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Progressive Policy Changes on Physician-Assisted Suicide for Dementia Patients

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Abstract

Many philosophers believe that physician-assisted suicide is morally permissible if a patient has a terminal illness, is suffering, and expresses a wish to die. J. David Velleman disagrees with this popular line of reasoning. He argues that human beings do not have a moral right to terminate themselves. On his account, physician-assisted suicide is morally permissible only if the patient no longer has the property of dignity. Velleman laments that current physician-assisted suicide legislation in the United States is too broad. It permits human beings who have not lost dignity to access the medical procedure. In the articles “Against the Right to Die” (1992) and “A Right of Self-Termination” (1999), Velleman states that he cannot figure out how to craft legislation that would make physician-assisted suicide available only to patients who no longer possess the property of dignity. I propose a solution to this problem of over-inclusive public policy.

My argument that it is possible to craft legislation about physician-assisted suicide that is not too broad in its application has three premises. My first premise is that a human being cannot possess dignity if they do not have the capacity for agency. My second premise is that it is possible for observers to determine whether a human being has lost the capacity for agency, and thus lost dignity. My third premise is that it is morally permissible to end the existence of a patient with a terminal illness who has lost the capacity for agency and thus dignity if they have expressed their wish for physician-assisted suicide in an advanced care directive while they were cognitively competent.

Legislation that permits patients to communicate their desire for physician-assisted suicide in an advanced care directive if they lose the property of dignity at a future time includes only the population for whom Velleman believes physician-assisted suicide is morally justified without legalizing a right to terminate oneself.

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Introduction

Physician-assisted suicide is a controversial moral issue and a hot topic among state legislators in the United States. Physician-assisted suicide is a medical procedure in which a patient who has a terminal illness and is suffering requests a lethal drug from a medical professional. Physician-assisted suicide is currently legal in California, Colorado, Hawaii, Montana, Oregon, Vermont, Washington, and the District of Columbia. In spring 2019, the Nevada state legislature considered a bill that would legalize physician-assisted suicide.

Although the state laws have minor differences, the general contours of the legislation are the same. The patient must create a written request for assisted suicide and present this document to a medical professional. In some states, patients must receive diagnoses from two different medical professionals that indicate they have a terminal illness. The patient must wait two weeks and make a second request for the lethal drug. Ending one's life is a serious and irreversible decision, and medical professionals want to ensure that patients make this decision with full information about the course of their disease and their options for pain management. When it is clear that the patient fits the eligibility requirements and is making the decision freely, without being coerced or pressured, the medical professional prescribes the patient a lethal drug that the patient must take at home, of their own accord.

What distinguishes physician-assisted suicide from euthanasia is that the patient self-administers the medication. If the medical professional were to administer the lethal drug to the patient, the correct term to describe the action would be euthanasia and not

physician-assisted suicide. In physician-assisted suicide, the medical professional confirms that the patient meets the criteria to access the medical procedure and provides them with the necessary medical resources. Some patients who receive the lethal drug change their mind and never ingest it.

Many philosophers judge physician-assisted suicide to be morally permissible. The values of autonomy and beneficence are central in their arguments. Competent adults have a moral right to make important choices about their lives. How one dies is an important choice about one's life. Therefore, competent adults have a moral right to end their lives. Moreover, when a patient is suffering from a terminal illness, it seems to fall within the medical professional's moral duty to provide benefits and not harms to the patient. If the patient believes that continuing to exist is a harm, and if they autonomously request medical assistance in dying, it is morally permissible and perhaps even morally required for the physician to comply with their patient's wish.

Carl Wellman's "A Legal Right to Physician-Assisted Suicide Defended" is a representative example of this line of reasoning. Wellman stresses the importance of protecting in law the moral right to end one's life if one has a terminal illness and is suffering. He writes,

Some patients enduring intolerable, unrelievable suffering as well as some terminally ill patients enduring lesser but still severe suffering need this legal right, for they cannot escape from their suffering without it. Those who die within hours or a few days will soon obtain relief without taking any action, and those who are on life-prolonging intensive care can often end their lives simply by refusing continued treatment. But others are condemned to continuing severe suffering by any legal system that confers no legal right to physician-assisted suicide.¹

¹ Carl Wellman, "A Legal Right to Physician-Assisted Suicide Defended." *Social Theory and Practice* 29, no. 1 (2003): 23.

Although this argument about the moral permissibility of physician-assisted suicide and its corresponding legal recommendation are popular, they are misguided. I am not alone in this belief. J. David Velleman rejects the adequacy of this account of the moral permissibility of physician-assisted suicide and offers his own account. Velleman appeals to the value of dignity rather than to autonomy or beneficence in his argument, which he articulates in “Against the Right to Die” and in “A Right of Self-Termination?” However, Velleman fears that efforts to legalize physician-assisted suicide will enable patients to access the medical procedure even if their cases are not morally justified. In this thesis, I expand on Velleman’s position by identifying how a medical professional should judge whether a patient has dignity. I also propose a legal strategy by which to limit access to physician-assisted suicide to terminally ill patients who no longer possess dignity and who have expressed at an earlier time, when they possessed dignity, their wish to access this medical procedure.

According to my view, whether the patient is suffering is irrelevant when determining whether a patient should be considered eligible for physician-assisted suicide. Suffering is a natural component for many diseases, including dementia. Suffering is different from pain, as pain is primarily a physical state of being. Suffering is a form of pain that is felt mentally, emotionally, and existentially. However, suffering cannot be a component to determine the eligibility of physician assisted suicide because a person who is suffering tends to make decisions based on their self-interest. As suffering is more of a mental experience than that of pain, suffering can often lead people to make irrational decisions, one of which could be a desire for physician-assisted suicide. A person who expressed such a wish while in the throes of suffering might not understand

that they still possess the capacity to attach value to their experiences. If the person still has agency, the ability to desire, value, and choose, then they still have the property of dignity. Patients who attempt to make decisions about their death based on self-interested reasons demonstrate that they still have the capacity to make a value judgment about their existence. Although current legislation permits such patients to choose physician-assisted suicide, my proposed changes include stricter eligibility criteria that would exclude this type of patient.

Velleman's Argument for the Moral Permissibility of Physician-Assisted Suicide

Velleman argues that physician-assisted suicide is morally permissible only when the patient no longer possesses the property of dignity. He writes,

When a person cannot sustain both life and dignity, his death may indeed be morally justified. One is sometimes permitted, even obligated, to destroy objects of dignity if they would otherwise deteriorate in ways that would offend against that value. The moral obligation to bury or burn a corpse, for example, is an obligation not to let it become an affront to what it once was.²

It is difficult to understand Velleman's claim that it is morally permissible for someone to destroy an object that possesses dignity if that object loses the property that was associated with its dignity. He attempts to explain what he means by giving an analogy about the morally appropriate way to treat a damaged flag. A flag is a symbol of a country. When an American flag is torn, stained, or faded, the owner of the flag has a moral duty to retire and dispose of the flag. Velleman posits in his analogy that a human being can be like a flag. When a human being loses its dignity because of the progression

² J. David Velleman, "A Right of Self-Termination?" *Ethics* 109, no. 3 (1999): 617.

of a terminal disease that interferes with the property that is associated with human dignity, it is morally appropriate for a medical professional to end the patient's life.

To be clear, a flag is not an agent or a self. A flag is not sentient, and it does not have desires and wishes. It makes sense to attribute dignity to a flag, though the property that associated with a flag's dignity differs from the property that is associated with the dignity of a person. If any entity has dignity, it possesses a property that commands others to show respect and reverence towards it. It is true that objects do not have dignity in the same manner that human beings do. Nevertheless, a flag that has become tattered is similar to a human being who has lost the capacity for agency. Both entities have lost the property that is foundational to the kind of entity it is. A tattered flag is still an example of a flag, but it can no longer serve as a symbol of the country. United States Flag Code states, "The flag, when it is in such condition that it is no longer a fitting emblem for display, should be destroyed in a dignified way, preferably by burning."³ This federal law conveys that when the flag has reached a stage in which its symbolism-generating properties have been diminished, there is a moral obligation to dispose of the flag in a way that is dignified.

Velleman rejects the idea that human beings are able to determine from their subjective standpoint whether they have dignity or not. Dignity is not a subjective property that a person has if they feel that they have it. A human being does not lose dignity simply because they feel as if they do. Dignity is an objective property. Although people sometimes speak as if dignity were a matter of being able to live independently

³ Title 4, United States Code, Chapter 8, "Respect for flag," (1998).

and to control one's bodily functions, Velleman claims that dignity is a property that concerns a human being's cognitive capacities.

Velleman does not describe in detail what cognitive capacities are associated with human dignity. In "A Right of Self-Termination?", he uses the term "rationality" to describe the relevant capacity. For example, Velleman writes, "[T]he self-interested choice of suicide cannot be an exercise of rationality, because it entails treating oneself as an instrument of one's interests, which is incoherent."⁴ Velleman's account of rationality is confusing and controversial. For Velleman, dignity is connected to a human being's ability to be rational. In a later section, I will improve on Velleman's view by arguing that dignity is connected to a human being's capacity for agency, that is, their ability to attribute value to objects, other people, or a way of existing in the world. Nevertheless, it is clear that Velleman believes that failures of rationality occur when a human being's subjective perception is not in harmony with an objective assessment of the matter. According to Velleman, physician-assisted suicide is morally permissible only when an external observer makes a correct objective assessment that the patient has lost the property of dignity. When a patient who has dignity requests physician-assisted suicide, they are treating themselves like an object. Treating oneself like an object is morally inappropriate when it is objectively the case that one is a subject.

Velleman believes that many terminally ill patients who request physician-assisted suicide are motivated by reasons of self-interest. These patients no longer view continued existence as a benefit to themselves. According to Velleman, many people who

⁴ J. David Velleman, "A Right of Self-Termination?" *Ethics* 109, no. 3 (1999): 615.

are diagnosed with terminal illnesses nevertheless possess dignity. On his view, reasons of self-interest do not morally justify a human being in ending their life with or without medical assistance. It is for this reason that Velleman rejects the standard moral justification of physician-assisted suicide, which is grounded in the value of personal autonomy and the conviction that a human being has the moral authority to treat their existence as a tool for their own pleasure or benefit.

Velleman's Argument for the Impossibility of Enacting Physician-Assisted Suicide Legislation with Morally Appropriate Scope

Velleman acknowledges that many patients who have terminal illnesses experience intense pain and suffering. Nevertheless, he denies that the fact that one is in pain or one is suffering leads to an expansion of one's moral or legal rights. Velleman is unsure how to craft legislation that permits only human beings who have lost dignity to access medical assistance in dying. Velleman believes that current physician-assisted suicide legislation is over-inclusive because human beings who have agency are able to request this medical procedure. The fact that these patients can assign value to their non-existence indicates that they possess agency and thus dignity.

I suspect that Velleman does not believe that legislation could be designed to restrict eligibility for physician-assisted suicide to patients who have lost dignity because he does not think philosophers can articulate clear criteria that observers could use to determine objectively whether a human being has or lacks dignity. I disagree. Agency is central to dignity, and medical professionals could perform a test that assesses a dementia patient's capacity for agency.

A More Precise Description of What It Means for a Human Being to Have Dignity

Velleman uses the term “rationality” to describe the cognitive capacity that a human being must have in order to possess dignity. I argue that agency and not rationality is the most relevant property that distinguishes subjects from objects. We often take for granted our capacity for agency. Attaching value to things or states of affairs is such a common and ordinary aspect of being alive that we do not pause to notice that we are exercising this capacity. However, this is not how many patients who have moderate and severe dementia experience the world.

Human beings have dignity because they have the capability to attach value to things in the world. Human beings who have the property of dignity are subjects or agents. They act upon the world. Without agency, a patient with moderate or severe dementia cannot exercise the central capacity of being a human being, namely, the capacity to attribute value to the world.

It is important to mention at this point that I am giving an account of dignity for the purpose of answering legal and moral obligations regarding physician assisted suicide, not attempting to develop a new theory of dignity. Many philosophers have developed sophisticated accounts of dignity. Many people feel strongly that their inner experience of having dignity is not captured well by these scholarly analyses, and some people even worry that it is not possible to communicate to observers the depth of what it means for a person to possess dignity. My interest in this thesis is in improving public policy on physician-assisted suicide and not in the more removed or detached debate among philosophers about dignity. My proposed public policy concerns legal protections for patients with dementia, so I have limited the scope of my philosophical comments

about dignity to create action-guiding criteria for medical and legal professionals to use in practical contexts.

Agency is the defining feature that separates a human subject from a human object. When a patient's dementia has progressed such that they no longer have the cognitive functioning to value anything or anyone, they have lost the capacity for agency. The patient at this stage remains a biological human being, but they are not a subject. They are a human object with functioning organs. Many but not all patients at this stage will lose the capacity to communicate in speech and writing. Even if a patient is verbal, at this stage they cannot express that they desire or value something or someone.

Agency differs from autonomy. Agency is the capacity to assign value to a thing or a state of affairs. Autonomy is the capacity to make an informed decision without interference from others. Agency refers to the cognitive faculties of an agent, whereas autonomy focuses on whether factors external to the agent are influencing unduly their action.

Testing Whether a Dementia Patient Has Agency

Dementia is a cognitive disorder for which there is currently no cure. In 2019, the Alzheimer's Association estimated that 5.8 million Americans live with the disease. According to the Alzheimer's Association, there are seven stages of dementia. In the first stage, the patient does not present symptoms. By stage two, mild cognitive decline becomes apparent, as the person begins to display a pattern of memory loss. At stage three, the patient or their family members and friends usually start to suspect that the patient has dementia. Stage four is the stage at which most medical professionals make an

official diagnosis. Dementia at this stage causes a large decrease in the patient's cognitive functioning. At stage four, the patient often displays changes in their personality, especially during unpredictable and dramatic mood swings. At stage five, the patient loses the majority of their short-term memory, and this is the stage in which the patient loses a great deal of their agency. At stage six, the patient struggles to perform basic hygiene tasks and to eat on their own. Assisted living becomes relevant at this stage. The seventh stage is the final stage. The patient can no longer communicate, and they need 24-hour care so that they do not injure themselves or others.

Stage three is the last stage of mild dementia. In stage three, the patient suffers from memory loss but is still able to perform daily tasks. More importantly, patients at this stage still possess the capacity for agency. This is the last stage at which a patient has the cognitive ability to understand their diagnosis and to draft an advanced care directive that includes their wishes for medical care after their disease progresses and they lose agency. Stage four is the beginning stage of moderate dementia. At this stage, the patient no longer responds to their environment. The patient has difficulty performing basic every day actions such as eating and bathing, as they no longer has the ability to desire to do so. They are not able to attach a sense of value onto anything. I argue that patients with dementia lose agency when their disease enters stage four.

The speed at which dementia progresses varies among patients. Nevertheless, medical professionals currently conduct tests to determine the severity of a patient's dementia. They can conduct these tests multiple times throughout the course of treating the patient. Here is an example of a simple memory test that medical professionals often administer to patients who have dementia. The medical professional sits with the patient.

The medical professional asks the patient to remember three words, such as ball, cat, and train. These words do not have any connection among them. The medical professional then asks the patient a more complex question, such as how would you sketch out what a clock looks like. The patient then explains how they would sketch out a clock, and the medical professional may follow up by asking them to draw the example as they are explaining. At the end of the test, the medical professional then asks the patient to recall the three words that they were asked to remember at the beginning of the test. This test assesses the patient's cognitive capacity with respect to short-term and long-term memory. It measures how much information the patient is able to memorize and recall after being presented with new and more in-depth information.

However, the relevant cognitive capacity in the moral justification for physician-assisted suicide is agency and not memory. I propose that medical professionals create a test that assesses whether the patient has the capacity for agency. The test would need to be performed in multiple sessions in order to have certainty that the patient has reached the stage in which they would be eligible to participate in physician-assisted suicide, if they had indicated earlier this preference on an advanced care directive. Here is an example. A medical professional would attempt to feed the patient. The capacity to desire food and to attach value to consuming it is a significant and vital component of a human being's capacity to keep itself in existence. If the patient is not able to communicate their desire for the food using verbal or nonverbal cues, and if they are unable to do so after multiple tests, then the medical professional can conclude that the patient has lost the capacity for agency. The patient is no longer a subject who is able to interact with the

world. They are an object that other people must feed in order to keep their bodies in existence.

A medical professional would need to conduct this test multiple times over the course of a period of time to ensure that the patient has the same response—the complete absence of desire or aversion—each time they are presented with food. The medical professional needs to watch closely for body language, facial expressions, or verbal cues. If the patient is able to signal their desire for the food, their frustration at not being able to feed themselves, or their judgment that the offered food is undesirable and that they would prefer something different to eat, then they have the capacity to assign value to things in their environment. In this case, the patient has not yet lost the property of dignity, and physician-assisted suicide is not morally justified. If after four weeks of observation and testing during mealtimes, when the patient is being fed, the patient does not show the slightest interest in eating, then the medical professional can conclude that the patient has lost the capacity to have and attach value to the world. Such a patient has lost the capacity for agency, the property that is connected to human dignity, and is now eligible to receive physician-assisted suicide if they have expressed this wish in an advanced care directive.

I acknowledge that my proposed test measures observable behavior. It is possible to imagine a scenario in which a patient who has moderate dementia has the cognitive ability to make a value judgment, but fails the test because they cannot communicate to observers their ability to value food. Such a scenario is concerning. Since my proposed policy states that a patient is eligible for physician-assisted suicide only once they have lost dignity, a scenario could arise when the patient who has dignity but cannot

demonstrate that fact to others is provided with medical assistance in dying. This means that there is a risk that this kind of patient could be aware that they are going to receive the procedure while they are unable to express their refusal or change of mind.

Opponents of my proposed policy might argue that physician-assisted suicide for dementia patients is far too risky of a practice to implement if it permits this unlikely but possible scenario. I judge that the best way to alleviate concerns about patients who are unable to communicate to observers that they have the capacity to attach value to the world is to make sure that patients are aware of this possibility when they complete their advanced care directive. If patients who are choosing what kind of medical treatment they would like when they are no longer competent are aware that behavioral observations will determine their eligibility for physician-assisted suicide, they can consent to this risk.

Advanced Care Directives

An advanced care directive is the best tool a competent person can use to express their wishes about end of life care. An advanced care directive is a legal document by which a patient can transfer their authority to make medical decisions to another person if they lose their capacity to make informed decisions. Advanced care directives ensure that the patient's wishes about their medical care are carried out even when they lack the agency to articulate wishes and desires. State legal requirements set procedural requirements on how patients create advanced care directives. If a family member, friend, or medical professional coerces the patient as they create an advanced care directive, the content of the directive is not legally binding.

In an advanced care directive, the creator indicates which medical procedures they desire medical professionals to perform in response to a variety of medical conditions. For example, someone can express a wish not to be resuscitated if they stop breathing or a wish not to have a feeding tube inserted if they cannot swallow. Currently, no state permits the creator of an advanced care directive to express their wish to receive medical assistance in ending their life. Gerald Dworkin is one of the few philosophers who has considered this possibility. In a 1997 article, he writes, “I leave open for now the important question of what role—if any—advanced directives should play in allowing competent persons to request euthanasia if they are no longer sufficiently competent to participate in assisted suicide.”⁵

My thesis is an answer to Dworkin’s question. If physician-assisted suicide is a morally permissible course of action, then state law ought to permit patients to communicate their desire for it. As I have argued, physician-assisted suicide is morally permissible only in cases where the patient has lost the capacity for agency. Before a patient has lost this capacity, they can request this medical procedure for their future self in an advanced care directive. If state legislators worry that patients may indicate their desire for physician-assisted suicide if they lose the capacity for agency without considering seriously the implications of their choice, they can write procedural safeguards such as a waiting period into the requirements that an advanced care directive must meet in order to be legally binding.

⁵ Gerald Dworkin, “Physician-Assisted Suicide and Public Policy.” *Philosophical Studies* 89, nos. 2-3 (1998): 140.

The difference in time explains why legalizing a request in an advanced care directive for physician-assisted suicide when the patient no longer has agency and dignity is not a legal right of self-termination, which Velleman rejects. In current physician-assisted suicide legislation, the human being who exercises the legal right to request assistance in dying is equivalent to the human being who dies. In an advanced care directive, the human being who creates the document is different in an important respect from the human being who experiences the medical procedures indicated in the legal document. The first human being possesses the properties of the capacity for agency and dignity, and the second human being does not.

The waiting period is crucial as it allows the patient to make a rational, well-informed judgment about their preferences for medical treatment. I judge that a four-week waiting period is necessary. Patients can sometimes make hasty and irrational decisions. Being required to reaffirm one's decisions about future medical treatment after a period of four weeks is a way for medical and legal professionals to ensure that the patient is making decisions that they fully understand and endorse.

In the unfortunate event that the patient with dementia moves from stage four to stage five before the waiting period for the advanced care directive expires, the patient is not eligible for the medical procedure. Because the patient was not able to reaffirm their wish to receive physician-assisted suicide if they lose the capacity for agency, the advanced care directive is not legally binding. A physician who carries out the procedure without the legal protection of the advanced care directive risks being sued by the patient's friends or family for medical malpractice. The consent of the patient is an

essential component to the legalization of including physician-assisted suicide as a possible medical preference in an advanced care directive.

Patients can also use an advanced care directive to indicate whether, if they were to lose the capacity for agency, they would prefer to be kept alive so that they can participate in dementia research. Researchers might develop treatments that aim to restore the cognitive functioning of people who are in the later stages of dementia. Patients who are at earlier stages of dementia might find value in participating in these clinical trials, and indicating this wish in an advanced care directive will allow medical professionals to enroll patients in these studies because they have given prior consent. Just as items that have been damaged can be fixed and restored, a patient may wish to choose to participate in experimental treatments rather than to have physician assistance in dying. It is important that patients who are in the early stages of dementia choose freely what kind of medical care they would like if they lose the capacity for agency and that they express this wish in a legally-binding document.

Conclusion

In my thesis, I described what physician-assisted suicide is and the current legislation that permits its practice in some American states. I reconstructed the best argument for the conditions under which physician-assisted suicide is morally permissible. J. David Velleman is correct that physician-assisted suicide is morally permissible only when the patient no longer possesses dignity. It is not morally permissible to provide the medical procedure to a patient who wishes to die because they are in pain or because they do not wish to depend on others for care. Velleman laments

that legislation that permits physician-assisted suicide is too broad. It permits patients who possess dignity to qualify for the medical procedure. The goal of my thesis was to propose legislation that permits only patients who no longer have dignity to access physician-assisted suicide. I have improved upon Velleman's view by explaining how it is possible for observers to determine whether a human being has lost the capacity for dignity. I have argued that allowing patients to consent in an advanced care directive to physician-assisted suicide if they are judged to have lost the property of dignity is a strategy that does not legalize the right of self-termination. Nevertheless, it legally protects an important choice that a competent person can make for their future self if that self loses the capacity for agency.

As my thesis title states, my proposed changes to the existing laws about physician-assisted suicide are progressive in nature. Progressive proposals are new and modern. Progressive proposals are also broadly liberal and promote human freedom. Expanding physician-assisted suicide as a medical treatment for which certain dementia patients are eligible is progressive in both sense of the word. Suicide is a morally controversial and an unpleasant topic. Many cultures and traditions have viewed suicide as a topic that is taboo and shameful. My thesis attempts to view suicide in a more positive light. Encouraging patients to consider their wishes about medical treatment if they lose the capacity for agency can reduce the stigma around suicide. Protecting the right to choose physician-assisted suicide expands human freedom and choice.

Dementia is a horrible disease. The number of cases of documented dementia has been rising steadily, and there is no cure for the disease in sight. Millions of patients are diagnosed with this disease every year, and the legislation I propose has the potential to

help every single one of them. My recommended policy change allows these human beings to choose how they would like to be treated by medical professionals if they lose the human capacity to make choices on their own. Physician-assisted suicide is an opportunity for dementia patients to die with dignity when they no longer possess the property that is associated with human dignity: being able to be the author of one's fate and the creator of values in the world.

Bibliography

Alzheimer's Association. "Stages of Alzheimer's." Accessed May 7, 2019.

<https://www.alz.org/alzheimers-dementia/stages>

Dworkin, Gerald. "Physician-Assisted Suicide and Public Policy." *Philosophical Studies* 89, nos. 2-3 (1998): 133-41.

Velleman, J. David. "Against the Right to Die." *The Journal of Medicine and Philosophy* 17, no. 6 (1992): 665-81.

-----, "A Right of Self-Termination?" *Ethics* 109, no. 3 (1999): 606-28.

Wellman, Carl. "A Legal Right to Physician-Assisted Suicide Defended." *Social Theory and Practice* 29, no. 1 (2003): 19-38