

ARTICLE

# Euthanasia and Assisted Suicide Are Compatible with Palliative Care and Are Not Rendered Redundant by It

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## Abstract

It is often argued by health professionals working within the field of palliative care that palliative care and euthanasia/assisted suicide are incompatible. Across the literature, this claim is grounded on the three claims that (1) palliative care and euthanasia/assisted suicide have different aims, (2) euthanasia/assisted suicide is at odds with the doctor's fundamental role as a healer, and (3) euthanasia/assisted suicide constitutes patient abandonment. Furthermore, even if palliative care and euthanasia/assisted suicide are compatible, it is often argued that the availability of palliative care renders euthanasia/assisted suicide redundant. This depends on two claims that (1) palliative care is always available and effective, and (2) palliative care is always preferable to euthanasia/assisted suicide. This article argues that all of these claims are false, ultimately aiming to establish that palliative care and euthanasia/assisted suicide are complementary rather than mutually exclusive.

**Keywords:** euthanasia; assisted suicide; palliative care; doctor as healer; patient abandonment

Suppose that a fully conscious patient with a terminal illness, such as end-stage metastatic lung cancer, voluntarily requests to be killed by their doctor as a means to relieve their suffering. After other options are explored and discussed, and after it is ensured that the patient has provided informed consent, the doctor obliges and injects a lethal combination of drugs, with the full intention of those drugs killing the patient, as a means to respect their autonomy and relieve their suffering. This constitutes the paradigm case of “euthanasia” as I will use the term in this essay. Suppose that instead, the patient asks the doctor to supply a lethal combination of oral drugs that they can take at home. Again, the doctor obliges, with the full intention of those drugs killing the patient, as a means to respect their autonomy and relieve their suffering; this constitutes the paradigm case of “assisted suicide.”<sup>1</sup>

Now suppose, as a premise of this essay, that these paradigm cases of euthanasia and assisted suicide are not inherently unethical.<sup>2</sup> Nonetheless, it is often argued by health professionals working within the field of palliative care that palliative care and euthanasia/assisted suicide are incompatible.<sup>3</sup> Across the literature, this claim is grounded on the three claims that (1) palliative care and euthanasia/assisted suicide have different aims, (2) euthanasia/assisted suicide is at odds with the doctor's fundamental role as a healer, and (3) euthanasia/assisted suicide constitutes patient abandonment. Furthermore, even if palliative care and euthanasia/assisted suicide are compatible, it is often argued that the availability of palliative care renders euthanasia/assisted suicide redundant. This depends on two claims that (1) palliative care is always available and effective, and (2) palliative care is always preferable to euthanasia/assisted suicide. In this essay, I will argue that all of these claims are false. I will then explore some of the motivations surrounding views on the relationship between palliative care and euthanasia/assisted suicide, with the ultimate aim of establishing that palliative care and euthanasia/assisted suicide are complementary rather than mutually exclusive.<sup>4</sup>

## Palliative Care and Euthanasia Are Compatible

### *Palliative Care and Euthanasia Share the Same Aims of Promoting Autonomy and Relieving Suffering*

One of the key aims of palliative care is promoting autonomy.<sup>5</sup> Autonomy is just as important in palliative care as in any other medical specialty. However, euthanasia promotes autonomy as well, so the question beckons: “*Why is promoting autonomy at the end of life of the utmost ethical importance, just not when it comes to euthanasia?*” The standard response goes along the lines of: “because euthanasia does not actually promote autonomy—at least not in the same way as palliative care—because autonomy cannot reach so far as to include its own immediate destruction.”<sup>6</sup> This claim is false. To show this, consider the example of Richie Fernando SJ, a missionary working in Cambodia who dived on a grenade, sacrificing himself to save a classroom full of disabled children.<sup>7</sup> His decision to dive on the grenade was autonomous; thinking otherwise is absurd. Richie’s autonomous decision did include its own immediate destruction. Furthermore, according to any ethical theory that has autonomous action as a necessary criterion for ethical responsibility, if Richie’s action really was not autonomous, then he was not ethically responsible for his action and hence cannot be praised for it. This is equally absurd. Another problem with the claim that autonomy cannot extend to its own immediate destruction is vagueness as to what counts as “immediate.” Richie’s decision clearly meets this immediacy criterion, whereas a decision to sunbake and get badly sunburnt, leading to death from a melanoma in 40 years’ time, clearly does not. But what if Richie had given away almost all of his food to the children, resulting in him dying from starvation a few months later? This seems to fall into a gray area. The ethical significance of the immediacy criterion is also questionable in and of itself.

*Even if* the argument that autonomy cannot extend to its own immediate destruction were true, it applies equally to the “passive” end-of-life decisions essential to palliative care. Voluntary decisions to withhold or withdraw inappropriate or futile life-sustaining treatments, such as withholding cardiopulmonary resuscitation in the instance of cardiac arrest, or turning off a mechanical ventilator in a patient still dependent upon it, extinguish future autonomy in the same way as euthanasia or diving on a grenade. Lars Materstvedt and George Bosshard admit this, asking in relation to these “passive” palliative practices: “Has not the patient then contributed to extinguishing his autonomy? Put differently: Is there a moral duty to stay alive as long as possible in order that one be able to exercise one’s autonomy until the end?”<sup>8</sup> I think that this serves as an *argumentum ad absurdum* against the “autonomy cannot extend to its own immediate destruction” argument.

All of the aforementioned sources agree that the other key aim of palliative care is relieving suffering. “Suffering” includes physical symptoms (e.g., pain, shortness of breath, nausea, and vomiting), which may be alleviated through opioids or other drugs. It also includes emotional, psychological, spiritual, and existential suffering, for example, feeling confused, angry, or scared; feeling worthless or hopeless; or feeling like a burden on others. Avoiding these different types of suffering is largely achieved through avoiding the inappropriate and unnecessary prolongation of dying, that is, by withholding or withdrawing inappropriate or futile life-sustaining treatments.<sup>9</sup> However, euthanasia relieves suffering as well, so the question beckons: “*Why is relieving suffering at the end of life of the utmost ethical importance, just not when it comes to euthanasia?*” The standard response goes along the lines of: “because euthanasia does not actually relieve suffering—at least not in the same way as palliative care—rather, euthanasia *ends* suffering.”<sup>10</sup> This is also false. Distinguishing between “relieving” and “ending” suffering is both ontologically and ethically tenuous. Palliative care and euthanasia both ultimately aim at *achieving an absence of suffering*; the terms “relieving” and “ending” just pick out different means to that shared end. Euthanasia achieves an absence of suffering indirectly by virtue of removing the potential for that suffering (via death; the suffering is “ended”). Conversely, “relieving” suffering combats the suffering directly. This difference does not seem ethically significant to me. Although *even if it is*, palliative care often “ends” suffering just as much as euthanasia does. Withholding cardiopulmonary resuscitation, or turning off a mechanical ventilator, despite arguably being “passive” processes, still have the end result of death coming about sooner, thereby removing the potential for continued suffering by “ending” it.

Furthermore, consider the less common but nonetheless important “active” palliative care practice of “continuous deep palliative sedation,” whereby dying patients are sedated to the level of unconsciousness and then allowed to die via withholding or withdrawing inappropriate or futile life-sustaining treatments. *Even if* continuous deep palliative sedation does not hasten or bring about death itself, it too removes the potential for suffering and thereby “ends” rather than “relieves” suffering by virtue of its permanently sedating patients to unconsciousness so that they can no longer suffer. On the previous point, it also prevents that patient from ever exercising their autonomy again. Owing to this, Materstvedt and Bosshard admit that continuous deep palliative sedation “has an unclear border with euthanasia.”<sup>11</sup>

### *Euthanasia Is Not at Odds with the Doctor’s Fundamental Role in the Palliative Setting*

It is often argued that euthanasia is “fundamentally incompatible with the physician’s role as a healer.”<sup>12</sup> The British Medical Association similarly claims that euthanasia is “contrary to the ethics of clinical practice, as the principal purpose of medicine is to improve patients’ quality of life, not to foreshorten [them].”<sup>13</sup> This argument is deeply misguided. *Whilst healing is usually one of the fundamental roles of a doctor, it is not one of their fundamental roles in the palliative setting.* This reflects the central tenet of palliative care: it *palliates* rather than striving for a cure or “heal.” Michael Rabow and Steven Pantilat explain that until recently it was—and sometimes still is—incorrectly assumed that death “is a failure of medical science [... and] an enemy to be battled furiously in hospitals rather than an inevitable outcome to be experienced as a part of life.”<sup>14</sup> Karen Steinhauer *et al.* provide a similar explanation.<sup>15</sup> Palliative care originated as a response to these misconceptions, which was necessary because of observations such as those found in one study in which 38 percent of patients dying in a hospital spent at least 10 days in the Intensive Care Unit before death, 50 percent of family members reported moderate or severe pain in the patient at least half of the time, and median hospital charges for families were between USD \$21,000 and \$29,000.<sup>16</sup> Owing to the palliative care movement, the modern management of dying patients has become much more appropriate. Palliative care correctly recognizes that “death is not necessarily a defeat.”<sup>17</sup> The doctor’s role beyond that of a healer is recognized by medical bodies globally; for example, the British Medical Association emphasizes that it “does not believe that it is appropriate to prolong life at all costs, with no regard to its quality or the burdens of the intervention.”<sup>18</sup> For these reasons, euthanasia is not at odds with the doctor’s fundamental role in the palliative setting.

### *Euthanasia Does Not Necessarily Constitute Patient Abandonment*

Patient nonabandonment is of the utmost ethical importance.<sup>19</sup> This is also recognized by Heather Cereste and Joseph Fins, who claim that nonabandonment is the doctor’s “primary responsibility.”<sup>20</sup> Similarly, James Marcum claims that “passionate physicians do not abandon their patients; [...] the physician pledges to see the patient through to the end,”<sup>21</sup> and Rabow and Pantilat claim that “the promise of nonabandonment is perhaps the central principle of end-of-life care and is the [doctor’s] pledge to an individual patient as a caring partner.”<sup>22</sup> These sources strongly imply that euthanasia constitutes patient abandonment; the suggestion is that euthanasia does not accompany the patient right up until the end, and instead “only goes halfway” by taking the easy way out and bringing about death prematurely. This is incorrect. Palliative care and euthanasia are alternative options at the end of life. I agree that if a patient requests palliative care but is instead offered euthanasia then that patient has been abandoned. *By the same token, if a patient requests euthanasia (as an informed decision) but is instead offered palliative care then that patient has also been abandoned.* When a patient has sufficient decision-making capacity, respecting that patient’s autonomous decision is what constitutes companionship, whether that decision is for palliative care or euthanasia.

### Palliative Care Does Not Render Euthanasia Redundant

Now suppose that euthanasia is not inherently incompatible with palliative care. Nonetheless, it is often argued that palliative care renders euthanasia redundant.<sup>23</sup> This redundancy claim in turn depends on two claims: (1) the factual claim that palliative care is always available and effective, and (2) the stronger ethical claim that palliative care is always preferable to euthanasia. Both of these claims are false.

#### *The Factual Claim that Palliative Care Is Always Available and Effective*

The “always” qualifier should make the falsity of this claim obvious. Let us turn to Australia as an example. The Australian and New Zealand Society of Palliative Medicine admits that there are “significant deficits in the [current] provision of palliative care”<sup>24</sup> and that the “Specialist Palliative Care workforce is currently too small to be able to care for all [patients dying expected deaths in Australia and New Zealand] and their families, loved ones and carers, even though this would be highly desirable.”<sup>25</sup> It also identifies various “evidence-to-practice gaps,” which impede the provision of palliative care, including the coordination and integration of care (e.g., opioid access through community pharmacies) and management of the terminal phase (the last 7–10 days of life).<sup>26</sup> It also identifies a number of vulnerable populations, including “patients with [noncancerous] life-limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations, and those from culturally and linguistically diverse backgrounds.”<sup>27</sup> Many interlocutors agree that palliative care should always be available and have formulated plans to achieve this goal.<sup>28</sup> For instance, the Australian and New Zealand Society of Palliative Medicine boldly claims that palliative care is “achievable for all patients” and that “all primary care and specialist providers, patients and families should have access to specialist palliative care in all settings.”<sup>29</sup> I agree that this would be ideal, although I suspect that it is naïve. No doubt the availability of palliative care can be substantially improved. But it is important not to conflate this *should* claim with the current state of affairs. *Even if* palliative care will be available to everyone at some point in the future, this is not currently the case.

Irrespective of its availability, it is widely (and regrettably) recognized that palliative care is not always completely effective.<sup>30</sup> For example, the Australian Medical Association admits that “there are some instances where it is difficult to achieve satisfactory relief of suffering,”<sup>31</sup> and the Australian and New Zealand Society of Palliative Medicine admits that “despite the best that palliative care can offer to support patients in their suffering, appropriate specialist palliative care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.”<sup>32</sup> Furthermore, I have stressed that suffering extends beyond physical symptoms. It is more feasible to relieve someone’s pain than it is to relieve, for example, their loss of independence and their indignity owing to dual incontinence. Palliative care can and does incorporate psychological, emotional, spiritual, and existential aspects of care; however, it is simply false that palliative care is always able to relieve these kinds of suffering.

#### *The Ethical Claim that Palliative Care Is Always Preferable to Euthanasia*

Suppose for the sake of argument that palliative care is always available and effective. It still would not render euthanasia redundant because the ethical claim is false; palliative care is not always preferable to euthanasia. As before, the “always” qualifier should make the falsity of this claim obvious.

The most immediate reason for preferring euthanasia to palliative care is if the patient requests euthanasia rather than palliative care. But opponents correctly argue that a request for euthanasia may not necessarily be *voluntary*. Ensuring voluntariness is difficult, perhaps even impossible.<sup>33</sup> “Voluntary” means “supported with informed consent,” which in turn most interlocutors agree has three necessary and sufficient criteria: sufficient provision of information, sufficient decision-making capacity (which is decision-specific and may vary with time), and freedom from coercion.<sup>34</sup> Although the first criterion should always be ensured, decision-making capacity can be undermined by dementia, clinical depression, or judgment clouded by pain; and subtle coercion may be introduced if the patient feels like an

emotional or financial burden on their family, or like a financial burden on their state.<sup>35</sup> Clinical tests for measuring decision-making capacity do exist, however, their reliability is questionable.<sup>36</sup>

Ensuring voluntariness in requests for euthanasia through advance care directives (ACDs) has its own host of problems; for example, unambiguous wording is difficult to achieve and it is difficult to know what one would *really* want ahead of time.<sup>37</sup> ACDs are especially problematic in the context of dementia: depending on one's theory of personal identity, if the current patient with dementia is not the same person as the last person at the time when the ACD was written, then the ACD should have no bearing on the current patient. Conversely, if the patient is still the same person as the past person, there may nonetheless be a conflict of interests, in which case it is contentious as to whose interests should be prioritized.<sup>38</sup> There are also problems in ensuring voluntariness owing to the relinquishing of control in the final moments of the euthanasia procedure itself: if the patient gets cold feet it might be too late for them to reverse their decision.<sup>39</sup>

I do not have solutions to the problems of ensuring that a direct request for euthanasia is voluntary or ensuring that a request for euthanasia via an ACD is voluntary. *What I do want to point out, however, is that it has been overlooked that these problems apply equally to "passive" palliative practices: a request for withholding or withdrawing inappropriate or futile life-sustaining treatments might also have its voluntariness undermined by any of these problems.* Therefore, these problems cannot be reasons for preferring palliative care to euthanasia.

Interlocutors claiming that palliative care makes euthanasia redundant often point toward the evidence that, when offered palliative care, many patients withdraw their request for euthanasia.<sup>40</sup> There is also evidence that in the United Kingdom, where palliative care is more widely available than in most other places, requests for euthanasia are less frequent than elsewhere.<sup>41</sup> This shows that some patients prefer palliative care to euthanasia—of course, they do!—but it does not show that this is the case for all patients. Furthermore, we have only been presented one side of the story: no doubt many patients being offered palliative care would opt for euthanasia if it were made available to them. Ideally, patients would have access to both palliative care and euthanasia, allowing them to make an informed choice for one or the other. Robert George, Ilora Finlay, and David Jeffrey<sup>42</sup> are correct in arguing that choosing euthanasia when palliative care is not available as an alternative option for consideration is unideal, although the converse is also true: choosing palliative care when euthanasia is not available as an alternative option for consideration is also unideal. So even if palliative care was universally available, it still would not render euthanasia redundant.

There are often good reasons for preferring euthanasia to palliative care. The most common reasons for requesting euthanasia include: wanting to avoid indignity, unbearable or hopeless suffering, and functional decline; loss of enjoyable activities and weariness of life; not wanting to become a burden on family; and wanting to maintain control of death and desiring a good quality of death.<sup>43</sup> It is reasonable that some patients "do not want to live through a deteriorating physical and psychological process that inevitably leads to death."<sup>44</sup> For many patients, euthanasia is primarily "a way of limiting the loss of self due to personal disintegration"<sup>45</sup> and a way of controlling the manner and timing of death.<sup>46</sup> Palliative care simply cannot achieve this, irrespective of its capacity to alleviate pain and other symptoms. This is not a radical view; almost two-thirds of Dutch doctors in one empirical study agree with me.<sup>47</sup>

### Accepting Euthanasia as Being Complementary to Palliative Care Does Not Indicate the Failure of Palliative Care and Should Not Threaten to Subtract from It

Suppose that I have succeeded in establishing that palliative care and euthanasia are compatible and that the former does not render the latter redundant. In the final part of this essay, I will consider the two main motivations for the arguments that palliative care and euthanasia are incompatible and that the former renders the latter redundant, in order to better elucidate the relationship between palliative care and euthanasia.

The first main motivation is that euthanasia is perceived as an indicator of palliative care's failure. The American Medical Association describes requests for euthanasia as being "tragic."<sup>48</sup> Deborah Kirklín

claims that “a call for euthanasia is an indictment of the care being given,” and “whilst death is clearly not viewed as a sign of failure in palliative care, it would seem that a call from the patient for help in dying often is.”<sup>49</sup> Materstvedt and Bosshard claim that euthanasia “should be unnecessary if terminal care patients are properly cared for.”<sup>50</sup> Rabow and Pantilat claim that the right to die movement is an “expression, at least in part, of patient dissatisfaction with how people are cared for at the end of life.”<sup>51</sup> However, I maintain that an individual’s personal preference for euthanasia does not necessarily reflect a failure of palliative care and vice versa. Euthanasia is sometimes more successful at relieving suffering than palliative care; *always* expecting palliative care to relieve physical suffering—let alone nonphysical suffering—is unreasonable and is not a “failing” of palliative care in any important sense.

The other main motivation for the argument that palliative care renders euthanasia redundant is that euthanasia threatens to detract from palliative care.<sup>52</sup> I have argued that it is important that palliative care does not detract from euthanasia, *although I have not stressed enough that the opposite is also true*. Palliative care is invaluable. When euthanasia becomes legalized in more jurisdictions across the world, political and organizational bodies should, and no doubt will continue to lobby for increased palliative care funding, emphasizing the responsibility of providing good quality palliative care regardless of the ethics or current laws on euthanasia. Palliative care and euthanasia are not “like fire and water” (as Materstvedt and Bosshard query)<sup>53</sup>; rather, they should be viewed as complementary alternatives at the end of life. This is how palliative care and euthanasia are viewed under the Belgian model of “integral palliative care,”<sup>54</sup> which I believe to be the correct view.

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## Notes

1. I have deliberately not *defined* the terms “euthanasia” and “assisted suicide” since there is considerable disagreement amongst interlocutors as to what the correct definitions of the terms actually are, and as to whether or not certain *nonparadigm* cases constitute euthanasia or assisted suicide. This is a topic for another essay. For the purposes of this essay, it will suffice to focus on the aforementioned paradigm cases. It is also important to note that “informed consent” implies that the patient has sufficient decision-making capacity and that the decision has been made free from any coercion.
2. This premise could of course be contended, although this is also a topic for another essay.
3. American Medical Association. *AMA Code of Medical Ethics: Opinions on Caring for Patients at the End of Life*; 2016; available at <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf> (last accessed 11 Mar 2018); Australian and New Zealand Society of Palliative Medicine. *Position Statement on the Practice of Euthanasia and Assisted Suicide*; 2017; available at <http://www.anzspm.org.au/c/anzspm?a=da&did=1005077> (last accessed 5 Mar 2018); British Medical Association. *End-of-Life Decisions: Views of the BMA*; 2009; available at <http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z> (last accessed 11 Mar 2018); British Medical Association. *Physician-Assisted Dying*; 2017; available at <http://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/physician-assisted-dying> (last accessed 11 Mar 2018); Palliative Care Australia. *Position Statement on Euthanasia and Physician Assisted Suicide*; 2016; available at <http://palliativecare.org.au/position-statements> (last accessed 5 Mar 2018); World Health Organization. *WHO Definition of Palliative Care*; 2018; available at <http://www.who.int/cancer/palliative/definition/en/> (last accessed 11 Mar 2018).
4. For the sake of brevity, in the rest of this essay, I will refer only to euthanasia, although the same arguments apply equally to assisted suicide unless otherwise stated.

5. See [note 3](#), American Medical Association 2016; Australian and New Zealand Society of Palliative Medicine. *ANZSPM Position Statement on Quality End-of-Life Care – Part 1*; 2014; available at <http://www.anzspm.org.au/c/anzspm?a=da&did=1005077> (last accessed 11 Mar 2018); Australian Medical Association. *Role of the Doctor*; 2011; available at <https://ama.com.au/position-statement/role-doctor-2011> (last accessed 11 Mar 2018); Australian Medical Association. *Position Statement on End of Life Care and Advance Care Planning*; 2014; available at <https://ama.com.au/position-statement/end-life-care-and-advance-care-planning-2014> (last accessed 11 Mar 2018); Cereste HX, Fins JJ. Common indications for ethics consultation. In: McKean SC, Ross JR, Dressker DD, Brotman DJ, Ginsbery JS, eds. *Principles and Practice of Hospital Medicine*. New York: McGraw-Hill; 2012:209–15, at **209**; Rabow MW, Pantilat SZ. Palliative care and pain management. In: Papasakis MA, McPhee SJ, eds. *Current Medical Diagnosis and Treatment 2014*. New York: McGraw-Hill; 2013:Sec. 4.1.2–4.1.7, at Sec. 4.1.7, Para. 1; See [note 3](#), Palliative Care Australia 2016; Bernacki RE, Meier DE. Principles of palliative care. In: McKean SC, Ross JR, Dressker DD, Brotman DJ, Ginsbery JS, eds. *Principles and Practice of Hospital Medicine*. New York: McGraw-Hill; 2012:1781–85, at 1783; Kane RL, Ouslander JG, Abrass IB, Resnick B. Ethical issues in the care of older persons. In: *Essentials of Clinical Geriatrics*. 7th ed. New York: McGraw-Hill; 2013:447–65; World Medical Association. *Medical Ethics Manual*. 3rd ed. Ferney-Voltaire: World Medical Association; 2015; available at <https://www.wma.net/what-we-do/education/medical-ethics-manual/> (last accessed 5 Mar 2018).
6. Materstvedt LJ, Bosshard G. Euthanasia and physician-assisted suicide. In: Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy R, eds. *Oxford Textbook of Palliative Medicine*. 4th ed. New York: Oxford University Press; 2009:304–19, at **316**.
7. Richie Fernando SJ. Unknown author; 2006; available at <http://20thcenturymartyrs.blogspot.com.au/2006/07/richie-fernando-sj.html> (last accessed 11 Mar 2018). Please note that, actually, the facts of the matter are a little hazier than this. A troubled student came into class with a grenade and threatened to use it, so Richie restrained the student. The grenade fell to the floor and exploded, killing Richie whilst he was shielding the troubled student. Whether or not Richie deliberately martyred himself by diving on the grenade to save the troubled student and all the other students is not completely clear; please grant that he did for the sake of the example.
8. See [note 6](#), Materstvedt, Bosshard 2009, at 316.
9. See [note 5](#), Australian and New Zealand Society of Palliative Medicine 2014.
10. See [note 6](#), Materstvedt, Bosshard 2009, at 315–6.
11. See [note 6](#), Materstvedt, Bosshard 2009, at 316.
12. See [note 3](#), American Medical Association 2016.
13. See [note 3](#), British Medical Association 2017.
14. See [note 5](#), Rabow, Pantilat 2013, at Sec. 4.1.2, Para. 2.
15. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;**284** (19):2476.
16. Knaus WA. A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatments (support). *JAMA* 1995;**274**(20):1591–98.
17. Marcum JA. *An Introductory Philosophy of Medicine: Humanizing Modern Medicine*. Heidelberg: Springer; 2008, at 13.
18. See [note 3](#), British Medical Association 2009.
19. See [note 3](#), American Medical Association 2016; See [note 5](#), World Medical Association 2015.
20. See [note 5](#), Cereste and Fins 2012, at 213.
21. See [note 17](#), Marcum 2008, at 325.
22. See [note 5](#), Rabow, Pantilat 2013, at Sec. 4.1.3, Para. 3.
23. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 7th ed. New York: McGraw-Hill; 2010:152–3; Lo B. Ethical issues in clinical medicine. In: Longo DL, Fauci AS, Kasper DL, Hauser SL, Jameson JL, Loscalzo J, eds. *Harrison's*

- Principles of Internal Medicine*. 18th ed. New York: McGraw-Hill; 2012, at Sec. e5.3; See note 3, British Medical Association 2009; See note 3, British Medical Association 2017; Young R. Voluntary euthanasia. In: Zalta EN, ed. *Stanford Encyclopedia of Philosophy*. Stanford: Stanford University; 2010; available at <http://plato.stanford.edu/archives/fall2010/entries/euthanasia-voluntary/> (last accessed 11 Mar 2018).
24. See note 3, Australian and New Zealand Society of Palliative Medicine 2017.
  25. See note 5, Australian and New Zealand Society of Palliative Medicine 2014.
  26. See note 5, Australian and New Zealand Society of Palliative Medicine 2014.
  27. See note 3, Australian and New Zealand Society of Palliative Medicine 2017.
  28. See note 3, Palliative Care Australia 2016.
  29. See note 5, Australian and New Zealand Society of Palliative Medicine 2014.
  30. See note 5, Bernacki, Meier 2012, at 1783; Karlawish JHT, James BD. Ethical issues. In: Halter JB, Ouslander JG, Tinetti ME, Studenski S, High KP, Asthana S, eds. *Hazzard's Geriatric Medicine and Gerontology*. 6th ed. New York: McGraw-Hill; 2009:399–406, at 404.
  31. Australian Medical Association. *Euthanasia and Assisted Suicide*; 2016; available at <https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016> (last accessed 11 Mar 2018).
  32. See note 3, Australian and New Zealand Society of Palliative Medicine 2017.
  33. See note 23, Young 2010.
  34. Charland L. Decision-making capacity. In: Zalta EN, ed. *Stanford Encyclopedia of Philosophy*. Stanford: Stanford University; 2011; available at <http://plato.stanford.edu/archives/sum2011/entries/decision-capacity/> (last accessed 11 Mar 2018); Eyal N. Informed consent. In: Zalta EN, ed. *Stanford Encyclopedia of Philosophy*. Stanford: Stanford University; 2012; available at <http://plato.stanford.edu/archives/fall2012/entries/informed-consent/> (last accessed 11 Mar 2018).
  35. See note 5, Bernacki Meier 2012, at 1785; See note 3, British Medical Association 2009; George RJD, Finlay IG, Jeffrey D. Legalised euthanasia will violate the rights of vulnerable patients. *British Medical Journal* 2005;**331**(7518):684–85; See note 23, Jonsen et al. 2010, at 152–3; Hendry M, Pasterfield D, Lewis R, Carter B, Hodgson D, Wilkinson C. Why do we want the right to die? A systematic review of the international literature on the views of patients, carers and the public on assisted dying. *Palliative Medicine* 2013;**27**(1):13–26, at 20–21; See note 6, Materstvedt, Bosshard 2009, at 313–4; Battin MP, van der Heide A, Ganzini L, van der Wal G, Onwuteaka-Philipsen BD. Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in 'vulnerable' groups. *Journal of Medical Ethics* 2007;**33**(10):591–97, at 596; Oxenham DR. Pain management and palliative care. In: Colledge NR, Walker BR, Ralston SH, eds. *Davidson's Principles and Practice of Medicine*. 21st ed. Edinburgh: Churchill Livingstone Elsevier; 2010, at 287.
  36. See note 34, Charland 2011.
  37. See note 5, Australian Medical Association 2014; See note 3, British Medical Association 2009; See note 23, Young 2010.
  38. Jaworska A. Advance directives and substitute decision-making. In: Zalta EN, ed. *Stanford Encyclopedia of Philosophy*. Stanford: Stanford University; 2009; available at <http://plato.stanford.edu/archives/sum2009/entries/advance-directives/> (last accessed 11 Mar 2018). Note that ACDs originated as legal tools to be used in the context of permanent comas and persistent vegetative states. In this setting, ACDs are very successful; however, for the aforementioned reasons, they are less suited to dementia.
  39. This is one of the reasons for preferring assisted suicide to euthanasia; however, comparing the pros and cons of euthanasia versus assisted suicide lies beyond the scope of this essay.
  40. See note 5, Bernacki Meier 2012, at 1785; Kirklin D. The role of the humanities in palliative medicine. In: Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy R, eds. *Oxford Textbook of Palliative Medicine*. 4th ed. New York: Oxford University Press; 2009:1603–12, at 1605; See note 23, Lo 2012; See note 6, Materstvedt, Bosshard 2009, at 315; See note 5, Rabow, Pantilat 2013, at Sec. 4.1.6, Para. 1; See note 35, Oxenham 2010, at 287.
  41. See note 6, Materstvedt, Bosshard 2009, at 315.



42. See [note 35](#), George et al. 2005, at 685.
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44. See [note 6](#), Materstvedt, Bosshard 2009, at 314.
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46. See [note 40](#), Kirklin 2009, at 1605.
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48. See [note 3](#), American Medical Association 2016.
49. See [note 40](#), Kirklin 2009, at 1605.
50. See [note 6](#), Materstvedt, Bosshard 2009, at 315.
51. See [note 5](#), Rabow, Pantilat 2013, at Sec. 4.1.6, Para. 1.
52. See [note 35](#), Hendry et al. 2013, at 14, 21; See [note 23](#), Jonsen et al. 2010, at 151.
53. See [note 6](#), Materstvedt, Bosshard 2009, at 315.
54. See [note 6](#), Materstvedt, Bosshard 2009, at 315.