ENGLISH1101

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Death With Dignity

Today, American society is obsessed with the young and successful and their endless pursuit of beauty, fame, and fortune. People are bombarded with images of youth in movies, music, and ads for ordinary items such as toothpaste. Advertisers create the illusion that people can forever defer death by plastering "anti-aging" across drugstore aisles to sell their products. In the search for eternal youth, people become desensitized to the importance of life's inevitable end. Every day, countless people quietly pass away after long and painful struggles with terminal illnesses, and their loved ones are often reduced to helpless observers. Terminally ill patients are not merely a statistic; they are mothers, fathers, children, friends, and lovers who leave behind many distraught loved ones in death. By continuing to prohibit assisted suicide, the law denies many terminally ill patients the peaceful death they desire. Instead, patients must waste away slowly and endure constant pain, unless they have powerful and expensive medications to dull their senses. However, no amount of medication can remedy emotional pain, and patients sometime feel helpless and alone because death is their only release from suffering (Girsh 3). The law cannot rightfully ignore the special circumstances of terminal illnesses and deny people a dignified death simply because they retain brain function. Terminally ill patients need an option to prevent spending their final days, months, or years painfully deteriorating as they approach their inevitable deaths.

Throughout the controversy, the public has focused on moral aspects of assisted suicide and overlooked the fact that one form has already been in practice for nine years. Oregon voters approved the Oregon Death with Dignity Act in 1994, but a legal injunction delayed implementation until voters approved the law again in 1997. The law allows physicians to prescribe drugs to terminally ill patients who request to end their lives. Attorney General John Ashcroft attempted to invalidate the Oregon Death with Dignity Act in 2001, and the judicial system met his requests with multiple restraining orders. Ashcroft subsequently appealed to the Supreme Court, and the justices voted to uphold the law in January 2006. Ashcroft's actions sparked public disapproval because a majority of the American public approved of the statute at the time. In early 2002, a poll indicated that only 35% of people approved of his actions while 58% disapproved of them (*The Harris Poll* 2002). Due to the strength of the Oregon Death with Dignity Act's provisions, no people have reported abuses or mis-diagnoses since its implementation (Oregon Department of Human Services Report, 1994-2005). Explaining the Oregon Death with Dignity Act to the national level will remedy the controversy of assisted suicide by providing an option for terminally ill patients, implementing adequate safeguards against abuse, and protecting physicians against wrongful prosecution.

Despite the common assertion that assisted suicide is immoral and unnecessary under any circumstances, people suffering from terminal illnesses desperately need options. People in American society have the well-recognized right to withdraw from life support or reject medical treatment without explanation. If people are lawfully allowed to end their lives by starving or depriving themselves of medical treatments, people logically should be allowed to die by taking

medication designed to end their lives in a peaceful manner. The pill prescribed under the Oregon Death with Dignity Act causes no pain; the patient loses consciousness, slips into a coma, and dies peacefully (*Death with Dignity National Center*). Providing an option for terminally ill patients not only relieves them of pain and suffering, but also dissolves the uncertainty and fear associated with wasting away slowly. Faye Girsh, the former director of the Hemlock Society USA, describes the general American sentiment about death:

> . . . most of us hope to be fortunate enough to experience a "good death" when we have to die, and to be spared an agonizing ordeal at the very end. Many of us hope that if we do end up in such unfortunate circumstances, we [can have] . . . a relatively quick and painless death. (3)

A terminally ill patient can choose a "quick and painless death" with assisted suicide; otherwise, he or she faces a future involving an indefinite amount of pain and suffering and culminating in an uncertain death. Without control over their deaths, terminally ill patients can become overwhelmed and sometimes opt for violence that hurts the ones they love. Girsh explains their thought process, stating that "some terminally ill people end their lives while they can, often prematurely, fearing there will be no way to do it if they wait too long. Without the reassurance that someone will be there to help, people often commit suicide and use the wrong methods" (3). Assisted suicide is a necessary option to protect both the terminally ill and their loved ones from unnecessary pain, and with today's medical rights, prohibiting the right to end lives with prescribed pills is illogical.

The Oregon Death with Dignity Act also provides a strong series of safeguards to present the misuse of assisted suicide. Provision 172.820 requires two physicians to confirm that a patient is terminally ill and mentally sound, and they also must confirm that the patient is acting voluntarily and is well-informed about other options. The provision prevents people who are suffering from depression or other treatable ailments from ending their lives and forces physicians to ensure that nobody can undergo assisted suicide without understanding what they are consenting to. However, the physicians' judgment is not enough to allow a patient to end his or her life. People who request assisted suicide also must prove that they are capable of making decisions by repeatedly vocalizing and notarizing their desire to die. The law defines the nature of requests in Provision 127.840:

> In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request.

Additionally, two witnesses must be present during the requests, and one of them cannot be a relative or a representative from a facility where the patient is being treated (127.810). The patient's attending physician is ineligible to sign as a witness at any stage of the process, but he or she must also be present during the requests. The restrictions protect patients from people who would gain from their death and help physicians ensure that their decisions are voluntary. The fifteen day waiting period between the original request and the reiteration gives patients time to reflect on their decision and possibly rescind their request. The waiting period also gives physicians time to fully explain all other options, like hospice care, so the patient does not feel

pressured into assisted suicide as a last resort. The Oregon death with Dignity Act effectively provides the option of assisted suicide and protects the patient from abuse with detailed and universally applicable safeguards.

The Oregon Death with Dignity Act clearly establishes patient/physician rights and their boundaries to protect physicians willing to provide life-ending medication to the terminally ill. Provision 127.820 prevents physicians from encouraging patients to undergo assisted suicide by requiring two physicians to verify separately that a patient is terminally ill and sensible enough to choose assisted suicide on their own. The provision also relieves physicians of liability for their patients' actions by removing them from the actual decision and limiting their influence on it. Furthermore, the requirement that the patient take the medication his or herself removes the physician from the cause of death altogether. Under the Oregon Death with Dignity Act, a physician is allowed to prescribe the medication and give it to the patient, but he or she cannot directly administer the medication to the patient and cause his or her death. Additionally, since patients are free to refuse the medication at any time, physicians cannot force the patient to take the medication and end his or her life. The right to refuse medication is described in Provision 127.845, which states the following:

> A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication . . . may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

The patient's right to rescind his or her request also relieves pressure to "complete" the death process if the patient decides he or she wants to live the last moment. By regulating both the patient and physician responsibilities in assisted suicide, the Oregon death with Dignity Act protects physicians from wrongful prosecution and relieves fears of unlawful deaths.

One of the principle arguments offered by opponents of assisted suicide constitutes the fear that patients will be wrongly encouraged by their physicians to choose assisted suicide. As mentioned previously, the provisions of the Ohio Death with Dignity Act restrict physicians' influence by separating them from the patient's choice to undergo assisted suicide. Opponents of assisted suicide exploit the negligible influence physicians have over their patients to convince the public that assisted suicide leads to active euthanasia. They also claim that physicians can abuse the privilege to the point that they are, in essence, murdering people by euthanizing those who do not wish to die. The argument that once physicians are given the power to end lives they will carelessly or maliciously "murder" people, exhibits fallacious slippery slope logic, which is stating that one event will eventually follow another without proving that the second event is inevitable. In reality, the increasing costs of American medicine may be a motive for physicians to end lives, but pressure from family members takes precedence. The patient is more likely to feel pressured by the "burden" he or she is placing on family members by undergoing "futile" and expensive treatments rather than encouragement from a physician to consider the option (Levinson 2). In addition to barring relatives from being witnesses, Provision 127.897 requires patients to sign a lengthy waver clearly affirming their will to die. One paragraph requires them to acknowledge the following: "I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control." The affidavit also requires the patient to state that the physician is not influencing his or her decision, which

ultimately ensures that no outside influences are pressuring the patient into suicide. Therefore, arguments stating that other people can force a patient to his or her death through assisted suicide are inherently flawed.

American society must conquer its fears and confusion about what is "moral" and stop confusing morality with justice in order to provide a necessary option to terminally ill patients. The issue is not about the morality of ending a life, it is not about power, and it is not even about what is right; the issue is about how people view the end of a life. If the general public continues to believe that a long and painful death cannot or should not be averted, terminally ill patients will continue to die undignified deaths. If people can look past the boundaries of morality and face the fear surrounding death, they will support peaceful ends to life and control over death when possible. People must consider the situation of terminally ill patients over their personal convictions and abolish the boundaries keeping them from having a peaceful end to their lives.

Works Cited

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