The Common Good in Catholic Social Teaching and The Legalization of Physician Assisted Suicide

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Abstract:

The legalization of physician assisted suicide (PAS) in several states in the U.S. and the growing social approval of euthanasia have created confusion, pastoral challenges, and conflicts between Catholic and non-Catholic healthcare institutions. For many of its supporters, the legal and moral legitimacy of PAS is grounded on the right to autonomy. I concur with Callahan that the right to autonomy, while may be pertinent when it comes to moral debate on suicide, does not justify PAS. Unlike suicide, PAS is not a private matter. It involves the medical institution represented by the physician who is given authority to legitimize the termination of human life, and the society that will give it an imprimatur. If autonomy per se is the basis of this so-called dignity of PAS from the viewpoint of its proponents, they will not hesitate to declare suicide as more dignified than any other way of dying. But current laws in the U.S. on PAS are silent with regard to legal rights to suicide or assisted suicide in general. According to the U.S. Supreme Court, the legislature is the venue for the legalization of PAS, not the court, for PAS is about social approval of assisted suicide. Therefore, the debate concerning the legalization of PAS should shift from individual rights to common good, from autonomy to collective harms and benefits, and from justifying individual cases of PAS to legitimizing it as a social policy.

Keywords: Catholic Ethics, Healthcare Organizations, Death and Dying, Bioethics, Social Justice

The legalization of physician assisted suicide (PAS)[1] in several states in the U.S. and the growing social approval of euthanasia[2] have created confusion, pastoral challenges, and conflicts between Catholic and non-Catholic healthcare institutions. For many of its supporters, the legal and moral legitimacy of PAS is grounded on the right to autonomy. But "Autonomy alone can never be a substitute or a foundation for moral reasoning. To claim such would be to equivalently state that what we decide as acceptable for us becomes moral, merely by our deciding." (Bloodworth et al. 2015, 52) Further, I concur with Callahan (1992) that the right to autonomy, while may be pertinent when it comes to moral debate on suicide, does not justify PAS. Unlike suicide, PAS is not a private matter. It involves the medical institution represented by the physician who is given authority to legitimize the termination of human life, and the society that will give it an imprimatur.[3]

The physician is not a mere individual provider or the patient, an individual consumer. Both are members of the human community bound by common goals, basic needs, universal transitoriness, and shared vulnerabilities, and it is from this human finitude that the need for medical care is born. By involving physicians as professionals, PAS legitimizes assisted suicide in the eyes of society.

Thus, the central issue in the legalization of PAS is social approval. Rather than autonomy, it appears that the reason why many are beginning to falsely think that PAS is an "act of dignity" is the social acceptance and potential normalization that come from its legalization. If autonomy per se is the basis of this so-called dignity of PAS from the viewpoint of its proponents, they will not hesitate to declare suicide as more dignified than any other way of dying. But current laws in the U.S. on PAS are silent with regard to legal rights to suicide or assisted suicide in general. According to the U.S. Supreme Court, the legislature is the venue for the legalization of PAS, not the court, for PAS is about social approval of assisted suicide. Therefore, the debate concerning the legalization of PAS should shift from individual rights to common good, from autonomy to collective harms and benefits, and from justifying individual cases of PAS to legitimizing it as a social policy.

The aim of my essay is to apply the concept of common good in Catholic Social Teaching (CST) to the issue of PAS legalization. My thesis is that the legalization of PAS is contrary to the common good as envisioned in CST and that healthcare professional organizations that express commitment to common good should continue to oppose it.[4] Although CST was developed as the Church's response to economic challenges in the modern world, its teaching on common good needs to be concretized in our present historical situation and applied to specific contemporary questions. "The Church's social teaching proposes principles for reflection; it provides criteria for judgment; it gives guidelines for action." (John Paul II [JPII] 1992, 2423)

Since several articles have already been written about this topic from the perspective of Catholic morality, I do not anymore focus on explicitly religious arguments or norms concerning euthanasia that are straightforwardly expressed in Vatican documents.[5] By centering on the common good, I present a religious-based argument against PAS rooted in Catholic ethics that may be acceptable to non-Catholics or non-religious because it is comprehensible from a non-religious point of view. While the common good is an important concept in CST, it is also a fundamental principle in political philosophy, whether classical or contemporary. It has the potential to be a common ground for discussion and debate among Catholics, other religious, atheists, and secular thinkers since CST's view on common good is influenced by philosophical teachings from ancient Greeks. There is also an overlapping consensus between CST and contemporary political theory regarding this concept. In this essay, I limit my presentation of the common good in relation to the person's temporal/natural ends. I acknowledge that in CST the person's ultimate end is supernatural, but this is beyond the scope of this essay as a study in applied ethics. In our pluralistic society, the religious good of salvation envisioned in CST cannot be accepted by all citizens as the ultimate common good. As mentioned, my emphasis is the morality of legalizing PAS, not the morality of individual acts of PAS. This is because legal PAS has consequences that are not present in isolated cases of PAS.

THE MEANING OF COMMON GOOD IN CST

The common good has deep roots in Western intellectual tradition going back to the time of ancient Greeks. "Every state is a community of some kind, and every community is established with a view to some good." (Aristotle 1885, Book 1.1) As social beings, humans are united by a common end. "For Aristotle, the principal question is not individual liberty but flourishing within community." (Critchley 2013, 2) Human community is not merely a conglomeration of autonomous, self-interested individuals that live together, but rather involves interhuman actions and interpersonal relations in pursuit of a common end. The community is objectively formed in virtue of its relation to its good or telos. The good which is the end of politics and the perfection of the whole community is the common good. It is only attainable by the community, for it is "the good of all and each one, at the same time and for the same reason." (Argandona 2009, 5)

The idea of a good, however, that extends beyond individual gain and is "necessarily linked to social living" (Benedict XVI 2009, 7) is somewhat inimical to the Western individualistic mindset. There is also the tendencies to interpret the common good in utilitarian terms or to identify it with the good that is popular, or that which serves the interest of the dominant group. "One attempt to provide a more determinate notion of the common good is the formulation that has been regularly employed by the Roman Catholic magisterium in authoritative statements on social, political, and economic questions over the last half-century." (Lewis 2016, 121)

Human rights and dignity and our reciprocal duties arising from our natural sociality, i.e. our natural inclination to establish relations (Pontifical Council for Justice and Peace [PCJP] 2005, 445) are the key constituents of common good in CST. Sociability is an essential element of humanum (Benedict XVI 2009). Society is not an artificial being that results from social contract. CST anchors this view of human nature on relationship anthropology expressed in the book of Genesis that tells the story of human creation in God's image and likeness. In the same way as the Trinitarian God is relational, so too are humans (JPII 1995). Since *Rerum Novarum*, CST has sought to clarify and make relevant the concept of common good while remaining faithful to its classical meaning. The common good is the object of human law, following scholastic tradition that defines law as the ordinance of reason promulgated for the sake of common good (PCJP 2005, 398). Leo XIII (1891, 51) defines the common good as "the interests of all in general, albeit with individual interests also in their due place and degree." *Quadragesimo Anno* relates the common good with social justice, especially in socioeconomic terms. "By this law of social justice, one class is forbidden to exclude the other from sharing in the benefits." (Pius XI 1931, 57) It follows *Rerum Novarum* in identifying the common good as the primary obligation of states, for it is the reason why political authority exists.[6] "The public institutions, of peoples, moreover ought to make human society conform to the needs of the common good; that is the norm of social justice" (Pius XI 1931, 110). Pius XI focuses on how the common good limits the exercise of individual rights such as the right to private ownership. Since humans are social beings, individual rights should be exercised and experienced within the context of common good.

Rather than giving a precise definition, *Mater et Magistra* relates the common good to those conditions necessary for the person to achieve integral perfection. According to John XXIII (1961, 65) the common good embraces the sum total of "those conditions of social living which favor the full development of human personality." Some of these conditions include education, healthcare, peace, living wage, etc. On the other hand, conditions that make it difficult to share in social living in a manner that actualizes one's potential as a person and as a contributing member of the community are morally wrong. The common good consists not of one, but of several goods essential for the person to flourish and develop her potentials. These aspects of human wellbeing cannot be achieved if people only act independently and self-centeredly. "The human person cannot find fulfillment in himself, that is, apart from the fact that he exists 'with' others and 'for' others." (PCJP 2005, 165) Thus, the common good is about structuring society to promote authentic human development. Because these conditions are the outcome of social living and cooperation, institutions and social organizations are responsible for them. All members of society contribute to and benefit from the common good.

The common good is the precondition for individual goods, when individuals contribute to it, they also promote their own private goods. Thus, social wellbeing and the development of the public may be prioritized over individual interest. The common good "is very difficult to attain because it requires the constant ability and effort to seek the good of others as though it were one's own good." (PCJP 2005, 167) "We must add, therefore, that it is in the nature of the common good that every single citizen has the right to share in it—although in different ways, depending on his tasks, merits and circumstances." (John XXIII 1963, 56) While the common good may require some form of personal sacrifice, it cannot be advanced at the expense of the poor. "Precisely because the poor are powerless, their needs must be prioritized otherwise, as is clear from the disparity between the rich and poor in our own country, their basic needs will not be met, their human dignity will be violated. The poor include, but are not limited to, those who are economically needy. It entails a much wider spectrum including those who are most vulnerable in society" (Salzman 2000, 70). Relating the common good with integral human perfection means it transcends mere economic conditions. The Catechism elaborates this by presenting the common good's three essential components: "respect for and promotion of the fundamental rights of the person; prosperity, or the development of the spiritual and temporal goods of society; the peace and security of the group and of its members." (JPII 1992, 1925)

Pacem in Terris contains an extensive treatment of personal rights and duties that are meant to guarantee everyone's participation in the common good according to his or her abilities and needs. CST's doctrine on common good is personalist, not collectivist or socialist. It is not in opposition to individual rights. Underlying this concept is respect for the person endowed with inalienable rights that are ordered toward her integral perfection. By relating the common good with human rights, the encyclical views it as consisting of those goods that are due to us as humans. That human rights serve to protect individuals from state abuses is indeed very important, but this is not their essence.[7]

They are positive rights that ensure full participation of every individual in communal living. They are also bound up with duties, both for oneself and for others, for rights and duties are reciprocal and correlative having their origin from natural law. Human rights are not just about how persons should be treated, but how we treat and relate to each other and this involves mutual duties. Promoting the common good implies more than having our rights and autonomy respected, it is also about fulfilling our duties to others. "The chief concern of civil authorities must therefore be to ensure that these rights are recognized, respected, coordinated, defended and promoted, and that each individual is enabled to perform his duties more easily." (John XXIII 1963, 60)

Gaudium et Spes follows the tradition of *Mater et Magistra* when it identifies the common good "as the sum total of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment" (VCII 1965, 26). The common good is about communal flourishing. As individual members act together to develop their potentials, there is a mutual feedback loop between private and social wellbeing that redounds to the benefit of the least advantaged. "Unlike private goods, common good remains 'common,' because it is indivisible and because only together is it possible to attain it, increase it and safeguard its effectiveness, with regard also to the future." (PCJP 2005, 164) It is universal and all-inclusive. The common good, therefore, is concerned with the welfare of all: rich or poor, strong or weak, young or old. Unlike utilitarianism's principle of utility, it is not the good of the majority, but rather the good shared by all members of society. However, where social inequality is high, concern for the common good dictates that more attention must be given to those who have less power and privilege. Individual human rights cannot be understood apart from the common good, for the very purpose of a right is to give to an individual what is her due, and the latter is conditioned by the common good. It is not a question of limiting individual rights for the sake of the common good or balancing the two – both views already presuppose that there is a genuine conflict between the good of the individual and the good of the community. Since individual rights promote individual good and the latter is part of the common good, common good conditions the proper ends of individual rights (VCII 1965, 73).

While reaffirming the magisterium's emphasis on the need for integral human development, the encyclicals of JPII highlight the notion of solidarity in understanding the common good. This becomes the emergent theme after Vatican Council II. Solidarity is the moral and social virtue that comes from recognizing our interdependence, "it is a firm and persevering determination to commit oneself to the common good" (JPII 1987, 38). Solidarity – universal love of thy neighbors, also known as social participation, interdependence, friendship, social charity, or socialization – is the ground of common good, for we are all responsible for all.[8] Solidarity supports the central argument of this paper, that private good and common good are related so that common good should enter into our pursuit of private good. This means awareness of the deep bond in our humanity. "Solidarity highlights in a particular way the intrinsic social nature of the human person, the equality of all in dignity and rights and the common path of individuals and peoples towards an ever more committed unity." (PCJP 2005, 192)

The paradox of our increasing existential isolation and political polarization as we collectively face the global threats of climate change and COVID-19 pandemic occupies center stage in CST's treatment of the common good in the 21st century. "We are more alone than ever in an increasingly massified world that promotes individual interests and weakens the communitarian dimension of life." (Francis 2020, 12) Many people today are marginalized and denied inclusion and participation in our society because of their disability, race, class, and citizenship. They are deprived of their human rights and considered expendable. All these happen on a global scale. In response, CST proposes charity as a path in the practice of common good. To strive for a truly universal common good is not only a requirement of justice, but of charity as well. "When animated by charity, commitment to the common good has greater worth than a merely secular and political stand would have." (Benedict XVI 2009, 7)

THE LEGALIZATION OF PAS AND THE COMMON GOOD

1. The Law and the Common Good

The purpose of the law and the exercise of civil authority is the promotion of the common good. It follows that the common good is essential to establish the legitimacy of any law. A law that runs counter to the common good is not a law in essence, and citizens do not have any moral obligation to follow it but rather, have the obligation to repeal it. The common good in *Centesimus Annus* "demands a correct understanding of the dignity and rights of the person." (JPII 1991, 47) Dignity is inherent in every person, it is not conferred to a person by society or the worth that one believes one has as an individual. It has nothing to do with abilities, health, or longevity. A person who has 6 months to live has the same worth or value as a person who has 20 years more. The essence of human dignity is not autonomy in the Kantian sense or the ability to exercise reason or higher intellective capacity, but rooted in the person being created in God's image and likeness. It is not autonomy per se that makes us complete persons, for "no aspect of human experiences is wholly personal and private. Like birth, our knowledge of death comes from others. The way we die- when, under what circumstance, and from what cause or reason – is shaped in profound ways by relationships with others and by large social and institutional forces." (Dougherty 1993, 151) CST also affirms that "the positive meaning of human life is something already knowable by right reason, and in the light of faith is confirmed and understood in its inalienable dignity." (SCDF 2020, 6)

At the outset, it is clear that the concept of human dignity in CST is different from the manner in which dignity is understood in *Dying with Dignity Movement*, which is behind the campaigns for PAS legalization. Dignity in the latter means "possession or lack of particular psychological or physical functions, or sometimes simply by the presence of psychological discomfort" (SCDF 2020, 6), it refers to "dying to avoid the so-called indignity of being disabled and dependent on others." (NASEM 2018, 32) The total control over one's life and death is the source of this dignity. Dependency resulting from loss of independence due to illness is considered a problem that needs to be eliminated like the disease itself. Emphasis is placed on the quality of human life rather than its sanctity, on its instrumental or conditional value over its inherent one. To receive care is undignified, no matter how care is "willingly or lovingly administered."

It may be argued that suicide is the devaluing only of the life of the individual who willfully commits it. While this is not necessarily true as "Moral actions very much and very often have consequences for others, even when there appears to be no connection" (Sulmasy et al. 2016, 252), legal PAS as mentioned previously is not merely an individual action. By engaging our healthcare institutions PAS aims to declare in medical/scientific terms that some lives are not worth living or preserving. PAS is not simply about supplying the means, it is also about rendering judgment. Laws are not merely regulatory instruments, they also send strong public messages. Every law should be judged by the effect it has on human dignity and the common good (Pius XI 1931). By legalizing assisted suicide and requiring some form of government oversight and immunity, PAS laws give the medical institution the authority to decide who should live and who may die based on some manner of assessing the quality of human life,[9] and make healthcare professionals complicit in suicide.

From *Rerum Novarum* to *Caritas in Veritate*, CST claims that respect for human rights is the underlying principle of the common good. These rights do not exist in a vacuum, they are positive rights—rights to something that the state must protect or provide. This does not mean that there is no such thing as negative rights or rights that can be transferred, for those rights exist in many circumstances as Lachs (1994) explains. However, the rights to goods that are essential for the person's integral development such as the right to life or healthcare are positive. The notion of human rights presented in CST is personalist rather than individualist. It recognizes that persons are social beings who are linked together in a network of reciprocal rights and obligations. The personal rights that belong to every human in an immediate way create duties that bind us in society. The right to life implies the duty to protect life. Both rights and duties are inseparable constituents of the common good. The best way to uphold the common good is to recognize the right to life as fundamental, unconditional, and non-contingent. The very idea of a "right to die" as the freedom to kill oneself and be assisted in doing so is contrary to the notion of human rights in CST.[10] An individual's private interest, taken in isolation from the common good, is not sufficient to impose a duty on society to deliver it. If an individual benefits from the common good, it is because what benefits society as a whole is also for the individual's benefit, but not the other way around. We flourish with the support of our community, acquire more options from which to choose, and become more capable of making personal choices than when we are isolated from each other.

Because of the confidential nature of doctor-patient relationship and provisions that make legal PAS opaque such as certification of the cause of death,[11] little study is done on the aftermath of PAS. "The patient's health care provider is not required to be present when the patient takes the lethal drugs. There is no way to know who, if anyone, is present or what actually takes place leading up to the patient's death." (NCD 2019, 42) The only oversight measure that the law requires is for the state to publish statistical information from reports submitted by physicians and pharmacists, but there is no sanction or penalty for non-reporting.[12] In fact, PAS laws are at their core immunity laws. Everyone involved in the procedure needs only to invoke good faith in order to receive immunity from criminal or civil liability. "However, a claim of a good faith effort to meet the requirements of the law is virtually impossible to disprove. As a result, this provision renders all other alleged safeguards effectively unenforceable." (Golden and Zoanni 2010, 22)

While most PAS laws require that patients be given adequate information about alternative treatments, there is no evidence that patients who receive prescriptions for lethal medication have all the necessary information and access to these alternatives to give their informed consent. In spite of the preponderance of evidence in medical literature showing that many terminally ill suffer from anxiety and depression, psychiatric referral in the law is only optional, and only a small percentage of patients who qualified for PAS had been referred. "Yet the law's supporters frequently suggest that, as a key safeguard, depressed people are ineligible for assisted suicide." (NCD 2019, 23) Not all doctors in general practice who can certify PAS are competent to diagnose and treat depression, specifically depression among chronically ill patients.

2. Social Justice

The legalization of PAS is not possible without committing social injustice to some groups, either because they will not benefit from it, or they will be negatively impacted without reaping any of its benefits while at the same time, involving them against their wishes through the social institutions they support: namely the government and healthcare institutions.

CST "lays stress on reverence for humanity; everyone must consider his every neighbour without exception as another self, taking into account first of all his life and the means necessary to living it with dignity, so as not to imitate the rich man who had no concerns for the poor man Lazarus." (VCII 1965, 27) Since it is about structuring society to promote authentic human development, the common good according to *Pacem in Terris* requires social policies that are not only humane and just, they must have positive impacts especially on vulnerable population, which includes the poor, people of color, the elderly, and other disadvantaged groups who are most likely not to have medical insurance or access to health services. But like other public programs in the U.S., healthcare services are implemented through the prism of classism, racism, ageism, ableism, and other forms of social inequities.[13] There are reasons to be concerned that once legalized, the negative impacts of PAS would fall hardest on the least well-off members of society (Golden and Zoanni 2010).

According to the Center for Disease Control (CDC), there is a rise in suicidal ideation and actual suicides among people of color, those who are poor and underinsured, veterans, and residents in isolated rural areas. The sick, the aged, those who are cognitively impaired and physically disabled constantly face "socially constructed obstacles to one's life goals, social devaluation of disability, social isolation, financial concerns, and lack of support to make life meaningful." (NCD 2019, 27) Some studies point out that preference for PAS is positively associated with internalized oppression (Lapierre et al. 2018) felt by patients after "being conditioned by dominant cultural values... that needing help is undignified, less than fully human, and again, burdensome to others."

(NCD 2019, 26) This feeling may also arise from societal discourse on the high cost of health and long-term care especially during times of economic downturn, and on how social security benefits drain the U.S. economy.[14] Another study indicates that "negative attitude toward old age significantly contributed to the endorsement of PAS for oneself, even when sociodemographic variables, religiosity and death anxiety were controlled for." (Lamers and Williams 2016, 1078) Many elderly have a strong fear of adverse social judgments regarding dependency, whether or not such fear is justified (Howarth and Jeffreys 1996). Based on the study of Suarez-Almazor et al. (2002), psychological distress is significantly associated with terminal patients' favorable attitude toward euthanasia or PAS. Perceived loss of purpose or meaning is the main reason why cancer patients would opt to hastened death. On the other hand, patients who are given adequate palliative care and treatment of depression lose interest in hastening their own death (Arras 1997).

PAS may provide incentive to minimize costs at times when communities face budgetary challenges related to caring for the elderly, sick, and disabled. Nevertheless, there is no "logically necessary reason that legalizing PAS or euthanasia will improve the way we care for dying patients. Care for the dying is much more complex than ending a patient's life." (Emanuel 1998, 985) Some problems faced by terminally ill are lack of access to pain management, nursing care, and mental health resources, as well as lack of support from family members. Many of them suffer from isolation, neglect, societal indifference, and maltreatment. They also experience additional symptoms that need attention like existential and spiritual distress.

Based on the work of Kubler-Ross (1969) and subsequent academic research (Oates and Maani 2022; Berlin et al. 2021; Guy and Stern 2006), people have different reactions when they receive tragic information like those pertaining to death or dying, and how this information is processed varies from one individual to another. Generally this process takes time – longer than the 15-day waiting period that most PAS laws in the U.S. require. Wilson et al. (2000) add, on the basis of their empirical study that terminal patients' desire for death is not stable over time. Overall, clinicians can never be certain about the point in time when terminally diagnosed patients are in "ready to die mode" both physically and mentally. "Evidence indicates that pinning down a patient's mental status and declaring it 'autonomous' at the end of life is much more complicated than simply asking what her preferences are." (Fernandes 2008, 28) In addition, they are vulnerable to manipulation, influence, pressures from their own families, caregivers, insurers, and even from doctors themselves. Physicians and family members can influence vulnerable patients to opt for PAS, even in a non-malicious manner. The mere mention of PAS by some doctors as one possible option to consider may be interpreted by very sick patients as a suggestion.

3. Solidarity

Suicide is morally unacceptable because it is a rejection of human solidarity. It is not just a rejection of one's life, but a rejection of the possibility of a life made meaningful and fulfilling when lived or shared with others. We all live not just for ourselves, but also for and with others. If embracing life is to open oneself to the love of God and others, suicide is the closing of oneself to such loves and opportunities for being cared for. As individuals we are all endowed with unique gifts, to commit suicide is to deny these gifts to others. Even the sick and the aged have something that they can share with others such as laughter, memories, wisdom, and experience. But even in the state when one is already incapable of giving anything because of old-age and sickness, this does not diminish the value of human life. We become more, not less of a person when we receive support and compassion from our fellow humans. The suffering experienced by one individual has an interhuman and social dimension. "The world of suffering possesses as it were its own solidarity. People who suffer become similar to one another through the analogy of their situation, the trial of their destiny, or through their need for understanding and care" (JPII 1984, 8). Even if a terminal patient may judge that the quality of her life is unacceptable or not worth living from her own standpoint, given love and care coupled with adequate pain management and empathetic counselling, the quality of her life can still improve significantly.[15]

"Granted, the human condition necessarily entails an eventual deterioration of one's health, in which case, ultimately the community has a duty to care for individuals to whom it is responsible." (Salzman 2000, 69) As mentioned, caring for terminally ill is very challenging. Because of their physical condition, providing them with needed healthcare is not cost-effective compared to those who are more able and healthy. But giving and receiving care is essential in every community, no human community is sustainable without them. In caring for dependent persons, communities express solidarity, social justice, charity, and responsibility. "When interdependence becomes recognized in this way, the correlative response as a moral and social attitude, as a "virtue", is solidarity. This then is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far." (JPII 1987, 38) While this caring can also be shown to those who are healthy, most terminally-ill persons are in the lowest point of their lives. Death and dying are not only universal phenomena, they are the final stages of human existence. The human community is founded on our common recognition that our lives begin and end in the same way: birth and death. Illness, anguish, old-age, physical deterioration, and dying are human realities that we all share and cannot fully control or eliminate. We "ought to view vulnerability as an inseparable part of living in communion with others—not a condition to escape from or fear. It is in the vulnerable sick person that we realize our own vulnerabilities, and in doing so, learn something of the value of humanity." (Fernandes 2008, 221)

We do not live alone and we should not die alone. PAS separates the person from the community and promotes an individual-focused and self-directed solution to death and suffering. The philosophy behind PAS is that dying is a private matter subject to self-determination and individual choice, so that each person should die on her/his own terms and time. "This is compatible with the notion that, in the U.S., life-and-death decisions are thought mainly to involve individuals, rather than their communities or groups." (Peng et al. 1999, 2624) According to *Laudato Si*, the "lack of physical contact and encounter, encouraged at times by the disintegration of our cities, can lead to a numbing of conscience and to tendentious analyses which neglect parts of reality." (Francis 2015, 40) The notion of "*every man for himself* will rapidly degenerate into a free-for-all that would prove worse" (Francis 2020, 36). Legal PAS alters our social values and priorities – how we see disability, death, and illness, the value we give to caring unconditionally for our loved ones – and may exacerbate our already deteriorating social relationships and existential isolation. Legislative and electoral efforts and resources are being used to legalize and expand PAS rather than toward passing laws that promote the common good like healthcare reform, improvement in long-term, palliative, and end-of-life care, suicide prevention as well as increased social assistance to the aged and the disabled. Experience has taught us, according to *Pacem in Terris* that unless suitable action is taken "with regard to economic, political, and cultural matters, inequalities between citizens tend to become more widespread" (John XXIII 1963, 63).

4. The Common Good and Professional Organizations

For CST, healthcare professional organizations are vehicles and effective instruments of solidarity and social justice (JPII 1991, 16). They are part of what CST calls civil community which, together with the state and the economy, constitutes the third sector of society. "Apart from the family, other intermediate communities exercise primary functions and give life to specific networks of solidarity. These develop as real communities of persons and strengthen the social fabric, preventing society from becoming an anonymous and impersonal mass, as unfortunately often happens today." (JPII 1991, 50) Working with various groups, these organizations can "make a specific contribution to an even broader implementation of the common good." (VCII 1965, 74) For example, nursing exists "because of societal support and the perception that nursing is important to the preservation of health-related aspects of the common good." (Jairath et al. 2006, 61) The American Medical Association (AMA) "Principles of Medical Ethics" states that a physician "must recognize responsibility to patients first and foremost, as well as to society." Similarly, we find in the 2021 code of ethics of National Association of Social Workers (NASW): "A historic and defining feature of social work is the profession's dual focus on individual well-being in a social context and the well-being of society."

Professional services in general have social impacts, thus they are bound by ethical obligations. Healthcare services in particular are essential for the common good, the state has the duty to provide these services if they are lacking, and in countries with universal healthcare, these services are guaranteed by the state. But healthcare professionals cannot be mere agents of the state. Even if PAS laws give them permission to assist in suicide, they still need to reflect on the essence and purpose of their profession to find justification why assisting suicide is a positive obligation. The medical worker and the patient are two different self-determining subjects. "Assisting someone's death would require that the assistant believe it is the right thing to do – not just a response to autonomy claim, but as a conviction that the decision is objectively right." (Johannesen 2016, 41) The supposed legal right to choose of the patient is not a right to demand. The presence of terminal illness, regardless of how it is loosely defined, does not justify arbitrary and intentional termination of human life. Aside from compromising the moral integrity of medical care, legal PAS lowers the bar of professional responsibility by providing immunity to all healthcare participants. "In an ironic twist, assisted suicide physicians are safer from liability if they cause a patient's death than if they provide his or her medical treatment." (Golden and Zoanni 2010, 22)

It is the official position of AMA that "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[16] While there are groups of health workers who are supportive of PAS, other major healthcare organizations (American College of Physicians, American Nurses Association, World Medical Association, and British Medical Association) are against it while some expressed neutrality (e.g. American Psychological Association and American Academy of Hospice and Palliative Medicine).[17] PAS is not a form of medical-assistance in dying like palliative or hospice care. According to NASW *Standards for Palliative and End-of-life Care*, "death should neither be hastened nor postponed." (2004, 10) The focus of palliative care is compassion and attentiveness to the person's biophysical and spiritual needs "to help the patients live as actively as possible until death." (Ibid) "Palliative care is an authentic expression of the human and Christian activity of providing care, the tangible symbol of the compassionate 'remaining' at the side of the suffering person." (SCDF 2020, 10) Because of the incompatibility between the philosophy of PAS and the ethics of palliative care, and the fact that caring for terminally ill is not cost-effective (it is in general less expensive that they die sooner than later), integrating the two is conceptually impossible, and in practice, might lead to undermining of palliative and end-of-life services.[18] PAS is not a therapeutic alternative. It violates the bioethical principle of non-maleficence. It is not the role of doctors or other clinicians to judge the value of life of their patients. On the contrary, their job is to alleviate pain and care for their patients, whatever is their health status (SCDF 2020).

PAS AND SOCIAL SLIPPERY SLOPE

CST is not consequentialist in its moral outlook. But if we are to examine the ethics of legal PAS in relation to the common good, we need to focus on its social impacts and how they harm or promote the good of the community. CST does not regard human autonomy as doing what one wants regardless of consequences.[19] *Quadragesimo Anno* (Pius XI 1931, 74) warns of negative social consequences of unlimited freedom, especially when freedom is exercised without regard for the common good. Because the latter is about how we relate to each other in pursuing our common end, it is also about our social values and collective sensibilities.

When concerns about adverse long-term social consequences of legal PAS are raised, its advocates tend to dismiss them as a kind of slippery slope fallacy. Generally a slippery slope argument is a claim that a small step in one direction will lead to a series of events that will eventually result in a catastrophic end. Supporters of PAS claim that slippery slope arguments against it are unfounded for being hypothetical, speculative, and pessimistic. They are mere products of alarmist thinking and fear mongering. The solution often given is that human ingenuity, effectiveness of our legal system in dealing with many other controversial issues, and the practical wisdom of our policy makers will allow us to draft legislations that will address most, if not all of the concerns of critics, including potential misuse and abuse. Practical and administrative difficulties that might be encountered in implementation would be overcome with more time and experience.

First, it is helpful to distinguish counterarguments against legal PAS that resemble slippery slope. (1) Legal slippery slope – the legalization of PAS will set a precedent for legalizing euthanasia, including involuntary adult and infant euthanasia. (2) Logical slippery slope– Callahan is the main proponent of this counterargument. His claim is that there is no reasonable or logical stopping point to limit euthanasia/PAS "once the principle of taking life for that purpose has been legitimated" (1992, 55). If self-determination justifies PAS, then there is no logical moral reason to limit it to those who are terminally ill as the law requires. On the other hand, if compassion for the suffering of the patient justifies PAS, there is no logical moral reason why it should only be given to those who are competent, for it would seem "cruel and capricious to deny it to the incompetent" (e.g. mentally ill and children). (3) Empirical slippery slope – it will result in overuse as a consequence of social acceptance and normalization. Rather than being the last resort when pain/discomfort becomes unbearable, PAS "over time, become less of a last resort and be sought more quickly, even becoming a first choice in some cases." (Pereira 2011, 40) It may also lead to suicide contagion. These claims require empirical evidence for support. (4) Arguments that focus on administration or implementation – the law has the potential for misuse and abuse, including the use of coercion and intentionally ending the lives of those the use of PAS is not allowed such as patients who are very sick but not terminal. It is also impossible to devise procedures to make sure those who are legally qualified are not being persuaded, brainwashed or manipulated, if not coerced, to give their consent. This claim requires empirical evidence too. But there is no way to assess the effectiveness of monitoring and safeguard mechanisms in PAS laws to prevent abuse and misuse because of the difficulty in gathering relevant data. "Such data are critical… because there is no natural feedback loop to assess how the current laws are working, given that the procedure is final and the dead cannot provide feedback the way a person who has had a wrong limb amputated can." (NASEM 2018, 21) Thus, I will only focus on the first three types of argument.

With the successful passing of PAS laws in several states in the U.S. and Canada, the strong similarities of these laws, and the evolution of PAS/euthanasia laws in Western countries that legalized it early on like Belgium, Netherlands, and Luxemburg (BENELUX) we can formulate some ideas about how PAS laws evolve and their social impacts. In his 2006 analysis of PAS/euthanasia laws, legal scholar Allen (538) wrote, "arguments raised in the Netherlands parallel the arguments currently being raised in other European nations and the United States." Hence, we are now in a better position to make a moral evaluation of PAS laws from the perspective of the common good, and critical assessments based on projected long-term social consequences and negative prognostications cannot just be dismissed as fallacies. A slippery slope argument is fallacious when it deduces highly improbable scenarios from a single hypothetical event. But when it is based on empirical analysis and logic, i.e. when the consequences being considered logically follow, whether deductively or inductively from a valid evidence, the use of slippery slope is justified.

To begin with, slippery slope arguments have a place in debates about law and social policy. They should not be easily dismissed because they do have a role in legal reasoning (Lode 1999). Those that make use of hypothetical predictions can be valid arguments in legislation. Most people behind voters' initiative for PAS in the U.S. campaign on the ground that PAS and euthanasia are different, so the legalization of the former will not lead to the legalization of the latter. Being an ordinance of reason, logic guides law and logical consistency is essential in legal reasoning and application.

Like most critics, I submit that legal extension to voluntary euthanasia or even down to involuntary euthanasia once PAS is legalized is logically inevitable.[20] The reason for this is that the logical justifications for the acceptability of PAS and euthanasia are the same. The Netherlands, the first country that legally allowed PAS "is an example of the slippery slope on which legalizing physician-assisted suicide puts us. In the 1980s the Dutch government stopped prosecuting physicians who committed voluntary euthanasia" (Sulmasy et al. 2016, 251). Reports of euthanasia without patients' explicit request were documented since 1984 (NASEM 2018; Allen 2006). Voluntary euthanasia became legal in 2001, and its use was later extended to children older than 12 (Pereira 2011, 42). In 2016, euthanasia was extended to people with severe dementia. The Dutch government allowed euthanizing children aged one to 12 in 2020. Canada, which legalized PAS in 2014 for terminal patients, made voluntary euthanasia legal, first for adults whose death is "reasonably foreseeable" (2016), and then in 2021 to patients whose sickness is "grievous and irremediable" but not terminal – to be provided by either physicians or nurses.[21] Since 2018 (Davies), there has been a debate in Canada to expand assisted dying to children. Euthanasia became legal in Belgium in 2002. A study in 2010 (Inghelbrecht) indicates that Belgian nurses performed euthanasia to their patients without explicit request. Child euthanasia without age limit was allowed in 2014 (Reingold 2020). Euthanasia and PAS became legal in Luxembourg in 2008. Patients with psychiatric conditions and dementia who are not terminally ill can request euthanasia in BENELUX (Dierickx et al. 2017).

We see similar pattern on how assisted dying laws have evolved. Changes to the legislation were made to allow a broader group of people to qualify. Once PAS is legalized and socially accepted, the only way to maintain logical consistency is to expand the categories of people who are eligible (Callahan 1992). Sooner or later, the criteria meant to limit PAS (serious illness, unbearable suffering, or autonomy) will lead to the expansion of PAS, making "red flags become green flags" (NASEM 2018, 23). Safeguards in the original law that are necessary because of the irreversibility of the procedure are eventually eliminated or relaxed after being considered arbitrary and impractical barriers to a more efficient access.

Theoretical and empirical arguments have been presented to support the claim that legal PAS may lead to overuse and suicide contagion (Jones 2022; Jones 2018). Suicide contagion is defined by CDC as "a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide."[22] Prohibiting PAS "serve valuable societal goals, they protect the vulnerable individuals who might otherwise seek suicide" (New York Task Force).[23] Publicity about the practice may trigger increase in suicide, and preliminary studies suggest increased rates of suicides in the general population of states where PAS is legal (Jones 2022; Jones and Paton 2015; Dugdale and Callahan 2017). For Callahan (in NASEM 2018, 37) this is "not coincidental—his hypothesis is that the Oregon assisted-death law brought considerable media attention to suicide as an acceptable way to deal with the travails of one's life." Evidence that the increasing rates of suicide in the U.S. can be linked to the legalization of PAS is presented by Valko (2017), while the Doherty et al. (2022) and Jones and Paton (2015) papers show that legal PAS seemingly induces more self-inflicted deaths than it inhibits.

Since 1990, "a large majority of Dutch physicians consider euthanasia an exceptional but accepted part of medical practice." (Van Der Maas et al. 1996, 1705) Over the years the number of people dying of PAS and euthanasia has increased in BENELUX (Jones 2022; Mrozl et al. 2021; Vermee 2021; NASEM 2018; Sulmasy et al. 2018; Dierickx et al. 2017; Allen 2006). With only a few states having legal PAS in the U.S., there is no empirical data that shows consistent increase in the practice. The U.S. Supreme Court rulings on Washington v. Glucksberg (1997) and Vacco v. Quill (1997) that permit states to have laws criminalizing assisted suicide mean that the legalization of PAS will not occur on the federal level, but rather on state-by-state basis. Because the philosophy of PAS is based on individualistic themes[24] such as privacy, independence, suffering in isolation, solitude, autonomy, ableism, and self-care, and because individualism is a value championed by our dominant culture, and because of deficiencies in the quality of hospice care in the U.S.,[25] and the shifting of U.S. population demographics toward greater number in elderly, it his highly predictive that PAS, once legalized in most states will be normalized and widely used in the long run (Peng 1999, 262).[26]

Many Americans believe that it is good to provide those who are terminally ill with this option. However, the mere availability of an option is not good in itself. On the contrary, by declaring that this is how some people die "with dignity," the law sends a message that there is a "dignified" and "undignified" manner of dying, and that it is good for people to exercise their "human right" to die on their own terms. This puts individuals who are in their most vulnerable condition because of their deteriorating health, old-age, or disability in a defensive position. They may be challenged to justify to others and to themselves why should they not take this option. "The idea that hastened death is a pathway to dignity for people facing physical decline reveals the public's extreme disparagement of functional limitations and a perception that 'dignity' is not possible for people who rely on supports, technology, or caregivers to be independent or alive." (NCD 2019, 15) Many are opposed to the legalization of PAS on the ground that it devalues the lives of people with disability, thereby reinforcing their marginality, while some express concern that widespread social acceptance of PAS will trigger a very subtle but broad community-based abuse of elderly (NASEM 2018). Others suggest there are serious risks of abuse for disabled if PAS laws evolve to even greater permissiveness (Stainton 2019).

CONCLUSION

The coronavirus pandemic reveals our fractured healthcare system. Despite its wealth and technology, more people died from COVID-19 in the U.S. than in any other country. Nursing homes were devastated. Hundreds of dead bodies were kept in refrigerated trucks parked in vacant lots for more than a year. Legalizing PAS is not a solution but rather a symptom of our larger social problem. Even if it benefits some people, it creates more harms, puts more people especially the vulnerable at risk because of the lack of effective safeguards, affects our collective values and sensibilities, and alters the delicate role of healthcare professionals in our community. It is not only contrary to the common good, it tends to perpetuate the deficiencies in our social institutions meant to foster the common good. Aside from palliative care, there are legal options available to terminally ill that can alleviate their conditions without unnecessarily prolonging their suffering or postponing the natural death process.[27] Under certain guidelines, they are morally acceptable to health professional organizations, to the Catholic Church and to other religious denominations. Being a natural part of life, CST never considers death as an absolute evil that we have to fight at all costs. State-released PAS data suggest that those who applied for PAS are worried about the prospects of being abandoned as they lose autonomy and control of bodily functions.[28] "This result supports qualitative studies that found that healthy older adults who supported euthanasia or PAS considered end-of-life practice as a way to avoid anticipated dependency and becoming a burden to their family or society." (Lapierre et al. 2018) If this is accurate, what they need is not assistance to suicide but assurance that these fears will not happen by promoting the common good through strengthening of our social institutions, advocating healthcare and social security reforms, and fostering genuine human relationships. "The more we strive to secure a common good corresponding to the real needs of our neighbours, the more effectively we love them." (Benedict XVI 2009, 7) Support should also be given to healthcare organizations that campaign for regulations to ensure just and humane care for their patients.

With many states still to decide on PAS legalization and ballot measures are being proposed across the U.S. almost every election, this is about to be a very important public health subject. At the center of discussions and debates should be the concept of common good. All of us are involved because all of us are affected directly or indirectly. When human right is viewed in relation to the common good, we have a clearer and comprehensive picture of what is at stake. "No expression of social life — from the family to intermediate social groups, associations, enterprises of an economic nature, cities, regions, States, up to the community of peoples and nations — can escape the issue of its own common good, in that this is a constitutive element of its significance and the authentic reason for its very existence." (PCJP 2005, 165)

Foot (1977, 112) warns that "As things are, people do, by and large, expect to be looked after if they are old or sick. This is one of the good things that we have, but we might lose it, and be much worse off without it." Our treatment of terminally ill affects the way we treat each other and our society as a whole. When one's conscience is coarsened toward those who are in need and suffering, when he fails to "recognize in himself and in others the value and grandeur of the human person, he effectively deprives himself of the possibility of benefitting from his humanity and of entering into that relationship of solidarity and communion with others for which God created him." (JPII 1991, 41) In the final analysis, what is at issue is the kind of community we want to create for ourselves and for the future generation.

> A truly human and fraternal society will be capable of ensuring in an efficient and stable way that each of its members is accompanied at every stage of life. Not only by providing for their basic needs, but by enabling them to give the best of themselves, even though their performance may be less than optimum, their pace slow or their efficiency limited. (Francis 2020, 110)

Endnotes:

1. PAS refers to "a practice by which physicians provide, but do not directly administer, the means for a patient voluntarily to hasten his or her own death. This typically is done by prescribing lethal doses of medication that the patient then ingests." (Institute of Medicine 1997, 203) The terms "physician-assisted death" and "medical-aid in dying" are euphemistic and ambiguous. They are used sometimes to mean euthanasia and PAS; others used them to mean PAS only; still others use them to include withholding life-prolonging treatment (National Academies of Sciences, Engineering, and Medicine [NASEM] 2018).
2. According to the *Death with Dignity* website, seven in ten Americans support the right to die "under their own terms." See https://deathwithdignity.org. Legislation for various forms of assisted dying has expanded in Europe, U.S., Canada, and Australia over the past 25 years.
3. Legal PAS may also affect to some extent the services of pharmacists, psychologists, caregivers, death certifiers, and other healthcare professionals.
4. While the subject of this essay is PAS, the logic of the moral motives for euthanasia and PAS are the same, and they contain within them the same ingredients of abuse (Callahan 1992).
5. See *Declaration on Euthanasia* (Sacred Congregation on the Doctrine of Faith [SCDF] 1980).
6. "The political community exists, consequently, for the sake of the common good, in which it finds its full justification and significance, and the source of its inherent legitimacy." (Vatican Council II [VCII] 1965, 74)
7. From the perspective of CST, the state is not a morally neutral institution. "The stress on civil liberties, and the tendency to limit basic material rights to the right to life, expressed as a negative right of which we are not deprived, are features of a position on rights derivable more directly and obviously from the U.S. political doctrines than from the standard traditional or modern examples of Catholic social teaching." (Cahill 1987, 86)
8. "This principle is frequently stated by Pope Leo XIII, who uses the term 'friendship', a concept already found in Greek philosophy. Pope Pius XI refers to it with the equally meaningful term 'social charity.' Pope Paul VI, expanding the concept to cover the many modern aspects of the social question, speaks of 'civilization of love.'" (JPII 1997, 10)
9. Most PAS laws use the 6 months-or-less life expectancy as one of the criteria in determining who may qualify. But terminal uncertainty and misdiagnoses of terminal illness, though the latter is rare, are well documented in medical literature (National Council for Disability [NCD] 2019). "Prognostic uncertainty is the inability to determine and provide an accurate prognosis and it occurs with many

illnesses that are chronic in nature, such as heart failure. This is due to the chronic exacerbating illness trajectory, in which a patient will have an exacerbation and then get better. This makes it more difficult for physicians to determine when the patient is nearing the end of life." (Lowey 2015, 47). One study indicates that the accuracy of terminal prognosis is as low as 20% (Christakis and Lamont 2000, see also White et al. 2016).

10. CST defines the right to die as "the right to die peacefully with human and Christian dignity." (SCDF 1980, 2)
11. Current laws in the U.S. state that the underlying terminal disease will appear as the cause of death on death certificates of PAS patients.
12. See Initiative Measure No. 1000 The Washington Death with Dignity Act Filed 2008. Despite differences in how PAS was legalized, there are strong similarities on PAS laws across the U.S. in terms of patient qualifications, consent guidelines, prescription and ingestion of life-ending *medications*, reporting procedures, and safeguards.
13. See "Implicit Bias in Healthcare Professionals: A Systematic Review" (2017). Authors found some kind of bias was evident either in diagnosis, treatment recommendations, number of questions asked of the patient, number of tests ordered, or other responses indicating bias against the characteristic of the patient under examination. See also Wachterman and Sommers (2021).
14. The Social Security Old-Age and Survivors Insurance Trust Fund in the U.S. is projected to be depleted in 2033. The U.S. of course is one of the richest countries in the world. The problem is not the lack of wealth, but the concentration of wealth on the hands of a few. This is also a social justice issue that is outside the scope of this essay.
15. See National Association of Social Workers (NASW) 2004.
16. See AMA code of ethics https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide.
17. "However, as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks unintended long-range consequences that may not yet be discernable, including effects on the relationship between medicine and society, the patient and physician, and the perceived or actual integrity of the medical profession." American Academy of Hospice and Palliative Medicine http://aahpm.org/positions/pad.
18. The World Health Organization defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual." This definition, anchored on a holistic view of the person is incompatible with PAS or Euthanasia. https://www.who.int/news-room/fact-sheets/detail/palliative-care. Despite the confusion it creates, many proponents of PAS prefer the term *medical-assistance in dying*.
19. Prostitution, indentured servitude, online gambling are outlawed because of undesirable social consequences of their legalization, regardless of whether participants in these activities have consented or not. Consent alone does not justify the legalization of *morally questionable* actions. *Populorum Progressio* (Paul VI 1967, 59) states, "When two parties are in very unequal positions, their mutual consent does not alone guarantee a fair contract; the rule of free consent remains subservient to the demands of the natural law."
20. "Voluntary euthanasia refers to euthanasia performed upon the explicit and affirmative request of a patient. In contrast, 'involuntary euthanasia' signifies an act of euthanasia performed without the request or consent of the patient. The term involuntary euthanasia itself is subject to confusion. For some, involuntary euthanasia implies situations where the patient did not provide consent but possessed the capacity to do so. As such, involuntary euthanasia is different from "nonvoluntary"

euthanasia, which involves patients who lack the legal or physical capacity to provide consent. Under this approach, nonvoluntary euthanasia is the correct term to describe euthanasia performed on adult patients who are mentally incapacitated or infants who therefore lack the legal capacity to either provide or withhold consent. Other commentators reject this approach and characterize any euthanasia performed without an explicit and affirmative request as involuntary euthanasia." (Allen 2006, 541)

21. Government of Canada Department of Health https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html.
22. USCDC https://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm.
23. New York State Department of Health "Task Force on Life and the Law" https://www.health.ny.gov/regulations/task_force.
24. "Individualism, in particular, is at the root of what is regarded as the most hidden malady of our time: solitude or privacy." (SCDF 2020, 7)
25. "Hospice Deficiencies Pose Risks to Medicare Beneficiaries." US Department of Health and Human Services Office of Inspector General 2019.
26. Dougherty, Gula, Callahan, and Foot present theoretical arguments to support the claim that once legalized, PAS or euthanasia will be socially accepted and expand overtime to become a regular/standard practice of dying. Although empirical data are relevant especially when it comes to calculating social consequences and effects on the common good, morality is not only a matter of empirical assessment. The common good is greater and more perfect than the individual good, not empirically, but in terms of the whole being greater than its parts.
27. Some of these options are passive euthanasia, medical refusal of aggressive end-of-life treatments, withholding of extraordinary medical means, DNR orders, in-home health aide, and hospice care. The application of the moral doctrine of double-effect may be relevant in ethical analysis of some cases. However, "It is not right to deprive the dying person of consciousness without serious reason." (SCDF 1980, 3)
28. "Instead, cumulative Oregon data suggest that the vast majority of patients elect AID because they are concerned about "losing autonomy" (90.6%) or are "less able to engage in activities making life enjoyable" (89.1%). Some fear a "loss of dignity" (74.4%); being a "burden on family, friends/ caregivers" (44.8%); or "losing control of bodily functions" (44.3%). Concern about inadequate pain control was the reason for pursuing a lethal ingestion in only 25.7% of cases." (Dugdale, et al., 2017, 749) See also Lamers and Williams (2016).

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