

Okay – college essay



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? Euthanasia The word " euthanasia" comes from combining two greek words: " Eu" meaning " good", and " thanatos" meaning " death". So euthanasia actually means " good death. " The idea is that a death is good if it is painless. Now an important distinction must be made: not all painless deaths are euthanasia. Only those deaths in which an individual directly causes the death of another as a means of eliminating that other person's pain are euthanasia.

For example, if a doctor lethally injects a paraplegic who has many years to live but asks to be put to death because he can't stand the psychological distress of not having his full mobility-that's a case of euthanasia. However, a case of someone who dies normally from a disease (for example, from cancer) while under sedation (so that this person does not feel pain) is not euthanasia. In short: euthanasia involves killing the patient to eliminate the pain, while normal end-of-life care involves eliminating the pain so that the patient can die painlessly, from natural causes (e. . disease or old age).

Nobody is against eliminating the pain when a patient is dying. But everyone should be against killing the patient as a means of eliminating pain. Some people think they are for euthanasia because they are for allowing a patient to refuse treatment for a terminal illness when that treatment is judged disproportionate. For example, some would say: " If living means I have to be hooked up on life-support machines for months and months, then I would rather die. " However, refusing treatment in this case is not euthanasia.

If you have cancer, and you refuse another painful chemotherapy session, and then you die, the cause of death is the cancer, not the doctor or yourself. We call it euthanasia when your doctor or someone

else intentionally causes your death, before your death is caused naturally by disease or by old age. And this is something everyone should be against, in every circumstance. Here's why: The Bible tells us that it is God who appoints people to die. Essentially, assisted suicide is an attempt to deny God his sovereign right to appoint who dies when.

We must be careful not to take into our own hands the right that belongs to God. There is nothing in the Bible that tells us we must do everything we can to keep someone alive for as long as possible. So, we are not under obligation to prolong the life of someone who is suffering. If someone is terminally ill and in great pain, we should make the person as comfortable as possible during this process of dying. We should not hasten his death. Instead, we should let death take its natural course, but make every effort to comfort those who are suffering.

Finally, like so many things in the world, when a small compromise is made many injustices are eventually allowed. If euthanasia is permitted under the emotional and moral claim that it is best for the individual, what is to prevent the government from eventually stepping in and determining who else needs to be terminated? Might the definition of euthanasia be expanded to include those who are suffering from chronic depression, or just don't like living — or are not productive in society? We must ask that if the door to killing people in their old age is opened, can it ever be closed again? Think about it.

The beginning of life is now open to destruction in abortion, and the end of life is now being considered for destruction as well. Like a vise that closes from either end, how many of those in the middle will fall prey to the

depravity of man's moral relativism and love affair with sin that always brings death? PRO Euthanasia or Physician-Assisted Suicide CON Euthanasia or Physician-Assisted Suicide 1. Right to Die PRO: " The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty.

The exercise of this right is as central to personal autonomy and bodily integrity as rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by bringing about his or her own death.

A state's categorical ban on physician assistance to suicide — as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death — substantially interferes with this protected liberty interest and cannot be sustained. " — ACLU Amicus Brief in *Vacco v. Quill* (72 KB) American Civil Liberties Union (ACLU) Dec. 10, 1996 CON: " The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it.

That being the case, our decisions lead us to conclude that the asserted ' right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. " — *Washington v. Glucksberg*

(63 KB) US Supreme Court Majority Opinion June 26, 1997 2. Patient Suffering at End-of-Life PRO: " At the Hemlock Society we get calls daily from desperate people who are looking for someone like Jack Kevorkian to end their lives which have lost all quality... Americans should enjoy a right guaranteed in the European Declaration of Human Rights — the right not to be forced to suffer.

It should be considered as much of a crime to make someone live who with justification does not wish to continue as it is to take life without consent. " — Faye Girsh, EdD Senior Adviser, Final Exit Network, " How Shall We Die," Free Inquiry Winter 2001 CON: " Activists often claim that laws against euthanasia and assisted suicide are government mandated suffering. But this claim would be similar to saying that laws against selling contaminated food are government mandated starvation. Laws against euthanasia and assisted suicide are in place to prevent abuse and to protect people from unscrupulous doctors and others.

They are not, and never have been, intended to make anyone suffer. " — Rita Marker, JD Executive Director Kathi Hamlon Policy Analyst International Task Force on Euthanasia and Assisted Suicide " Euthanasia and Assisted Suicide: Frequently Asked Questions," www. internationaltaskforce. org Jan. 2010 3. Slippery Slope to Legalized Murder PRO: " Especially with regard to taking life, slippery slope arguments have long been a feature of the ethical landscape, used to question the moral permissibility of all kinds of acts...

The situation is not unlike that of a doomsday cult that predicts time and again the end of the world, only for followers to discover the next day that

things are pretty much as they were... We need the evidence that shows that horrible slope consequences are likely to occur. The mere possibility that such consequences might occur, as noted earlier, does not constitute such evidence. " — R. G. Frey, DPhil Professor of Philosophy, Bowling Green State University " The Fear of a Slippery Slope," Euthanasia and Physician-Assisted Suicide: For and Against 1998

CON: " In a society as obsessed with the costs of health care and the principle of utility, the dangers of the slippery slope... are far from fantasy... Assisted suicide is a half-way house, a stop on the way to other forms of direct euthanasia, for example, for incompetent patients by advance directive or suicide in the elderly. So, too, is voluntary euthanasia a half-way house to involuntary and nonvoluntary euthanasia. If terminating life is a benefit, the reasoning goes, why should euthanasia be limited only to those who can give consent?

Why need we ask for consent? " — Edmund D. Pellegrino, MD Professor Emeritus of Medicine and Medical Ethics, Georgetown University " The False Promise of Beneficent Killing," Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide 1998 4. Hippocratic Oath and Prohibition of Killing PRO: " Over time the Hippocratic Oath has been modified on a number of occasions as some of its tenets became less and less acceptable. References to women not studying medicine and doctors not breaking the skin have been deleted.

The much-quoted reference to ' do no harm' is also in need of explanation. Does not doing harm mean that we should prolong a life that the patient

sees as a painful burden? Surely, the 'harm' in this instance is done when we prolong the life, and 'doing no harm' means that we should help the patient die. Killing the patient—technically, yes. Is it a good thing—sometimes, yes. Is it consistent with good medical end-of-life care: absolutely yes. ” — Philip Nitschke, MD Director and Founder, Exit International “Euthanasia Sets Sail,” National Review Online

June 5, 2001 CON: “The prohibition against killing patients... stands as the first promise of self-restraint sworn to in the Hippocratic Oath, as medicine's primary taboo: 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect'... In forswearing the giving of poison when asked for it, the Hippocratic physician rejects the view that the patient's choice for death can make killing him right. For the physician, at least, human life in living bodies commands respect and reverence—by its very nature.

As its respectability does not depend upon human agreement or patient consent, revocation of one's consent to live does not deprive one's living body of respectability. The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and therefore, also what the Oath calls the purity and holiness of life and art to which he has sworn devotion. ” — Leon Kass, MD, PhD

Addie Clark Harding Professor, Committee on Social Thought and the College, University of Chicago “Neither for Love nor Money,” Public Interest

Winter 1989 5. Government Involvement in End-of-Life Decisions PRO: “ We’ll all die. But in an age of increased longevity and medical advances, death can be suspended, sometimes indefinitely, and no longer slips in according to its own immutable timetable. So, for both patients and their loved ones, real decisions are demanded: When do we stop doing all that we can do? When do we withhold which therapies and allow nature to take its course?

When are we, through our own indecision and fears of mortality, allowing wondrous medical methods to perversely prolong the dying rather than the living? These intensely personal and socially expensive decisions should not be left to governments, judges or legislators better attuned to highway funding. ” — Los Angeles Times “ Planning for Worse Than Taxes,” Opinion Mar. 22, 2005 CON: “ Cases like Schiavo’s touch on basic constitutional rights, such as the right to live and the right to due process, and consequently there could very well be a legitimate role for the federal government to play.

There’s a precedent—as a result of the highly publicized deaths of infants with disabilities in the 1980s, the federal government enacted ‘ Baby Doe Legislation,’ which would withhold federal funds from hospitals that withhold lifesaving treatment from newborns based on the expectation of disability. The medical community has to have restrictions on what it may do to people with disabilities – we’ve already seen what some members of that community are willing to do when no restrictions are in place. ” — Stephen Drake. MS Research Analyst, Not Dead Yet End of Life Planning: Q & A with Disabilities Advocate,” Reno Gazette-Journal Nov. 22, 2003 6. Palliative (End-
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of-Life) Care PRO: “ Assisting death in no way precludes giving the best palliative care possible but rather integrates compassionate care and respect for the patient’s autonomy and ultimately makes death with dignity a real option... The evidence for the emotional impact of assisted dying on physicians shows that euthanasia and assisted suicide are a far cry from being ‘ easier options for the caregiver’ than palliative care, as some critics of Dutch practice have suggested.

We wish to take a strong stand against the separation and opposition between euthanasia and assisted suicide, on the one hand, and palliative care, on the other, that such critics have implied. There is no ‘ either-or’ with respect to these options. Every appropriate palliative option available must be discussed with the patient and, if reasonable, tried before a request for assisted death can be accepted... Opposing euthanasia to palliative care... either reflects the Dutch reality that palliative medicine is incorporated within end-of-life care nor the place of the option of assisted death at the request of a patient within the overall spectrum of end-of-life care. ” — Gerrit Kimsma, MD, MPh Associate Professor in Medical Philosophy Evert van Leeuwen, PhD Professor in Philosophy and Medical Ethics Center for Ethics and Philosophy at Free University in Amsterdam (Amsterdam, Netherlands) “ Assisted Death in the Netherlands: Physician at the Bedside When Help Is Requested” Physician-Assisted Dying: The Case for Palliative Care & Patient Choice 2004

CON: “ Studies show that hospice-style palliative care ‘ is virtually unknown in the Netherlands [where euthanasia is legal]. ‘ There are very few hospice facilities, very little in the way of organized hospice activity, and few

specialists in palliative care, although some efforts are now under way to try and jump-start the hospice movement in that country... The widespread availability of euthanasia in the Netherlands may be another reason for the stunted growth of the Dutch hospice movement. As one Dutch doctor is reported to have said, ' Why should I worry about palliation when I have euthanasia? "' — Wesley J. Smith, JD

Senior Fellow in Human Rights and Bioethics, Discovery Institute Forced Exit
1997 7. Healthcare Spending Implications PRO: " Even though the various elements that make up the American healthcare system are becoming more circumspect in ensuring that money is not wasted, the cap that marks a zero-sum healthcare system is largely absent in the United States...

Considering the way we finance healthcare in the United States, it would be hard to make a case that there is a financial imperative compelling us to adopt physician-assisted suicide in an effort to save money so that others could benefit... " — Merrill Matthews, Jr. PhD Director, Council for Affordable Health Insurance " Would Physician-Assisted Suicide Save the Healthcare System Money? ," Physician Assisted Suicide: Expanding the Debate 1998

CON: " Savings to governments could become a consideration. Drugs for assisted suicide cost about \$35 to \$45, making them far less expensive than providing medical care. This could fill the void from cutbacks for treatment and care with the ' treatment' of death. " — International Task Force on Euthanasia and Assisted Suicide " Frequently Asked Questions," www.internationaltaskforce.org (accessed May 27, 2010) 8. Social Groups at Risk of Abuse

PRO: " One concern has been that disadvantaged populations would be disproportionately represented among patients who chose assisted suicide. Experience in Oregon suggests this has not been the case. In the United States, socially disadvantaged groups have variably included ethnic minorities, the poor, women, and the elderly. Compared with all Oregon residents who died between January 1998 and December 2002, those who died by physician-assisted suicide were more likely to be college graduates, more likely to be Asian, somewhat younger, more likely to be divorced, and more likely to have cancer or amyotrophic lateral sclerosis...

Moreover, although 2.6 percent of Oregonians are African American, no African American patients have chosen assisted suicide. " — Linda Ganzini, MD, MPH Professor of Psychiatry and Medicine Senior Scholar, Center for Ethics in Health Care at Oregon Health & Science University " The Oregon Experience," Physician-Assisted Dying: The Case for Palliative Care and Patient Choice 2004 CON: " It must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care.

Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society – only that they are not exempt from the prejudices manifest in other areas of our collective life. While our society aspires to eradicate discrimination and the most punishing

effects of poverty in employment practices, housing, education, and law enforcement, we consistently fall short of our goals.

The costs of this failure with assisted suicide and euthanasia would be extreme. Nor is there any reason to believe that the practices, whatever safeguards are erected, will be unaffected by the broader social and medical context in which they will be operating. This assumption is naive and unsupportable. " — New York State Task Force on Life and the Law " When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context," newyorkhealth.gov 1994 9. Religious Concerns

PRO: " Guided by our belief as Unitarian Universalists that human life has inherent dignity, which may be compromised when life is extended beyond the will or ability of a person to sustain that dignity; and believing that it is every person's inviolable right to determine in advance the course of action to be taken in the event that there is no reasonable expectation of recovery from extreme physical or mental disability... BE IT FURTHER RESOLVED: That Unitarian Universalists advocate the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths; and... BE IT FINALLY RESOLVED: That Unitarian Universalists, acting through their congregations, memorial societies, and appropriate organizations, inform and petition legislators to support legislation that will create legal protection for the right to die with dignity, in accordance with one's own choice. — Unitarian Universalist Association: The Right to Die With Dignity, 1988 General Resolution Unitarian Universalist Association 1988

CON: " As Catholic leaders and moral teachers, we believe that life is the most basic gift of a loving God- a gift over which we have stewardship but not absolute dominion. Our tradition, declaring a moral obligation to care for our own life and health and to seek such care from others, recognizes that we are not morally obligated to use all available medical procedures in every set of circumstances. But that tradition clearly and strongly affirms that as a responsible steward of life one must never directly intend to cause one's own death, or the death of an innocent victim, by action or omission...

We call on Catholics, and on all persons of good will, to reject proposals to legalize euthanasia. " — United States Conference of Catholic Bishops " Statement on Euthanasia," on www.usccb.org Sep. 12, 1991 10. Living Wills

PRO: " Living wills can be used to refuse extraordinary, life-prolonging care and are effective in providing clear and convincing evidence that may be necessary under state statutes to refuse care after one becomes terminally ill. A recent Pennsylvania case shows the power a living will can have.

In that case, a Bucks County man was not given a feeding tube, even though his wife requested he receive one, because his living will, executed seven years prior, clearly stated that he did ' not want tube feeding or any other artificial invasive form of nutrition'... A living will provides clear and convincing evidence of one's wishes regarding end-of-life care. " — Joseph Pozzuolo, JD Professor, Neuman College Lisa Lassoﬀ, JD Associate, Reed Smith Jamie Valentine, JD Associate, Pozzuolo & Perkiss Why Living Wills/Advance Directives Are an Essential Part of Estate Planning," Journal of Financial Service Professionals Sep. 2005 CON: " Not only are we awash in evidence that the prerequisites for a successful living wills policy are

unachievable, but there is direct evidence that living wills regularly fail to have their intended effect... When we reviewed the five conditions for a successful program of living wills, we encountered evidence that not one condition has been achieved or, we think, can be.

First, despite the millions of dollars lavished on propaganda, most people do not have living wills... Second, people who sign living wills have generally not thought through its instructions in a way we should want for life-and-death decisions... Third, drafters of living wills have failed to offer people the means to articulate their preferences accurately... Fourth, living wills too often do not reach the people actually making decisions for incompetent patients... Fifth, living wills seem not to increase the accuracy with which surrogates identify patients' preferences