The curtains in your room are blue, with subtle white stitching on the end. There is a stain resembling either a leaf or an unfortunately crude design that you wouldn't care to mention depending on the lighting. To everyone else, these curtains are simply blue; no one notices their arbitrary idiosyncrasies other than you. That is because you have been staring at these curtains day in and day out for the past four months, ever since your cancer took a turn for the worst and left you completely bedridden. It is terminal, you are in hospice, unsure of just how long you have left. There is not much more you can do than study that stain on those blue curtains and try to ignore the impending progression of your illness.

This scenario may not be true for you, but it is the horrific reality that plagues millions of Americans every year. As harrowing as this is to think about, it is not exactly shocking. People have been dying from diseases since the beginning of time – it is the circle of life. However, the way we approach this circle is changing. Traditionally, a terminally ill person would be placed in the hospital or in palliative care until death. Nowadays, in some states, terminally ill patients have a new choice when considering their end-of-life options. A choice allowing them to bypass the days of staring at curtains and end their lives on their own terms. A choice that is pejoratively known as assisted suicide.

At a glance, the issue of assisted suicide seems black and white, with proponents arguing that it is an essential human right and opponents countering that it is a bastardization of morality. The obvious resolution would be to ask yourself which category assisted suicide falls into depending on your moral compass – and for some people, it is that simple. Just ask Colorado State Representative and doctor, Joann Ginal, who was integral in passing Proposition 106, which legalized assisted suicide for terminally ill patients in Colorado following the 2016 election. For

Rep. Ginal, the answer to the ethical dilemmas surrounding assisted suicide comes down to the right to choose. “It’s just a choice. It’s just another choice and I totally believe in choice for people and that’s the last one someone makes,” Ginal said, making sure to emphasize it was fine to disagree with assisted suicide, so long as the choice was available to supporters.

On the other (often religious) hand, assisted suicide is not a choice, but a grave repudiation against fundamental beliefs. Father Nathan Cromly, priest of the Congregation of St. Johnin Englewood, Colorado, gave this straightforward statement regarding assisted suicide: “It’s against the teachings of Christ and the tradition of Christian belief.” To Fr. Nathan, the entire notion of assisted suicide is a violation of the belief that only God is allowed to take human life, and that is inexcusable. He cannot, in good conscience, idly sit by and allow someone else to make what he sees as such a volatile choice.

These are the most prominent arguments that people consider in relation to assisted suicide. This binary approach to assisted suicide brushes over the many important factors to be considered when voting on a serious issue. Like any controversy, assisted suicide is incredibly multi-faceted, affecting anyone from the terminally ill to the general public. As best put by Dr. Alan Rastrelli, a specialist in hospice and palliative care at Exempla St. Joseph’s Hospital in Denver, Colorado, the practice of assisted suicide “opens up a slippery slope.”

The concept of assisted suicide, defined as a patient self-administering lethal drugs prescribed by a doctor to end their life, is nothing new. Talks of the idea have been around since ancient Greece; the state of Oregon passed a law in 1997 legalizing it for the terminally ill. Since then, six states, including Colorado and Washington D.C., have passed similar laws. 37 states have

laws strictly prohibiting it, while the other seven either have not addressed the issue or prohibit it by common law. Yet, despite the longevity of the topic in political and religious venues, assisted suicide was not on the radar of the mainstream public until 2014 with the case of Brittany Maynard, a 29-year old woman who chose to end her battle with terminal brain cancer via assisted suicide on November 1st of that year.

Maynard became the poster child for a movement known as Death with Dignity, a nonprofit named after the Oregon law advocating for the legalization of assisted suicide. In an editorial piece for *CNN*, Maynard described her battle with cancer in a gut-wrenching plea to legalize assisted suicide in every U.S. State (she had to relocate from California). Her words moved many, and 'death with dignity' now serves as the mantra for proponents of assisted suicide.

The term 'dignity' is controversial in itself. Death with Dignity insists on its use, claiming that it is a more accurate description than assisted suicide. In fact, Death with Dignity refuses to use the term suicide, arguing that the patients are not killing themselves – their disease is. Doctors are not even allowed to put down suicide as the cause of death in these patients; instead, they must list the disease or phrases such as 'medical aid in dying'. Some see this as being respectful, others, such as Dr. Rastrelli, see this as sugarcoating: "They [proponents] try to change the terminology or the semantics...but you can't get away from the actual definition of it [suicide] when you actually look at the act itself, what people are doing."

'Dignity' even takes on a blurred meaning from a medical standpoint. The process of assisted suicide is incredibly complex – it can take weeks to obtain the medication, an unpleasant mixture of lethal secobarbital, anti-nausea, and anti-anxiety drugs. Once the drugs are obtained,

Rastrelli revealed the unsettling process that follows: “...some patients didn’t die. There’s been some that regurgitated [the medication]. It’s not a euphoric, very ideal environment that this happens in.”

Linda Van Zandt, a California-based writer, expressed similar concerns in an editorial for the *LA Times*, detailing her family's struggles when her aunt chose assisted suicide following a long battle with ALS. There was not a doctor present on the designated day, so the family had to mix the $3,000 medication themselves – its sludgy texture was difficult for her aunt to swallow. Despite its arduousness, Van Zandt supports assisted suicide, hoping that her story will encourage improvements to future laws.

Van Zandt’s wish was not far off – a similar story motivated Ginal to sponsor Proposition 106. Her inspiration was Dr. Charlie Hatchette, a local Fort Collins physician who passed away from ALS in January of 2015. Before his death, Hatchette advocated for assisted suicide, believing that he would have found great comfort in his final months had the option been available to him. Ginal credits people like Hatchette for the bill’s eventual success: “Proposition 106 won 67 percent of people in the state of Colorado’s vote. That just goes to show you that people want that choice.”

One of the concerns of the opposition vote was that the bill did not contain the proper safeguards to keep the practice in check. Detailing the surprising vagueness surrounding assisted suicide, Rastrelli explained there are no requirements to report on these cases, leaving the quality of the affair left unknown. He also takes issue with how the law handles the psychological state of patients, who often suffer from major depression. While Prop. 106

requires patients to be referred to a psychiatrist if they have doubts about their mental health, Rastrelli revealed that a psychiatric rejection does not stop most patients – nonprofits like Compassion & Choices, another assisted death advocate, help arrange other doctors to sign off on the procedure.

Another source of consternation for Rastrelli is the possibility of coercion. Patients are not required to take the medication immediately after receiving it. For Rastrelli, this waiting period opens the door for pressure from friends or family: “You never know if the family member kind of makes the person feel ‘gosh, it’s been too long’...maybe I’ll go ahead and take the medicine now even though I could have had a natural death later.”

Rastrelli also fears that laws like Prop. 106 will begin to normalize suicide. In his mind, the underlying message of legalizing assisted suicide is if you are not living what is considered to be a ‘quality’ life, then you should die. While current laws in America prohibit anyone without a terminal illness (and more than six months to live) from utilizing assisted suicide, he believes it sets a precedence for those who are struggling with depression that it is okay to end your life if you do not fit into society’s definition of quality.

Opponents warn that such precedence will send assisted suicide down the slippery path that leads to euthanasia, which allows the doctor to administer the lethal medication to a patient (assisted suicide requires the patient to self-administer the medication). Currently legal in Belgium and the Netherlands, the practice is likely to expand to other countries in the coming years. As reported by Rachel Aviv in “The Death Treatment” published in *The New Yorker* in 2015, these countries allow euthanasia for any patients “who suffer from severe and incurable

distress, including psychological disorders." Ailments such as chronic depression or dementia both meet the euthanization criteria. Belgium, in particular, has no age requirement for euthanasia; a terminally ill 17-year old became the country's first child to be euthanized in September of 2016.

Ginal also voiced concerns about Belgium's euthanasia laws. She asserts, however, that Prop. 106 is not comparable. "Proper safeguards are in place with Proposition 106...I would never run a bill that would ever put people at risk..." Ginal said, reiterating that the bill only applies to those who are suffering from a terminal physical illness with less than six months to live (an estimate that must be approved by two physicians). She explained that patients must individually meet with their doctor first to discuss their end-of-life options to avoid any coercion. In regards to patients also suffering from psychological issues, Ginal is confident in psychologists' abilities to discern a patient's natural fears about death from serious mental problems. Addressing doubts about safeguards, Ginal harkened back to the Oregon bill that Prop. 106 was modeled after: "...thank God that we have twenty years of data that show this has not been abused...I feel very good about what we've set forth in protecting people."

Herb Myers is one of the people who feels protected by Prop. 106. His wife Kathy, who had suffered from Chronic Obstructive Pulmonary Disease (COPD) for about 10 years, died via assisted suicide on March 12th of this year, becoming one of the first people in Colorado to do so. Toward the end, Kathy's COPD grew so unbearable that she was unable to live the life she wanted to. Myers explained to *The Denver Post* that assisted suicide gave Kathy a tremendous amount of relief, allowing her to take back the control that COPD had robbed her of for years.

Control is a crucial element in the assisted suicide debate. During her research for “The Death Treatment,” Aviv found that the driving force behind assisted suicide patients was their need to be autonomous. Rastrelli concurred based off of his own experience with patients in hospice: “...they’re losing control over their lives...in hospice and palliative care, we should be able to help address [those feelings] along with any other symptoms they may have.” He feels that if more effort was put into improving hospice and palliative care, then less patients would request assisted suicide. Unfortunately, Rastrelli admitted that the resources required to improve these areas are not always feasible in today’s medical world.

While Ginal agrees that hospice and palliative care are important near the end of someone’s life, she thinks some circumstances exceed what hospice can do. She personally witnessed the limits of palliative care with her own brother, who passed away from a rare blood disease while in hospice. “Even in palliative care...he winced in pain,” Ginal said. “...there’s a pain threshold for different people. In some cases, pain medication works fine. In other cases, according to people’s metabolism and how they process the medications, sometimes they still feel the pain.”

There is no definitive solution to assisted suicide; attempting to implement one requires someone to compromise their entire belief system. Legalizing it requires opponents to accept what they see as a complete disregard for the sanctity of life, and banning it forces proponents to submit to what they see as civil oppression. Small changes can be made – doctors like Rastelli can continue working toward improving hospice care, while politicians like Ginal can continue sponsoring assisted suicide bills in their respective states. But ultimately, the fate of assisted suicide rests in the hands of voters. When more states address the issue in the future,

the general public will vote yes or no. Regardless of civil rights or morality, assisted suicide will be decided in this way.

It is possible, however, to ensure the public's vote is an educated one. On either side of the coin, there are ethical dilemmas to address no matter how uncomfortable they may be. It is the hope that, after fleshing out the ethics surrounding assisted suicide, the public will not only be able to make an informed decision on the stance, but also be more understanding of their opponent's respective views. When armed with an understanding of its ethical complexities, assisted suicideis a deeply personal concept. After all, it is your curtains that are blue – how will you feel when you begin to notice the stains?