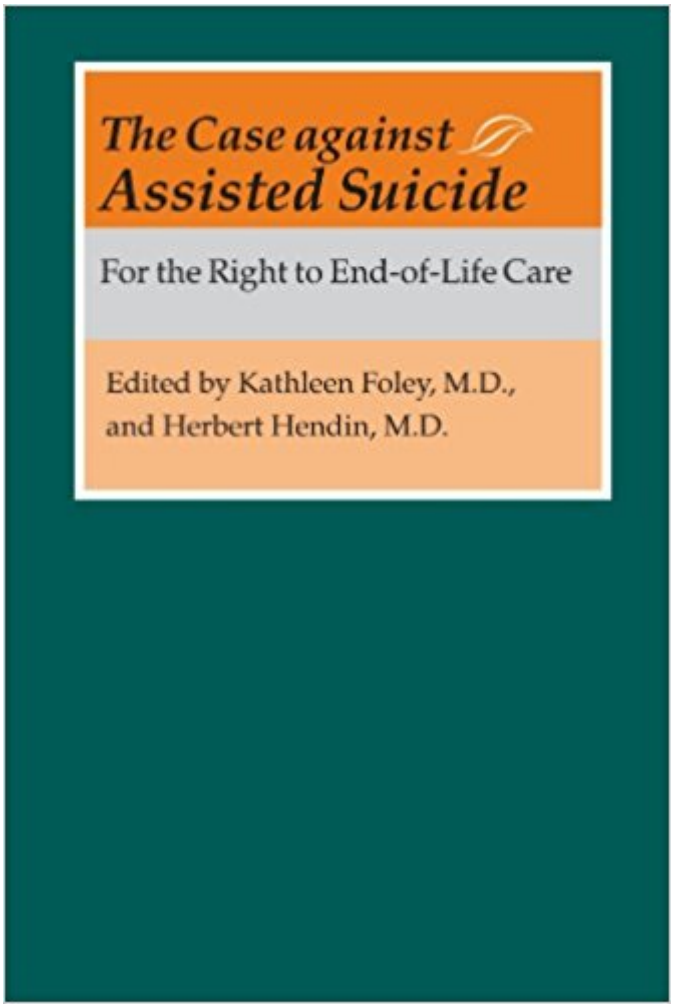
The Case Against Assisted Suicide: For The Right To End-of-Life Care



Synopsis

In The Case against Assisted Suicide: For the Right to End-of-Life Care, Dr. Kathleen Foley and Dr. Herbert Hendin uncover why pleas for patient autonomy and compassion, often used in favor of legalizing euthanasia, do not advance or protect the rights of terminally ill patients. Incisive essays by authorities in the fields of medicine, law, and bioethics draw on studies done in the Netherlands, Oregon, and Australia by the editors and contributors that show the dangers that legalization of assisted suicide would pose to the most vulnerable patients. Thoughtful and persuasive, this book urges the medical profession to improve palliative care and develop a more humane response to the complex issues facing those who are terminally ill.

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Customer Reviews

Few medical issues arouse such strongly passionate opinions among health care professionals and laypersons alike as the debate about physician-assisted suicide. This valuable and intentionally provocative book will add much light -- and undoubtedly some heat -- to the debate. Foley and Hendin have assembled contributions from leading experts in diverse disciplines, all for the explicit purpose of making the "case against assisted suicide." The editors are well qualified in their own right. Foley, a neurologist, is an attending physician on the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center, and Hendin, a psychiatrist, is medical director of the American Foundation for Suicide Prevention. The writing is of uniformly high quality, and the book achieves stylistic consistency while still reflecting an individual voice in each chapter. In addition, the clustering of chapters into sections, the appropriate use of cross-referencing among chapters, and

introductory and concluding statements by the editors result in a well-organized, cohesive statement -- a rarity for a multiauthored book. In brief, this book's carefully reasoned and carefully written arguments flow as follows. The first section considers the ethical and legal arguments against assisted suicide. A major focus is the fundamental ethical argument used by proponents of assisted suicide -- namely, respect for the principles of compassion and patient autonomy. Among the best in the book, these chapters posit that proper application of the principles of compassion and autonomy, within the context of the medical as well as legal professions, actually argues against assisted suicide. One point made repeatedly is the "slippery slope" argument. The application of compassion and autonomy as demanded by proponents of assisted suicide must inevitably lead to the sanction of assisted suicide, not merely for the terminally ill but also for patients with chronic suffering from any cause, life-threatening or not. This section then segues to an examination of legalized assisted suicide in Oregon and of legalized assisted suicide or euthanasia in the Netherlands and (briefly) in the Northern Territory of Australia. The conclusions are that legalization does indeed result in physician-caused deaths beyond the narrow confines of purported safeguards and that, together with social and financial pressures, it actually limits the development or availability of proper palliative care for the dying. Parts of this section depend on reinterpretation of the published data, an approach that leads to different conclusions from those made by the original authors. The reinterpretations are well presented, but some readers will differ and pose counterarguments. Much of this section also depends on vignettes involving particular patients or particular clinicians' practices. These stories are well told and are highly disturbing in precisely the manner intended. With any such vignettes, one wonders about information that is left out or shaped by the bias of the storyteller. Of course, concern about distortion is also paramount in interpreting the vignettes presented elsewhere by proponents of assisted suicide. The next section offers several "reasons to be concerned" that condoning assisted suicide will adversely affect vulnerable populations. One chapter focuses on the rights of the disabled, noting how the public debate is (too often invisibly) influenced by society's prejudices against them. Another provides a thoughtful review of the role of depression and the will to live. There is also a chapter that usefully summarizes and rebuts key arguments made by proponents of assisted suicide. The final section introduces "a better way" -- that is, hospice and palliative care. The editors conclude with their opinion that assisted suicide and euthanasia must be opposed, noting that the central objective must be to "stimulate the medical community . . . into accepting the challenge to provide better care at the end of life." Some detractors will criticize this work for not being what it is not. It is not a detailed explication of the principles and practice of palliative care. It does not present wholly new arguments against assisted

suicide but, rather, collects these perspectives in well-organized and well-articulated form. It is not a scientific treatise on the shades of our uncertainty; rather, it only obliquely critiques the still scant empirical data on which to base discussions and implies, rather than sets, a research agenda to address the huge gaps in the literature. In addition, it is certainly not a balanced discussion among those with divergent views but, rather, a highly charged polemic. Do we need such a polemic, however comprehensive and clear? I recall a recent case conference for medical students. The patient was an elderly nursing home resident who had been debilitated by strokes and other conditions. She had become acutely suicidal, a state of mind indisputably caused by the recurrence of severe depression. As with previous episodes of depression, she responded well to treatment and subsequently returned to a pleasurable life at the nursing home. I was dismayed to see many of the students' reactions to this case. Surely, they said, we should have respected this patient's "autonomy" and shown her "compassion" by allowing her to die as she initially (though no longer) wished, rather than treat her depression. Here was an instance of the "expendable elder" dynamic -- one that I believe was strongly affected by the distorted public debate about assisted suicide. I purposely reveal my own biases here, since each reader's views will exert a dominant influence over his or her responses to this book. Having said that, I believe that this book is sorely needed. Many will argue against its details, but it will be of tremendous interest to a wide audience both within and outside of medicine. Jeffrey M. Lyness, M.D. --This text refers to the Hardcover edition.

"The writing is of uniformly high quality, and the book achieves stylistic consistency while still reflecting an individual voice in each chapter. The book is sorely needed." (Jeffrey M. Lyness New England Journal of Medicine)"The methods of palliative care, or comfort care, have in the past few decades reached a level of effectiveness such that suffering thought at first to be intractable can almost always be relieved. And this is the ultimate message of this vastly important book that now makes its timely appearance." (Sherwin B. Nuland, M.D. New Republic)"A major contribution to our understanding of the practice, theory, and limitations of assisted suicide and euthanasia in seriously ill patients. The book is superbly written and intellectually challenging. I am convinced that it will become standard reading for allâ •whether advocates or opponents of assisted suicideâ •who want to think more deeply and learn more about what we need to do to improve end-of-life care." (The Lancet)"The book is timely and important in the life and death debate that is of personal relevance to us all." (Review of Disability Studies)"This excellent book will be a valuable resource for anybody

interested in the delivery of better end-of-life care, whether they are clinicians, ethicists, or health care policymakerrs." (International Association for Hospice and Palliative Care)"Foley, Hendin, and their contributors have produced a truly outstanding resource." (Cambridge Law Journal)"Brings together some well known and respected players in the debate, whose contributions lend considerable weight to the case... A thought-provoking and comprehensive look at the case against assisted suicide." (Bulletin of Medical Ethics)"Provides a comprehensive, persuasively argued case against assisted suicide." (Tony O'Brien Metapsychology)

Editors Kathleen Foley and Herbert Hendin note in their preface to The Case Against Assisted Suicide that much of the dialogue on physician-assisted suicide (PAS) involved one side invoking religious principles against assisted suicide, while the other proponents of PAS invoked feelings compassion and talk about autonomy. This book is a welcome change to that deadlock by investigating in non-sectarian language the very problematic nature of physician-assisted suicide. Even better, the primary contributions are from physicians in end-of-life care or disability advocates and hospice workers, giving the reader an intimate view of the realities of end-of-life care.The book is divided into four sections:The first section has an impressive line-up. Bioethicist Dan Callahan's essay on compassion and its limits undercuts some of the strongest arguments that PAS proponents make. He is joined by Yale Kamisar's legal critique of PAS, and also an essay on the patient-doctor relationship by Leon Kass, the head of the Presidential Committee of Bioethics.The second section is the most disturbing as it examines the reality of physician assisted suicide in Oregon, the Netherlands, and during a period of time in the Northwest Territory of Australia. Every essay is written by one or two physicians who practice medicine in the country or state affected by assisted suicide. Running as a theme through all these accounts is the silence surrounding suicides, the squelching of meaningful discussion of suicide alternatives, and the lack of any real oversight.Upon reading the second section, a PAS proponent may retort, "oh fine, the Dutch and the Oregonians have messed it up, so we'll just improve it in the future." The third part of the book, however, has several articles that show that the problems in Oregon and elsewhere are symptomatic of inherent vulnerabilities in the disabled population. Diane Coleman, a disabled lawyer and founder of the disability organization Not Dead Yet, has a particularly good piece on the struggles of the disabled in America to obtain proper care and the threats posed to them by institutionalized suicide.The fourth section has a brief history on the first modern hospice in London, and how its mission has involved, often from the experiences of their first patients. The last piece is by editor Kathleen Foley, who summarizes some of the current American initiatives on improving

end of life care, and also how both physicians' and the public's views on death and its psychology have evolved, and where they need to improve.The Case Against Assisted Suicide is a well-organized volume that brings together a very complicated issue and develops a powerful argument for how we need to practice medicine and care for some of society's most vulnerable members.

Kathleen Foley, MD & Herbert Hendin, MD, editorsThe Case Against Assisted Suicide:For the Right to End-of-Life Care(Baltimore, MD: Johns Hopkins UP: [....], 2002) 371 pages(ISBN: 0-8018-7901-9; paperback)(Library of Congress call number: R726.C355 2002)(Medical call number: W32.5AA1C337) This is a collection of articles and essays by several different authors,all pointing out problems with the right-to-diesuch as the physician aid-in-dying now available in Oregon and Washington.Johns Hopkins University Press also published a similar collectionthat took the opposite point of view:Physician-Assisted Suicide:The Case for Palliative Care and Patient Choiceedited by Timothy E. Quill, MD & Margaret P. Battin, PhD.This book is reviewed in the companion bibliography:"Best Books on the Right-to-Die".Search the Internet for that exact expression.This review is actually a review of some chapters from the book.Only the most insightful and original chapters are reviewed.~~~~~~~~ Chapter 1: "I Will Give No Deadly Drug":Why Doctors Must Not Killby Leon R. Kass, MD, PhD. People who are old and sick can sometimes be persuadedthat death is the best option for them.It relieves them of any further suffering.And their families are also relievedof the further stress of their disease and dying.Kass wonders whether we have gone too farin the direction of patient autonomy.Just because a patient 'wants to die'does not mean that death is the best choice. The answer to this worry is to make surethat more people than just the doctor and the patientare involved in every life-ending decision.If several open-minded and thoughtful personsare involved in examining all of the options,then the best decision is more likely to emerge.But society should not go so far asto prohibit all voluntary deaths and all merciful deathsbecause of the worry that some chosen deathsmight be coerced and/or manipulated.We need wise ways to separate the harmful deaths from the helpful deaths.Here are more than 30 safeguards,many of which call for the opinions of other persons. Kass points out that the doctors already have overwhelming powerand authority in making medical decisions.Often the doctor has a strong recommendation,based on past experience with similar cases.And many patients simply follow the recommendations of their doctors,even if they do not fully understandtheir medical problems and the options available.Thus if the doctors could legally recommenda voluntary death or a merciful death,how many patients and families would resistand ask for a second medical

opinion?How many suffering patients and/or their proxiescan really make independent choices at the end of life? One way to counter-balance this great power of doctorsis to make sure that other knowledgeable personsare involved in the decision-making process.When only one doctor and one patient are involved,and if the doctor can recommend death as the best option,how many dying patients will have the courage to resist?We should not automatically assumethat doctors are always acting in the best interests of their patients.Sometimes they make recommendations that would be simpler for themselves.Sometimes they want to get rid of difficult patients.And rarely doctors do commit murder under the guise of medical care.But the correct way to restrain this overwhelming power of doctorsis not to prohibit any discussion of the option of deathbut to make sure that other wise persons are also involvedin the process of making thoughtful medical decisions,which should also include the option of a voluntary death or a merciful deathif the patient cannot be cured. Leon Kass argues against allowing anyone to choose a voluntary deathbecause of the spill-over effect this would have on less obvious cases.In other words, once voluntary death and/or merciful deathbecome available, legal options for every patient to choose,then some people who should not be helped to diewill be encouraged to commit irrational suicidebecause they know about otherswho have chosen a voluntary death or a merciful death.Kass thinks that even the obvious cases involving a wise choice of deathshould be prohibited because some less-wise cases will follow.If we allow the voluntary choice of death by the patient and/or the proxies,how much longer will it be before involuntary choices of deathare imposed on patients and familieswho have little power to resist medical authority? This reviewer is not convinced.By the use of careful and comprehensive safeguards,we can say "yes" to wise and compassionate choices of deathand we can say "no" to foolish and ill-considered choices of death.We need safeguards to prevent manipulated-death,not a blanket ban on all forms of chosen death.Here is a list of possible forms of abuses and mistakes,linked to the specific safeguardsto avoid those distortions of the right-to-die. One of the most basic and comprehensive of Kass’s objectionsto doctors helping people to dieis that this will fundamentally change the doctor-patient relationship.Even doctors who never participate in life-ending decisionswill have their role tainted by the fact thatsome doctors are involved in the process of helping their patients to die.Especially when patients do not know their doctors very well,there is a serious worry that their doctors might too easily recommend death.When patients put their lives into the hands of doctors,they do not want the additional worrythat their doctors might be considering recommendingvoluntary death or merciful death instead of continued medical treatment. There are valid worries about the proper role of doctors.Some potential patients already have irrational fears of doctors and hospitals.And if it became part of the doctor’s standard role to

recommend death,then such irrational fears might become worse.Perhaps the proper response to this worry is to keep regular doctorsfar away from any practice of advising about death.We do not want to confuse patients about what medical care includes.When the patient has exhausted standard medical care,and when death is being considered as a valid option,then specialists who deal only with life-ending decisions could be called into help explore the various options at the end of life.This would allow society to follow the dictum in the title of this chapter:"Doctors must not kill."Most doctors would be confined to their healing roles.They would recommend various options for treating the disease or condition.Ending all treatments would still be an optionthat could be considered by ordinary doctors.But even the option of discontinuing treatmentneeds to be protected from mistakes and abuses. Kass argues that death can never be a benefit to the patientbecause once death has come, there is no person remaining to benefit. This reviewer would suggest reframing this question another way:We are not confronted with the question: to die or not to die?What we face is dying now or dying later.When is the best time to die?What are the best circumstances?Which is the best pathway towards death?There is no pathway that avoids death.We must all die one way or another, at one time or another.When we reframe the question this way,some of the experiences we might have to undergobetween now and death might better be avoided.Each of us can ask: What is the ideal way for me to die? I, for one, do not want to be kept ’alive’if there is no meaning for my continued life.Meaningless existence should be shortened in my case.I wonder if Leon Kass really wants his existence as a former personextended as long as possible. (This reviewer has written a book encouraging everyoneto create an Advance Directive for Medical Care:Your Last Year:Creating Your Own Advance Directive for Medical CareEight Questions in PART III deal with life-ending decisions.These would be the ideal places for anyoneto express his or her wishes with respect to end-of-life medical care.) I think Leon Kass began to write this articlewith the established principle that doctors must not kill.Then he proceeded to defend it to the best of his ability.In my opinion, he has not met the argumentsof those who favor allowing (at lease some) doctorsto have some role in helping their patients to die.He does not offer a better approach to dying.He merely says that the doctor should always striveto keep their patients alive.~~~~~~~~~~ In Chapter 3 Daniel Callahan also argues againstallowing doctors to recommend death.Allowing physicians to participate in death(even when there is obvious benefit to the patient)will inevitably lead to practices we all regard as evil.Even if we create legal safeguards to prevent abuses and mistakes,the logic of the argument for permitting the option of deathwill still persuade some people who should not die nowthat death is also the best option in their cases.Patients and doctors so convinced will evade any safeguardsbecause the marginal cases

and obvious cases seem similar enough.Since we cannot draw the line against mercy-killing,we must resist all attempts to legalize new forms of socially-approved death. This is the slippery-slope argument:If we allow even a few wise voluntary deaths and a few wise merciful deaths,then unwise deaths will follow.Several years of experience with the Oregon Death with Dignity Actshow that no foolish deaths have followed the wise ones.For several years in Oregon,physicians have been prescribing life-ending drugsfor people who were already dying--and no further chain of horrors has followed. Callahan criticizes some of the safeguards proposedas arbitrary and legalistic.For example: The patient must be suffering and competent.If we allow the principle of patient autonomy to be paramount,how do we limit the right-to-die to people who are suffering?And what kinds of suffering qualify?How severe must the suffering be? This reviewer agrees that safeguards should not attempt to limit the right-to-dieto people who can claim to be suffering in some sense.Suffering is always subjective to some degree.Rather than requiring some kind of certification of suffering,we should allow any and all reasons for dying to be offered and argued.Then other people who can be balanced in their approachshould examine the reasons offered by the patient and/or the proxiesto determine their degree of validity.An open-minded analysis of each casewill lead to saying "no" to some requests for deathand "yes" to others. Requiring the patient to be conscious and capableto the very end is not a wise safeguardbecause it will encourage some patients to choose a premature deathfor fear of losing the capacity to choose death at some later time.Wiser safeguards would allow the patient’s wishes to be carried forwardeven after the patient has lost the ability to make wise medical decisions.Then the life-ending decision should be made by the duly-authorized proxies,who will take the settled values of the patient into accountas well as all of the medical facts and medical opinions they can gather.The proxies should have the same optionsthat were available to the patientwhen the patient was still clearly able to make medical decisions,including the decision to end medical treatmentsand to choose a wise pathway towards death. Doctors are also human persons with their own moral beliefs and ethical standards.And few doctors comply with every wish of their patients.The autonomy and integrity of the doctor should also be preserved. Under most systems of safeguards,doctors have a right to refuse to participate in life-ending decisions.If I were a doctor, I also would want to be completely convincedthat death at this time is the best option for the patientrather than waiting for death at a later time.But some doctors believe that it is never better to choose death nowover continued efforts to treat the patient.Such doctors would never agree to assist a patient in choosing death.And Callahan is right to insist that doctors have a right to preserve this integrity.But the autonomy of such doctors should not become an absolute barrierto the autonomy of the patient to choose a wise pathway towards death.Doctors opposed to any form of

the right-to-dieshould refer patients who wish to claim their right-to-die to other doctors,who have different moral standards and ethical beliefs. Callahan believes allowing physicians to help their patient to diewill change our culture for the worse.Because the doctor-patient relationship is private,safeguards will be ignoredwhenever it seems convenient for all involved. This danger illustrates the need for safeguardsthat require more than convincing one doctor that death is the wisest course.The reasons for choosing death now rather than death latershould be reasons that could be examined in a court of lawif there is ever any question that a harm has been committed.Even tho courts should not be asked to rule on every case,the reasons for choosing death should be stated in writingto accommodate any possible future judicial review.Even tho the public should never become involvedin the decision-making process at the bedside,the principles by which medical decision are madeshould be such that they could be reviewedin various public forums--and approved or disapproved depending on the facts. The family of the patient should also be involved when possible.The best way to do this is for the patient to appoint official proxies.If there are no family members willing and able to participate,then other groups of wise adults should be called uponto review the life-ending decision before it is carried forward. This reviewer agrees with Callahanthat we must be careful not to create a "culture of death".If it becomes too easy and casual to choose death,then there will be additional irrational suicides.But if we have open safeguards privately considered--as we now have for all medical decisions--then there should be no fundamental change in our culture.Our culture will still strongly affirm life.~~~~~~~~~ Chapter 4 by Yale Kamisar tracesthe rise and fall of the "right" to assisted suicide.The US Supreme Court foundno right to assistance in dying in the Constitution.But there is a continuing right to privacy,which includes the private right to choose death. In a New York case, it was arguedthat the principle of equal protection of the lawsshould extend the right-to-die to patients who are not on life-supportsbecause this right is already assuredfor patients whose lives are sustained by machines.Patients on respirators, for example,can choose to die now rather than laterby turning off their life-support systems.This argument did not prevail on appeal. Such subtle legal distinctions are lost on most patientswho are suffering on the way to death.We all agree that there is no right to require a physician to help us to die.But we do have the right to refuse any further medical treatments,even if such withdrawal from medical support will result in an earlier death.Thus patients and doctor can cooperate in choicesthat legally fall within the right to refuse treatment.Also it is completely legal for the doctor to increase the pain-medication,even if everyone can foresee that this will shorten the process of dying.It would be very difficult for our culture to retreat to some positionin which no medical decisions could be takenthat would have any impact on the time and

place of death. Some of the right-to-die cases reviewed by the Supreme Courtwere decided by a one-vote margin.This means that new facts, better arguments, & better safeguardswould allow the Supreme Court to go the other way next time.And even now, the high court clearly allows the statesto enact their own laws regarding the right-to-die. Yale Kamisar argues that the public can be turned against the right-to-diewhen doubts are raised about the details of the proposed laws.In general, the public does affirm the right-to-die.But when a complex bill is offered, people turn against it.Some worry that the proposed safeguards are too looseand others worry that the safeguards are too restrictive.The proposed law in Michigan had 12,000 words.Public opinion turned against itafter pre-vote polling said it would win the referendum. This chapter mainly raises doubts about the fall-out from liberalizing laws.Many commentators think thatwe will not be able to restrain bad consequencesif we allow even a few people to exercise their right-to-die. Thus we need easy-to-understand safeguardsthat everyone agrees would prevent the vast majorityof possible mistakes and abuses of the right-to-die.It is better to have a law with (even difficult) safeguardsthat require careful examination of all the optionsthan to have no law and no safeguards at all.At present, there are few public procedures for making life-ending decisions.Thus, unreported and unexamined decisions for deathwill continue and expand--until some reasonable order is created.~~~~~~~~~ In Chapter 5 Herbert Hendin examines the Dutch experience.Hendin worries about the spill-over effects of allowing the right-to-die.Doctors feel justified in doing things that are not strictly legalbecause other similar actions are permitted by law.For example, in Holland the patient is required to beconscious and capable up until the last moment of life.But sometimes doctors go ahead with a planned deatheven if the patient has lost consciousnessand/or the capacity to make medical decisions.In the Netherlands about 5% of all deathswere achieved by means of physician assistance.But Hendin shows that some of these were actuallychosen by the doctor and/or the family rather than by the patientwhen the patient's thinking capacitydeclined beyond choosing one way or another. This reviewer does not see that as a serious problem--since we should not be required to be conscious and capable to the last moment.As long as the decision for death was a wise decision,the mental capacities of the patient at the last moment should not matter.Also such requirements deprive patients with Alzheimer's disease(or similar problems that render patients incapable of deciding)of their right-to-die. Another problem with the Dutch law and practiceis that it requires the patient to be suffering intolerably.But what about patients who refuse medical careand thereby increase their suffering to an intolerable level?The law permits all patients to refuse treatment.If they begin to suffer beyond what they can endure,they are permitted to request death.But they are not required to accept any medical carethat might reduce or eliminate

their suffering. For this and other reasons, this reviewer does not believethat intolerable suffering should be requiredas a condition for requesting death.Suffering is always subjective.How are other persons to know the truth about the patient's suffering?Strangers should never be called uponto evaluate the suffering of patients they have never met before.Let everyone who is suffering explain as fully as they wish.But do not require a certain level of sufferingbefore voluntary death or merciful death is permitted. Under Dutch law, even mental sufferingis permitted as a reason for choosing death.Hendin points out some problems that might easily arise here. Mental suffering is even more subjective than physical suffering.And people who commit irrational suicidealmost always have some sort of mental torment.Certifying suffering does not seem to be a workable safeguard. And sometimes people choose death nowbecause they fear some future suffering.Hendin does not approve of this 'reason' for choosing death. But this reviewer believes that future suffering is sometimes a valid reason.Let all the facts and opinions be presented.If the patient will never recoverand can only be expected to suffer more deeply,then the patient should take his or her future suffering into account.This would be especially relevantwhen the patient has a well-known disease like cancer.When future suffering can be predicted with accuracy,it should be considered as an important factorin choosing the best time to die. In many life-choices we rightly consider future suffering.Divorce would be a prime example:If the marriage is only going to create more misery and suffering,then it is better to end it nowthan to wait for the suffering to become intolerable. If present suffering were a requirement,it would always be subject to second-guesing:The committee might decide that the patient's suffering todayis not intense enough to justify a voluntary death.Let the people most closely involved consider the present and future sufferingand all the other options that might become available. Hendin points out that consultation with a second physician in Hollandis often ignored or treated superficially.When the first doctor is not planning to report the death as a chosen death,97% of the time the first doctor does not ask for a second opinion.And even when there is a consultation, it is often perfunctory.The colleague merely signs a form without really considering the patient.Thus, the second opinion becomes a meaningless exercise in seeking signaturesrather than a genuine attempt to prevent mistakes and abuses. This reviewer agrees that the second professional opinionmust be thoro and genuinely independent.And we might even require consultation with a hospice physician.Let's see how best to make sure that this safeguard actually makes a difference.Sometimes the second physician will notice some factsor suggest some options not considered by the first physician. Hendin shows that under-reporting is a very serious problem in the Netherlands.Now that the right-to-die is well accepted,some doctors merely go ahead with their practice of helping patients to die peacefully.But they skip the paperwork by means of

which they are supposed to report this death.Rather, they record the death (incorrectly) as having been due to natural causes. This reviewer agrees that non-reporting of voluntary deathswill be an almost inevitable result of liberalizing lawsto allow patients to choose death.Originally under Dutch law, the doctor was supposedto report the death to the public prosecutor.Why would any doctor be inclined to report a voluntary death to law-enforcement?No crime has been committed.And the public prosecutor can do nothing to bring the patient back to life.Since only bad consequences for the doctor could follow such a report,we can all understand why doctors do not do the paperwork after deathif they can avoid it. I suggest that the paperwork should be submitted before death.Then if there are going to be any mistakes or abuses,they can be prevented by the authority to which the coming death was reported.The Dutch system has now been reformedso that reporting goes to a local committee--before the death has been achieved.This should improve the rate of correct and honest reporting of voluntary deaths. Hendin next takes up the problem of deaths without explicit request.According to Hendin about 1,000 deaths per year fall into this category. Some of these might be mistakes and abuses of the Dutch system.But most of them are probably patientswho had requested death when they were still capable.Also, several were probably deaths approved by relativesafter the patient was unconscious or otherwise unable to decide.Safeguards better than the Dutch systemwould permit us to request death in advance--specifing what conditions would justify merciful death.And better safeguards would permit proxiesto exercise the same powers of choicethat belonged to us when we were still conscious and capable. Hendin points out that sometimes doctors suggest voluntary death.This is not supposed to happen under the Dutch system.The patient alone is permitted to start the discussion of voluntary death. In this reviewer's opinion, this is a fairly meaningless and useless safeguard.Is there any adult in the Netherlandswho does not already know about the right-to-die?How would such a safeguard be enforced?Doctor-patient communications are private.Who is going to report that the wrong personbrought up the subject of voluntary death?Who starts the discussion is not as importantas preventing any coercing or manipulating of the patient.And pressure from all people should be counteracted:friends, family, nurses, social workers, clergy--as well as doctors.Careful safeguards would make surethat the patient is really making a free, informed, & wise choice to die--without undue influence from anyone. Hendin has investigated some cases in depthin which the choice of death might not have been the wisest course of action.One husband was 'forced' to choose deathbecause his wife could no longer care for him at home.He had to choose between a nursing home and death!Often the family has a stronger wish for death than the patient. We need careful safeguardsthat avoid even the appearance or suggestion ofcoercion or manipulation leading to a

’choice’ of death.Here the ’views’ of the patient and the family will not be sufficient.In the case cited, perhaps a trial period in a nursing homewould have been a wiser course than going directly to death.Then the patient would have known first handwhether or not he could tolerate life in a nursing home.He might even have preferred a nursing home to living with his wife.But if he finds his life in a nursing home intolerable,then he still should have the right to choose a voluntary death instead.At least all will know that he gave the nursing-home alternative an honest try. In cases of possible manipulation or coercion,we need the careful opinions of third partieswho have no personal or emotional stake in the final decision.Neutral third parties can hear all the facts and opinionsbefore urging caution about ’choosing’ deathor recommending voluntary death as the best course of action. Perhaps more than one wise person should be consulted.But this person should not be a public official,who would always be under public and media pressureto decide one way or another.And these neutral third parties should be genuinely open to either outcome:Either the patient should be kept alive and given further medical careor the patient should be permitted to choose a voluntary death.If any such ’neutral’ third partywere known to recommend only one kind of action,then he or she is not the appropriate person to consult. Another case, which became famous in Holland,involved mental suffering only.The woman who wanted to die was grief-stricken by deaths in the family.If her psychiatrist would not help her to die,she threatened to kill herself. Thus presented, most people would agree that death is not the best option.Millions of people have recovered from griefand gone on to live meaningful lives. But can we think of situations of mental sufferingwhere that would be sufficient reason to choose to end life?Herbert Hendin and others professionally involved in preventing irrational suicideswould probably say that all mental reasons for choosing death are invalid.Such a presupposition would lead to principles requiring physical sufferingbefore a voluntary death would be permitted and approved. This reviewer suggests that we ought to remain opento all valid reasons for choosing death.And strangers who have never met the patientshould not become involvedin deciding which reasons are valid enough. Let the patient state his or her reasons for wanting to dieas clearly and completely as possible.(The reasons for death should probably be put into writing.)Then others who know the patient wellwill be called upon to express their opinionsabout the validity or non-validity of the presented reasons. All other options for responding to the problems should be exploredbefore anyone concludes that death is the best remaining option.Such an approach would be able to respect mental reasonsfor choosing death as well as physical suffering.But when the suffering is ’merely’ mental,then we need to be especially carefulthat all of the alternative courses of action have been tried. Strangers and the news media will always be able to raise doubtsbased on limited information.But the legal deciders are the only

ones who must examineall the facts and opinions before deciding what to do. In another case reviewed by Herbert Hendin,the wife did all the talking for the patient who 'wanted to die'.Thus, there was no way to knowwhether he had a different view of his own impending death. This illustrates the need for better safeguardsto prevent 'voluntary death' from being a choice by others.Perhaps the best way would be to have a documentclearly written by the patient, proven to be his of her own viewby as many means of proof as might be workable.Especially when there might be any questionof pressure from other family members,safeguards should insure that the choice for deathis not only a wise choice given all the circumstancesbut that it is a free choice by the patient who wants to die. Of course, if the patient can no longer make a wise and informed decision,then the duly-authorized proxies should have the power to decide. In another case, a man newly diagnosed with HIVdecided he preferred to die now rather than waiting for AIDS to take him.His doctor explained that modern drugscould insure him several more years of disease-free life,But he still insisted on dying immediately.The doctor honored this autonomous wish. This reviewer agrees that just given these facts,this seems to have been an unwise, premature death.This 'autonomous decision' to die might have been basedat least in part on irrational fears of a terrible death in the future.But the patient with HIV was not sick and dying at the time he chose death.Perhaps he should have been helped to seethat choosing death later--when he actually got AIDS--would have been more rational than choosing death nowbecause he has the virus that causes AIDS.Comprehensive safeguards should protect peoplefrom their own foolish decisions,even if at the time they believe that death is the best option.Stated more broadly, safeguards should prevent irrational suicides.All of the safeguards linked from the catalog of safeguardsexplain in some detail how they would discourage irrational suicide. In the Netherlands, few requests for voluntary deathare referred to psychiatrists for evaluation.Hendin believes that some of the patients who chose deathwere suffering from psychological depressionthat should have been treated instead of granting their wish to die.The Dutch statistics show that the number of irrational suicideswhen down when the number of voluntary deaths went up.And the total of these two kinds of chosen death went up. Such problems with the numbers show the needfor clear lines separating voluntary deaths from irrational suicides.~~~~~~~~~~~~~~~Because of space limitations, cannot publish the rest of this review.It will be found on the Internet by searching these words: "One Book Opposing".And other books opposing the right-to-die will be found by searching:"Books Opposing the Right-to-Die".James Leonard Park, advocate for the right-to-die.

Assisted Suicide and End-of-Life Care Death Talk, Second Edition: The Case Against Euthanasia and Physician-Assisted Suicide CAT CARE: BEGINNERS GUIDE TO KITTEN CARE AND TRAINING TIPS (Cat care, cat care books, cat care manual, cat care products, cat care kit, cat care supplies) Euthanasia and Assisted Suicide: Global Views on Choosing to End Life Law at the End of Life: The Supreme Court and Assisted Suicide Euthanasia and Physician-Assisted Suicide (For and Against) Assisted Suicide and the Right to Die: The Interface of Social Science, Public Policy, and Medical Ethics Arguing Euthanasia: The Controversy Over Mercy Killing, Assisted Suicide, And The "Right To Die" The Nixon Administration and the Death of Allende's Chile: A Case of Assisted Suicide Suicide was at the end of my Rainbow: For those with suicidal ideations and suicide attempts Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying, 3rd Edition The Future of Assisted Suicide and Euthanasia (New Forum Books) Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide (Biomedical Law and Ethics Library) Summary: The Future of Assisted Suicide and Euthanasia by Neil Gorsuch: 45 Minutes - Key Points Summary/Refresher Understanding Assisted Suicide: Nine Issues to Consider (Writers on Writing) The Euthanasia/Assisted-Suicide Debate (Historical Guides to Controversial Issues in America) When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context Intending Death: The Ethics of Assisted Suicide and Euthanasia