Article

CATHOLIC MEDICAL ASSOCIATION

The Linacre Quarterly
2025, Vol. 92(4) 435-443

DOI: 10.1177/00243639251356676
journals.sagepub.com/home/lqr

Sage

The Power of Words: Rebranding Euthanasia and Undermining Life's Sanctity

Jay J. Oh, DBE, DMin, MPH[1,2,3,4]

Abstract

Language shapes ethical perceptions, profoundly influencing societal attitudes toward euthanasia and physician-assisted suicide (PAS). Historically condemned by Western medicine as a violation of life's sanctity, euthanasia has undergone a dramatic transformation through deliberate linguistic reframing. Euphemisms such as "death with dignity" and "medical aid in dying" align euthanasia with values of compassion, autonomy, and patient empowerment, often overshadowing its moral implications for human dignity. This article critically examines how these linguistic shifts have influenced the normalization of euthanasia; broadened eligibility criteria; and facilitated its legal acceptance across nations like the Netherlands, Belgium, and Canada. Engaging secular arguments from consequentialism and autonomy-based ethics reveals their limitations, particularly their disregard for moral intentionality, relational responsibilities, and the intrinsic worth of life. Drawing on Catholic moral theology and virtue ethics, this study advocates for precise, transparent language alongside actionable policies, expanded palliative care, robust conscience protections, comprehensive public education, and stringent safeguards to protect vulnerable populations and resist ethical erosion. Reclaiming ethical clarity requires more than abstract discussion – it demands bold action in language and policy to counter euphemistic normalization and affirm the inherent dignity of human life.

Keywords

dignity, euthanasia, suffering, physician-assisted suicide, palliative care, public policy, theology, ethics, Catholicism, value of life

Introduction and Historical Background

Language does more than describe reality - it shapes it, framing our perceptions, moral intuitions, and societal norms. This insight is echoed in the work of Karol Wojtyła (St. John Paul II)'s *Person and Act*, where he emphasizes the centrality of intentionality and language in moral experience and ethical discernment, underscoring that how we describe an action

[1] Spiritual Care Services, NYU Langone Health, Mineola, NY, USA
[2] Department of Philosophy, Fordham University, New York, NY, USA
[3] Department of Philosophy, Molloy University, Rockville Centre, NY, USA
[4] Public Health & Healthcare Leadership, Cornell University, Ithaca, NY, USA

Corresponding Author:
Jay J. Oh, Spiritual Care Services, NYU Langone Health, Mineola, NY, USA.
Email: Jay@thebioethics.com

reflects, and shapes, how we morally evaluate it (Wojtyła 1979, 187–194).

Cognitive linguist George Lakoff demonstrates how linguistic choices create conceptual lenses, subtly guiding cultural attitudes toward acceptance or rejection of complex ethical issues (Lakoff 2014, 3–6). Throughout history, deliberate shifts in language have often preceded profound ethical transformations, normalizing practices once deemed impermissible (Kass 2002, 17–21; MacIntyre 2007, 2–5). The evolving discourse around euthanasia and physician-assisted suicide (PAS) vividly illustrates this power, turning a once-condemned act into a widely debated and increasingly accepted practice.

The Power of Language: Framing Euthanasia through Terminology

Each shift in nomenclature related to euthanasia reveals a calculated cultural agenda. The term *Euthanasia,* derived from the Greek *eu* (good) and *Thanatos* (death), inherently implies that intentionally ending a life can be a "good death." While the term remains morally problematic from a Catholic standpoint, it at least retains an acknowledgement of the gravity and deliberateness of the act. It recognizes that this decision involves the intentional termination of a human life.

For centuries, Western medicine rejected euthanasia as incompatible with its ethical foundation. The Hippocratic Oath's pledge, "I will neither give a deadly drug to anybody who asked for it nor make a suggestion to this effect," embodied a commitment to preserving life, a principle upheld across generations (Miles 2004, 13). This stance reflected a societal consensus, deeply rooted in Judeo-Christian values, that intentionally ending human life violated fundamental moral standards and intrinsic dignity.

A significant shift emerged in the late twentieth century, driven by intentional linguistic reframing. In the early 1990s, U.S. pathologist Jack Kevorkian challenged these norms by assisting over 130 terminally ill patients in ending their lives. Promoting his actions as "death with dignity," Kevorkian emphasized autonomy and compassion, reframing euthanasia from a medical taboo to a personal choice (Quill 1991, 691–694). His emotionally resonant campaign ignited public debate, shifting perceptions and making euthanasia a serious ethical question (Callahan 1993, 84–89). Though controversial, Kevorkian's efforts exposed a growing tension between traditional ethics and modern values of self-determination.

This reframing gained legal traction in 1997 when Oregon enacted the "Death with Dignity Act," becoming the first U.S. state to legalize PAS. By 2020, it reported 143 deaths under this law, its title deliberately tying euthanasia to dignity and compassion rather than confronting life's sanctity directly (Oregon Health Authority 2020). This alignment with ideals of choice and humane care set a powerful precedent, influencing attitudes and legislation worldwide.

The international response was swift. The Netherlands' 2002 "Termination of Life on Request and Assisted Suicide Act" framed euthanasia as compassionate medical care, initially restricting eligibility to terminally ill patients with "unbearable suffering with no prospect of improvement" (Dutch Ministry of Health 2002, Article 2). Yet, as this language normalized euthanasia as healthcare, criteria expanded. By 2022, it encompassed psychological distress, chronic non-terminal conditions, and minors aged 12–16 with parental consent, with an estimated 8,720 cases reported (Dutch Ministry of Health 2022). Belgium legalized euthanasia in 2002, extending it to children by 2014 (Keown 2012, 175–178), while Canada's 2016 Medical Assistance in Dying (MAID) Act broadened to include chronic pain by 2021 (Lemmens 2018, 251–259). New Zealand joined this trend in 2021. These expansions reflect how euphemistic language reshapes cultural norms.

Historical parallels reinforce this pattern. Abortion's shift from "killing the unborn" to "reproductive healthcare" softened moral

resistance (Singer 1995, 83–89), while slavery's sanitization as "servitude" delayed ethical action (Orwell 1946, 252–265). Modern military terms like "collateral damage" for civilian deaths further show language's capacity to dull ethical sensitivity (Lakoff 2014, 34–38). Daniel Callahan warns that euphemisms like "medical aid in dying" mask euthanasia's moral weight, eroding protections for vulnerable populations and risking subtle coercion (Callahan 1993, 125–132).

This article investigates how these linguistic transformations challenge Catholic moral thought, which views life's intrinsic dignity as inviolable. Tracing the historical evolution and ethical implications of this reframing underscores the need for precise language to resist euthanasia's normalization, safeguard human dignity, and maintain ethical integrity in medicine and policy.

Ethical Frameworks in Tension: A Catholic Critique of Autonomy and Consequentialism

Consequentialism and the Ethics of Outcomes

Consequentialism assesses the morality of actions based on their outcomes, prioritizing results over intentions or inherent values. Peter Singer, a leading advocate, argues that ethical duty lies in maximizing well-being by minimizing suffering. In the context of euthanasia and physician-assisted suicide (PAS), Singer focuses on practical effects: if euthanasia reduces severe, incurable pain more effectively than alternatives, it's not only permissible but morally commendable (Singer 1993, 176–179). He dismisses distinctions between killing and letting die as irrelevant when outcomes align, rendering the sanctity of life secondary to relief (Singer 1995, 82–85). This reframes euthanasia as a compassionate act, aligning with medicine's goal of alleviating suffering, a perspective reflected in Canada's Medical Assistance in Dying (MAID) expansion to chronic pain cases by 2021 (Lemmens 2018, 251–259).

While Singer's compassion for suffering patients is evident, critics highlight flaws. Daniel Sulmasy argues that fixating on outcomes overlooks intentions, virtue, and intrinsic dignity, risking justification of troubling acts if benefits seem clear (Sulmasy 2017, 543–548). For example, euthanasia might expand beyond terminal cases to the economically burdened, under the guise of compassion, subtly coercing vulnerable groups. Consequentialism's rational appeal falters here, lacking safeguards to uphold medicine's historical commitment to life over death.

Autonomy-Based Arguments and the Appropriation of Informed Consent

Timothy Quill argues that physician-assisted suicide empowers patients by preserving their moral agency in the face of terminal illness. His rhetoric emphasizes autonomy, presenting euthanasia as a compassionate, dignified choice that allows patients to avoid unnecessary suffering and retain control even in the midst of physical decline (Quill 1997, 2101–2104). This framing resonates strongly with modern medical ethics' emphasis on informed consent and patient rights.

However, this invocation of informed consent must be critically examined. From a Catholic moral perspective, informed consent is not ethically sufficient to justify actions that are intrinsically immoral, such as the intentional ending of life. Quill's use of informed consent risks conflating personal choice with moral legitimacy, effectively using the language of autonomy to obscure the deeper ethical concerns surrounding euthanasia.

This rhetorical shift is evident in the legal expansion of euthanasia eligibility in countries like Belgium, where, by 2018, the criteria were extended to include psychological suffering. These expansions were often justified in the name of respecting patient autonomy and informed consent, yet they reveal a troubling redefinition of care that undermines the

sanctity of life (Keown 2012, 175–178). True informed consent, rightly understood, requires more than voluntary agreement—it demands that the options presented uphold the moral good and protect vulnerable individuals from harm masked as choice.

Yet, autonomy's primacy draws scrutiny. Edmund Pellegrino acknowledges its value but warns that without safeguards, it risks pressuring vulnerable populations - elderly, disabled, or poor - to see euthanasia as a duty, not a choice (Pellegrino 2001, 60–63). Daniel Callahan adds that death decisions affect families and society, suggesting autonomy must be relational, not absolute (Callahan 1993, 39–42). Proponents might argue resource scarcity limits alternatives, but this underscores the need for communal context to prevent coercion.

Catholic Counterarguments: Intentions, Virtue, and Intrinsic Dignity

Catholic ethics offers a robust counterpoint rooted in natural law and virtue. Thomas Aquinas holds that moral actions require right intentions, proper means, and alignment with inherent goods, beyond mere outcomes or choice (Aquinas 1947, II-II, Q. 64, Art. 5). In *Evangelium Vitae*, Pope John Paul II condemns euthanasia as a violation of life's sacredness, a divine gift not reducible to a commodity, regardless of intent or relief gained (John Paul II 1995, para. 57–65).

Virtue ethics, per Tom Beauchamp and James Childress, contrasts palliative care's holistic relief with euthanasia's intentional death, favoring compassion through accompaniment over elimination (Beauchamp and Childress 2019, 174–180). Daniel Sulmasy extends this, noting euthanasia's coercive potential in resource-strapped systems, where vulnerable patients might feel compelled to choose death (Sulmasy 2017, 543–548). Alasdair MacIntyre critiques secular individualism, emphasizing communal virtues - solidarity, empathy, patience - that secular frameworks often ignore (MacIntyre 1999, 102–106).

Thus, Catholic and virtue ethics reject consequentialism's outcome focus and autonomy's absoluteness, prioritizing intentions, dignity, and relational duties. These principles safeguard ethical integrity, protect the vulnerable, and uphold authentic compassion in medical practice.

Catholic Theological Foundations

Sanctity of Life and Intrinsic Dignity

Catholic theology holds human life is sacred, a divine gift from God, demanding unconditional reverence. The *Catechism of the Catholic Church* asserts that life, from conception to natural death, holds intrinsic dignity, unswayed by subjective measures of quality or autonomy (Catechism 1997, para. 2270). Grounded in humanity's creation in God's image (Genesis 1:27), this dignity is absolute and universal, transcending utilitarian or self-determined value.

In *Evangelium Vitae*, Pope St. John Paul II reaffirms this, arguing that euthanasia, however compassionate in intent, violates this sacredness. He contends that life's worth persists through suffering or illness, and euthanasia risks reducing it to a disposable commodity subject to human judgment (John Paul II 1995, para. 57–65). Daniel Sulmasy builds on this, critiquing secular views that tie dignity to autonomy or well-being. He warns that such definitions marginalize those lacking agency, due to disability, illness, or dependency, heightening their vulnerability to coercion (Sulmasy 2017, 540–543). True dignity, Sulmasy insists, is inalienable, demanding policies that protect all, especially the weakest.

Edmund Pellegrino aligns this theology with medical ethics, asserting that euthanasia contradicts medicine's core mission: healing and caring, not killing. He views intentional termination as an ethical breach, even for relief, emphasizing medicine's role in honoring life's dignity over controlling death (Pellegrino 2001, 50–53). Together, these

perspectives frame euthanasia as antithetical to Catholic principles, prioritizing reverence over expediency.

The Redemptive Meaning of Suffering

Catholic theology offers a distinctive view of suffering, contrasting sharply with secular ethics' drive to eliminate it. In *Salvifici Doloris*, Pope John Paul II presents suffering as redemptive, uniting individuals with Christ's sacrifice and fostering spiritual growth, virtues like patience and hope, and communal solidarity (John Paul II 1984, para. 24–28). Far from a mere evil, suffering holds transformative potential; euthanasia, he warns, cuts this short, depriving individuals and communities of its spiritual depth (John Paul II 1984, para. 27–28).

Saint Augustine laid early groundwork, arguing in *The City of God* that suffering prompts humility and reliance on divine providence (Augustine 2003, Book I). Alasdair MacIntyre complements this, critiquing secular individualism for ignoring relational duties. He sees suffering as a chance to nurture communal virtues - solidarity, empathy, courage - diminished in autonomy-focused cultures (MacIntyre 1999, 102–106). Gerald McKenny integrates this into modern bioethics, challenging euthanasia's emphasis on control and comfort. He advocates compassionate accompaniment, arguing that true care embraces suffering's relational and spiritual significance rather than ending it prematurely (McKenny 1998, 87–90).

This theology critiques secular paradigms, offering a compassionate alternative rooted in dignity, solidarity, and spiritual meaning, resisting euthanasia's reductionist lens.

Public Policy Implications

The rebranding of euthanasia through euphemisms like "medical aid in dying" and "death with dignity" carries profound implications for public policy, healthcare practices, and societal values. Policies are not just bureaucratic mechanisms; they embody cultural narratives shaped by language. These terms subtly shift public views, normalizing euthanasia and raising critical issues: risks of coercing vulnerable populations, erosion of medical ethics, and a weakened commitment to alternatives like palliative care (Table 1).

International Policy Trends and Ethical Concerns

Internationally, euthanasia laws illustrate how linguistic framing propels policy beyond initial boundaries. The Netherlands' 2002 "Termination of Life on Request and Assisted Suicide Act" began with stringent limits, terminal patients with "unbearable suffering with no prospect of improvement" (Dutch Ministry of Health 2002, Article 2). Over time, framing euthanasia as compassionate care expanded eligibility. By 2022, it covered psychiatric conditions (e.g., depression), chronic illnesses (e.g., arthritis), dementia, and minors aged 12–16 with parental consent, with ~8,720 cases reported (Dutch Ministry of Health 2022). Belgium's 2002 law followed suit, broadening to psychological distress by 2007 and children by 2014 (e.g., a 9-year-old in 2018), logging 2,699 cases in 2022 (Keown 2012, 85–95, 175–178). Canada's 2016 Medical Assistance in Dying (MAID) Act, initially for terminal cases, extended to chronic pain and mental illness by 2021, with 10,064 deaths in 2022—some linked to cost pressures, like a 2021 veteran offered MAID over treatment (Lemmens 2018, 251–259).

These expansions fuel ethical concerns. Vulnerable groups - elderly, disabled, economically disadvantaged, mentally ill - may internalize euthanasia as an expected choice, especially where healthcare resources falter. In Canada, critics note economic incentives: a 2021 study suggested MAID could save millions annually, raising fears of subtle coercion (Lemmens 2018, 251–259). Linguistic normalization as "medical care" obscures these risks, undermining original safeguards (Keown 2012, 184–189).

Table 1. Euthanasia Eligibility Trends.

Country	Initial Criteria (Year)	Current Criteria (2022)	Annual Cases (2022)
Netherlands	Terminal, unbearable pain (2002)	Psychiatric, chronic, minors	8,720
Belgium	Terminal illness (2002)	Psychological, non-terminal	2,699
Canada (MAID)	Terminal prognosis (2016)	Chronic pain, mental illness	10,064

Ethical and Practical Policy Recommendations

To counter these trends, policies grounded in dignity and solidarity are crucial. Below are detailed recommendations:

1. **Mandating Clear Language**

   Euphemisms like "aid in dying" blur euthanasia's moral stakes, risking public misunderstanding. Daniel Callahan argues precise terms like "physician-assisted suicide" uphold integrity and protect against coercion (Callahan 1993, 178–180).

   Policy: Mandate accurate terminology in legal documents, healthcare settings, and public discourse.

   Implementation: Independent ethics committees review and enforce usage across media, law, and medicine, ensuring transparency.

2. **Expanding Palliative Care**

   Comprehensive palliative care reduces requests for euthanasia - UK investments cut demand by ~40% (Quill 2012, 142–146). It provides meaningful relief for suffering patients without intentionally ending life, thereby aligning with ethical principles that honor both compassion and the sanctity of life.

   Policy: Increase funding for universal access, targeting rural and underserved communities.

   Implementation: Develop certification programs for providers, emphasizing pain management, counseling, and spiritual care.

3. **Robust Conscience Protections**

   Healthcare professionals need legal freedom to object without professional backlash. Edmund Pellegrino stresses this preserves trust and ethics (Pellegrino 2001, 60–63).

   Policy: Legislate protections against discrimination or licensing penalties, with clear referral options.

   Implementation: Regulatory bodies establish guidelines, monitoring compliance across institutions.

4. **Public Education Campaigns**

   Education counters normalization by highlighting alternatives, reducing euthanasia's perceived necessity (Sulmasy 2017, 545–548).

   Policy: Launch national campaigns showcasing palliative care's dignity-affirming approach.

   Implementation: Partner with patients, families, and experts for testimonials, workshops, and media outreach.

5. **Safeguards for Vulnerable Populations**

   Robust protections prevent coercion among the elderly, disabled, and mentally ill (Keown 2012, 184–189).

   Policy: Require mandatory psychological evaluations, impartial oversight committees, and enhanced social supports.

   Implementation: Independent review boards conduct regular audits, ensuring voluntariness and accountability.

6. **Neutral Counseling Services**

   Impartial counseling ensures informed, uncoerced choices (Sulmasy 2017, 545).

   Policy: Establish independent services detailing palliative, psychological, and spiritual options.

Implementation: Ethics oversight committees train counselors, barring provider conflicts of interest.

Integrating Catholic Social Teaching

These policies align with Catholic principles - human dignity, solidarity, subsidiarity, and preferential care for the vulnerable (John Paul II 1995, para. 57–65). Clear language guards truth, palliative care honors life, conscience rights respect the moral agency, education fosters understanding, and safeguards protect the weak. Together, they resist euthanasia's normalization, reflecting moral courage and ensuring care that upholds intrinsic worth over coercive pressures.

Engaging and Critiquing Opposing Views: A Summary

Euthanasia advocates primarily rely on two ethical frameworks: autonomy-based ethics, which prioritizes personal choice; and consequentialism, which focuses on outcomes such as suffering relief. Both present euthanasia as a positive act, emphasizing dignity, compassion, and tangible benefits.

Margaret Battin and Timothy Quill lead the autonomy charge, arguing that patient agency in end-of-life decisions upholds dignity. Battin, driven by respect for individual freedom, sees denying euthanasia as a violation, especially when illness strips quality of life (Battin 2005, 127–132). Quill, motivated by empathy for the suffering, posits that offering euthanasia empowers patients to shape their fate, aligning with informed consent principles (Quill 1997, 2099–2104). Conversely, Peter Singer's consequentialism deems euthanasia permissible, even obligatory, if it best reduces severe pain, dismissing distinctions between killing and letting die as irrelevant (Singer 1993, 186–189).

Catholic and virtue ethics mount robust critiques. Edmund Pellegrino acknowledges autonomy's appeal but warns it risks coercion without relational context, elderly or disabled patients might feel pressured to choose death (Pellegrino 2001, 60–63). Daniel Callahan agrees, noting end-of-life choices ripple through families and society, requiring a communal lens to ensure voluntariness (Callahan 1993, 39–42). Against Singer, Daniel Sulmasy argues consequentialism's outcome focus neglects intentions, dignity, and virtue, potentially justifying acts that erode moral boundaries, such as euthanasia for cost-saving (Sulmasy 2017, 543–548).

Rooted in natural law, Catholic ethics - per Thomas Aquinas and Pope John Paul II - rejects euthanasia as incompatible with life's intrinsic dignity, a sacred gift not subject to disposal (Aquinas 1947, II-II, Q. 64, Art. 5; John Paul II 1995, para. 57–65). Tom Beauchamp and James Childress contrast palliative care's holistic compassion with euthanasia's deliberate end, favoring accompaniment over termination (Beauchamp and Childress 2019, 174–180). Alasdair MacIntyre adds that ethical decisions thrive in community solidarity, not isolated choice, supporting vulnerability over control (MacIntyre 1999, 102–106).

International trends affirm these concerns. In Belgium, Netherlands, and Canada, expanded eligibility (e.g., Canada's 10,064 MAID deaths in 2022, including mental illness) reflects autonomy and consequentialism's societal toll: coercion risks and reduced palliative care support (Keown 2012, 137–142; Lemmens 2018, 251–259). This underscores the need for precise language, conscience protections, oversight, and palliative investment to protect ethical integrity (Callahan 1993, 178–180; Quill 2012, 142–146).

Recommendations for Ethical Clarity in End-of-Life Care

Addressing euthanasia's ethical challenges demands clear, actionable strategies to uphold integrity, dignity, and protection for the vulnerable. Informed by Catholic social teaching and virtue ethics, society can adopt these key measures:

1. **Precise Ethical Language**

   Accurate terms like "physician-assisted suicide" distinguish euthanasia from palliative care, preventing normalization through euphemisms. Daniel Callahan argues this transparency preserves moral clarity, countering linguistic manipulation (Callahan 1993, 178–180). It ensures public discourse reflects euthanasia's gravity, fostering informed ethical debate.
2. **Robust Investment in Palliative and Hospice Care**

   Comprehensive, accessible palliative care offers a dignified alternative, reducing euthanasia's appeal. In the UK, such investment cut requests by ~40%, addressing physical, emotional, spiritual, and social suffering holistically (Quill 2012, 142–146). This aligns with dignity-based ethics, prioritizing life's worth over termination.
3. **Strong Conscience Protections for Healthcare Providers**

   Legal safeguards for conscientious objection, without fear of discrimination or penalties, are vital. Edmund Pellegrino emphasizes this maintains trust and ethical practice, allowing providers to honor life-affirming principles (Pellegrino 2001, 60–63). Clear referral pathways ensure patient access while respecting moral agency.
4. **Enhanced Safeguards for Vulnerable Populations**

   Rigorous protections - mandatory psychological evaluations, independent oversight, neutral counseling, and robust social supports - shield the elderly, disabled, poor, and chronically ill from coercion (Keown 2012, 184–189). These ensure decisions are truly voluntary, reflecting informed choice, not societal pressure.

Engaging autonomy and consequentialist frameworks through Catholic and virtue ethics lenses, as Daniel Sulmasy advocates, strengthens these efforts (Sulmasy 2017, 543–548). This approach safeguards the vulnerable, upholds clarity, and delivers compassionate care rooted in life's intrinsic value.

Conclusion: Restoring Moral Integrity Through Language, Policy, and Care

Reclaiming ethical clarity demands more than reflection; it requires bold action in language and policy to counter euphemistic normalization and affirm human dignity. Catholic theology, with its focus on life's sanctity, intentionality, virtue, and solidarity, equips society to resist coercion and linguistic distortion around euthanasia. Authentic compassion and ethical integrity in end-of-life care are fostered through the use of precise and accurate terminology when describing euthanasia and PAS. When combined with robust palliative care, strong conscience protections, and institutional safeguards such as clarity, end-of-life care transforms into a testament to moral courage and communal responsibility, honoring the inherent worth of every human life.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Jay J. Oh https://orcid.org/0000-0002-1921-029X

References

Aquinas, Thomas. 1947. *Summa Theologiae.* Translated by Fathers of the English Dominican Province. New York: Benziger Brothers.

Augustine. 2003. *The City of God.* Translated by Henry Bettenson. London: Penguin Books.

Battin, Margaret P. 2005. *Ending Life: Ethics and the Way We Die.* Oxford: Oxford University Press.

Beauchamp, Tom L., and James F. Childress. 2019. *Principles of Biomedical Ethics*. 8th ed. Oxford: Oxford University Press.

Callahan, Daniel. 1993. *The Troubled Dream of Life: Living with Mortality*. New York: Simon & Schuster.

Dutch Ministry of Health, Welfare, and Sport. 2002. "Termination of Life on Request and Assisted Suicide (Review Procedures) Act," Article 2. The Hague: Dutch Ministry of Health.

Dutch Ministry of Health, Welfare, and Sport. 2022. "Annual Report 2022." The Hague: Dutch Ministry of Health.

John Paul II. 1984. *Salvifici Doloris (On the Christian Meaning of Human Suffering)*. Vatican City: Libreria Editrice Vaticana.

John Paul II. 1995. *Evangelium Vitae (The Gospel of Life)*. Vatican City: Libreria Editrice Vaticana.

Kass, Leon R. 2002. *Liberty and the Defense of Dignity: The Challenge for Bioethics*. San Francisco: Encounter Books.

Keown, John. 2012. *Euthanasia, Ethics, and Public Policy: An Argument against Legalisation*. Cambridge: Cambridge University Press.

Lakoff, George. 2014. *Don't Think of an Elephant!: Know Your Values and Frame the Debate*. White River Junction, VT: Chelsea Green Publishing.

Lemmens, Trudo. 2018. "The Conflict Between Open-Ended Autonomy and Public Safety in Euthanasia Laws." *Journal of Medical Ethics* 43 (4): 251–259.

MacIntyre, Alasdair. 1999. *Dependent Rational Animals: Why Human Beings Need the Virtues*. Chicago: Open Court.

MacIntyre, Alasdair. 2007. *After Virtue: A Study in Moral Theory*. 3rd ed. North Dame, IN: University of Notre Dame Press.

McKenny, Gerald P. 1998. *To Relieve the Human Condition: Bioethics, Technology, and the Body*. Albany: SUNY Press.

Miles, Steven H. 2004. *The Hippocratic Oath and the Ethics of Medicine*. Oxford: Oxford University Press.

Oregon Health Authority. 2020. *Death with Dignity Act Annual Report 2020*. Portland, OR: Oregon Health Authority.

Orwell, George. 1946. "Politics and the English Language." In *Essays*, 252–265. London: Penguin.

Pellegrino, Edmund D. 2001. "Physician-Assisted Suicide and Euthanasia: Rebuttals and Reflections." In *Euthanasia and Assisted Suicide: The Current Debate*, edited by Daniel Callahan, 47–68. Baltimore: Johns Hopkins University Press.

Quill, Timothy E. 1991. "Death and Dignity: A Case of Individualized Decision Making." *New England Journal of Medicine* 324 (10): 691–694.

Quill, Timothy E. 1997. "Palliative Options of Last Resort." *Journal of the American Medical Association* 278 (23): 2099–2104.

Quill, Timothy E. 2012. "Physician-Assisted Death in America: Ethics, Law, and Policy Conflicts." *Journal of Law, Medicine & Ethics* 40 (2): 142–146.

Singer, Peter. 1993. *Practical Ethics*. Cambridge: Cambridge University Press.

Singer, Peter. 1995. *Rethinking Life and Death: The Collapse of Our Traditional Ethics*. New York: St. Martin's Griffin.

Sulmasy, Daniel P. 2017. "Death and Dignity in Catholic Christian Thought." *Medicine, Health Care and Philosophy* 20 (4): 537–548.

United States Catholic Conference. 1997. *Catechism of the Catholic Church*. Vatican City: Libreria Editrice Vaticana.

Wojtyła, Karol. 1979. *Person and Act*. Translated by Andrzej Potocki. Dordrecht: D. Reidel Publishing Company.

Biographical Note

Jay J. Oh, DBE, DMin, MPH, is a bioethicist with teaching appointments at Yale University, Cornell University, Fordham University, and Molloy University. In addition to these academic roles, Reverend Oh serves as a chaplain at NYU Langone Health, and as a clinical ethicist, collaborating with organizations such as Yale New Haven Health and Northwell Health.