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# Morality vs. Mortality: The Ethics of Physician-Assisted Death in the United States

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**Abstract**

According to the American Academy of Hospice and Palliative Medicine, physician-assisted death is defined as a physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life (American Academy of Hospice and Palliative Medicine, n.d.). This paper will examine the different perspectives on the prevalent issue revolving around the ethics and criminality of physician-assisted death and euthanasia in the medical field – a heavily debated topic since the concept was conceived. It will explore the history and controversy revolving around the practice using ethical, faith-based, and scientific perspectives relating respectively to the ideas of death with dignity, autonomy, vitality, and the sacredness of life as well as taking the criminal aspect of it into consideration. In order to understand the correlation between political, religious, and social beliefs and the support for the legalization of physician-assisted death, this paper will explore and analyze Gallup's 2018 Values and Beliefs poll regarding physician-assisted death and public opinion. The ultimate goal of this research paper is to allow the reader to become more informed on the topic of physician-assisted death and to shed light on the differing perspectives regarding the controversial subject.

**Historical Background**

In ancient Greece, suicide was considered to be the "humane choice when facing the curse of sickness." The word euthanasia in Greek quite literally means good (*eu*) death (*thanatos)*. Greek and Roman culture preferred "voluntary death over endless agony," and could have a physician give them medication that would bring about their own demise (Bando, 2018). It was a culturally accepted and celebrated practice that held no negative connotations as people had control over their own lives, including whether or not they wished to end it due to an illness in order to preserve peace of mind. This was often carried out through the use of hemlock that was given by Greek city magistrates, and as long as it was used in the case of someone with an incurable or causing extreme torment and suffering to an individual, the concept of hastening death was not uncommon (Bando, 2018). The Hippocratic Oath, a pledge in which a physician agrees to prescribe treatments that are solely beneficial and refrain from causing harm towards patients, explicitly states that "(…) I will not give a drug that is deadly to anyone if asked (for it), nor will I suggest the way to such a counsel: (National Library of Medicine, 2002). This did not prevent Ancient Greek and Roman physicians from offering these euthanasia-inducing drugs.

This perspective has changed with different cultures and religions, the root of "official opposition to suicide in the Christian tradition" stemming from the ideology of Augustine (c. 354-430). Augustine was one of the first theologians who wrote about the prohibition of suicide, basing his condemnation on the following premises: "(1) scripture does not specifically permit it, (2) it violates the fifth commandment, (3) killing oneself is homicide since it is not ae n authorized, punishable killing, and (4) suicide allows no opportunity for repentance" (Bando, 2018). In Christianity, there is a notion that God trusts those He created with life and that

shortening it would go against God's plan and may deny permission into the afterlife or reincarnation (Brenna, 2021). In other words, suffering is a part of life that must be accepted due to its divinity. Common Law condemned and forbade physician-assisted death (also referred to as PAD) in British and French colonies, which eventually spread to areas such as the Americas – this would continue on for centuries before the idea of legalizing euthanasia was brought into light (Brenna, 2021).

In the United States, the first euthanasia bill was proposed in 1906 in Ohio, and by 1947, roughly 37 percent of individuals supported PAD. Though the advocates for legalizing euthanasia in the early 1900s were the minority of the population, the procedure was still being practiced in a relatively secret manner (Dugdale, et al., 2019). One of the first accounts of assisted death in the United States appeared in Lael Wertenbaker's 1958 book, *Death of a Man,* where she wrote about "her husband's battle with terminal cancer and how she ultimately helped him commit suicide to ease his suffering." One infamous case of PAD in the U.S. was the case of Dr. Jacob "Jack" Kevorkian, also known by the nickname of "Dr. Death" due to euthanizing over 100 people in Michigan during the 1990s. Kevorkian advertised himself in a local Detroit newspaper of being a "death counselor," having studied Dutch physicians in the Netherlands and their techniques of assisted death (Dugdale, et al., 2019). Following this research, he would create an instrument similar to lethal injection called the 'Thanatron' (Greek for "Instrument of Death"), an automated drip connected to an IV that allowed patients to "trigger an injection that began by putting them to sleep, then stopping their hearts while they were unconscious.

In 1998, Kevorkian videotaped the death of Thomas Youk, a man who was suffering from Lou Gehrig's disease. He submitted the video to CBS's *60 Minutes* where it showed Kevorkian injecting Youk, to which he was subsequently charged with second-degree murder rather than

assisted death. This raised many questions, however, about whether or not he was at fault (Tetrault, 2021). A handful of his supporters filed a lawsuit against the Attorney General of New York, claiming that the state prohibiting physician-assisted death was in violation of the 14th Amendment's Equal Protection Clause – per their argument, "the right to refuse treatment was effectively the same as the right to end one's life" (Dugdale, et al., 2019). In *Vacco v. Quill* (1997), a case regarding whether or not prohibiting euthanasia is in violation of the 14th Amendment, it was decided that there is no violation of the Equal Protection Clause when a state criminalizes assisted death. In short, this case decided that the Constitution does not protect the right to die. Along with this, the 1997 case *Washington v. Glucksberg* furthered this by ruling that aid in death is not protected by the Due Process Clause (Legal Information Institute, 2019).

From a modern perspective, the debate is as such – even if there are numerous opportunities for a patient to ensure proper consent to this procedure, is physician-assisted death ethical? Now, this can be answered through multiple different perspectives, whether it be faith-based, morality-based, or based on societal norms as a whole, all of which contribute to this ongoing argument.

**Facts & Figures**

In 1994, Oregon was the first in the United States to legalize PAD. A ballot containing the Death With Dignity Act was approved by Oregon voters – by passing this act, physicians were allowed to prescribe "a lethal dose of medication that a patient voluntarily self-administers" (Ganzini & Back, 2016). An anonymous survey conducted by mail in 1996 was administered to the American Medical Association's master file of physicians practicing in the United States, and only included doctors that were less than 65 years old. The sample drawn represented roughly 40% of this population, which was 3,102 physicians – only 1,902 questionnaires were

completed. This survey revealed that across America, 11% of physicians would be willing to prescribe medication to quicken a patient's death, 7% would be willing to provide a lethal injection (36% and 24% would if it were legal, respectively). 42 out of 516 physicians who had requests for assisted death had written at least one prescription to hasten death, and 59 had administered at least one lethal injection (Emmons, et. al., 1998).

Oregon was the only state in which this practice was legal until 2008 when Washington joined alongside Oregon in legalizing PAD, followed by Vermont in 2013 and California in 2015. Currently, Washington, D.C., California, Colorado, Oregon, Vermont, New Mexico, Maine, Montana, New Jersey, Hawaii, and Washington have all legalized this procedure. Data reports from 18 years (1998-2015) in Oregon and 7 years (2009-2015) in Washington reveal that physician-assisted death accounts for fewer than 0.4% of all deaths. In Oregon, the rate of deaths by request ranges between 47.7% and 81.8%, and there has been a steady increase of requests for physician-assisted death each year. Around 75% of those that opt for this end-of-life option are dying of cancer, and typically less than 15% have neurodegenerative diseases (Emanuel, et. al., 2016).

The Gallup's annual Values and Beliefs poll shows that as of 2017, public support for PAD has risen to roughly 73%, the highest percentage since 2005. Similarly, as of 2019, out of a random sample of 1,000 physicians, 60% of physicians believe that PAD should be legal. This study published by the National Library of Medicine shows that of that 60%, 13% answered that they would perform this practice if legal. 49% of this sample agreed that pain was the main reason for patients seeking out PAD, and 58% agreed that current safeguards for PAD are adequate. Of those who claimed they would not perform this procedure, 47% cited lack of

training/expertise, 11% for religious reasoning, 7% for legal implications/hurdles, and 5% were due to ethical and moral oppositions (Hetzler, et. al.).

**End-Of-Life Options**

End-of-life care refers to the period of time in which a seriously ill patient has a condition that will cause their death. In the United States, there are a few options outside of PAD that can be explored. Hospice care is an option in which the quality of life of the ill patient is the priority, treating the symptoms of the disease rather than the actual disease itself. It is family-centered, allowing the family to help make decisions regarding the care the patient is receiving (American Cancer Society, 2023). Palliative care, on the other hand, is used to prevent side effects and symptoms to a condition rather than treat the condition itself. It can help manage discomfort, nausea, pain, and other negative symptoms that may reduce a patient's quality of life. Palliative care can be given at any time during a serious illness, and hospice is given when a person's condition cannot be controlled by targeted treatment (American Cancer Society, 2023). Hospice is often given to patients while they are in the comfort of their own home as it is a private and familiar setting that can ease the negative feelings that may arise about a life nearing its end. Visiting nurses can be a more convenient way of getting hospice while at home, along with having hospital bed and bedside commodes be arranged to have in their rooms (National Institute on Aging, 2022).

There have been public concerns, however, on the quality of the United States' end-of-life care options. The Journal of Palliative Medicine published an article from 325 doctors that "in recent years, we have observed an increasing prevalence of serious deficiencies in hospice care and high variability in quality of care" (Byock, 2023). Ira Byock, the author of the article (2023), is a long-time hospice and palliative care physician and wrote about how there are issues

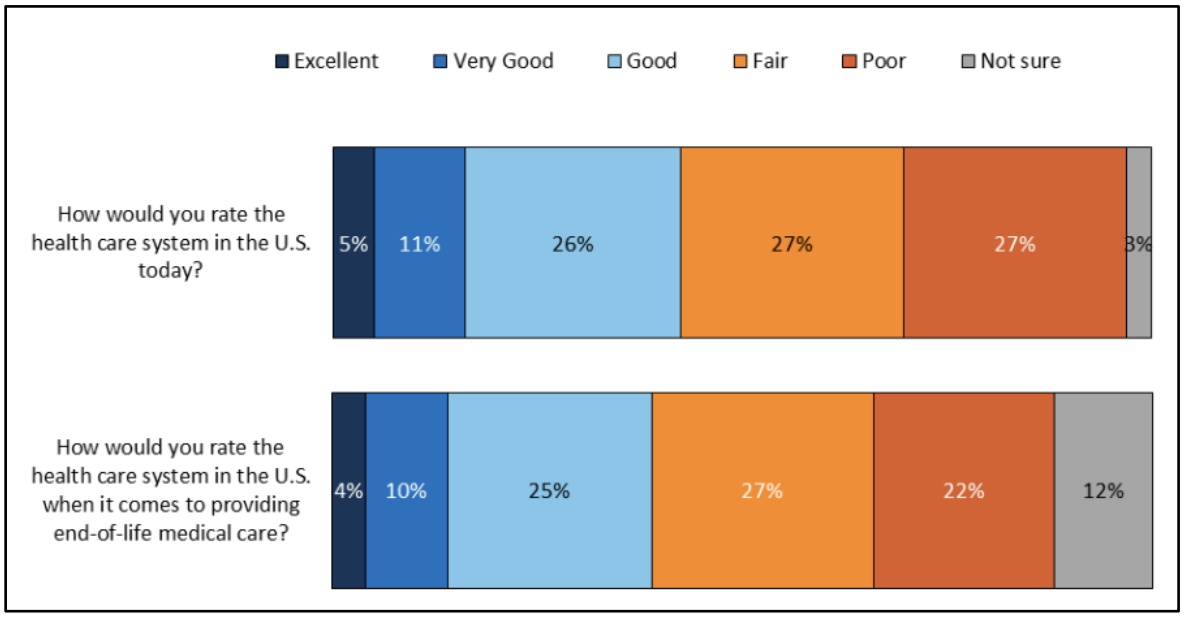
regarding limited physician involvement in patient care, unmanageable caseloads, and inadequate care teams available for hospice and palliative care. He goes on to say that legislative changes for improving this type of care are not enough as there have been many calls over the years from advocates without compliance from Congress, but there needs to be more effort into protecting the quality of hospice and palliative care, to understand the patient's needs in a vulnerable situation, and improving the options in general (Byock, 2023).

Similarly, the president of the American Academy of Hospice and Palliative Care, Dr. Holly Yang, was said to have thought that challenges faced do not have to do with nonprofit vs. for-profit ownership of hospice care as much as it is about the fact that hospice care has not changed with the times. In the early days of hospice, it focused primarily on cancer (which has a course that is more predictable and shorter course than other treatments), but now involves patients with dementia and congestive heart failure among other conditions which has a much less predictable course. With this being said, people who live longer with these conditions may need support for longer, but it is difficult to know when the best time to act on it (Kenen, 2023).

A study conducted by the Kaiser Family Foundation in 2016 was administered to rate the healthcare system for its provided end-of-life care. In terms of satisfaction ratings, 49% said that the system was "fair" or "poor," whereas only 14% said it was "excellent" or "good" (*Figure 1*). Furthermore, the study found that people tend to value allowing death to be a painless experience rather than preventing death in general. 71% of respondents claimed that helping people die without pain, discomfort, and stress was the most important when it comes to health care at the end of people's lives, and only 19% believed preventing death and extending life as long as possible to be more important. When asked how they felt about how well the health care system

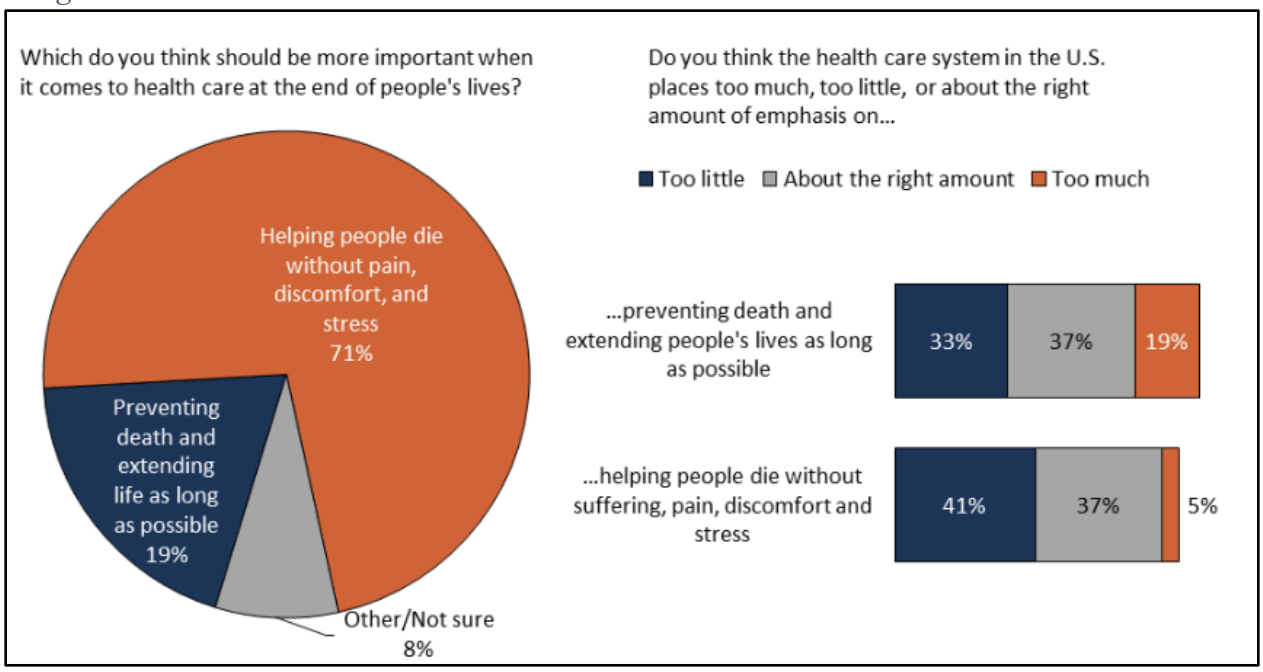
in the United States was addressing this, most claimed that the system was putting too little emphasis on both of these issues (Hamel, et. al., 2017) (*Figure 2*).

*Figure 1*




SOURCE: Kaiser Family Foundation (2016). *The Economist Four-County Survey of Aging and End-of-Life Medical Care* [Health Care System Rating].

*Figure 2*




SOURCE: Kaiser Family Foundation (2016). *The Economist Four-County Survey of Aging and End-of-Life Medical Care* [Importance During End-of-Life Care].

**The Perspectives**

There are many arguments that supporters of physician-assisted death wholeheartedly believe in, one of the most prominent of which being respect for patient autonomy and relief of suffering. For example, there are many cases in which a patient is terminally ill and is predicted to only have a limited time to live. Some of these illnesses bring suffering and ailments throughout their duration, and many believe that allowing a patient to willingly end this torment on their own terms is a very reasonable option. Lydia S. Dugdale, a physician at Columbia University believes that "patients accustomed to making their own health care decisions throughout life should also be permitted to control the circumstances of their deaths" (Dugdale, et al., 2019). This ties into the aspect of autonomy, allowing the patient to put their life in their own hands just as they could choose to ergo or forgo a medication or treatment. This all stems down to the root of euthanasia support, which is dignified death. Bilquees Jan further proves points along this way of thinking by putting this 'death with dignity' theory into perspective.

> Every patient has a right to decide about his mode of treatment including when and how they should die based upon the principles of autonomy and self-determination. Autonomy is a concept granting the right to a patient to make decisions relating to their health and life. A patient's own decision taken after all consideration cannot be argued and challenged. It is his wish either to continue his treatment or withdraw it, even though the outcome may result into his death. It is argued that as a part of our human rights, there is a right to make our own decisions and a right to a dignified death (Jan, 2018).

Along with this, Jan (2018) also touches upon the point of how an individual should be able to put an end to their own suffering on their own terms, claiming that, "…the fundamental moral values of society, compassion and mercy, require that no patient be allowed to suffer unbearably

and relieving patients from their pain and suffering by performing euthanasia will do more good than harm" (Jan, 2018).

In general, proper care during end-of-life treatment is the goal in any medical setting. Symptom management, treatment according to a patient's request, psychological health, spiritual well-being, social support, and the experience of death are all factors that play into quality of death and dying. After PAD was legalized in Oregon and Washington, it was speculated by experts that those that opted for this practice chose to do so for reasons being to avoid poor quality of dying caused by distress and impaired physical functioning, psychological aspects such as depression and hopelessness, lack of social support, spiritual distress, and the idea of being a burden (Smith, et. al., 2011). With the implementation of PAD, these issues can be alleviated if not completely avoided.

Those who support physician-assisted death tend to mention how there are procedures put into place Lydia S. Dugdale (2019) offers an example of this, examining how in most cases, states usually "propose a number of safeguards to prevent abuses and to provide structure for an act that some people will do anyway, albeit more haphazardly or even dangerously" and that there are many safeguards such as "requiring that a patient electing be informed of all end-of-life options; that two witnesses confirm that the patient is requesting [physician-assisted death] autonomously; and that patients are free of coercion and able to ingest the lethal medication themselves" (Dugdale, et al., 2019). Washington's Death with Dignity Act contains these types of restrictions that many individuals support, being that the patient must be verified by two physicians to be confirmed as mentally competent, have a terminal illness with less than six months to live, and make a voluntary request for euthanasia without coercion. Along with this, the patient must be informed of all other options, including palliative and hospice care, wait 15

days between the first oral request and a written request, and wait 48 hours between the written request and the writing of the prescription. Two witnesses, at least one of which unrelated to the patient, must sign the written request. Furthermore, the patient is encouraged to discuss with family and they are able to change their mind at any point of this process (Moore & Worrall, 2018).

While the concepts of personal choice and medical autonomy are at the top of the list in terms of the arguments for legalizing PAD, there are also major financial aspects to take into account. Any relating to medical services is fairly expensive, and while money is not at the top of most people's worries when dealing with or having a loved one deal with a terminal illness, it is a burden that will ultimately need to be addressed. "The cost of maintaining [a dying person] . . . has been estimated as ranging from about two thousand to ten thousand dollars a month" (Dworkin, 1991, pg. 187). A competent patient who is dying understands the financial burden that will be placed on their family once they have passed, and many do not want this fate for them. Medical bills of this nature can put a family in debt once the patient has passed, and consenting to assisted death could ease both suffering and financial burdens (De La Torre, n.d.).

As for the other side, some people believe that physician-assisted death is criminal and unethical, mostly stemming from a faith-based perspective. Many hold the belief that the value of life is sacred, and vitality is a concept that must be upheld without any technicality. Madeline Jordan, a student at the Abilene Christian University, reinstates this faith-based belief by speaking on her own Christian morals.

> As a Christian, I believe that our virtues cause us to act, and I believe that these virtues are given to each of us from God in the form of the Holy Spirit. On the matter of Christianity and physician-assisted suicide, Lammers and Verhey state, "We need not

> glorify or seek suffering, but we must be struck by the fact that a human being who is a willing sufferer stands squarely in the center of Christian piety. Jesus bears his suffering not because it is desirable but because the Father allots it to him within the limits of his earthly life" (Lammers & Verhey, 1998, p.659 as cited in Jordan, 2017).

Jordan uses a religious perspective to condemn the practice of physician-aided death, convinced that God is the only deity that can decide if something is ethical or unethical, and in this case, deems the value of life more important than the relief of suffering. This can also be furthered by the belief in the existence of the afterlife, primarily of two realms such as Heaven and Hell. Shane Sharp, a professor of sociology at Northern Illinois University, elaborates on this theory of the afterlife by stating how "those who believe in heaven and hell may have negative attitudes toward physician-assisted [death]" due to the fact that many of them "may believe that engaging in this practice, even when death is imminent, will negatively influence their destinations in the afterlife" (Sharp, 2018). Religious folk, especially those of Christian denominations, will usually be more inclined to condemn this medical practice as it breaches the idea of the "commandment 'You shall not murder' (*Holy Bible, New International Version*, 1978, Exodus 20:13 as quoted in Sharp, 2018). This is an example of the Scare Tactic fallacy, convincing the reader that if they support euthanasia, they will go to Hell.

In the medical field, no procedure is entirely without flaw – physician-assisted death is not excluded from this. Complications during this procedure are other reasons as to why some do not support this end-of-life option, though it has been difficult to determine the rate of complications due to hazy definitions and lack of witnesses (Emanuel, et al., 2016). Oregon is one of the ten states that have legalized physician-assisted death and has reported no complications for many years.

> Between 1998 and 2015 (average number of deaths per year, 55), Oregon reported absence of data on complications for 43.9% of cases, no complications for 53.4% of cases, and regurgitation of medication in 2.4% of cases as the sole complication. The state reported that between 2005 and 2012, 6 patients (0.7%) regained consciousness after ingesting the lethal medications but paradoxically does not classify this as a complication (Emanuel, et al., 2016).

Furthermore, it was reported that the average time between the ingestion of the medication and death was 25 minutes, but it could take up to 104 hours which is more than four days – though the number of procedures that were prolonged have not been reported by the state (Emanuel, et al., 2016). Washington state, another state that has legalized this procedure, has reported data relating to the length and complications of physician-assisted death. In 2014 and 2015, out of 292 reported cases, 1.4% of patients regurgitated the medications, one patient experienced a seizure, and 66.8% of patients passed away in less than 90 minutes – though Washington's range extends to upward of 30 hours (Emanuel, et al., 2016).

Not all who oppose the legalization of physician-assisted death come from a faith-based perspective. Many organizations that specialize in disability rights oppose PAD out of the belief that it actively discriminates against the disabled. More specifically, they criticize the popular notion that the main reason people opt for physician-assisted death is due to relieving pain. This is not the most popular reason – in reality, it is often chosen to relieve the fear of losing autonomy and bodily function. When looking into the patients that have reportedly undergone PAD in Oregon, most people did not list pain as their main reasoning behind wanting to die, "…but for reasons associated with disability, including the loss of autonomy (89.9 percent), the loss of the ability to engage in activities that make life enjoyable (87.4 percent), the loss of

dignity (83.8 percent), and the loss of control of bodily functions (58.7 percent)" ("Why Assisted Suicide Must Not Be Legalized," n.d.). This fear of disability combined with the feeling of "losing dignity" furthers stigma that revolves around being disabled and can even lead to issues regarding class. The founder, Diane Coleman, of Not Dead Yet – a disability organization opposed to the legalization of assisted death – has gone on to say that:

> Public image of severe disability as a fate worse than death … become[s] grounds for carving out a deadly exception to longstanding laws and public policies about suicide intervention services . . . Legalizing assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death to the socially devalued group (Diane Coleman, 2002, p. 221).

**Criminality**

The 1997 case of *Washington v. Glucksberg* ruled that there is no constitutional right to assisted death. The Supreme Court decision held that bans on PAD did not violate any Constitutional rights, and that was up to the states to uphold their own laws regarding physician-assisted death (McCall, 2023). When dealing with the criminality of PAD, it is important to distinguish between the concepts of physician-assisted death and euthanasia respectively.

The topic at hand, physician-assisted death, is when the patient themselves administers the lethal dose of medication by their own hand, no medical professional aiding with that. The only role the physician plays in this situation is prescribing the medication that the patient will use to end their life (Brazier, 2023). On the other hand, euthanasia is virtually the same procedure of bringing about the end of life of a patient, but the major difference is that with

euthanasia, it is the physician or other third party that is administering the lethal drug (Brazier, 2023). Euthanasia is illegal in the United States and is clearly prohibited in existing medical-aid-in-dying laws. It is a common argument that no medical professional should be the one to end a patient's life (even with full permission given by the patient themselves), but that is not what is being discussed in this paper. Many believe that a physician should be held criminally liable if they are the one who is administering the drug as they are the main actor of the hastened death, but the concept of criminality regarding PAD is more difficult to gauge as the medical professional is not involved in the end-of-life administration.

In 1999, a survey was mailed out to 2,844 prosecutors who were members of the National District Attorneys Association (NDAA). It consisted of four different scenarios regarding situations in which a physician would be administering some type of drug to an ill patient, the fourth scenario revolving around a cancer patient with less than 6 months to live requesting a prescription for a lethal dosage of morphine that they could take themselves in order to end their life. 761 of the surveys were returned, and of those 761, 12.1% of the prosecutors had been formally involved in an end-of-life case, and 30.4% had been contacted about the legality of this process. 513 prosecutors believed writing the prescription to be a morally correct decision, and 59.6% of those would not choose to prosecute a case of this nature. However, of the 248 that believed that it was morally wrong, 70.7% said that they would prosecute the case (Meisel, et. al., 1999).

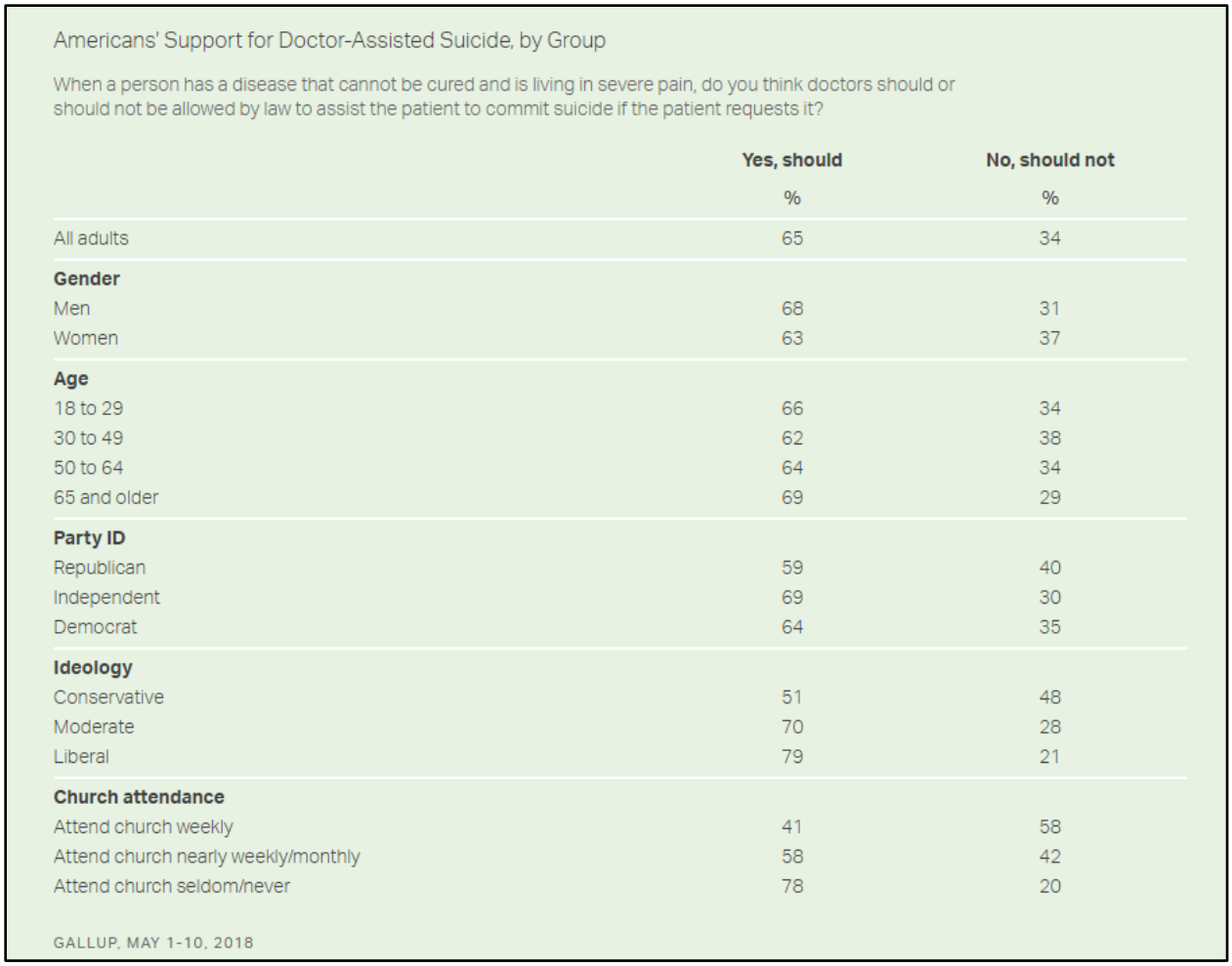
According to many state laws regarding suicide, assisted suicide is a criminal offense, and, due to the notion that physician-assisted death is "assisted suicide," it is considered to be a crime as it falls under the scope of suicide in general. One of the leading elements of criminalizing PAD is the fact that there is both intent and causation in terms of the death of a

patient. An argument refuting this is that there is a major difference between suicide and assisted death, as medical aid in dying is a "rational choice of a competent, terminally ill patient who finds herself trapped in an unbearable dying process to precipitate death in order to avoid further suffering and preserve her personal dignity," whereas suicide does not tend to stem from a terminal illness and the decision can potentially be deterred through counseling, medication, or other means of support (Pope, 2018). The unwavering debate on whether PAD should be considered assisted suicide or not is one of the many factors that play into the difficulty of considering the criminality and liability surrounding physicians who play a role in medical aid in dying.

**Social Factors and Public Opinion**

After looking into the history and variety of perspectives on the controversial subject of physician-assisted death, the question arose as to whether or not social factors such as religious views and political ideology have any correlation to an individual's stance on the ethics and criminality of this procedure. To gauge this information, this paper will analyze Gallup's 2018 Values and Beliefs poll. Conducted May 1$^{st}$-10$^{th}$, 2018, the poll surveyed a sample of 1,024 adults in the United States with a margin of sampling error of ±4 percentage points at a 95% confidence level (Jones & Saad, 2018). The question presented was "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?" (Brenan, 2018). The results, categorized by gender, age, political party, political ideology, and church attendance, are posted below (*Figure 3*).

*Figure 3*



Americans' Support for Doctor-Assisted Suicide, by Group

When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?

| | Yes, should | No, should not |
|---|---|---|
| | % | % |
| All adults | 65 | 34 |
| **Gender** | | |
| Men | 68 | 31 |
| Women | 63 | 37 |
| **Age** | | |
| 18 to 29 | 66 | 34 |
| 30 to 49 | 62 | 38 |
| 50 to 64 | 64 | 34 |
| 65 and older | 69 | 29 |
| **Party ID** | | |
| Republican | 59 | 40 |
| Independent | 69 | 30 |
| Democrat | 64 | 35 |
| **Ideology** | | |
| Conservative | 51 | 48 |
| Moderate | 70 | 28 |
| Liberal | 79 | 21 |
| **Church attendance** | | |
| Attend church weekly | 41 | 58 |
| Attend church nearly weekly/monthly | 58 | 42 |
| Attend church seldom/never | 78 | 20 |

GALLUP, MAY 1-10, 2018

SOURCE: Brenan, M. (2018) *Gallup Values and Beliefs Survey* [Americans' Support for Doctor-Assisted Suicide by Group].

Gallup uses the term "doctor-assisted suicide" in their poll, but it will continue to be referred to as physician-assisted death / PAD in this paper. Overall, 65% of Americans believe that PAD should be legalized in the United States. While only 51% of those who identify as conservative support it, 79% of liberals support legalizing physician-assisted death. Along with political ideology, church attendance is the other demographic that has a vast difference in its results. Less than half of Americans who attend church weekly think that PAD should be legalized, as opposed to those who seldom / never attend church, which has a 78% approval rate for legalization. These two are the most notable subcategories regarding a major difference in

approval, which is unsurprising given the values and beliefs that coincide with those who attend church regularly and conservative individuals. When the term "suicide" is used to describe this medical procedure, people are less likely to answer 'yes' to this question – as Christian and Jewish religions tend to teach that suicide is a sin, it is apparent that those who attend church will be less likely to support legalizing PAD (Brenan, 2018). Those who are less religious and left-leaning politically tend to support legalizing physician-assisted death more than other demographics, which could be due to the fact that leftist political views usually focus on individual choice, which encompasses medical autonomy.

When it comes to morality, only 54% of Americans feel that physician-assisted death is moral (Brenan, 2018). "Again, liberals (71%) and infrequent churchgoers (69%) are much more likely than their conservative (39%) and weekly churchgoing (26%) counterparts to say [physician-assisted death] is morally acceptable" (Brenan, 2018). Gallup has been surveying public opinions on physician-assisted death since 1996, and support for it has not fallen below 51%. There is a much closer divide regarding morality – however, it seems that some of the respondents who do not think it is moral still believe that it should be a legal practice in the United States. This may be due to the notion that, while a person may not agree with a practice, there is no reason someone else should not have that as an option. This can be seen with the debate on abortion – while some believe it to be morally wrong and they would never undergo that procedure, they do not want to prevent another person from having access to it if it is a procedure that they need. In the case of PAD, even if someone would never use physician-assisted death as an end-of-life option, they would not want to prevent someone else from going through with it if it is what they wish to do. This falls back onto the topic of medical autonomy –

what a person wishes to do medically is up to them, no one else has the power to dictate what another wishes to do regarding medical treatment.

**Conclusion**

Legalizing physician-assisted death is not a black-and-white concept. There are many concerns and issues that arise when the thought of implementing this as a legal medical procedure is taken into consideration. Death itself is not an easy subject to form an opinion on. With the finality of this type of option, it is no surprise that the debate surrounding PAD has yet to cease, even in regions in which it has been legalized. Is PAD the same as suicide, and should it be treated as such? Does medical autonomy include the choice to actively end one's own life? Should medical professionals who partake in physician-assisted death be held criminally liable? These are all concerns that are addressed in this ongoing debate. Differing political, religious, and social values all play a role in developing an opinion on this procedure, and it comes as no surprise that those with more traditional religious and conservative beliefs and ideologies tend to condemn PAD more often than liberal, nonreligious folk do. To some, it goes against the sacred nature of human life and is seen as an incredibly dangerous procedure to legalize as the concerns relating to abuse of the system, morality, and legal issues outweigh the potential positives that can stem from having this as an accessible option for terminally ill patients.

On the other hand, many believe this to be a viable option for those who are suffering with no end in sight. With all the safeguards put into place in the states where PAD is legal, protection from pressure by family and medical professionals to go through with this, multiple stages of written and verbal consent, and options of other potential end-of-life care options are all emphasized throughout the entire process. Autonomy and having a dignified death should be completely up to the patient, no one else. For those who support physician-assisted death, many

believe that, as long as the proper procedures are followed to prevent anyone from abusing the system, there is no reason as to why this should not be legalized across the entire country.

Realistically, the debate all boils down to one major question – should assisted death be akin to medical autonomy, or is it a criminal act that should be prohibited? Because of all of the social influences that affect a person's opinions on the legality of PAD, policy change in regard to this procedure is not a simple case. Despite having been a topic of discussion for decades, it may be many, many more before any substantial changes occur within the United States. Sue Rodriguez, diagnosed with Lou Gehrig's disease in 1991, was told by the Supreme Court that she could not legally take her own life by means of a doctor using physician-assisted death (City Desk, 2013). Not wanting her manner or time of death to be dictated by her disease or the law as she was given less than one year to live, she became an advocate for PAD and allowing terminally ill patients to have a dignified death. In her own words, "If I cannot give consent to my own death, whose body is this? Who owns my life?"

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