

Guidelines for physician-assisted suicide

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Abstract

The article presents the Argument from Autonomy and the Respect for Others Argument as pleas for physician-assisted suicide (PAS). The Kantian argument in support of respecting people always as ends rather than means is emphasized together with the principles of concern and care. The author explains who the patients who wish to die are. The importance of comprehensive palliative care is accentuated and objection to euthanasia is expressed, insisting on checks and balances when we wish to come to the patient's aid. The plea is confined to physician-assisted suicide, where it is the patient who is in control and performs the final act. The plea for PAS is promoted especially for cancer patients, at the end stage of the disease, who express a repeated wish to die with the help of a doctor. Detailed guidelines for physician-assisted suicide are presented, arguing that we need to insist on them as human lives are at stake. Caution is a must to prevent potential abuse.

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Introduction

Empirical research shows very clearly that most people would like to continue living. In my experience of having visited more than 30 hospitals in Israel, England, Canada, USA, Australia, New Zealand, the Netherlands and Belgium, most patients, even in the most dreadful conditions, opt for life – especially, it seems, if they are practising members of the Catholic, Jewish and Islamic faiths [1], but less so in the Netherlands and Flemish Belgium [2, 3].

The general picture is clear: we all possess a zeal for life. Therefore, whenever we are unclear about patients' wishes, the default position we should take is that the patients opt to choose life [4].

Only a small minority of patients expressly wish to die. This article discusses who these patients are, and further emphasises the importance of comprehensive palliative care. I voice my objection to euthanasia, insisting instead on a system of checks and balances that ought to be in place when a physician comes to a patient's aid. This plea is confined to physician-

assisted suicide, wherein the patient themselves perform the final act.

The 'argument from autonomy'

When speaking of death with dignity, the focus of attention is on the rights of the patients over their own body. The notion of autonomy involves the person's ability to reflect upon beliefs and actions, and ability to form ideas about these so as to decide how to lead his or her life. The term 'autonomy' is derived from the Greek *autos* ('self') and *nomos* ('rule,' 'governance,' or 'law'). By deciding between conflicting trends, patients consolidate their opinions more fully and review the ranking of values for themselves. Obviously, to be able to exercise autonomy, patients must have options to choose from; some may be of significance to the patient, others may not. Having options allows people to sustain activities they regard as worth pursuing. As Joseph Raz asserts, a person who has never had any significant choice, or was not aware of it, or has never exercised choice in

significant matters but simply drifted through life, is not an autonomous person [5-9]. Choosing the best option or thinking correctly is not a requirement for autonomy so long as the agent exercises deliberation in assessing the alternatives. The emphasis is not on deciding the 'best' options or on holding 'true' opinions, but on the way in which we come to make our decisions and to hold our convictions.

The liberal state is founded upon the principles of autonomy and individuality: everything stems from the individual, everything returns to the individual. The state is perceived as a developed instrument to help sustain our individuality within a just society. It is far more powerful than a mere individual; it is a tool to enrich individuality, to enable people developing their innate capabilities to facilitate the progress of individuals, which, in turn, will yield societal progress. At the end of life, autonomous people may expect liberal society to address their needs and concerns, provided that these needs and concerns do not harm others, are deemed justified and are done in a *bona fide* manner.

The view that holds we should always preserve life no matter what the patient wants, and that patients who opt to die are unable to comprehend their own interests in a fully rational manner, and that therefore we know what is good for those patients better than they do, is morally unjustifiable because it ignores patients' desires and fails to acknowledge that the preservation of dignity may be valued more by some patients than the preservation of life. We must strive to reconcile the duty of keeping patients alive with their right to keep their dignity, which may also be considered as an intrinsic value. Therefore, the request for assisted dying may be justified; it has a place in the framework of liberal-democracy, which should not turn a blind eye to such appeals. It should not desert its patients and should attempt to accommodate their needs.

The 'respect for others' argument

This argument is derived from the Kantian deontological school that accords all people equal respect. Respect for a person means conceiving of the other as an end rather than as a means to something. As Immanuel Kant explains, a limit is imposed on all

arbitrary use of people who are thus objects of respect. A person is, therefore, an objective end; such an end, Kant maintains, "is one for which there can be substituted no other end to which such beings should serve merely as means, for otherwise nothing at all of absolute value would be found anywhere" [10].

According to Kant, to respect a person is to treat her as a human being, as an autonomous being who acts in recognition of the moral law. The assumption is that beings are moral, and Kant demands that people act in accordance with the Categorical Imperative: "act only on the maxim that can be universalized and that always treat humanity, yourself and others, as an end". In formulating his Categorical Imperative, Kant recognized that each person has an inviolable dignity, which is the reason for respecting other people. The Categorical Imperative refers to the will itself, not to anything that may be achieved by the causality of the will. Morality, according to Kant, cannot be regarded as a set of rules prescribing the means necessary to achieve a given end, whether the end be general happiness, human perfection, self-realization, or anything else. The postulate, "you ought never to tell lies" is an example of the Categorical Imperative. There is no way of evading the command or the moral requirement of practical reason that it expresses, for no end is mentioned and there is therefore no end that can be given up. (See [11-13] for further discussion.)

Kant does not speak of the process of decision-making. In contrast, I wish to emphasize the process of reaching a decision. In this process we exercise our faculties, using concepts, categories, principles, norms, and to some degree - whether we like it or cannot help it - our emotions. We construct and deconstruct realities, converse and exchange ideas, listen to the advice of others, and share our opinions with people we appreciate. At least on matters of importance, we strive to reach the right decision. As long as people accept the two basic principles underlying a liberal society: respect for others and not harming others, we accord others respect when we respect their right to make decisions because they are *their* decisions, regardless of our opinions of them. We assume that each person holds her own course of life as intrinsically valuable, at least for herself, and in most cases we respect the individual's reasoning. (On some issues the liberal state adopts a paternal

approach that overrides individual decision-making: see [14, 15].)

We should give equal consideration to the interests of others and should grant equal respect to the others' life projects, so long as these do not deliberately undermine the interests of others by interfering in a disrespectful manner. As John Rawls asserts, "the public culture of a democratic society" is committed to seeking forms of social cooperation that can be pursued on a basis of mutual respect between free and equal persons [16-18].

Kant's line of reasoning should be supplemented by our emphasis on the notion of concern. We not only respect people, but we also care for them. Kant wanted to base his reasoning on logic, attempting to exclude emotional worries, but we need to acknowledge that peoples' acts are often dictated by emotions. Human nature enables us to rationalize but it is often controlled by emotional drives. Thus, it is not sufficient to speak only of respect: we should also speak of concern [19-23].

The notion of 'concern' signals the value of well-being: we ought to show equal concern for each individual's good. Treating people with concern means treating them with empathy; viewing people as human beings who may be furious and frustrated, capable of smiling and crying, of careful decision-making and impulsive reactions. 'Concern' does not demand giving equal weight, utilitarian fashion, to the welfare of a stranger as to the welfare of a person's children [24]. Instead, it means giving equal weight to a person's life and autonomy.

Medical staff should do nothing that might impair the patients' dignity in keeping them alive. Some situations present grave difficulties, but physicians and nurses are said to give their foremost concern to preserving the dignity of gravely-ill people. They take care of them; they clean them; they treat bodies that do not communicate with them as human beings. Physicians acknowledge that the introduction of tubes causes discomfort and may be painful to conscious patients. Any interference with the wholeness of the human body may be perceived as infringement of dignity. However, as long as patients are not perceived as a means to something, and the prevailing view regarding patients is as objective ends, the attitude towards patients can be said to respect their

dignity. This view perceives the patient's existence in itself as an end. Preserving patients' dignity requires that no other object can be substituted for such an end.

Generally speaking, the common denominator among patients expressing a desire to die with dignity is a strong sense of autonomy. We are unable to control the moment we are born but we are able, to an extent, to control the moment we depart life. These patients insist on having this right: they wish to control the moment of their death and ask to die when life has lost its appeal for them. To them, continuous life is perceived to be disrespectful and agonizing, and they approach the medical profession for help because they wish the procedure to succeed first time, rather than take the risk that they might be forced to live with the deteriorated consequences in the event that their suicide attempt goes wrong. In Oregon, research over the past few years has consistently showed that the most frequently mentioned end-of-life concerns are loss of autonomy, a decreasing ability to participate in activities that made life enjoyable, and loss of dignity [25-30].

Patients who wish to die are usually inflicted with degenerative, incurable and painful diseases. They are gravely ill people who know that death is near, and who wish to cease their fight against it. Weighing the continuation of life against death they see more advantages in departing life than in maintaining it. In the Netherlands [31-34] and Belgium [35-38] most of the people who approach physicians with requests for physician-assisted suicide (PAS) and euthanasia are cancer patients. Cancer is a painful disease that inflicts significant suffering [39-42]. Many patients do not wish to fight against it for too long.

For some strong-willed, suffering patients physician-assisted suicide is a solution. They would like to decide the time of their death. Only they can say: "Enough is enough. Now it is time to say goodbye, because I can no longer cope with my state, and because medicine does not have a cure for me." Physician-assisted suicide can be the solution, especially for suffering cancer patients, at the last stage of their lives. It is humane to cater for these people, enabling them to die in their own bed, in the company of their loved-ones. Respecting those patients dictates honouring their request to end their life-journey.

One of the conclusions I have reached during my 20+ years of research is to advocate voluntary physician-assisted suicide and not active euthanasia. Dutch people do not pay much attention to the distinction between the two, although it is viable. Physician-assisted suicide gives patients control until the very last moment of their lives, prevents possible abuse, and assures that they genuinely want to die. In most cases, patients are able to carry out the final act to terminate their lives. In rare occasions of complete paralysis or suffocation to death, when the patient is absolutely unable to move a muscle, only then may the doctors complete the final 'act of mercy' [1, 2]. It is one thing to support euthanasia on general moral principles, and quite another to support it in the face of reality. Ethically speaking, one may support euthanasia. Practically speaking, I do not, and as we are talking about end-of-life care, practical considerations outweigh unfounded, purely philosophical arguments. Indeed, for a number of years I supported euthanasia, believing in the fundamental right of patients to seek unqualified help from their physicians. However, I was forced to

change my views after fieldwork in the Netherlands and Belgium, the two countries that have legalized euthanasia. A fine line distinguishes theoretical principles and health policy. To date, health policy in both countries is insufficient to prevent abuse. Every year, a worrying number of patients are killed without a pronounced wish to die [35, 43-48]. I cannot support such a system. Thus my plea is confined to physician-assisted suicide, where the patient performs the final act, not the physician.

Guidelines for physician-assisted suicide (PAS)

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. The following is a circumscribed plea for voluntary physician-assisted suicide on their behalf.

Guidelines for physician-assisted suicide

1. Physicians are best equipped in terms of knowledge and expertise to provide aid-in-dying. It is the only profession that could come to patients' aid when they insist on their right to die. The medical profession is in flux. Rapid scientific and technological progress, the rise of chronic disease, the ability to keep chronic patients alive for many years, and the democratization of knowledge are all important in the shaping of medicine. The medical profession should be attentive to wishes of all patients, and strive to accommodate their wishes. In this context, the Croatian Medical Chamber's Code of Medical Ethics and Deontology (2006) holds that: "one of the primary obligations upon a medical doctor who has a patient in care is to relieve that patient's pain and suffering. That is especially important in providing treatment and care to terminally ill and dying patients" [49].
2. 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 the trust between the physician and the patient, conveying to patients that the doctor is giving up on them and values their lives only to the extent of offering assistance to die. Such an offer might undermine the will to live and to explore further avenues for treatment. Many Dutch researchers and physicians do not see this issue as a significant one [50-52]. Some of them consider it important to raise the issue when it seems as though patients would not dare to initiate it on their own. Undoubtedly, however, all people in the Netherlands are aware of the availability of euthanasia and physician-assisted suicide. Any reluctance shown by patients in regard to this issue should be honoured and respected.

3. The request for physician-assisted suicide of a competent adult patient suffering from an intractable, incurable and irreversible disease must be voluntary [53, 54]. The patient should state this wish repeatedly over a period of time. We must verify that the request for physician-assisted suicide does not stem from a momentary urge; an impulse or a product of passing depression. This emphasis of enduring request was one of the requirements of the abolished Northern Territory law in Australia [55], and is one of the requirements of the Oregon Death with Dignity Act [56] as well as of the Dutch and Belgian legal guidelines [57]. It should be ascertained with a signed document that the patient is ready to die now, rather than depending solely upon 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 that the patient is capable, is acting voluntarily, and is not being coerced to sign the request [56]. Individuals may express general attitudes regarding end of life in an informal discussion made in a social setting, possibly saying that they would not want to live if they were unable to function alone and had to depend on the mercy of others. However, such hypothetical observations do not constitute reliable evidence of a patient's current desires once an 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 state of pain, degradation and hopelessness, 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, and to struggle to sustain life. This tendency grows as the body weakens. Many people change their minds when they confront the unattractive alternatives, preferring to remain in what others term the "cruel" world, and continue the Sisyphean struggle for their lives.
4. Thus the patient can rescind at any time and in any manner. This provision was granted under the Australian Northern Territory Act [70] and under the Oregon Death with Dignity Act [56]. Chapter III, Article 4 of the Belgian Euthanasia Law says that patients can withdraw or adjust their euthanasia declaration at any time [71].
5. At times, the patient's decision might be influenced by severe pain. The Oregon Death with Dignity Act requires the attending physician to inform the patient of all feasible alternatives, including comfort care, hospice care and pain control [56, 58, 59].
6. The patient must be informed of the situation and the prognosis for recovery or escalation of the disease, with the suffering that it may involve. There must be an exchange of information between doctors and patients (On this issue, see [56; section 3]. Many bill proposals to legislate PAS in the United States specify certain information that must be communicated by the physician to the patient before honouring his or her request.) [54, 56].
7. It must be ensured that the patient's decision is not a result of familial or environmental pressures. At times, patients may feel that they constitute a burden on their loved ones. It is the task of social workers to examine patients' motives and to assess to what extent they are affected by various external pressures (as opposed to a truly 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 patients toward their loved ones are not relevant to the decision-making process [60-62].

8. The decision-making process should include a second opinion in order to verify the diagnosis and minimize the chances of misdiagnosis, as well as to allow the discovery of other medical options. A specialist, who is not dependent on the first doctor, either professionally or otherwise, should provide the second opinion [3, 54, 63]. A Dutch study revealed that the nature of the relationship with the consultant in the euthanasia decision-making process was sometimes unclear. The consultant was reported to have been an unknown colleague (39%), a known colleague (21%), other (25%), or not clearly specified in the report (24%). Review committees relatively often scrutinized the consultation process (41%) [64]. One Belgian survey revealed that 27% of physicians think that euthanasia is a private matter that does not need to be controlled by the Control and Evaluation Commission [65]. The patient's attending physician, who supposedly knows the patient's case better than any other expert, must be consulted, and 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 subsequently confirm, in writing, the attending physician's diagnosis that "the patient is suffering from a terminal disease." Furthermore, the consulting physician must verify that the patient is capable, is acting voluntarily, and has made an informed decision [56]. The American Medical Association (AMA)'s council on ethical and judicial affairs suggests the participation of consultants to facilitate discussions that would help the parties reach a course of action. AMA strongly objects to PAS [66]. The Northern Territory Rights of Terminally Ill Act required that a physician who specialized in treating terminal illness examine the patient [55].
9. It is advisable for the identity of the consultant to be determined by a small committee of specialists who will review the requests for physician-assisted suicide. This is in order 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." For further discussion in this context, see [67-69]).
10. Some time prior to the performance of physician-assisted suicide, a doctor and a psychiatrist are required to visit and examine the patient so as to 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 family members in the room in order to avoid familial pressure. A date for the procedure is then agreed upon. The patient's loved ones will be notified so that they can be present right until the performance of the act, making the day an intimate, family occasion.
11. 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 protocol would serve as a safety valve against possible abuse. Perhaps a public representative should also be present during the entire procedure, including the decision-making process and the performance of the act. This extra caution should ensure that the right to die with dignity does not become a duty, and it will contribute to reporting of cases. The experiences of both the Netherlands and Belgium raise alarm, as many end-of-life cases are not reported. In Belgium, only one out of two euthanasia cases is reported to the Federal Control and Evaluation Committee [36, 72, 73]. The doctor performing the assisted suicide should be the one who knows the patient best, having been involved in the patient's treatment, taken

part in the consultations, and verified through the help of social workers, nurses and psychologists that PAS is the true wish of the patient.

12. Physician-assisted suicide may be conducted in one of three ways, all of them discussed openly and decided upon by the physician and the patient together: (1) oral medication; (2) self-administered, lethal intravenous infusion; (3) self-administered lethal injection. 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 is provided and the dying process is lingering on for long hours, the physician is allowed to administer a lethal injection [74].
13. 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 incentive and no special payment that might cause commercialization and promotion of such procedures.
14. There must be extensive documentation in the patient's medical file, including the following: diagnosis and prognosis of the disease 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 her request; documentation of discussions with the patient's loved ones; and a psychological report confirming the patient's condition. This meticulous documentation is meant to prevent exploitation of any kind - personal, medical, or institutional. Each report should be examined by a coroner following completion of the physician-assisted suicide. Directive 6 in The General Manager Circular, Israel Ministry of Health (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." [75-77].
15. Pharmacists should also be required to report all prescriptions for lethal medication, thus providing a further check on physicians' reporting [78].
16. Doctors must not be coerced into taking actions that contradict their conscience or their understanding of their role.
17. The local medical association should establish a committee, whose role will be not only to investigate the underlying facts that were reported but also to investigate whether there are "mercy" cases that were not reported and/or that did not comply with the Guidelines.
18. Licensing sanctions will be taken to punish those health care professionals who violate the Guidelines, fail to consult or to file reports, engage in involuntary termination of life without the patient's consent or with patients lacking proper decision-making capacity. Physicians who fail to comply with the above Guidelines will be charged and procedures to sanction them will be brought by the Disciplinary Tribunal of the Medical Association. The maximum penalty for violation of the Guidelines will be the revocation of the physician's medical license. In the event that this penalty proves insufficient in deterring potential abusers, there will be room to consider further penalties, including heavy fines and prison sentences.
19. An annual report should be published documenting all cases of aid-in-dying. The reports should be made available to the public. Discussions and debates about their findings should be promoted and encouraged.

Conclusions

Treating patients with respect means treating them as human beings who are capable of forming and acting on intelligent conceptions of how their lives should be lived. Respecting a person involves giving credit to the other's ability for self-direction; acknowledging the other's competence to exercise discretion when deciding between available options. Accordingly, each person is viewed as speaking from that person's point of view, having perceived interests in his or her own way. We may be asked to give our opinions, or decide to express our views anyway; nevertheless, in many instances we recognize the other's right to make choices. This notion of autonomy is crucial in our considerations. The medical profession is required to respect the wishes of certain incurably ill patients.

While most patients prefer to continue living even when their health deteriorates significantly, some patients would rather die. The medical profession should not turn its back to these patients. The medical profession should cater to the needs of all patients, not only some of them. It should be cognizant of their self-perception and their subjective view of their dignity. The thesis is that patients, as autonomous moral agents, deserve to be treated with dignity and respect until the very last day of their lives. To do this requires an acknowledgement of their choices and life decisions. If a patient decides that her life is no longer worth living, we should respect that decision and not compel her to live. Coercion *qua* coercion is repulsive. At the same time, a voice of caution is raised in the conducting of mercy killing, thus detailed Guidelines are required to prevent abuse. As human life is at stake, caution is simply a must.

References

1. Cohen-Almagor R. *The right to die with dignity: an argument in ethics, medicine, and law*. Piscataway, NJ: Rutgers University Press; 2001.
2. Cohen-Almagor R. *Euthanasia in the Netherlands: the policy and practice of mercy killing*. Dordrecht: Springer-Kluwer; 2004.
3. Cohen-Almagor R. Euthanasia policy and practice in Belgium: critical observations and suggestions for improvement. *Issues Law Med*. 2009;24(3):187-218.
4. Israel Dying Patient Law, Chapter C, Section 4 (December 15, 2005).
5. Raz J. *The morality of freedom*. Oxford: Clarendon Press; 1986, p. 204.
6. Childress JF. *Practical reasoning in bioethics*. Bloomington and Indianapolis: Indiana University Press; 1997. p. 59-68.
7. Cohen-Almagor R. *The boundaries of liberty and tolerance*. Gainesville, FL: University Press of Florida; 1994., Chapter 1.
8. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. New York, NY: Oxford University Press; 1994. p. 120-32.
9. Sumner LW. *Assisted death*. New York, NY: Oxford University Press; 2011.
10. Kant I. *Foundations of the metaphysics of morals*. White Beck L, translator. Indianapolis: Bobbs-Merrill Educational Publishers; 1969. p. 52-3.
11. Kemp J. *The philosophy of Kant*. Oxford: Oxford University Press; 1979. p. 58.
12. Guyer P. *Kant's system of nature and freedom*. Oxford: Clarendon Press; 2005.
13. Jost L, Wuerth J, editors. *Perfecting virtue: new essays on Kantian ethics and virtue ethics*. Cambridge: Cambridge University Press; 2011.
14. Mill JS. *Principles of political economy*. Book 5: On the influence of Government. London: Longmans, Green, Reader and Dyer; 1869. p. 479-91.
15. Cohen-Almagor R. Between autonomy and state regulation: JS Mill's elastic paternalism. *Philosophy*. 2012;87(4):557-82.
16. Rawls J. Liberty, equality, and law. In: McMurrin SM, editor, *Tanner lectures on human values*. Cambridge, England: Cambridge University Press; 1987. p. 1-87.
17. Rawls J. Justice as fairness: political not metaphysical. *Philosophy Public Affairs*. 1985;14(3): 223-51.
18. Rawls J. Fundamental ideas. In: *Political liberalism*. New York: Columbia University Press; 1993. p. 3-46.
19. Dworkin RM. *Taking rights seriously*. London: Duckworth; 1977. p. 150-183, 266-78.
20. Dworkin RM. *Liberalism*. In: *A matter of principle*. Oxford: Clarendon; 1985. p. 181-204.
21. Dworkin RM. *Justice for hedgehogs*. Cambridge, Mass: Belknap; 2011.
22. Buchanan AE. Assessing the communitarian critique of liberalism. *Ethics*. 1989;99:879.
23. Abel RL. *Speaking respect, respecting speech*. Chicago: University of Chicago Press; 1998.
24. Griffin J. *Well being*. Oxford: Clarendon Press; 1986. Chapter IX.
25. Oregon.gov. *Death with Dignity Act 2013* [Internet]. Available from: <http://public.health.oregon.gov/ProviderPartnerResource>

s/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

26. Oregon.gov. Oregon's Death with Dignity Act 2011 [Internet]. Available from: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>.
27. Oregon Department of Human Services. Eighth annual report on Oregon's Death with Dignity Act [Internet]; 2006. Available from: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf>.
28. Oregon.gov. Oregon's Death with Dignity Act - 2007 [Internet]. Available from: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year10.pdf>.
29. Oregon.gov. 2008 Summary of Oregon's Death with Dignity Act [Internet]. Available from: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year11.pdf>.
30. Oregon.gov. 2009 Summary of Oregon's Death with Dignity Act [Internet]. Available from: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year12.pdf>.
31. van der Maas PJ, van der Wal G, Haverkate I, de Graaff CL, Kester JG, Onwuteaka-Philipsen BD, et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. *N Eng J Med*. 1996;335(22):1699-705.
32. Onwuteaka-Philipsen BD, van der Heide A, Koper D, Keij-Deerenberg I, Rietjens JAC, Rurup ML, et al. Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet*. 2003;362:395-9.
33. van der Heide A, Onwuteaka-Philipsen BD, Rurup ML, Buiting HM, van Delden JJ, Hanssen-de Wolf JE, et al. End-of-life practices in the Netherlands under the Euthanasia Act. *N Engl J Med*. 2007;356(19):1957-65.
34. LivingAndDyingWell.org.uk. Dutch regional euthanasia review committees: 2009 annual report [Internet]. Available from: <http://www.livinganddyingwell.org.uk/publications/research/dutch-regional-euthanasia-review-committees-2009-annual-report>.
35. Deliens L, Mortier F, Bilsen J, Cosyns M, Vander Stichele R, Vanoverloop J, et al. End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. *Lancet*. 2000;356:1806-11.
36. Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. *BMJ*. 2010;341:c5174.
37. Deliens L, van der Wal G. The Euthanasia Law in Belgium and the Netherlands. *Lancet*. 2003;362:1239-40.
38. Cohen-Almagor R. "Belgian euthanasia law: a critical analysis. *J Med Ethics*. 2009;35(7):436-9.
39. Chow E, Merrick J, editors. Advanced cancer, pain and quality of life. Hauppauge, NY: Nova Science Publishers Inc; 2010.
40. Bruera ED, Portenoy RK, editors. Cancer pain: assessment and management. Cambridge: Cambridge University Press; 2009.
41. HealthCommunities.com. Cancer Pain Overview: Overview of Cancer Pain, and Incidence & Prevalence of Cancer Pain [Internet]. Available from: <http://www.healthcommunities.com/cancer-pain/cancer-pain-overview.shtml>.
42. Cancer-Pain.org. Cancer pain treatments [Internet]. Available from: <http://www.cancer-pain.org/treatments/treatments.html>.
43. Telegraph.co.uk. Beckford M. Fearful elderly people carry 'anti-euthanasia cards' [Internet]. The Telegraph; 2011. Available from: <http://www.telegraph.co.uk/health/healthnews/8466996/Fearful-elderly-people-carry-anti-euthanasia-cards.html>.
44. PJSaunders.Blogspot.co.uk. Euthanasia of woman with advanced dementia in Netherlands sounds loud warning to Britain [Internet]. Christian Medical Comment; 2011. Available from: <http://pjsaunders.blogspot.co.uk/2011/11/euthanasia-of-woman-with-advanced.html>.
45. DailyMail.co.uk. Nelson S. Senile 64-year-old Dutch woman is euthanised even though she was no longer able to express her wish to die [Internet]. Mail Online; 2011. Available from: <http://www.dailymail.co.uk/news/article-2059444/Senile-64-year-old-Dutch-woman-euthanised-longer-able-express-wish-die.html?ito=feeds-newsxml#>.
46. Beekman W. The self-chosen death of the elderly. Naarden, NL, America Star Books; 2011.
47. Chambaere K, Bilsen J, Cohen J, Onwuteaka-Philipsen BD, Mortier F, Deliens L. Physician-assisted Deaths under the Euthanasia Law in Belgium: a population-based survey. *CMAJ*. 2010;182(9):896.
48. Bilsen J, Vander Stichele R, Mortier F, Bernheim J, Deliens L. The incidence and characteristics of end-of-life decisions by GPs in Belgium. *Fam Pract*. 2004;21(3):283-6.
49. Juric H. Euthanasia in the context of the Croatian healthcare system, legislation and bioethical discussions. In: Jansen BES, Gasic N, editors. Croatia: Politics, legislations, patients' rights and euthanasia: law, public health care system and society. Munich, Martin Meidenbauer Verlagsbuchhandlung; 2011. p. 93-115.

50. Obstein KL, Kimsma G, Chambers T. Practicing euthanasia: the perspective of physicians. *J Clin Ethics*. 2004;15(3):223-31.
51. Shalowitz D, Emanuel E. Euthanasia and physician-assisted suicide: implications for physicians. *J Clin Ethics*. 2004;153:232-6.
52. Cohen-Almagor R. Should doctors suggest euthanasia to their patients? Reflections on Dutch perspectives. *Theoret Med Bioethics*. 2002;23(4-5):287-303.
53. Griffiths J, Bood A and Weyers H. Euthanasia and law in the Netherlands. Amsterdam: Amsterdam University Press; 1998. p. 66.
54. The Belgian Euthanasia Law. <http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=59>
55. Rights of the Terminally Ill Act (1995) (NT), <http://www.nt.gov.au/lant/parliamentary-business/committees/rott/rott95.pdf>
56. Oregon Death with Dignity Act, Oregon Revised Statutes, Vol. 8 (1998 Supplement),
57. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002, <http://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf>; Belgian Euthanasia Law 2002, <http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=59>
58. Cohen-Almagor R, Hartman MG. The Oregon Death with Dignity Act: review and proposals for improvement. *J Legislation*. 2001;27(2):269-8.
59. Schatman ME, Campbell A, editors. Chronic pain management: guidelines for multidisciplinary program development. New York, NY: Informa Healthcare; 2007.
60. Cohen-Almagor R. The patient's right to die in dignity and the role of their beloved people. *Ann Rev Law Ethics*. 1996;4:213-32.
61. Hardwig J. Families and futility: forestalling demands for futile treatment. *J. Clin Ethics*. 2005;16(4):328-37.
62. Casarett DJ. Last acts: discovering possibility and opportunity at the end of life. New York, NY: Simon and Schuster; 2010.
63. Cohen-Almagor R. First do no harm: pressing concerns regarding euthanasia in Belgium. *Int J Law Psychiatry*. 2013;36:515-21.
64. Buiting H, van Delden J, Onwuteaka-Philipsen B, Rietjens J, Rurup M, van Tol D, et al. "Reporting of euthanasia and physician-assisted suicide in the Netherlands: descriptive study. *BMC Med Ethics*. 2009;10:18.
65. Smets T, Cohen J, Bilsen J, van Wesemael Y, Rurup ML, Deliens L. Attitudes and experiences of Belgian physicians regarding euthanasia practice and the euthanasia law. *J Pain Symptom Manage*. 2011;41(3):580-93.
66. Charatan F. AMA issues guidelines on end of life care. *BMJ*. 1999;318:690.
67. Deschepper R, Vander Stichele R, Bernheim JL, De Keyser E, Van Der Kelen G, Mortier F, et al. Communication on end-of-life decisions with patients wishing to die at home: the making of a guideline for GPs in Flanders, Belgium. *Br J Gen Pract*. 2006;56:14-9.
68. Jansen-van der Weide MC, Onwuteaka-Philipsen BD, Van der Wal G. Implementation of the project Support and Consultation on Euthanasia in The Netherlands (SCEN). *Health Policy*. 2004;69(3):365-73.
69. de Diesbach E, de Loze M, Brochier C, Montero E. Euthanasia in Belgium: 10 years on. Brussels, European Institute of Bioethics; 2012.
70. Plattner AL. Australia's Northern Territory: the first jurisdiction to legislate voluntary euthanasia, and the first to repeal it. *DePaul J Health Care Law*. 1997;1:648.
71. Chamber of the Representatives of Belgium, Government Bill Related to Euthanasia (November 5, 2001), Doc 5014488/001, project transmitted by the Senate.
72. BioEdge.org. Cook M. Steep rise in official Dutch euthanasia [Internet]. BioEdge Report; 2010. Available from: http://www.bioedge.org/bioethics/steep_rise_in_official_dutch_euthanasia/9297
73. Le Soir, "Rise in assisted deaths", *Presseurop* (August 23, 2011),
74. Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der Wal G. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med*. 2000;342(8):551-6.
75. Directive 6, The General Manager Circular, Israel Ministry of Health, no. 2/96 (January 31, 1996) p. 12 (Hebrew).
76. Israel Patients' Rights Law. Chapter E: medical documentation and medical information. 1996(1591):331.
77. Suyver JJH. Regional euthanasia review committees: 2009 annual report. The Hague; May 2010.
78. Bilsen J, Bauwens M, Bernheim J, Stichele RV, Deliens L. Physician-assisted death: attitudes and practices of community pharmacists in East Flanders, Belgium. *Palliat Med*. 2005;19:151-7.