Variation in Opinions of Physician Assisted Suicide (PAS) with Age

Assessing the cause for opposition to PAS-systems, and exploring what disparities in opinion exist based on age.

Tag Words: Euthanasia, Right to die, suicide, age disparity

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Summary (KRP)

Medicine has changed the way we face our own mortality. A growing percentage of Americans believe that a system should be put into place which allows for an individual to end their last days of suffering, death with dignity. The states of Oregon, Montana, and Washington have began implementing such a system with some success (See section C), as well as other nations around the world. The current policy of the state of New Jersey does not allow for any form of active euthanasia/PAS, and instead relies on cessation of medical care to allow the underlying disease process bring about death. This results in prolonged and unnecessary periods of pain while a terminal patient waits to die. This article will explore some of the reasons for the opposition to a PAS-system, as well as explore age-disparities that exist. It is our hypothesis that older citizens, those that have seriously contemplated how they wish their end-of-life care to be conducted, will be more in favor of a PAS-system in New Jersey than any other age group.

Video Link

Support for Euthanasia/Physician Assisted Suicide: http://www.youtube.com/user/DRJULIEFAGANSTUDENTS?feature=mhsn#p/a/u/0/jwDovDveqkE
Introduction (KRP)

History

"...in this world nothing can be said to be certain except death and taxes" - Benjamin Franklin, 1789

The inevitability of death was apparent to at least one founding-father, as it certainly the case for all those involved in the construction of our nation. The process of death is a part of the cycle of life for all things known, and man-kind is no exception.

Various cultures have dealt addressed the topic of death, some of which have striking similarities. The process of burial is found throughout the world and may have been one of the first ceremonial practices. Evidence suggests Neanderthal man practiced simple shallow-grave burial. The first clear case of human burial is dated back 130,000 years ago, in what is now Israel. Since then cultures have fluxed in and out of existence, each with their own quirks and traditions on burial. It is clear, however, that treatment of the dead has always been an important part of what it means to be human.

Euthanasia, and it's associated topics, are concerned about the treatment of ill-persons around the time of death. The practice of medicine in early cultures was reflected in the understanding of the time. For most of human history medicine was reserved to a certain caste or element of society that performed treatment which included the supernatural, utilizing the gods or magic. Prehistoric Medicine, a general term used for the practice of medicine before the advent of the written word, is a wide span of time which varied by culture. These early practitioners, colloquially known as “witch-doctors” or “shaman”, were tasked with communication to the gods for many reasons, to include curing of the sick. With the passage of time, most cultures began to understand the natural cures for some diseases. The history of China bears this out: some of the traditional medicines of that nation have been proven to be effective for the treatment of diseases, and modern pharmaceutical companies are actively investigating Chinese medicine as a source of alternative treatments.

For most of history, those that practiced medicine also practiced dark-arts, using curses and other forms of magic to destroy an enemy. At some point, it became important to separate these two tasks. An important step in the evolution of this process could have involved the treatment of Dracunculus medinensis, a nematode-worm also known was the Guinea worm. This worm's definitive host is unique to humans, and is characterized by a large painful, burning ulcer in the lower leg. Suffers of this disease seek relief of pain by stepping into a pool of cool water, at this time the worm emerges from the skin and ejects it's eggs into the water supply. The host is left with a ruptured ulcer and a bit of worm protruding out from the wound. The treatment for this disease, as it is currently practiced and how it was many years ago, is to wrap the worm around a stick and gradually drag the worm out from the body. This picture of a worm wrapped around a stick is found in the Greek's depiction of the staff held by the god Asclepius, the god of healing.

A worshipper of Asclepius, a man known to history as Hippocrates, had a lasting effect on the understanding and practice of medicine in the Western world. Hippocrates founded the first school of medicine, and officially separated the profession from those that it had been traditionally associated. He is also credited with writing the Hippocratic Oath, the foundation of medical ethics.
The original version of the Hippocratic Oath contained the oft-quoted “do no harm” clause, although this phrase does not appear in modern versions of the Oath. Similarly, the original version of the oath strictly forbid euthanasia and physician assisted suicide, “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan”, while this sentiment is reflected in the modern version with “it may also be within my power to take a life; this awesome responsibility with be faced with great humbleness and awareness of my own frailty.”

Other differences exist in the Oaths, such as the stance on abortion, however, the main tenets of the Oath setup the modern practice of medicine within the Western world, and by effect, the United States.

Age Disparity Potential

Using the oath as a foundation, modern medicine finds itself in the middle of a long and complicated debate about the implementation of euthanasia and physician assisted suicide within the practice. Among the topics of concern are major philosophical questions (See Section D), as well as theological concerns. Major sects of religion, including Jewish, Christian, and Muslim believers, all are tasked with interpreting the Sixth Commandment, “Thou shall not kill”-(Exodus 10:13). Some exceptions to this commandment are included in the scriptures of these religions, to include time of war(Numbers 10:19), capital punishment(Numbers 35:31-34), and self-defense(Exodus 22:2). Such an exception for euthanasia does not exist, and has been strictly forbidden by various religious groups. Pope John Paul II approved a declaration stating, “For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against lie, and an attack on humanity” -(Sacred Congregation for the Doctrine of the Faith, May 5, 1980).

For the state of New Jersey, such proclamations carry a lot of weight. More people self-identify as Catholics than any other group (404/1000 people according to a 2000 survey) in the state. Research by the American Psychological Association suggests that religious activity and belief increase with age. Although federal law (Public Law 94-521, 1936) has prohibited the collection of census data on religion, some sources have attempted to collect reliable data to backup the notion of a relation of age and religious affiliation. For the purposes of this study, we can assume that those individuals most aged are more likely to be an adherent of a congregation.

This evidence might suggest that the aged population would be in agreement with their religious teachings, and the majority of which would not be in favor of implementing a system of euthanasia/physician assisted suicide. The purpose of this survey will be to test the hypothesis that older Americans, those most likely to have seriously considered the way they wish to have their end-of-life care conducted, will be more favorable to a euthanasia/physician assisted suicide. That is to say, they will go against the teachings of their religion. We expect to find that the age group most opposed to euthanasia/physician assisted suicide will be middle-aged Americans, those who are years removed from palliative care and may have recently experienced the loss of a parent. If this trend can be found, the evidence will suggest that the opposition to euthanasia/physician assisted suicide does not honor the wishes of those it is most likely to apply to.

do-of-life-care.shtml

Definitions/Classifications (KRP)

I. Advanced Directive (Living Will) – A legal document which outlines one’s preferences for care in the event the person is unable to deliver such opinions him or herself. Advanced directives can be used as a request for medical treat as well as refusal. A “Living Will” is a term sometimes used interchangeably with Advanced Directive, as both contain the same information. The legal term is Advanced Directive, according to the The New Jersey Advanced Directives for Health Care Act.

   The state of New Jersey recognizes three different kinds of Advanced Directives.

   a) Proxy Directive – the first way to decide future medical care is to appoint an individual able to make decisions on the patient's behalf. This person will be able to access all the patient's health care information and speak to the physicians and medical care team members. Also known as “health care proxy” and “durable power of attorney for health care”.

   b) Instruction Directive – another way is to clearly state the patient's medical treatment preferences. One can instruct what medical procedures are accepted, and refused, under certain situations. These situations can result in DNR/DNI/DNH.

   c) Combination Directive – combining the first two means of directive into a single document, appointing both a proxy and setting our preferences for him or her.


II. Autonomy - “self-directing freedom and especially moral independence” (Merriam-Webster Dictionary, def. 2) Often considered a human right, the ability of a person to make decisions which directly impact him or her self.

III. Death - “a permanent cessation of all vital functions : the end of life” (Merriam-Webster Dictionary, def. 1) The complex process of end of life, death occurs when a human becomes dead. Much like when life begins, there is some controversy as to when an individual is “dead”. The list below includes a few criteria for death

   a) Cardiac Death – “traditional death”, occurs when the heart ceases to beat on it's own. Only until recently was cardiac death immediately followed with the other classifications of death. Cardiac death is accompanied by the cessation of breathing and all other signs of life.

   b) Brain Death - “medical death”, occurs when the brain is no longer electrically active. Neural tissue requires oxygenation from blood to avoid necrosis, cell death.

Some recognize a difference between

i.“Lower Brain death” - the lower brain controls the most basic vital processes, including breathing, involuntary muscle processes, and pain reception

i.“Higher Brain death” - the higher brain controls consciousness, memory, and complex thought
IV. Do Not Resuscitate Order - “DNR”, often coupled with DNI, a possible element of Advanced Directive, provide instruction against attempting cardiopulmonary resuscitation. These orders should specify if chemical (administration of drugs) resuscitation should also be attempted.

V. Do Not Intubate Order - “DNI”, often coupled with DNR, a possible element of Advanced Directives, provide instruction against placing an emergency airway into the patient.

VI. Do Not Hospitalize Order - “DNH”, a possible element of Advanced Directives, provides instruction that the patient not be moved to a hospital. Possible exceptions include but not limited to during true, life-threatening acute emergencies, or when pain control requires hospitalization. DNH is related to, and is sometimes used interchangeably with, Hospice care.

VII. Euthanasia - “the act or practice of killing or permitting the death of hopelessly sick or injured individuals in a relatively painless way for reasons of mercy” (Merriam-Webster Dictionary, def 1). The active administration of a lethal drug by an outside individual, especially a physician.

VIII. Hospice Care - “a facility or program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill”(Merriam-Webster Dictionary, def 2)
For the state of New Jersey, Hospice Care is under the supervision of “New Jersey Hospice and Palliative Care Organization” which states “To be admitted to hospice care, the patient must be certified by two physicians as having a terminal illness and a life expectancy of six months or less. In electing hospice care, the patient is merely acknowledging that he or she is seeking comfort rather than cure.” Hospice Care in NJ is not a physical building, but rather a general term for the care of the terminally ill. Most patients on hospice care live at home with family, and others long-term in nursing homes. Patients on Hospice Care often have Advanced Directives that include a DNH.

IX. Informed Consent – the concept that any legal document, and by extension any decision for one's health care, can only be considered valid if the person deciding has access to the facts pertinent to the decision, and is of proper mental state to make said decision.

There are three types of consent we should consider:
  a) Voluntary – This type of consent is when a competent patient agrees to a certain medical treatment, or refusal of a medical treatment, knowing all the relevant facts. This type can also be conducted in the arrangement of a Advanced Directive.
  b) Non-voluntary – This type of consent is when a certain treatment is given to, or denied, to patient that has not made a decision about the medical decision in any regard. This is common for individuals that are unable to make decisions (altered mental status, etc) that do not have Advanced Directives. Such cases are commonly refered to as “implied consent”
  c) In-voluntary – This type is when a competent patient does not agree with the selected or denied treatment decision. These cases are rare, and in relation to euthanasia would instead be classified as murder.
X. Murder - “a crime of unlawfully killing a person especially with malice aforethought” (Merriam-Webster’s Dictionary, def. 1) a word reserved for the intentional killing of an innocent with poor/evil intentions.

XI. Method Differences – potentially, a difference exists between methods of euthanasia. For clarity, these two main methods appear below
   a) Passive – Negative – the withholding of medical treatment, or ceasing of certain medical treatment, which are necessary for life to continue
   b) Active – Positive – the use of lethal substances or treatment which brings about death.

XII. Palliative Care – palliate “to reduce the violence of (a disease); also: to ease (symptoms) without curing the underlying disease” (Merriam-Webster Dictionary, def. 1) actions taken to comfort patient during the diagnosis and treatment of serious illness. Differs from hospice care in that a curative treatment can still be sought out.

www.getpalliativecare.org

XIII. Physician Assisted Suicide (PAS) - “suicide by a patient facilitated by means (as a drug prescription) or by information (as an indication of a lethal dosage) provided by a physician aware of the patient's intent” (Merriam-Webster Dictionary, def. 1) An end-of-life decision in which a lethal drug is prescribed to a terminally ill patient, the patient does the physical act of introducing the drug into their own body.

XIV. Power of Attorney – also “Health care Proxy” and “durable power of attorney for healthcare”, see Advanced Directives.

XV. Terminal illness / Terminally ill - “(1) : leading ultimately to death : fatal <terminal cancer> (2) : approaching or close to death : being in the final stages of a fatal disease <a terminal patient> (3) : of or relating to patients with a terminal illness <terminal care>” (Merriam-Webster Dictionary, def. 2) a characterization of disease processes that cannot be cured or deterred from causing death in a patient within a relatively short period of time.

Current Situations and Policies (KK)
NJ Today
The current policy for euthanasia in New Jersey prohibits assisted suicide and all forms of active euthanasia. According to legislation codes 26:2H-77 and 26:2H-54, no one has the right to or is authorized to practice active euthanasia. Under the same legislation, however, passive euthanasia is legalized. It states that withholding or withdrawing of life-sustaining treatment pursuant to an advanced directive for healthcare when performed in good faith shall not constitute homicide, suicide, assisted suicide, or active euthanasia. Thus, although the state of New Jersey opposes the practice of active euthanasia, it nonetheless recognizes the importance of withholding medical care in cases where prolonging the patient’s dying process is inappropriate.
State Policies Which Allow for PAS
Oregon

Upon passage of the Death with Dignity Act (DWDA) in 1994, Oregon became the first jurisdiction in the world to legalize physician-assisted suicide. Today, Oregon holds this record with three other states in the US. This Act sanctions competent, terminally ill adult patients to request a lethal prescription from their physician for the sole purpose of hastening their own death through self-administration of the medication. Although intolerable suffering is a basic requirement for many PAS models that exist, Oregon’s policy simply requires a terminal diagnosis with a prognosis of six months or less to live. After a 15-day waiting period and the completion of various types of documentation, the physician prescribes the lethal dose and the patient administers it to himself. A point to be noted is that the physician is not allowed to administer the dose, which is a process different from PAS termed voluntary euthanasia.

The entire process of PAS under Oregon law, from the patient’s request to the patient’s self-administration of the lethal drug, remains in the boundaries of the patient-physician relationship perhaps with the inclusion of the pharmacist. Any other party would be liable in such a situation since assisted suicide remains illegal under Oregon legislation. Since 1997, 341 terminally ill Oregon citizens have opted for PAS to end their lives under the DWDA (less than 1/10th of 1% of all deaths in the state). Statistics from the Oregon Health Division (OHD) reveal nearly 88% of these individuals were enrolled in hospice at the time. With the use of compliance and surveillance forms, OHD ensures proper regulation, notification, and monitoring of the PAS procedures. Such strict protocols maintain the integrity of the program and prevent governmental intrusion.


Washington

“Even with pain and symptoms properly managed, there are still terminally ill patients that want to have Death With Dignity as an option. And we support that choice.” – a staff member of Compassion & Choices

In November 2008, voters in the state of Washington approved their own model of PAS referred to as Initiative 1000. The policy mandates physician assisted suicide under the Death with Dignity Act, authorizing terminally ill patients to request the lethal dose of drugs to hasten and further demedicalize their dying process. Similar to the Oregon model of PAS, this model also requires that a physician notify the patient of all the alternative forms of end-of-life care such as hospice and pain management. Under the Act, the participating physician is not permitted to list assisted suicide as the cause of death but instead is obligated to report an underlying illness present at the time of request for PAS and subsequent death. Statistics reveal that the young program has delivered lethal doses of prescription to 63 individuals thus far. Most of these individuals were terminal cancer patients with less than six months to live. Participating physicians later divulged that most of the requesting patients feared a loss of autonomy and expressed sincere concerns about death with dignity – they feared a death that would spoil their last moments with severe agony and a feeling of grave hopelessness.
Although the legislation escaped a narrow margin and was passed, there are many citizens of Washington, a majority of them from religious groups, that refuse to accept the new law. Despite this, however, the state of Washington has shown no signs of regret thus far and continues to support physician-assisted suicide.
http://www.ncregister.com/daily-news/washington_first_year_under_legalized_assisted_suicide/

Montana

In a Supreme Court ruling on December 31, 2009, physician assisted suicide was legalized in the state of Montana, making it the third state in the US with legislation to protect patients’ wishes to request assisted suicide. Earlier this year in February, Montana legislators were expected to establish regulations and invent a standard policy that would outline the basic roles of physicians and requesting patients and the essentials of the procedure itself. However, legislators have not yet replied to this request and it seems that they will continue to ignore it. Physicians in the state of Montana are hesitant to perform the procedure since a standard policy is not in place and they could be subject to prosecution.
http://billingsgazette.com/news/state-and-regional/montana/article_a35791fe-3d00-11e0-bff3-001cc4c002e0.html

International Look

The Swiss Model

“A Peaceful Death is Everyone’s Right” – Exit International

In Switzerland, the practice of euthanasia and physician assisted suicide have been around since the 1940’s. Under the Swiss Penal Code Article 115, the emphasis primarily focuses on the motive of the action and not the intent. Thus, if the motive is not selfish, then the act is not a crime. This tradition drastically differs from the PAS models that exist in the United States in that it is far more lenient with its policies. The practice is not limited to the physician or medical field in any way. Instead, right to die organizations and their volunteer staff play a significant role in facilitating assisted death. The penal law does not differentiate between physicians and non-physicians in terms of assistance. Additionally, the Swiss model does not limit assistance to only those who are terminally ill.

The policy calls for judicial involvement, unlike the Oregon model. When the patient is successfully administered the lethal dose, the death is immediately reported to the police. The police, then, thoroughly investigate and analyze the video (a requirement) to ensure that the motives leading up to the patient’s death were indeed altruistic. As long as the act is deemed selfless and genuinely altruistic, there is no crime. Swiss law and tradition also protect those who assist in suicide, as long as a benign motive can be proved. Despite the vast differences between the two models, however, both Oregon and Swiss law remain in opposition to voluntary euthanasia.

In Switzerland, the policies for assisted suicide have been around for seven decades now and as a result, they appear to be a lot more polished than those that exist in the US and in other countries. Allowing third party organizations to assist with the procedure greatly reduces the involvement of physicians, which is necessary to maintain the integrity of the physician-patient relationship. In addition, with the immediate involvement of the police, the procedure becomes justified and is reported as so. This averts criticism from those in opposition to assisted suicide and also prevents condoning of murder that may be concealed as assisted dying. Overall, the Swiss model offers a very lenient, yet highly appropriate policy for euthanasia and assisted suicide.
The Netherlands’s Approach

In the spring of 2001, the Dutch Parliament passed a law formally legalizing euthanasia and physician assisted suicide in the Netherlands. Voluntary euthanasia currently falls under the Termination of Life Request and Assisted Suicide Act of 2002. These acts were widely practiced long before they were sanctioned, however. A recent study revealed that in a population of about 14.5 million, about 1,900 cases of voluntary active euthanasia or PAS occur annually in the Netherlands. While assisted suicide is still a crime under the Dutch penal code, the Act authorizes physicians to help terminate the patient’s life upon request. The policy states that the patient must be over 16 years of age and his/her medical condition must be irreversible. In a case where the patient is between the ages of twelve and sixteen years, the physician may ignore the request as long as the patient demonstrates adequate understanding and a parent/guardian consents. The policy also requires the involvement of at least one other physician for proper and thorough consultation. The Dutch mode of PAS is a proponent of reporting and monitoring all cases in order to remain in accordance with the law and social acceptance.

Belgium

After much debate, the Belgian Parliament decided to adopt the Netherlands’ policy regarding euthanasia/physician assisted suicide on May 28, 2002. Under the Belgian mode of PAS, the patient must be terminally ill with immense physical and/or psychological suffering and no hope for recovery. The Belgian policy also differentiates between procedure protocols on a case-by-case basis. For example, the approach to euthanasia/assisted suicide is different for terminally ill patients versus patients with incurable diseases with significant time to live. Belgian euthanasia is a lengthy process that includes thorough examination of the patient over a course of time and a series of medical tests. The policy requires the physician to inform the patient about his/her life expectancy, alternate end-of-life options, pain management, etc. In addition, the physician is required to consult extensively with another physician before administering the lethal dose of drugs. Physicians’ rights and integrity are protected under this Act and Belgian law.

Ethical Arguments/Issues (KK)

Killing and Letting Die
For: There is a significant ethical difference between killing and letting die.

The few PAS models that exist in the world today do so because of a subjective boundary between active and passive euthanasia. A majority of the policies for PAS/euthanasia allow passive acts of euthanasia, but strongly prohibit any sort of active form. That is, withholding of
medical treatment and prescribing the lethal dosage of the drugs is legal whereas direct administration of the drug and withdrawing of a medical aid (that results in the patient’s death) is illegal. Is there a difference between the two acts? Such controversial and vulnerable settings often necessitate an evaluation of motive. A selfish motive in the process of assisted suicide or euthanasia undoubtedly results in killing of the patient. However, an act that lessens the patient’s agony and is of no benefit to anyone but the patient can be termed as “letting die.” Again, only a thorough assessment of motive can reveal whether the patient was killed or was allowed to die.

Against: There is no meaningful difference - these two are the same.

Opponents of physician-assisted suicide often employ this criticism. Killing someone and allowing them to die are identical acts since the result in both cases is the death of the patient. In this scenario, motives and ethics fail to be the principal considerations. Instead the focus shifts solely to the physiological survival of the patient. Therefore, acts such as withholding life support and withdrawing the respirator take on equal meanings and both result in the death of a patient, who would otherwise still be breathing.


Death Process: Heart Death vs. Brain Death

When an individual undergoes cardiac arrest and subsequent cardiac death, his heart stops beating and loses all function. Within religious and even most traditional medical boundaries, this occurrence along with respiratory cessation equates to death – the person is no longer considered living. However, with the advent of modern medical technology, it is now possible to salvage organ functions even when others are failing. Thus, although a patient with considerable and irreversible brain damage can use the respirator as a surrogate, this does not mean that he/she will be able to survive once it is removed. Is brain death sufficient to declare death even when the heart is still beating? Medical ethics lie on both sides of the debate. Religious groups often only accept the classic cardiac death and respiratory failure as dying and refute any validity associated with brain death. On the other hand, most physicians and scientists believe that brain death is indeed irreversible and in such cases, time is crucial if there is any hope to harvest viable organs.

http://wings.buffalo.edu/bioethics/man-death.html

Patient Autonomy

Patients are able to make decision to end own life.

A chief argument against euthanasia/PAS is whether an individual should reserve the right to determine when to end his/her life. With sufficient mental and psychological competence, many argue that a patient can rightfully make decisions regarding his dying process. Additionally, a medical casuist supporting PAS may assert that denying a person the right to make a decision so essential to the quality of life is an outright violation of patient autonomy. In our service project, we would like to demonstrate that a part of patient autonomy also deals with being able to make decisions without the interference of the decisions of others who may or may not be affected by it.

Patients are not allowed.
Experts in the field of psychology may argue that a patient pushed as far as to request death is either psychologically affected by the pain/suffering or is not mentally competent for other unknown reasons. How can a perfectly sane, competent individual request to be killed?

Scope of Practice

PAS is within scope of medical practice.

Supporters of PAS have broadened their definitions of a physician’s role. A physician not only practices medicine to save lives, but also applies medicine to enhance the patient’s quality of life. With this concept, the physician is expected to employ PAS if and when the terminally ill patient requests it.

PAS is not within medical scope.

Ever since the inception of medicine, physicians and medical care providers are associated with sustaining life and preventing death with whatever means necessary. With these ideals in place, it is not surprising that many people have difficulty accepting notions such as euthanasia and physician-assisted suicide. Moreover, “killing” is never thought of as a part of a physician’s job description. PAS opponents believe that the sole purpose of physicians is to save lives.

The Service Project: Survey

Link to Survey: http://www.surveymonkey.com/s/FGC7GZD

Hypothesis: (KK)
Our service project consists of obtaining and analyzing the results of a survey on euthanasia/PAS and publishing the survey in an appropriate magazine to raise awareness. The survey will be completed on paper as well as online. The link to the survey is available above. The survey is comprised of ten questions, eight of them directly addressing the issues of euthanasia/PAS and the last two designed to evaluate the survey's effectiveness in terms of general application and religious involvement. The focus of our survey is to evaluate the overall beliefs within five distinct age groups regarding the subject of euthanasia/PAS and end-of-life care. If we can prove that the majority of the older age groups are in favor of the practice of euthanasia/PAS, then we can conclude that those who it essentially applies to feel that a system of physician-assisted suicide should be implemented in the state of New Jersey. With this survey, we hope to clarify and analyze the validity of opposition to end-of-life practices, such as euthanasia and physician-assisted suicide.

Materials and Methods: (KRP)
In order to test our hypothesis, we targeted two major age groups; younger adults and older adults. Subsequently, we had two major types of data collection; on line and paper surveys. Both of these mediums contained the same questions in the same order. The amount of bias people in general have about answering questionnaire's at the computer, or on paper, is unknown and not considered statistically significant for the purposes of this research.
The questions cover a range of subjects concerning end-of-life medical choices choices. They were ordered “randomly” as to not go in any order or progression. This was an attempt to avoid
the survey takers feeling as if they should start to answer differently as the questions got more probing.

The first medium of survey taking was online. The web-based company www.surveymonkey.com was used in processing the survey. SurveyMonkey is a fairly new, but very successful survey-creation and analytical web site. The company holds an accreditation and an A+ rating from the Better Business Bureau. This site allowed for easy and effective collection of our younger age groups. The social networks Facebook and Twitter were used to enlist survey takers for this portion of the survey. In particular, young adults from New Jersey were targeted. The results were fed into and the website for later review.

The second medium used for this survey was a paper form of the same survey. Paper printouts of the survey were handed to populations of older adults, with ages ranging from 65 to 92. The particular setting these individuals answered the survey was during a local “Bingo Night”. This method was largely successful.

There was an attempt to obtain even more results from a larger population through the use of mailings. Packets were prepared with ten blank surveys, two addressed and stamped envelopes, and a letter of instruction. These packets were sent to eleven different senior centers in different parts of the state. To date, none of the packets have been returned.

The survey responses gained were enough in number and completeness to help gain insight which will test our hypothesis. Although the best solution would be to gather the opinion of all citizens of New Jersey (and perhaps a general voting appeal should be done), for the purposes of this paper the sample size gathered will be adequate.

Survey

**Age – Please mark next to the age range which applies to you as of today:**

| 20 - 29 | 30 - 39 | 40 - 59 | 60 - 79 | 80+ |

Please fill in or mark the circle which corresponds to your opinion on the following:

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |

2. A person has the right to refuse hospitalization when sick.

   ○ ○ ○ ○ ○

3. A person has the right to refuse cardiopulmonary resuscitation (CPR) if needed, to include use of chemicals and the use of a tube to help the person breathe.

   ○ ○ ○ ○ ○

4. A system of Physician Assisted Suicide should be started in New Jersey.
As seen in Montana, Oregon, and Washington, this system is where a drug is given to a patient to take for him or herself.

5. Physicians should consider quality of life for the treatment of the terminally ill.

6. There is an important difference between passive (withholding medical treatment) and active euthanasia (use of lethal substances) to bring about death.

7. Death occurs when higher brain function stops (which includes consciousness, memory, and voluntary motor function), regardless of lower brain function (which includes heart beat, breathing, and pain reception).

8. A person has the right to choose euthanasia (“mercy killing”) in the face of incurable terminal illness.

1 - How sure are you on how you want your own end-of-life medical care to be conducted?

2 - How much influence do your religious beliefs have on your end-of-life medical care decisions?

Results (Kunwar Kaur)

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<td>155</td>
<td>34</td>
<td>45</td>
<td>171</td>
<td>29</td>
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<tr>
<td>Question #7</td>
<td>137</td>
<td>44</td>
<td>56</td>
<td>153</td>
<td>27</td>
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<tr>
<td>Question #8</td>
<td>174</td>
<td>37</td>
<td>49</td>
<td>170</td>
<td>31</td>
</tr>
<tr>
<td>Total # of Responses</td>
<td>40</td>
<td>17</td>
<td>21</td>
<td>43</td>
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<tr>
<td>Total Value/ # of Q’s</td>
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<td>52.86</td>
<td>62.14</td>
<td>181.29</td>
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<table>
<thead>
<tr>
<th>Ranges</th>
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<tbody>
<tr>
<td>Strongly Agree</td>
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<td>Agree</td>
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Discussion (KRP)
The number and complexity of questions made in this survey poses a bit of a challenge in interpreting the results. Each question is important, however, and gives us insight into some of the contributing thought processes that lead one to general opinions about PAS. To better understand these results, each question should be considered and it's results interpreted individually.

The first question was one in which little opposition was expected, “A person has the right to refuse hospitalization when sick.” This is a generally agreed on principle, and draws its arguments from autonomy. The results bear this out, with all age groups placing this question in the 4 or 5 point categories. Some feedback from test takers included possible exceptions for patients who are sick with communicable diseases (or in some other way, a threat to the public), or those that are in life-threatening traumatic situations. In fact, these considerations are in place at this time.

Question #3 was also a confirmation of a policy currently in place in the state of New Jersey. Through the use of DNR/DNI orders, a patient can refuse CPR or other life saving treatment. The 40-59 age group was the only group to place this answer outside the 4 and 5 point range, dipping into 2 point- “disagree”.

Question #5, “Physicians should consider quality of life for the treatment of the terminally ill.” received the highest marks of any question.

Question #6, “There is an important difference between passive (withholding medical treatment) and active euthanasia (use of lethal substances) to bring about death.” was the source of some confusion. This question on the difference between killing and letting die is explained in detail in the Ethical Issues section of this paper. However, many people do not realize that their own answer to this question can have a large impact on how they rationalize about cases of euthanasia and PAS. The results of this question show that no age group had particularly strong feelings in either direction. We can assume that the complexity of this question may have lead to many to select the “Neutral” answer, or that age is not a factor on how this question was answered, and no patterns were found.

Question #7, “Death occurs when higher brain function stops (which includes consciousness,
memory, and voluntary motor function), regardless of lower brain function (which includes heart beat, breathing, and pain reception)” was the second source of some confusion. This topic is covered in this paper in the Ethical Issues section under “heart death vs brain death” This question cuts to the core of when we consider a person dead. In effect, what characteristics are necessary to human life, which some would argue is higher brain function, while others would argue for all function. These answers ranged in the 3 and 4 point sections, probably for the same reasons as question #6.

Question #8, “A person has the right to choose euthanasia (“mercy killing”) in the face of incurable terminal illness.” Perhaps the most simply stated and polarizing question asked, this question cleanly separated the age groups. The youngest age group marked this answer as “Strongly Agree”, followed up by 60-79 and 80+ age groups giving a high “Agree” scores. The middle age groups both gave this question low “Disagree” scores.

The last two questions showed some interesting results and expected patterns. There seems to be a general trend that corresponds to age and preparedness of end-of-life decisions. There also seems to be a general trend on how much individuals rely on their religion as an influence to make these important decisions, which was also expected and explained in detail in the beginning of this paper.

Finally, the question that is most important our hypothesis was found at #4, which reads “A system of Physician Assisted Suicide should be started in New Jersey. As seen in Montana, Oregon, and Washington, this system is where a drug is given to a patient to take for him or herself.” This question showed the suspected age disparity in the following manner. Again, the younger age brackets and older age brackets answered similarly, with the 20-29, 60-79, and 80+ groups all indicated “Strongly Agree”. 30-39 entered a neutral decision, and 40-59 disapproved strongly.

Conclusion (KRP)
The purpose of this study was to determine what disparities exist on opinions of PAS/euthanasia, particularly based on age. From our results, it is clear that we are unable to determine if such an age disparity exists for some questions, like #6 and #7. We also know that some agreement for questions is across the board, as seen in questions #2 and #5.

Most importantly, we have also shown that some topics do have an age-disparity, to include the heart of this paper, implementing a system of PAS in the state of New Jersey. The youngest and oldest people of New Jersey are in support of a system of PAS. It's opposition comes from the middle-aged brackets.

How have these individuals arrived at such strong opinions? As discussed earlier in this paper, one possible answer to this question should come from religious influence. Interestingly, both age groups that strongly supported a system of PAS in New Jersey had quite opposite answers to this question. Young people attributed the lowest amount of influence to their own religion to their opinions, while older people answered attributed over 90%. This can be understood to mean that although these age groups arrived at the same conclusion, they arrived at this answer by very different means.

Another possibility is through the basic ethical questions surrounding PAS and the patient's rights in health care in general. These are largely up for debate, even among professional
philosophers. Such questions include if there is an important ethical difference between killing and letting die, if a person has the right to choose their own mode and time of death, and if PAS should be considered within the scope of medicine (a topic debated even among physicians).

Some of these very questions were asked during our surveys. The results of which mirror the pattern of age disparity seen previously. On important ethical questions which frame how one understands personal choice, the youngest and oldest of our survey takers agree. These results tell us that even though both groups arrived at the same opinions through similar thought processes. Perhaps this is evidence to suggest that on important ethical matters, the young and old see more eye-to-eye than previously thought.

What should be concluded is that while general public polling is used to determine the popular opinion on a certain topic, such as PAS, we must be mindful that an age disparity exists. That is to say, the people that PAS would most likely apply to are most in favor of it.

Editorials

Kunwar Kaur
Submitted to The Daily Targum (3/22/11)

The Right to Die – Choosing To Not Suffer

As Americans, we are promised many rights the moment we enter this world. These rights not only deem our country autonomous, but also promise an American citizen the chance to experience autonomy and make independent decisions at each step in his life. Why, then, do these privileges fall short during the closing chapters of our lives?

In 47 of the 50 states of the United States, a terminally ill patient is forbidden to request physician-assisted suicide (PAS). Often, terminally ill patients suffer till that very last moment of their lives – they suffer both physically and mentally until they breathe their last breath of air. Death is a very complex event in a person’s life and everyone wishes to leave this world with some dignity and comfort. However, what happens is quite the contrary. Many terminally ill patients agonize while their physicians increase their dosages of pain medication in futile endeavors to ease the patient’s pain and make them “as comfortable as possible.” The truth of the matter is, sometimes even the most effective pain meds fail to provide a dying patient with the comfort he so desires in his last moments. In addition, under the influence of such powerful sedation, a person loses the ability to interact with his loved ones for a chance to bid a final, meaningful goodbye. Thus, medicinal efforts to prolong and sustain life in terminal cases not only prolong the patient’s suffering, but also devalue a person’s death.

Adopting a PAS model offers a rational solution for these issues, especially in cases regarding the terminally ill and patients in vegetative states with irreversible brain damage. Limiting the practice to physicians under strict surveillance ensures that the process will be carried out specifically per regulations. Regulations can effectively prevent misuse of the practice and also help maintain the integrity of a physician’s role. Currently, Oregon, Montana, and the state of Washington are successfully utilizing a PAS system. Why is the idea of adopting a PAS model in the state of New Jersey so far-fetched? The mission of a physician-assisted suicide system complies with the fundamental, underlying motive of all medicinal endeavors: to eliminate a patient’s suffering with whatever means necessary. Instating such a system can certainly eliminate suffering for those who reach a stage outside the medical realm of recovery and can promisingly improve the quality of a person’s final days. An American ought to have the right to not suffer in his final moments and legalizing PAS can ensure that.
Planning for end-of-life care for yourself or a loved one is a difficult but necessary task. Because the stress of medical decisions is so huge, consideration should be given to how medical care should be conducted as early as possible.

Living Wills, also known as advanced directives, help outline your wishes to the medical care team in such a case that you are unable to communicate them yourself. These documents also help to relieve the stress experienced by family and loved ones. Some common elements include:

- Life Sustaining Procedures – These involve declaring opinions on receiving airways to assist in breathing, drug therapy, pumping of the heart (CPR), and/or receiving nutritional supply from artificial sources.
- Durable Power of Attorney – This option allows for an individual to make medical decisions on behalf of another.

Even if a legal document is not created, it is important to consider all the options available for end-of-life care decisions.

However, do you have access to all the options? Unless you live in Oregon or Washington, and soon, Montana, the answer is no. These states allow for the possibility of selecting physician-assisted suicide (PAS) as a end-of-life care plan. PAS is characterized by a medication being issued to a patient, at their request, which is then taken by the patient to bring about death.

These highly controlled programs in each state both issued less than 100 prescriptions each in 2010, and a small percentage of those medications issued were never taken by the patient. According to a report by the state of Oregon, 92.6% of the patients that were issued medications were on hospice care at the time. These individuals have been certified to have a terminal illness, with a life expectancy of six months or less.

Do you think you should be denied considering such an option? Research conducted at Rutgers, The State University of New Jersey, indicates that a vast amount of older New Jerseyans would like to able to consider the option. The same opinion surveys also found that young people (20-29) also think a system of PAS should be considered in the state.

The main reason to support a system of PAS is to honor personal liberty, especially in those who have expressed their wishes and are now suffering from incurable illness. You should be able to make decisions on end-of-life care using all resources available.

Talk with your loved ones, your doctor, and consider creating a Living Will. If you want to find out the current political situation of PAS systems in your state, contact your local legislature. [http://www.usa.gov/Contact/Elected.shtml](http://www.usa.gov/Contact/Elected.shtml)
Email Response from AARP:

Dear Mr. Parks:

Thank you for your interest in our publication and for giving us the opportunity to review your story idea.

Please be assured that our editors review all submitted story ideas. We receive many submissions each week and, understandably, our editors cannot personally respond to each one. If an editor is interested in pursuing your idea, we will contact you directly. If eight weeks pass and you have not heard from us, we encourage you to pursue other avenues toward getting your material published.

Be sure to visit our Digital Newsstand at http://newsstand.aarp.org where you can access past and current versions of our AARP publications online.

Again, we appreciate your interest and thank you for getting in touch with us.

Sincerely,

Jaimie
Member Communications
Member@aarp.org

Letter to Senior Citizen Centers of New Jersey:

To whom it may concern,

We are a team of Rutgers University researchers currently conducting a study on the opinion of various medical care options in New Jersey. Our purpose in this research experiment is to recognize and address a wide range of opinions on topics ranging from Living Wills to Physician Assisted Suicide(PAS). We are conducting a short survey in the hopes of obtaining the opinions of various age groups, and especially those who have already considered how they want their own end-of-life care to be conducted.

Enclosed are ten copies of the survey and two return envelopes. If at all possible, have some of your patrons and staff complete these short surveys and return it in the envelope provided.

Your participation in our study will be of significant value to our research, which will result in a more precise understanding on the complex decisions we will all one day have to face.

Thank you so much for the time and consideration.
Planning for end-of-life care for yourself or a loved one is a difficult but necessary task. However, do you have access to all the options currently available? Unless you live in Oregon or Washington, and soon, Montana, the answer is no. These states allow for the possibility of selecting physician-assisted suicide (PAS) as an end-of-life care plan. PAS is characterized by a medication being issued to a patient, at their request, which is then taken by the patient to bring about death, which avoids prolonged periods of pain and suffering.

Do you think you should be denied considering such an option? Research conducted at Rutgers University, The State University of New Jersey, indicates that a vast amount of older New Jerseyans would like to able to consider the option. The same opinion surveys also found that young people (20-29 years old) also think a system of PAS should be considered from implementation in the state.

Opinion polls are often presented in a very simple way, showing the percentage of all those polled on how they feel on a certain topic. This way of collecting and analyzing information may often be misleading. Certain questions, like ones that affect end-of-life care, can be received differently by different age groups. Does an age-disparity exist on opinions supporting physician assisted suicide?

A survey was conducted in which individuals were presented with a statement, and asked to rate how they agree or disagree with that statement. These statements ranged from the fairly innocuous “A person has the right to refuse hospitalization when sick”, to more controversial statements, such as “A system of Physician Assisted Suicide should be started in New Jersey.”

Reactions to the former, starting PAS in the state, showed patterns of age disparity. Young adults (20-29) indicated strong agreements with this statement. Middle-aged groups (40-59) showed strong disagreements. Older survey takers (60+) strongly agreed with this statement. These breakdowns were not without dissenting voices for their respective age groups, but the general trend is that Young and Old agree that such a system should be considered.

But how exactly does one arrive at a decision about how they feel about PAS? Why is it that young and old age groups could arrive at the same opinion?

When considering topics about life and death, an important source of insight we can turn to is our own religion. Major sects of religion, including Jewish, Christian, and Muslim believers, are tasked with interpreting the Sixth Commandment, “Thou shall not kill” -(Exodus 10:13). Some exceptions to this commandment are included in the scriptures of these religions, to include time of war(Numbers 10:19), capital punishment(Numbers 35:31-34), and self-defense(Exodus 22:2). Such an exception for euthanasia and PAS do not exist, and has been
strictly forbidden by various religious groups. Pope John Paul II approved a declaration stating, “For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity” -(Sacred Congregation for the Doctrine of the Faith, May 5, 1980).

However, our study found older age brackets attributed their beliefs to large percentage (~90%) to their religion. Young people attributed much less; about 33% of their decision-making was based on their religious beliefs. It is possible that these percentages follow the general trend of how much credit members of the respective age give to their religion. Furthermore, Since these percentages were so wide, it is unlikely that religion is the source of the agreement among age groups.

Another possibility is through the basic ethical questions surrounding PAS and the patient's rights in health care in general. These are largely up for debate, even among professional philosophers. Such questions include if there is an important ethical difference between killing and letting die, if a person has the right to choose their own mode and time of death, and if PAS should be considered within the scope of medicine (a topic debated even among physicians).

Some of these very questions were asked during our surveys. The results of which mirror the pattern of age disparity seen previously. On important ethical questions which frame how one understands personal choice, the youngest and oldest of our survey takers agree.

These results tell us that even though both groups arrived at the same opinions through similar thought processes. Perhaps this is evidence to suggest that on important ethical matters, the young and old see more eye-to-eye than previously thought.

Whatever the cause, we know that older New Jerseyans are in favor of considering the option of PAS. What should be concluded is that while general public polling is used to determine the popular opinion on a certain topic, such as PAS, we must be mindful that an age disparity exists. Since any such policy is more likely to apply to older age groups, special consideration should be given to that opinion.