸

Smith, also, writes that in the Netherlands, even though guide lines were established when PAS was first legalized in that nation, the guidelines were soon viewed by some medical practitioners “as impediments to be overcome instead of important protections to be obeyed”.²⁹

Smith claims that since the so-called “iron-Clad protections” against abuse had become meaningless, “Dutch doctors now legally kill terminally ill people who ask for it, chronically ill people who ask for it, disabled people who ask for it, and depressed people who ask for it.”³⁰

Smith points out that:

Euthanasia has also entered the pediatric wards, where eugenic infanticide has become common even though babies cannot ask to be killed. According to a 1997 study published in the British medical journal, *The Lancet*, approximately 8 percent of all Dutch infant deaths resulted from lethal injections. The

babies deemed killable are often disabled and thus are thought not to have a "livable life." The practice has become so common that 45 percent of neonatologists and 31 percent of pediatricians who responded to *The Lancet* surveys had killed. It gets worse: Repeated studies sponsored by the Dutch government have found that doctors kill approximately 1,000 patients each year who have not asked for euthanasia. This is not only a violation of every guideline, but an act that Dutch law considers murder. Non-voluntary euthanasia has become so common that it even has a name: "Termination without request or consent."³¹

According to Smith, Dutch doctors who over-step the established bounds "are very rarely prosecuted for such crimes, and the few that are brought to court are usually exonerated. Moreover, even if a doctor is found guilty, he or she is almost never punished in any meaningful way, nor does the (doctor) face discipline by the Dutch Medical Society."³²

Jos. VM Welie, writing in *Focus*, a publication of the Center for Health Policy and Ethics at Creighton University in the United States points to a movement in the Netherlands to gain public support for allowing "individuals other than physicians ...to assist in another person's suicide." This movement justifies its attempt to expand the Dutch euthanasia law on the basis of helping "Dutch citizens who are 70 years or older and who believe their life is complete and want to die" but who cannot obtain physician help in ending their lives since they are not ill in the medical sense of that term. This Dutch movement sees the need for another "profession" apart from the medical profession to be trained to assist the elderly with their suicide³³.

Another development in Oregon, one of the American states where PAS is practiced, also is worth noting. Data from a 2009 study of terminal patients in Oregon who requested PAS suggests that these patients did so not because of physical symptoms or quality of life concerns but out of a fear of future suffering that they *perceived* (my italics) would be intolerable. The authors of the study concluded that the patients'

...desire to die is not strong, and they do not believe that their life is poor in quality, meaningless, or worthless. Rather, they appear to be protecting against the risk of future experiences they do not believe they can endure. Although future physical symptoms are important considerations for

these individuals, they are more strongly motivated by the prospect of loss of autonomy—loss of control, quality of life, and ability to remain at home, with looming restrictions and dependence on others.³⁴

The 2009 Summary of Oregon's Death with Dignity Act fleshed out the above a bit more.

The most frequently mentioned end-of-life concerns among the 59 patients euthanized in that state in 2009 were: loss of autonomy (96.6%), loss of dignity (91.5%), and decreasing ability to participate in activities that made life enjoyable (86.4%). Some (25%) attributed their decision to worries about being a burden to their families, friends, or care givers. Despite the claims by activists that VAE/PAS is necessary to end the unbearable physical suffering of patients due to pain, the above statistics reveal that unbearable physical pain was not a major factor in the decision of these patients to end their lives. Indeed, what the statistics show is that psychological factors, such as anxiety, possibly played a more important role in patient end of life decision-making. It is important to note that Oregon law requires physicians who believe a patient's judgment is impaired by a psychiatric or psychological disorder, to refer the patient for psychological examination.³⁵ As well, the prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control. Despite this requirement in the Oregon *Death With Dignity Act*, none of the 59 patients above were referred for formal psychiatric or psychological evaluation.³⁶

Conclusion

I have attempted to show in this paper that we cannot, as a society enshrine individual autonomy as a sacred right in end of life choices if these choices include death through euthanasia or physician-assisted suicide. When the principle of individual autonomy is brought into balance with the principle of the common good, it reveals that VAE/PAS have serious negative and far reaching consequences for society, consequences which cannot always be effectively re-

strained through governmental controls. Legalizing euthanasia/PAS would rip apart our social fabric by overturning one of essential components of a civilized people: *we should not kill one another*. The legalization of euthanasia/PAS will numb us to the act of killing by accepting death-dealing as the “quick fix” to human suffering. Dying is not made more humane and dignified by killing.

Quebec society can be best served by adopting measures that make the process of dying more humane and dignified for all of us. In essence, this means adopting a palliative care³⁷ - inspired strategy of accepting death when it is inevitable, providing the best human support to ease suffering, and using every reasonable measure to control pain.

The common good must be part of the debate on dying with dignity since the principle of the common good demands protection of the social fabric which is built upon trust in human relationships. Legalized killing (once rejected as barbaric in the death penalty debate) degrades a society and reduces human dignity. When we all become complicit in dealing death through social policy, we do not protect human dignity, we cheapen it.

¹ An article by Harvey Max Chochinov, OM, MD, PhD, FRCPC in *CA: A Cancer Journal for Clinicians* states, “**The term *dignity* has become highly politicized and is frequently invoked as justification for various end-of-life care practices and policies. In many circles, the term “death with dignity” is synonymous with the right to assisted suicide and euthanasia. Several studies have reported that loss of dignity is very closely linked to why patients have either sought or, in some instances, received death-hastening assistance.**” Dying, Dignity, and New Horizons in Palliative End-of-Life Care”, *CA: A Cancer Journal for Clinicians*. *CA Cancer J Clin* 2006; 56:84-103. July 9,2010.<
<http://caonline.amcancersoc.org/cgi/content/full/56/2/84#SEC1>.>

² For the purposes of this paper, I will borrow Gula’s definition of voluntary active euthanasia (VAE): Voluntary active euthanasia means a deliberate intervention by someone other than the person whose life is at stake, solely intended to end the life of the competent, terminally ill patient who makes a fully voluntary and persistent request for aid in dying.” In *Euthanasia: Moral and Pastoral Perspectives*, Richard Gula, S.S (New York/Mahwah, N.J Paulist Press, 1994) 5-6.

³ Moral theologian, Richard Gula, S.S. defines physician-assisted suicide (PAS) as occurring when “a physician helps to bring on the death of the patient by providing the means to do it, or by giving the patient the necessary information on how to do it, but the patient performs the lethal act on himself or herself.” *Euthanasia: Moral and Pastoral Perspectives*, Richard Gula, S.S.(New York/Mahwah, N.J :Paulist Press,1994). 6.

⁴ It is important to know how the concept of ‘dignity’ is understood within the context of this consultation. I did not discover a definition of the concept in “What the Words Mean” section of the committee’s consultation document. Dr. Leon Kass, M.D. a professor on the University of Chicago’s Committee on Social Thought and former Chair of the President’s Council on Bioethics in the U.S. writes in his book, *Life Liberty and the Defense of Dignity: The Challenge for Bioethics*. that “...there is nothing of human dignity in the process of dying itself, only in the way we face it...A death with dignity ...entails more than the absence of external indignities. Dignity in the face of death cannot be given or conferred from the outside; it requires a dignity of soul in the human being who faces it. Leon Kass, *Life Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002) 245-246.

⁵ Kass, *Life Liberty and the Defense of Dignity: The Challenge for Bioethics*,6

⁶Humphrey, Derek. “Liberty and Death: A manifesto concerning an individual's right to choose to die”, Assisted Suicide, 24 March 2009 <[http://www.assistedsuicide.org/liberty and death manifesto right to die.html](http://www.assistedsuicide.org/liberty_and_death_manifesto_right_to_die.html)>

⁷ Gormally Luke. . “Autonomy, Dignity and the Legalisation of Euthanasia: Talk to the Bristol/Bath Branches of the Guild of Catholic Doctors 24 May 2006”. Catholic Medical Association Quarterly. July 2010 <[http://www.catholicdoctors.org.uk/CMQ/CMQ_full frame.htm](http://www.catholicdoctors.org.uk/CMQ/CMQ_full_frame.htm)>

⁸ Gormally, Luke. “ Autonomy, Dignity and the Legalisation of Euthanasia:Talk to the Bristol/Bath Branches of the Guild of Catholic Doctors”... <<http://www.catholicdoctors.org.uk/>>

⁹ Marcoux, Hubert. MD FCFP. “Should physicians be open to euthanasia?” Canadian Family Physician Vol. 56, No. 4, April 2010, pp.321 – 323. < <http://www.cfp.ca/cgi/content/full/56/4/321>

¹⁰ Moral theologian, William May quotes from, *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* by theologian Germain Griez and philosopher John Boyle who elaborate on this point: “If voluntary euthanasia is legalized without governmental regulation, those who do not wish to be killed beneficently are likely to become unwilling victims; this would deprive them of the protection they currently enjoy under the law of homicide. And since the denial is to serve a private interest and not the common good, it will be an injustice. If voluntary euthanasia is legalized with close governmental regulation, the government will be involved in killing innocent human persons, and those who abhor such killing as gravely immoral will be involved against their wishes, at least to the extent that their government and its institutions will be utilized for this purpose. Since the government’s involvement will be required only as a means of promoting the private interest of those sharing the worldview of euthanasiasts and not the common good, this state action will unjustly infringe the liberty of all who do not consent to mercy killing as a good to whose protection state action might legitimately be directed. A solution involving a compromise between legalization of voluntary euthanasia without government regulation and legalization with close governmental regulation would mean some degree of lessened protection together with some degree of governmental involvement—a situation which will result in injustice partly due to the reduced protection of the lives of those who do not wish to be killed and partly due to the unwilling involvement of those who do not wish to kill or to have their government involved in killing of this kind. Since the stated conditions are all the possible conditions under which voluntary euthanasia could be legalized, legalization is impossible without injustice. Therefore, the legalization of voluntary euthanasia must be excluded by civil law to protect fundamental human rights and liberties” [Here I have summarized the argument developed by Germain Griez and Joseph Boyle in *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*. Notre Dame, IN: University of Notre Dame Press, 1978, pp. 260-265.]

¹¹ Gula, *Euthanasia: Moral and Pastoral Perspectives*,9.

¹² Dougherty, Charles J. "The Common Good, Terminal Illness, and Euthanasia." *Issues in Law & Medicine*. BNET Fall, 1993, July 2010 <http://findarticles.com/p/articles/mi_m6875/is_n2_9/ai_n25021983/pg_5/?tag=content:coll1>

¹³ Dougherty, "The common good, terminal illness, and euthanasia"
<http://findarticles.com/p/articles/mi_m6875/is_n2_9/ai_n25021983/pg_5/?tag=content:coll1>

¹⁴ Callahan, Daniel. "When self-determination runs amok." BNET 03/01/92
<http://findarticles.com/p/articles/mi_go2103/is_n2_v22/ai_n28613052/?tag=content:coll1>

¹⁵ Dougherty, "The common good, terminal illness, and euthanasia".
<http://findarticles.com/p/articles/mi_m6875/is_n2_9/ai_n25021983/pg_3/>

¹⁶ Dougherty," The common good, terminal illness, and euthanasia"
<http://findarticles.com/p/articles/mi_m6875/is_n2_9/ai_n25021983/pg_3/>

¹⁷ Dougherty," The common good, terminal illness, and euthanasia"
,<http://findarticles.com/p/articles/mi_m6875/is_n2_9/ai_n25021983/pg_6/>

¹⁸ Gula, Richard M. "Dying Well: A Challenge to Christian Compassion". Religion On-Line.Org. July 2010.
<<http://www.religion-online.org/showarticle.asp?title=548>>

¹⁹ Callahan, *When self-determination runs amok.*"
<http://findarticles.com/p/articles/mi_go2103/is_n2_v22/ai_n28613052/pg_5/?tag=content:coll1>

²⁰ Beckford, Martin. "Baroness Warnock: Dementia sufferers may have a 'duty to die'" Telegraph .Co. UK. 6:05PM BST 18 Sep 2008. July 2010. < <http://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html>>

²¹ "A terrifying view of human worth" The *Daily Mail On-Line* (London, England). Dec 13, 2004. July 2010.
<<http://www.dailymail.co.uk/news/article-330551/A-terrifying-view-human-worth.html>>

²² Wilkinson, Dominic and Julian Savulescu."Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation." Wiley Interscience Published Online: 3 May 2010.
<http://www3.interscience.wiley.com/cgi-bin/fulltext/123413671/main.html.ftx_abs?CRETRY=1&SRETRY=0>

²³ Wilkinson, Dominic and Julian Savulescu."Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation." Wiley Interscience Published Online: 3 May 2010.
<http://www3.interscience.wiley.com/cgi-bin/fulltext/123413671/main.html.ftx_abs?CRETRY=1&SRETRY=0>

²⁴ Callahan, “[When self-determination runs amok.](#)”
<http://findarticles.com/p/articles/mi_go2103/is_n2_v22/ai_n28613052/?tag=content:coll>

²⁵ Gonzalo, Herranz, “Euthanasia: An Uncontrollable Power Over Death.” *The National Catholic Bioethics Quarterly*. Volume 6, No. 2 Summer 2006. .263-264

²⁶ Caldwell, Simon. “Belgian euthanasia nurses ‘fail to get consent’”. *The Vancouver Sun*. June 9, 2010
<<http://www.vancouversun.com/health/Belgian+euthanasia+nurses+fail+consent/3132473/story.html>>

²⁷ Caldwell, “Belgian euthanasia nurses ‘fail to get consent’”.
<<http://www.vancouversun.com/health/Belgian+euthanasia+nurses+fail+consent/3132473/story.html>>

²⁸ Smith, Wesley J. “Continent Death: Euthanasia in Europe”. *National Review On Line*. December 23, 2003, 1:01 a.m. July 2010 <<http://old.nationalreview.com/comment/smith200312230101.asp>>

²⁹ . Smith, “Continent Death: Euthanasia in Europe”. <<http://old.nationalreview.com/comment/smith200312230101.asp>>

³⁰ Smith, “Continent Death:Euthanasia in Europe.” 23, 200. <<http://old.nationalreview.com/comment/smith200312230101.asp>>

A 2005 report in the on-line version of the *British Medical Journal* states that the Netherlands a review procedure for euthanasia and physician assisted suicide has been in place since 1991. Although the system has increased reporting of VAE/PAS , around half of cases still remain unreported. Non-reporting seems to be associated with a lack of consultation with another doctor which is required by law. *BMJ*. 2005 September 24; 331(7518): 691–693.
<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1226258/>>

³¹ Smith, “Continent Death:Euthanasia in Europe.” <<http://old.nationalreview.com/comment/smith200312230101.asp>>

³² Smith, “Continent Death:Euthanasia in Europe.” <<http://old.nationalreview.com/comment/smith200312230101.asp>>

³³ Welie, Jos VM, “Physician Assisted Suicide and Euthanasia: Some Cautionary Reflections on Two New Developments in The Netherlands”. *Creighton University, Creighton Center for Health Policy and Ethics*. Spring, 2010. July 2010
<<http://chpe.creighton.edu/publications/focus/Spring-2010/euthanasia.htm> >

³⁴ Ganzini, Linda MD, MPH; Elizabeth R. Goy, PhD; Steven K. “Oregonians' Reasons for Requesting Physician Aid in Dying” *Dobscha, MD Arch Intern Med*. 2009;169(5):489-492.

³⁵ Oregon Death With Dignity Act Requirements,
<<http://www.oregon.gov/DHS/ph/pas/docs/Requirements.pdf?ga=t>>

³⁶ **Eighth Annual Report on Oregon’s Death with Dignity Act Department of Human Services Office of Disease Prevention and Epidemiology March 9, 2006. Pp7-8**

³⁷ Dr. Harvey Max Chochinov, OM, MD, PhD, FRCPC writes in *CA: A Cancer Journal for Clinicians* :

Palliative care offers specialized treatment to people whose illness is no longer considered curable. Its primary goals are to provide comfort and care for those with life-limiting illnesses and their families, so that patients are able to die peacefully in the setting of their choice—often their own home—while receiving all necessary nursing, medical, psychosocial, and spiritual care. The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” Embedded within the WHO definition is a commitment to relieving pain and other distressing symptoms, the affirmation of life while regarding dying as a normal process, an intent to neither hasten nor postpone death, an integration of psychological and spiritual aspects of patient care, the provision of support to help patients live as actively as possible until their death, with support being provided to help families cope during their loved ones’ illnesses and into their own bereavement. Whenever possible, palliative care endeavors to enhance the quality of life of patients as they move toward death. Palliative care can be applied at all stages of life-threatening disease and should intensify once cure is no longer deemed possible.

Chochinov, Dr. Harvey Max OM, MD, PhD, FRCPC, "Dying, Dignity, and New Horizons in Palliative End-of-Life Care" *CA: A Cancer Journal for Clinicians* : A Cancer J Clin 2006; 56:84-103. July 2010.
<<http://caonline.amcancersoc.org/cgi/content/full/56/2/84#SEC1>>