DOCTORS KILLING PATIENTS: THE SOCIETAL RISKS OF LEGALIZING
PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES

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ABSTRACT

In April 2001 the Netherlands became the first country in the world to legalize euthanasia, a practice that has been discreetly used by the Dutch medical profession for decades. The new law allows doctors to kill patients with terminal diseases who are in agony if they request it. Regulation requires the existence of a long term doctor-patient relationship. Physicians cannot suggest euthanasia as an option, the patient must be made aware of all other medical options, and a second professional opinion must be sought. The decision for euthanasia must be made by the patient while of sound mind but a patient may leave written instructions for a physician to use his own discretion when the patient becomes too mentally or physically incapacitated to make the decision for himself.

The United States has also been grappling with end of life issues for decades. In 1975 the case of Karen Ann Quinlan of New Jersey captured media attention and for many of us started the controversy over the “right to die” with the “right to refuse medical treatment”. In 1990 the U.S. Supreme Court decided that the United States Constitution would grant a competent person a constitutionally protected right to refuse medical treatment. The “right to die” issue has now been expanded to include not only termination of treatment but termination of life and assistance in doing so, or physician-assisted suicide. But it is a stretch to go from the refusal of medical treatment to assistance in ending life.
In 1997 the U.S. Supreme Court heard two cases that dealt with physician-assisted suicide, Vacco v. Quill and Washington V. Glucksberg, and decided that there is no constitutional right to assisted suicide. The Supreme Court did however allow the debate to continue by sending it back to the states for further consideration and from this came the passage of the Oregon Death with Dignity Act on October 27, 1997. This Act allows terminally ill Oregon residents to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. Under the Act, ending one’s life in accordance with the law does not constitute suicide. Physician-assisted suicide in this context is not to be confused with the practice of euthanasia in the Netherlands where a physician or other person directly administers a medication to end another’s life.

Like the euthanasia laws of the Netherlands, the Oregon Death with Dignity Act has specific requirements that must be met for the determination of eligibility before requesting a prescription for a lethal medication from a licensed Oregon physician. The patient must be an adult (an individual 18 years or older), a resident of Oregon, capable (able to communicate health care decisions), and diagnosed with a terminal illness that will lead to death within six months. The process involves receiving a second opinion from a consulting physician, referral for a psychological examination should either the prescribing or consulting physician think that the patient’s judgment may be impaired, and informing the patient of feasible alternatives to assisted suicide such as palliative care, hospice or pain control.

Euthanasia is legal in the Netherlands and from most accounts seems widely accepted. The use of euthanasia however has broadened. Not only are the numbers increasing but the mentality towards its use has crossed moral boundaries from voluntary euthanasia to non-voluntary and involuntary euthanasia. The Netherlands is on the slippery slope which may
ultimately lead to the morality of “anything goes”. It has already been proposed that the use of euthanasia be expanded to cover children under the age of twelve that are terminally ill.

What makes the United States so different from the Netherlands? What would keep us from going down that slippery slope if the legalization of physician-assisted suicide gains widespread acceptance and becomes a reality in our fifty states? If the pressure to turn a profit in the health care industry is any kind of gauge would we then be more susceptible to crossing the line by sacrificing lives to save dollars? What about the role of the physician? Are we compromising the physician’s role by asking him to make value judgments about the quality of life of the patient? What will happen to medical research? Will we continue to search for the cure to diseases that carry with them a terminal diagnosis if we become conditioned to the use of physician-assisted suicide? What about improvements to end-of-life care and pain control? What happens when physician-assisted suicide becomes the expectation not the exception?

Euthanasia in the Netherlands as a case study has been used to examine what the social reality of physician-assisted suicide could look like for the United States. The Netherlands is a racially and economically homogeneous country with a system of socialized medicine that allows everyone access to basic care yet they have transitioned from voluntary to non-voluntary and involuntary euthanasia even though access to health care is not an issue. The United States is not the Netherlands. We are a country of haves and have-nots and are further stratified by class and color. We have no system of universal health care that might alleviate the felt need by some to request physician-assisted suicide for economic reasons because the resources for long-term care are not available. The widespread acceptance of physician-assisted suicide in the United States would carry with it serious consequences for large segments of our population especially those whose autonomy is already compromised by lack
of access to medical care, the elderly, those suffering from depression, minorities and the poverty-stricken. The risks are too great.
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DEDICATION

This thesis is dedicated to my mother, Bernice, and my sister, Linda, both of whom have passed from this world. In death as in life they maintained their dignity.

I also dedicate this to my daughter, Kathryn Elise. You are as your name suggests, beloved. I pray that you have inherited from your grandmother and aunt their strong will and passion for life. May they never fail you.
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CHAPTER 1
EUTHANASIA IN THE NETHERLANDS

Euthanasia had been accepted in the Netherlands as a responsible medical procedure long before it became legalized in April 2001. In this chapter I will review the history of euthanasia in the Netherlands and examine some of the cases that brought euthanasia to the attention of the Dutch population and laid the groundwork for this practice to become a legalized medical procedure. I will start by introducing the country, its history, and its people to provide a greater understanding as to how euthanasia came to be so widely accepted. It is not my intent to argue that the Dutch are wrong to accept euthanasia as a viable medical option. Indeed, proponents of euthanasia advise that the Netherlands has veered away from the slippery slope and that the Dutch experience should be thoroughly reviewed in consideration of the legalization of physician-assisted suicide in the United States.

As Heleen Weyers explains in the Prologue of the book, Euthanasia and Law in the Netherlands, a closer look into the history and politics of the Netherlands is required for an understanding of how this once unthinkable practice of euthanasia has become an acceptable practice among not only the medical community but the Dutch population as a whole.

The Netherlands is one of the most densely populated countries of the world with a population of approximately 16 million people. Once under the authority of the Spanish crown, the Netherlands emerged as a superpower in the 17th century. Although the struggle for independence began as a battle to preserve traditions and to be free from the heavy taxes imposed by the Spanish crown, religion also played a major role by the Calvinists population of the Netherlands in seeking reform of the Church. The Netherlands emerged from warfare to
enjoy an economic and cultural revolution. During its “Golden Age,” the Netherlands was not only known throughout Europe for being a financial and trading center but also for its abundance of libraries, support of the arts and sciences, and allowance of religious freedom.¹ The Netherlands was considered by most Europeans to be socially progressive for the times with too many liberties granted to all regardless of sex, religion, or station in life and extending to all not only a freedom of consciousness but a way of life where every man was allowed to live without the interference of others. However, what was golden in the seventeenth century began to spiral downward and stagnate in the eighteenth century during an interlude of the Napoleonic wars. The Netherlands did not recover from this economic and cultural stagnation until the end of the nineteenth century and from this recovery a kingdom emerged.²

The Netherlands’s 1848 constitution, serving as the foundation for its parliamentary system, reflects its liberal political ideals. In 1919 the Netherlands established itself as a true democracy when universal suffrage for both men and women was established. In its modern parliamentary system the government is responsible to the Lower House of Parliament and requires the support of the majority of its members.

While there are many political parties in the Netherlands, most are religion affiliated. There is a Catholic party, several Protestant parties, and some secular parties that are either liberal or socialist. There are three religious parties that dominate the political center, two liberal parties to the left, one liberal party to the right, and one social-democratic party. In fact


² Ibid., 10.
there are so many parties that no one party has ever achieved a majority of seats in the Lower House of Parliament leaving the Dutch government to function based on coalition.

The agrarian country of the Netherlands during the nineteenth and early twentieth centuries has been described as economically backward and socially somnolent. The prevailing political culture of the Netherlands at the beginning of the twentieth century and until well after World War II can be defined by the pillarization of the different religious factions within the country. This religious segregation kept people isolated from each other as each “pillar” had its own ideology and its own trade unions, schools, newspapers, radio and TV stations, and hospitals. Except among leaders, social interaction over the boundaries of a pillar to which one belonged was rare.

The socio-economic system of the country has its foundation in the Catholic social philosophy of “corporatism” that abandons the capitalistic idea of competitive individualism in favor of an “ideology of common responsibility for the common good.” Wealth is of less importance than the community’s overall prosperity.

Pacification and toleration was and still is practiced between the elites of the pillars in a businesslike manner to solve differences concerning the distribution of scarce resources on the basis of proportionality and for the social welfare of the country. Cooperation is fundamental to a joint effort at making life better for all. This cooperation extends among

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employers, trade unions, and the government and is coordinated under a newly established system whereby policies are determined through discussion.  

On ideological issues such as abortion or euthanasia where no definitive resolutions could be sought, a policy of tolerance was practiced and avoidance and neutrality became the methods by which the government would postpone having to make any decisions in the areas where life and death meet. The elites learned to negotiate with each other in an effort to keep the greater public from becoming involved in the issues and thereby fostering an atmosphere of political passivity that remained a part of the Dutch political life until the 1960s.

After World War II, the Netherlands became a modern industrialized society with a system of social security rooted in the strong Dutch tradition of social solidarity. Pillarization and corporatism continue to influence political affairs. Consultations take place between the Government and leaders of the different social groups to determine policies for the common good of all. In the case of euthanasia, for example, there have been since the 1980s regular consultations between the Government, officials of the criminal justice system and the medical community in the establishment of policy. There exists a strong need for consensus which promotes resolving conflicts through meetings and compromise.

During the 1960s and 1970s the Netherlands once again transformed itself as it had in the seventeenth century to a nation more open to social and cultural experimentation through its legalization of abortion, the acceptance of drugs, and the questioning of religious authority


(primarily the Catholic Church). As the social revolution swept through the influence of the Catholic Church eroded. Liberalization was viewed as a welcome shift away from the austere conservatism of the Church.\textsuperscript{7} Acceptance of homosexuality, abortion, drug use, and marriage for priests were issues that challenged Church doctrine. At the Vatican, Dutch Roman Catholics were known as the most rebellious members of the Church.\textsuperscript{8}

Societal relationships also changed narrowing the gap between ordinary people and those in positions of authority. Politicians no longer commanded the respect they use to and the process of secularization that started in the 1960s undermined the position of the traditional pillars. The political elite adapted to this call for change and supported the new ideas with the traditional conviction that it is better to guide social developments than to try and stop them.

The Dutch historian, Han Van der Horst, attempted to explain the Netherlands and the Dutch to people in other countries. He characterizes them as egalitarian, tolerant, freedom-loving, believers in social solidarity, practical, conscientious, careful, moralistic, paternalistic, inclined to respect authority, conformist, punctual, calm, and very attached to their privacy.\textsuperscript{9} Van Stegeren advises that it is difficult to know the Dutch; that while they are tolerant of each other’s views and habits, one would find it difficult to learn this from the Dutch as they prefer


not to engage in conversation with people they do not know. There is a businesslike tolerance about them that lends itself to follow common sense rather than official rules.\textsuperscript{10}

It is within this context that the medical practices and legal decisions of the Netherlands should be understood and as the Netherlands was the first country in the world in which euthanasia became legally permissible their experiences are of particular interest to the United States and the rest of the world.

The word, euthanasia, means good death which in the Dutch context involves voluntary euthanasia which allows a physician to administer a lethal dose of medication as requested by a patient that is suffering unbearably, both parties knowing that death will occur as a result of this action. Regulation requires the existence of a long term doctor-patient relationship. Physicians cannot suggest euthanasia as an option, the patient must be made aware of all other medical options, and a second professional opinion must be sought. The decision for euthanasia must be made by the patient while of sound mind but a patient may leave written instructions for a physician to use his own discretion when the patient becomes too mentally or physically incapacitated to make the decision for himself.

This end-of-life legislation took more than twenty years and the subsequent law reflected the already existing medical practice. For almost fifty years prior to its legalization the Dutch people gave thought to the issue of euthanasia as cases presented themselves to the courts. One of the first known cases occurred in 1952. A doctor stood trial for killing his brother who had been suffering from advanced tuberculosis. The sick man spent weeks pleading for his brother to put him out of his misery before the doctor finally agreed by giving

his brother pills and a fatal injection of morphine. The doctor told the District Court that he
could not ignore the claims of his conscience which compelled him to comply with his
brother’s wishes. The District Court found the doctor guilty of killing on request, (Article 293
of the Criminal Code which prohibits killing a person at his request). The court decided to
sentence the doctor to one year probation stating that this was the first time that the Courts
were aware of a case of euthanasia being subject to the ruling of a Dutch judge.\footnote{Jonathan T. Smies, The Legalization of Euthanasia in the Netherlands, 7 Gonzaga Journal of
International Law (2003-04), available at \url{http://www.gonzagajil.org/}. Retrieved on August 17, 2009.}

A case that received quite a bit of media attention was that of Mia Versluis. This case
is important because it was ever present in the minds of the public at the time another landmark
case of reported euthanasia became known, the Postma case. In 1966, Mia Versluis, a 21 year
old sports instructor, underwent cosmetic surgery on her heel bones. During the surgery she
suffered cardiac and respiratory problems. She never recovered from the narcosis caused by
the general anesthetic. Severe and irreversible brain damage had occurred. After five months
on a ventilator the treating physician proposed to Mia’s parents that the ventilator be
disconnected. The parents interpreted this proposal as euthanasia and refused. More than five
years after the surgery, Mia died without medical interference. Mia’s lingering death made
many people anxious about medical procedures that kept patients in limbo between life and
death. Mia’s death on November 10, 1971 occurred during the time the Postma case was
under review in the Leeuwarden District Court.\footnote{Henk A. M. J. Ten Have and Jos V. M. Welie, Death and Medical Power: An Ethical
Analysis of Dutch Euthanasia Practice, (Berkshire: Open University Press, 2005), 8-9.}

The Postma case of 1972 is the most publicized case of euthanasia leading up to its
legalization. Mrs. van Boven-Grevelink had suffered a stroke that had left her with partial
paralysis and problems with her speech. She needed permanent care and was transferred from
the hospital to a nursing clinic where her condition worsened. She was wheelchair-bound, had
difficulty hearing and speaking, and her left arm was paralyzed. Mrs. van Boven blamed the
medical doctors and her family for saving her life, a life she deemed not worth living as a
disabled person unlikely to get better. She had made repeated requests to her daughters, one of
whom Mrs. Postma was a doctor herself, to end her suffering. Giving in to her mother’s
request, Mrs. Postma gave her mother a lethal injection of morphine. The director of the
nursing home where Mrs. Postma’s mother had lived reported the incident to the Medical
Inspectorate which in turn notified the prosecutor. Mrs. Postma stood trial for ‘killing on
request’. The hearing took place on February 7, 1973 and lasted seven hours. Two weeks later
the District Court of Leeuwarden issued its verdict. While the court did not agree that the
patient, in this case Mrs. Postma’s mother, was in the terminal phase of her illness and found
that it was wrong for Mrs. Postma to have used an injection that was immediately lethal, it
nevertheless gave only a conditional jail sentence of one week with one year probation. This
decision opened the door to the possibility of legally sanctioned euthanasia.¹³

The revelation about the Postma case and the media attention sparked several
developments. First the inhabitants of the village of Noordwolde, where Mrs. Postma and her
husband were both working as family practitioners, started a movement to support the
Postmas. They considered it unjust that their family physicians were now the sole focus of
legal attention. This local action attracted the interest of several other national newspapers and
television channels. Notifications of support came in from all over the country with 30

¹³ Henk A. M. J. Ten Have and Jos V. M. Welie, Death and Medical Power: An Ethical
Analysis of Dutch Euthanasia Practice, (Berkshire: Open University Press, 2005), 5-6, 9.
physicians from the province of Friesland officially declaring that they considered euthanasia an act of compassion and therefore did not reject it in the context of medical treatment. Baptist ministers in the northern parts of the country also declared their support of the Postmas.\textsuperscript{14}

The second development as a result of the \textit{Postma} case was the public debate that started with the medical, theological, legal and ethical experts to address the issue of euthanasia. All of the experts emphasized that euthanasia in practice was much more prevalent than accounted for in the media. They argued that the transitional line between life and death had been obliterated by modern medicine and that medicine was now capable of prolonging life beyond any reasonable state of existence.

The final development as a result of the \textit{Postma} case was the establishment of several societies and associations acting as public interest forums and political pressure groups. The Dutch Society for Voluntary Euthanasia was founded in February 1973 to promote the social acceptance of euthanasia as well as the legalization of euthanasia. The Foundation for Voluntary Euthanasia was also established in February 1973. The Foundation’s membership consisted of scholars, well-known lawyers and physicians who sought to develop and propagate a living will for euthanasia within the context of existing legislation.\textsuperscript{15}

The \textit{Schoonheim} case in 1983 was the first euthanasia case to reach the Supreme Court. On July 16, 1982, Dr. Schoonheim performed euthanasia on Maria Barendregt, a 95 year old bedridden patient. Ms. Barendregt, bedridden due to a fracture hip for which she had refused an operation, had on several occasions and in a quite an insistent manner requested that Dr.


\textsuperscript{15} Ibid., 9.
Schoonheim perform euthanasia. Dr. Schoonheim consulted with another physician who confirmed that Ms. Barendregt would likely not regain her health. Dr. Schoonheim then consulted with Ms. Barendregt one last time on July 16 in the presence of her son and her daughter-in-law. It was clear to him that it was Ms. Barendregt’s desire to die as soon as possible. Immediately upon conclusion of their discussion Dr. Schoonheim acceded to her request. On that same day Dr. Schoonheim reported his actions to the police. Dr. Schoonheim’s lawyer argued that there was no violation with the law and the District Court of Alkmaar acquitted Dr. Schoonheim. However, the prosecution appealed. The Court of Appeals in Amsterdam rejected Schoonheim’s defense and found him guilty but chose not to impose any punishment. There was one main difference between this case and other euthanasia cases that preceded it. Existing criteria for euthanasia at that time was based on the “continuous and unbearable suffering of a physical and spiritual nature”. In the Schoonheim case the Alkmaar Court required the defense to show that the patient was only under “continuous suffering” and that euthanasia could be justified on the basis of psychological suffering. On November 27, 1984 the Supreme Court affirmed the ruling of the Court of Appeals but remanded the case to the Court of the Hague to determine whether Schoonheim’s conduct was justified under the defense of necessity. Schoonheim testified that he had felt conflicted between preserving the patient’s life and alleviating her suffering and that he had acted out of a situation of necessity. The Supreme Court accepted Schoonheim’s defense of necessity in accordance with Article 40 of the Dutch Criminal Code and acquitted
him.\textsuperscript{16} Article 40 contains a defense of \textit{force majeure} or necessity. It allows that a person committing an offence under \textit{force majeure} is not criminally liable. “In the medical context, Article 40 has given rise to a particular defense known as \textit{noodtoestand} or ‘emergency’ in which the defendant faces an irreconcilable conflict of duties. The recognition of the \textit{noodtoestand} defense has played a central role in the development of Dutch jurisprudence and has ultimately provided a means by which doctors in the Netherlands can perform active voluntary euthanasia without incurring criminal sanction despite the prohibition in Article 293.”\textsuperscript{17} This was the first time a doctor who had performed euthanasia was not found to be criminally liable.

The \textit{Chabot} case was another landmark case heard by the Supreme Court in 1994. This assisted suicide case dealt with the non-somatic suffering of patients vs. physical suffering. The patient was a 50 year old female who was depressed due to several traumatic events that had occurred in her life. Her eldest son had committed suicide in 1986. Her father died in 1988. She divorced her husband in 1990 and her only remaining son died of cancer in 1991. The patient identified only as Ms. B in the court papers had attempted suicide after the loss of her younger son. She was then referred to Dr. Chabot, a psychiatrist, by the Dutch Association for Voluntary Euthanasia. Dr. Chabot met with Ms. B several times over the course of a five week period. He also consulted other psychiatrists, a clinical psychologist, a general practitioner, and an ethics professor. It should be noted however that none of these individuals ever examined Ms. B. Dr. Chabot made the determination that Ms. B was


\textsuperscript{17} Margaret Otlowski, \textit{Voluntary Euthanasia and the Common Law}, (Oxford: Clarendon Press, 1997), 393.
suffering psychologically in a manner that was subjectively unbearable to her and that she would not in all likelihood get better. Dr. Chabot was convinced that Ms. B had considered her options for therapy to which she declined. He therefore provided her with the necessary medications to end her life just seven weeks after first meeting her in 1991. "The Dutch Supreme Court held that, for a request of assisted suicide or euthanasia to be justified on "necessity" grounds, the patient’s suffering need not be physical, the patient need not be terminally ill, and purely psychological suffering can qualify a patient for an act of euthanasia.\textsuperscript{18} The Supreme Court determined that the only error on the part of Dr. Chabot was in not having the other professionals he consulted also examine Ms. B. However the court decided not to impose any penalty against Dr. Chabot for this "oversight".

In 1990 the Remmelink Commission was formed (so named after committee chairman, Jaabout Remmelink, who was then the Attorney General of the Dutch Supreme Court) to investigate the medical practice of euthanasia and physician-assisted suicide. The Remmelink Commission felt it was important to report not only on the cases where euthanasia was requested but also on the cases where the termination of the patient’s life was not explicitly requested. The Remmelink Commission turned to Professor Paul J. van der Maas and his colleagues from the Erasmus University to undertake the study. The study was approached in three ways. "First the team of researchers interviewed a sample of 400 physicians about their involvement in euthanasia. Second, it asked the same pool of physicians to complete a short questionnaire for each of their patients who would die in the subsequent six months (the prospective study). Third, the team analyzed a representative sample of 8,500 death

certificates completed in the preceding six months. In those cases where there might have been a medical intervention impacting the time of death, the aforementioned questionnaire was mailed to the physician.”

“According to the Remmelink Report (Paul J. van der Maas, MD, et al., “Euthanasia and Other Medical Decisions Concerning the End of Life,” The Lancet, 1991; English version), 54 percent of the surveyed physicians had performed euthanasia or assisted suicide. Another 34 percent indicated that they might perform euthanasia or assisted suicide, although some might do it only in extreme situations. While 12 percent reported that they would never participate in euthanasia or assisted suicide, two-thirds of these physicians (8 percent of the total) would refer patients to another physician. Four percent would never have anything to do with such requests. Of the nearly 129,000 deaths in the Netherlands in 1990, 2,300 (1.8 percent) were the result of euthanasia and 400 (0.3 percent) were assisted suicides.”

“The Remmelink Commission also reported 1,040 deaths (0.8 percent of all deaths) from involuntary euthanasia. The Dutch do not refer to this practice as euthanasia, but call it “termination of life without patient’s explicit request.” Fourteen percent of these patients were fully competent, and 72 percent had not given any indications that they wanted to be euthanized. In 59 percent of the deaths, the physicians claimed that discussions were held with the patients and that the patients had expressed an interest in euthanasia prior to becoming incompetent to make further medical decisions or became unconcious. Another 8,100

\[\text{\textsuperscript{19}} \text{Henk A. M. J. Ten Have and Jos V. M. Welie, Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice, (Berkshire: Open University Press, 2005), 62.}\]

patients died from a deliberate overdose of pain medication given by doctors, not to control pain but to hasten death. Sixty-one percent had not consented to the overdose.  

Follow up reports were issued by the Remmelink Commission in 1995 and 2001. The purpose of these reports was to chart the trend in the use of euthanasia, whether an increase or decrease, over the span of time from when the first report was issued in 1990. The 1995 study consisted of two parts; interviews with 405 physicians and a study of death certificates through questionnaires returned by about 5,000 physicians. Similar data was collected for the 2001 report. These reports found that there was an increase in the number of deaths by euthanasia from 1.9 percent in 1990 to 2.3 percent in 1994 and 2.6 in 2001. Requests for physician-assisted suicide were up slightly in 1994 from those reported in 1990 but did not rise at all from 1994 to 2001. This news was gratefully accepted by the Government which viewed the reports as the means to pacify the euthanasia debate. “Both the courts and the prosecutorial authorities have from the beginning made it clear that they are inclined both to follow the medical profession itself in fashioning rules concerning justifiable euthanasia and to leave a great deal of latitude in individual cases to professional judgment.”  

In the fall of 2000 the Second Chamber of the Dutch Parliament accepted a proposal for a law to legalize euthanasia. The proposal was then sent onto the First Parliament which passed the law in April 2001 and became effective in April 2002.

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The new law does little to change the existing practice of euthanasia in the Netherlands. The new law allows for a criminal liability exclusion to Article 293 (the killing of a person is unlawful even if that person requests it) and Article 294 (inciting a person to commit suicide, aiding in the suicide of another or procuring the means for a suicide is unlawful) if the physician has adhered to the criteria of due care. The "due care criteria" require that when ending a life the physician must:

- be convinced the patient's request was voluntary, well-considered and lasting
- be convinced the patient was facing unremitting and unbearable suffering
- have informed the patient about their situation and prospects
- have reached the firm conclusion with the patient that there is no reasonable alternative solution
- have consulted at least one other independent physician, who has examined the patient and formed a judgment about the above points
- terminate the life in a medically appropriate fashion\textsuperscript{23}

At the core of this new legislation is the retrospective review procedure. "In early 1999, five regional committees had already been established, each consisting of a lawyer (serving as a chair), an ethicist and a physician. Each committee judges retrospectively whether the euthanizing physician acted in compliance with the established procedure. Since the new law took effect in April 2002, the public prosecutor can no longer prosecute a euthanasia case if the committee finds that the physician involved has abided by all the

requirements of due care."® It should be noted that this system works only if physicians actually report their euthanasia cases. It is suspected that many physicians do not and that possibly as many as half of the cases of euthanasia continue to go unreported. One of the main reasons for physicians not to report these cases is their dislike of the complex judicial procedure entailed by the notification procedure as reported by Professor van der Maas of Erasmus University.®

In 2005 a follow-up study was performed by van der Maas and his colleagues of euthanasia, physician-assisted suicide, and other end-of life practices since the passage of the 2002 legislation. The results were published in the New England Journal of Medicine in May 2007. The methods used were similar to those of the Remmelink Commission. Questionnaires were mailed to physicians attending 6,680 deaths that were identified from death certificates. The response rate was 77.8%. The results are as follows:

In 2005, of all deaths in the Netherlands, 1.7% were the result of euthanasia and 0.1% were the result of physician-assisted suicide. These percentages were significantly lower than those in 2001, when 2.6% of all deaths resulted from euthanasia and 0.2% from assisted suicide. Of all deaths, 0.4% were the result of the ending of life without an explicit request by the patient. Continuous deep sedation was used in conjunction with possible hastening of death in 7.1% of all deaths in 2005, significantly increased from 5.6% in 2001. In 73.9% of all cases of euthanasia or assisted suicide in 2005, life was ended with the use of neuromuscular relaxants or barbiturates; opioids were used in 16.2% of cases. In 2005, 80.2% of all cases of euthanasia or assisted suicide were reported. Physicians were most likely to report their end-of-life practices if they considered them to be an act of euthanasia or assisted suicide, which was rarely true when opioids were used. The conclusion made is that the Dutch Euthanasia Act was followed by a modest decrease in the rates of euthanasia and physician-assisted suicide. The


25 Ibid., 50.
decrease may have resulted from the increased application of other end-of-life care interventions, such as palliative sedation.\textsuperscript{26}

All of this focus on euthanasia seems to have contributed to other improvements in end-of-life care in the Netherlands. The 2005 study in the New England Journal of Medicine article states that Dutch physicians have been found to consider high quality end-of-life care as an alternative to euthanasia or assisted suicide in some cases. In the past, the Netherlands was often criticized for its presumed lack of palliative care. In the beginning of the euthanasia debate palliative care was often ignored. In more recent years, however, much effort has been made to improve palliative care, partly in response to the international critique.\textsuperscript{27}

“Palliative care can be defined as ‘the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is quality of life’. The hospice philosophy is that care should be aimed at supporting the whole person in all his physical, psychological, social and spiritual needs. Patients are partners in care and loved ones and family members must be involved. Extension of life is never the primary goal, but death is not intentionally hastened either.”\textsuperscript{28} The Netherlands has expanded


the availability of palliative care. There are many options for receiving palliative care at home and terminally ill patients can also receive this care in nursing homes, hospitals, and hospices. “In mid-2002 there were hospice units in thirty-seven nursing homes and in twenty-six homes for the elderly. In addition, there were sixteen independent, professionally staffed hospices and twenty-one volunteer-run hospices. Most palliative care, however, is provided by the Netherlands’ seventy-eight hundred general practitioners, since 65 percent of the forty thousand people who die of cancer each year die at home. More and more, general practitioners receive support from hospital-based (so-called transmural) palliative care teams.”

29 Have and Welie report that Dutch palliative care journals and textbooks have been launched, professional societies have been founded, and the number of professional training programs and educational seminars and courses is multiplying every year. Palliative care has also become the explicit goal of health policy.

Available data is sparse about the effectiveness of preventing euthanasia through palliative care although there are indications that Dutch physicians believe it can. “Of the 3,200 patients euthanized in 1995, 88% were receiving medical treatment aimed at palliation. Yet in 83% of the cases the euthanizing physician stated that treatment alternatives were no longer available. This would suggest that the palliative interventions had failed for almost all


of these patients whose suffering could no longer be relieved and had become unbearable. A study in 1998 by Zbigniew Zylicz, M.D., a physician at the Hospice Rozenheuvel, yielded very different findings. Among 450 patients referred to the Hospice Rozenheuvel in a period of three-and-a-half years, 28% made an explicit request for euthanasia, usually at the first meeting with the hospice physician. But only two patients persisted in their wish and were eventually transferred to the hospital to undergo euthanasia."

In December 2002, in what has been called a test case for the newly passed euthanasia law, the Dutch Supreme Court upheld a conviction of Dr. Philip Sutorius for assisting in suicide and refused his appeal. Dr. Philip Sutorius was convicted of assisting in the suicide of an 86 year old man who was “tired of living”. Dr. Sutorius helped a former Senator, Edward Brongersma, to take his life in 1998 by providing him with a lethal cocktail of drugs. Mr. Brongersma was not terminally ill. He was suffering from incontinence, dizziness, and immobility and said he was tired of life. Mr. Brongersma had made a written euthanasia declaration in 1984 and had made numerous appeals for euthanasia to Dr. Sutorius since 1986. A lower court had acquitted Dr. Sutorius in November 2000 however the Netherlands Solicitor General convinced the High Court that the case should be heard again in light of the newly passed laws on euthanasia and physician-assisted suicide. Dr. Sutorius was found guilty for his assistance in Mr. Brongersma’s suicide by the Court of Appeals in Amsterdam in 2001. He did not receive a jail sentence because the court felt he had acted out of compassion for his patient.

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and because the court viewed this as a test case. The court ruled that being tired of living did not constitute unbearable suffering.\textsuperscript{32}

The commitment to a ‘good death’ created the euthanasia debate. Euthanasia is considered to be a medical intervention that should not be practiced as a norm in providing care to patients but one that should be a last resort. The physician should always look for reasonable alternatives. The consulting physician (second physician in the euthanasia process) must confirm that options for palliative care have been explored. Even the best palliative care, however, may not prevent a patient from deciding that his pain is unrelieveable, his suffering has gone on too long, and his dignity is slipping away. It is for these patients that the Netherlands has decided that euthanasia needs to be an available option.

As stated in the beginning of this chapter the Netherlands appears to have avoided the slippery slope. Although there is little data on the non-voluntary use of euthanasia to really know. Data compiled since legalization would suggest than the legalization has led to less non-voluntary use. As John Griffiths states in a briefing session at the House of Lords in 2003, “One can quarrel with these data, of course, but then one is simply left with empty hands: no quantitative evidence at all one way or the other as far as the ‘slippery slope’ argument is concerned.”\textsuperscript{33}


CHAPTER 2
EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES

The United States has long been grappling with end-of-life issues. When and how we die has never been so controversial an issue as in recent years. In the early part of the 20th century people typically died in their homes surrounded by their families and, when possible, comforted by their physician. We have made great strides in medical technology since the 1950's allowing terminally ill patients and those in a persistent vegetative state to live longer. These medical advances have brought to light some difficult issues for many dying patients and for their physicians and our healthcare administrators. Death has been removed from the home and moved to the hospital. Typically, our society has looked at a physician’s role as that of a healer, a sustainer of life. Today we have to ask the question, “But to what end”? Are we prolonging life or prolonging death? Although our earliest laws prohibited suicide the debate on how and when we die and who controls the means to our end wages on. We have transitioned from a debate for euthanasia to the debate for the acceptance of physician-assisted suicide to offer a humane, merciless or painless way to end a life. Currently two states, Oregon and Washington, have legalized physician-assisted suicide. How did this transition come about? In this chapter I will examine the progression of end-of-life issues in the United States.

In the United States and elsewhere as medicine evolved from a rudimentary science into a more sophisticated understanding of the human body euthanasia became a topic of discussion. The debate over euthanasia was spurred on in the 19th century by the marked development of anesthesia. The first articles advocating euthanasia in the context of modern medicine began appearing in the 1870s. In 1906 the first law to permit voluntary active
euthanasia, "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons," was defeated in Ohio. Later that same year a similar bill was defeated in Iowa. The bill in Iowa went so far as to allow for persons with a hopeless disease or injury or children that were hideously deformed or idiotic to be killed by the administration of an anesthetic.¹

Euthanasia became associated with the eugenics movement in the late 19th century and early 20th century. Proponents of eugenics envisioned perfection of the human race which could be accomplished through the sterilization of the unfit or degenerate and through the euthanasia of those damaged by disease, accident or mental retardation that would impose a burden to society. A popular case to support this line of reasoning was that of the Bollinger baby in 1915. A woman by the name of Anna Bollinger gave birth to a baby boy, Allan, at the German-American Hospital in Chicago on November 12, 1915. Allan was somewhat deformed and suffered from a host of complications. The chief of staff, Harry Haiselden, convinced Allan’s parents to deny the baby the surgery it needed to survive. The baby died several days later. “Haiselden did not quietly “let nature complete its bungled job” as he put it. He energetically publicized his decision not to operate in the hopes that it would generate widespread support for the legislation of euthanasia for disabled persons.”² Haiselden wrote articles for the Hearst newspapers and gave lectures for the cause of eugenics. Haiselden was not a lone advocate of the eugenics movement. He enjoyed the backing of such well known people as Clarence Darrow, Helen Keller, and Jack London.


² Ibid., 73.
The first case of assisted suicide made its way to the Michigan Supreme Court in 1920. A Michigan man was convicted of first-degree murder and given a life sentence. He had prepared and given his dying and bed-ridden wife a poisonous beverage to drink because she had wanted to die. The Michigan Supreme court upheld the man’s conviction ruling it was irrelevant that she had wanted to end her life but assisting in her death was relevant.\(^3\)

The Euthanasia Society of America (ESA) was organized in 1938 by Charles Frances Potter, a former Unitarian minister who also founded the Humanist Society of New York. Membership in the ESA included many humanists and Unitarians as well as a few prominent religious leaders. While many supporters believed that euthanasia should be limited to voluntary active euthanasia for the terminally ill some supporters believed that euthanasia for the severely retarded and physically deformed was more important. The ESA tried to find support to put a bill for active voluntary euthanasia before the New York legislature but was unsuccessful. Economics began to play a role in the arguments for ending lives that consumed precious resources without contributing anything to society. “In 1939 Dr. Foster Kennedy, president of the ESA, argued that euthanasia would shorten the life of “born defectives” and would relieve families of severe financial and psychological stress. Therefore, in his view, voluntary active euthanasia for the seriously ill would be only the first of new legislation that would recognize the value of reducing human suffering.”\(^4\) However a poll of New York physicians showed that support for euthanasia for the severely retarded and disabled was much less acceptable than for the terminally ill. Limiting their proposal to active euthanasia


requested by seriously ill adults, the ESA in 1941 tried to present another bill to the New York legislature but again was unable to find a sponsor. With expanded membership they tried again in 1946 but again no legislator would sponsor the bill.

The ESA suffered a similar defeat in New Hampshire in 1950 when it proposed a bill on the heels of the widely publicized trial of Dr. Hermann Sander. Dr. Sander was acquitted of killing a terminally ill cancer patient with an injection of air, despite admitting his guilt and having recorded the event in the patient’s medical record. In 1952 the ESA gave up trying to win support for voluntary active euthanasia.\textsuperscript{5}

The United States was not the only country to embrace the eugenics movement and in the midst of our debates the situation in Germany came to our attention which served to discredit not only the eugenics movement but euthanasia in any context as well. Ernest Haeckel, world renowned biologist and social scientist, spearheaded the eugenics movement in Germany. “Haeckel advocated euthanasia for the “hundreds of thousands of incurables — incurables, lepers, people with cancer etc… artificially kept alive,” whom he saw as a drain on the economy and a threat to the health of the Aryan race.”\textsuperscript{6} In 1920 Alfred Hoche, a psychiatrist, and Karl Binding, an attorney, having been influenced by Haeckel’s work, wrote \textit{The Permission to Destroy Life Unworthy of Life}, which was admired by Adolf Hitler. Their proposal advocated death for racially hygienic purposes or because they were a burden to


society or both, those who were retarded, deformed, or terminally ill and those damaged by accident or disease.\textsuperscript{7}

Voluntary euthanasia was legalized in Germany when the Nazis gained control. They eventually adopted the views of Haeckel, Hoche and Binding on a magnitude that became unfathomable. “Euthanasia was used by the German doctors first to end the lives of several hundred thousand mentally ill children and adults considered incurable and subsequently to eliminate Jews, gypsies, and others designated as racially or genetically undesirable.”\textsuperscript{8} What started as euthanasia in the name of eugenics became a case of mass genocide.

The United States was horrified by the Nazi euthanasia program and this coupled with the conservative political and moral atmosphere in the 1950s caused the euthanasia movement to flounder. The topic of euthanasia resurfaced in the 1960s but this time the focus was not on eugenics but on patient autonomy. Improvements in health and hygiene along with medical advances extended life expectancy but also increased the numbers of people dying from long-term painful illnesses. Life-support systems kept people’s bodies functioning even when their brains had stopped functioning. This led many to conclude that “individuals needed protection from an all too vigorous medical establishment.”\textsuperscript{9} Pauline Taylor, a lawyer and former director of the American Birth Control League of America, became president of the Euthanasia

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Society of America in 1962. She believed that the ESA had placed too much emphasis on an individual’s decision to end his life if terminally ill and in unbearable pain and decided that the time was right to convince the public that “letting someone die instead of resorting to extreme measures, was both humane and ethically permissible.”

This strategy became known as the right-to-die movement.

In 1967 a Chicago attorney named Luis Kutner proposed the first living will to the ESA. The concern of Kutner was “the rights of dying people to control decisions about their own medical care.” In 1968 the first living will legislature was presented to the Florida state legislature but was defeated. The bill was reintroduced in 1973 in Florida and again failed to pass. A similar bill failed to pass in California in 1972 but was reintroduced in 1976 and this time passed making California the first state in the nation to legally sanction living wills. By 1992 all fifty states and the District of Columbia had passed legislation to legalize some form of advanced directive.

In 1975 the case of Karen Ann Quinlan of New Jersey reached the media and for many started the controversy over the “right to die” with the “right to refuse medical treatment”. Karen Quinlan suffered severe brain damage as the result of anoxia and entered a persistent vegetative state. She was unable to breathe or eat on her own and was kept alive by a respirator or so they thought. Her father sought judicial approval to disconnect his daughter’s


respirator and the family undertook a long and arduous legal battle to have her removed from this machine. They argued that their daughter would not have wanted to be kept alive this way. The New Jersey Supreme Court granted the relief, holding that Karen had a right of privacy grounded in the Federal Constitution to terminate treatment.\textsuperscript{13} Recognizing that this right was not absolute, however, the court balanced it against asserted state interests. Noting that the State's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims," the court concluded that the state interests had to give way in this case. The court also concluded that the "only practical way" to prevent the loss of Karen's privacy right due to her incompetence was to allow her guardian and family to decide "whether she would exercise it in these circumstances."\textsuperscript{14}

Karen Quinlan's respirator was disconnected in 1976 and she lived nine more years in a persistent vegetative state sustained by tube feeding until she finally died of multiple infections. The effects of the Quinlan case remain with us today. This case made us realize that catastrophic medical situations can arise at any moment and there was a sudden awareness of planning ahead to make end-of-life wishes known. Hospitals also began to establish ethics committees to examine decisions made by guardians and to ensure that these decisions were in the best interest of the patient.

In 1990 the United States Supreme Court heard the "right to die" case of Nancy Cruzan. Chief Justice Rehnquist delivered the opinion of the Court, in which Justices White, O'Connor, Scalia, and Kennedy joined. "Petitioner Nancy Beth Cruzan was rendered

\textsuperscript{13} In the Matter of Karen Quinlan, An Alleged Incompetent, Supreme Court of New Jersey, 70 N.J. 10, at 3842, 355 A. 2d at 662664, March 31, 1976.

\textsuperscript{14} Id., at 41, 355 A. 2d, at 664.
incompetent as a result of severe injuries sustained during an automobile accident. Co-
petitioners, Lester and Joyce Cruzan, Nancy’s parents and co-guardians, sought a court order
directing the withdrawal of their daughter’s artificial feeding and hydration equipment after it
became apparent that she had virtually no chance of recovering her cognitive faculties. The
Supreme Court of Missouri held that because there was no clear and convincing evidence of
Nancy’s desire to have life-sustaining treatment withdrawn under such circumstances, her
parents lacked the authority to effectuate such a request. We granted certiorari, and now
affirm.\textsuperscript{15}

In brief the facts of the case are as follows, “On the night of January 11, 1983, Nancy
Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The
vehicle overturned and Cruzan was discovered lying face down in a ditch without detectable
respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at
the accident site, and she was transported to a hospital in an unconscious state. An attending
neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by
significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent
brain damage generally results after six minutes in an anoxic state; it was estimated that
Cruzan was deprived of oxygen for 12 to 14 minutes. She remained in a coma for
approximately three weeks and then progressed to an unconscious state in which she was able
to ingest orally some nutrition. In order to ease feeding and further the recovery, surgeons

\textsuperscript{15} Cruzan, by her parents and co-guardians, Cruzan et ux. v. Director, Missouri Department of
implanted a gastrostomy feeding tube and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing.\textsuperscript{16}

According to Nancy Cruzan's family she would not have wanted to be kept alive by such means and she had discussed this issue in a serious conversation with a housemate. The Supreme Court of Missouri did not recognize the housemate's testimony to be "clear and convincing" evidence of Nancy's desire to terminate her life. Chief Justice Rehnquist, staying away from the right to privacy issue of the Quinlan case, instead focused on the \textit{Fourteenth Amendment} and "due process of law" for the basis of his argument to uphold the decision of the Supreme Court of Missouri. The Supreme Court of Missouri found that the statements of the housemate were "unreliable for determining Nancy's intent" and "thus insufficient to support the co-guardians' claim to exercise substituted judgment on Nancy's behalf. It rejected the argument that Cruzan's parents were entitled to order the termination of her medical treatment, concluding that "no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here."\textsuperscript{17} Chief Justice Rehnquist writes as follows:

This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." The \textit{Fourteenth Amendment} provides that no State shall "deprive any person of life, liberty, or property, without due process of law".... Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above (reference was made to previous refusal of treatment cases Quinlan, Saikewicz, and Storar/Eichner) would embrace such a liberty interest, the dramatic

\textsuperscript{16} Cruzan, by her parents and co-guardians, Cruzan \textit{ex} \textit{ux.} \textit{v.} Director, Missouri Department of Health, et al. Supreme Court of the United States, 497 U.S. 261, June 25, 1990, Decided.

\textsuperscript{17} Cruzan, by her parents and co-guardians, Cruzan \textit{ex} \textit{ux.} \textit{v.} Director, Missouri Department of Health, et al. Supreme Court of the United States, 497 U.S. 261, 269, June 25, 1990, Decided.

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consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.¹⁸

This United States Supreme Court decision did not close the door on this debate once and for all but appears to have left it wide open in recognition of the constitutional right of a competent patient to refuse medical treatment. After all, Nancy Cruzan’s case was about the right of an incompetent person.

After the Supreme Court made its ruling, the Cruzans petitioned the trial court in Missouri to rehear their request to remove Nancy’s feeding tube. Nancy’s physician had since changed his mind and was now in favor of the request by the Cruzan’s and this along with the testimony of new witnesses that corroborated the previous testimony of the housemate, resulted in the court’s authorization to remove the feeding tube in December 1990. Nancy died that same month. As with the Quinlan case, the Cruzan case spurred many in the United States to examine end of life issues resulting with the passage by Congress of the Patient Self Determination Act effective December 1, 1991 making advance directives more accessible throughout the United States.

As a society we seem not to have a problem with a person choosing to exercise his or her right to refuse medical treatment or to withdraw from medical treatment even if by doing so it will result in that person’s death. Should we condone this method of suicide? Justice Antonin Scalia says no. He writes in a concurring opinion,

While I agree with the Court’s analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have

no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide - including suicide by refusing to take appropriate measures necessary to preserve one's life; that the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, that even when it is demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve his or her life, it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored. It is quite impossible (because the Constitution says nothing about the matter) that those citizens will decide upon a line less lawful than the one we would choose; and it is unlikely (because we know no more about "life and death" than they do) that they will decide upon a line less reasonable... 19

The "right to die" issue unfortunately did not stop here. The cause has been expanded to include not only termination of treatment but termination of life and the assistance in doing so, or assisted suicide.

Assisted suicide is knowingly providing the means to commit suicide or aiding in another's steps to commit suicide. Physician-assisted suicide most often refers to a physician knowingly providing medications with the understanding that a person plans to use them to commit suicide.

Seven years after hearing the case of Nancy Cruzan the United States Supreme Court found itself again facing the "right to die" issues in the cases of Vacco v. Quill and Washington v. Glucksberg, two cases that dealt with physician-assisted suicide.

In Vacco v. Quill the petitioners were various New York public officials (Dennis C. Vacco, Attorney General of New York, et al.). The respondents were Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman, physicians who practice in New York and

three gravely ill patients (who have since died). In Washington v. Glucksberg the petitioners were the State of Washington and its Attorney General. The respondents were Harold Glucksberg, Abigail Halperin, Thomas A. Preston, and Peter Shalit, all of whom are physicians who practice in Washington, and three gravely ill patients (who have since died), and Compassion in Dying, a nonprofit organization that counsels people considering physician-assisted suicide. In both the State of New York and Washington it is a crime to assist a suicide. Respondents in both cases sought relief under the Fourteenth Amendment.

Respondents in Vacco v. Quill claimed that New York’s assisted suicide ban violates the Fourteenth Amendment’s Equal Protection Clause. The Equal Protection Clause embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. Respondents in Washington v. Glucksberg asserted a liberty interested protected by the Fourteenth Amendment’s Due Process Clause which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide.

The United States Supreme Court rendered its decision on the cases on June 26, 1997. In a unanimous decision, the court ruling held that assisted suicide is not an American constitutional right. Chief Justice Rehnquist delivered the opinion of the court in both cases. In the Vacco v. Quill opinion he wrote:

We disagree with respondents’ claim that the distinction between refusing lifesaving medical treatment and assisted suicide is “arbitrary” and “irrational”. [Brief for Respondents 44] Granted, in some cases, the line between the two may not be clear, but certainly is not required, even were it possible. Logic and contemporary practice support New York’s judgment that the two acts are different, and New York may therefore,

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consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction—including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia—are discussed in greater detail in our opinion in Glucksberg, ante. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.\(^{22}\)

In Washington v. Glucksberg, Chief Justice Rehnquist referred to the \textit{Cruzan} case.

In \textit{Cruzan}, we considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistent vegetative state, 'had a right under the United States Constitution which would require the hospital to withdraw life sustaining treatment' at her parents' request. \textit{Cruzan}, 497 U.S., at 269. We began with the observation that "at common law, even the touching of one person by another without consent and without legal justification was a battery." \textit{Ibid}. We then discussed the related rule that 'informed consent is generally required for medical treatment.' \textit{Ibid}. After reviewing a long line of relevant state cases, we concluded that 'the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.' \textit{Id.}, at 277. Next, we reviewed our own cases on the subject, and stated that '[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.' \textit{Id.}, at 278. Therefore, 'for purposes of [that] case, we assume [d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.' \textit{Id.}, at 279; see \textit{id.}, at 287 (O'Connor, J., concurring). We concluded that, notwithstanding this right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of life sustaining treatment. \textit{Id.}, at 280-281.

The right assumed in \textit{Cruzan}, however, was not simply deduced from abstract concepts of personal autonomy. Given the common law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed the two acts are widely and reasonably regarded as quite distinct. \textit{See Quill v. Vacco, post}, at 5-13. In

Cruzan itself, we recognized that most States outlawed assisted suicide – and even more do today – and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. 497 U.S., at 280.23

There is in this opinion however, the implication that there is no constitutional bar that would prevent a state from passing a law that allows physician-assisted suicide and on October 27, 1997, the State of Oregon did just that. The United States Supreme Court’s decision sent this issue back to the individual states to be fought when Chief Justice Rehnquist ended his opinion with this: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. The decision of the en banc Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.”24

The Oregon Death with Dignity Act allows terminally ill Oregon residents to obtain and use prescriptions from their physicians for self-administered, lethal medications. Under the Act, ending one’s life in accordance with the law does not constitute suicide. Physician-assisted suicide in this context is not to be confused with euthanasia, where a physician or other person directly administers a medication to end another’s life, a practice which has been legalized in the Netherlands. (Chief Justice Rehnquist mentions this practice in the Netherlands in his opinion in Washington v. Glucksberg).

The Oregon Death with Dignity Act requires that a patient must be:

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24 Ibid.
• An adult – meaning an individual who is 18 years of age or older.

• A resident of Oregon.

• Capable (defined as able to make and communicate health care decisions).

• Diagnosed with a terminal illness that will lead to death within six months.

Patients meeting these requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician. To receive the prescription the following steps must be fulfilled:

• The patient must make two oral requests to the physician, separated by at least 15 days.

• The patient must provide a written, witnessed request to the physician (two witnesses).

• The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.

• The prescribing physician and a consulting physician must determine whether the patient is capable.

• If either physician believes the patient’s judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.

• The prescribing physician must inform the patient of feasible alternatives to assisted suicide including comfort care, hospice care, and pain control.

• The prescribing physician must request, but may not require, the patient to notify their next-of-kin of the prescription request.\(^{25}\)

The good citizens of Oregon certainly gave this Act a great deal of thought. Contrary to the beliefs of many, very few people have taken advantage of Oregon’s Death with Dignity

Act. Since the Act was passed in 1997, 401 patients have died under the terms of the law. The numbers are required to be reported annually by the Oregon Department of Health and Human Services. The numbers typically show an upward trend in the use of physician-assisted suicide and in the number of prescriptions written but not all of the recipients ingest the prescribed medication. Summary data from the 2008 report follows:

In 1998, 16 Oregonians used physician-assisted suicide, followed by 27 in 1999, 27 in 2000, 21 in 2001, 38 in 2002, 42 in 2003, 37 in 2004, 38 in 2005, in 2006, 49 in 2007, and 60 in 2008. As in prior years, participants were between 55 and 84 years of age (78%), white (98%), well-educated (60% had at least a baccalaureate degree in 2008, compared to 41% in previous years), and were more likely to have cancer (80%). Most patients died at home (97%); and the number of patients that were enrolled in hospice care (98%) was much greater than in previous years (86%). In 2008, 97% of patients had some form of health insurance. Compared to previous years, the number of patients who had private insurance (88%) was much greater than in previous years (63%), and the number of patients who had Medicare or Medicaid was much less (8% compared to 36%). As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (95%), decreasing ability to participate in activities that made life enjoyable (92%), and loss of dignity (92%). During 2008, more participants were concerned about loss of dignity than in previous years (82%). No complications were reported in 2008. During 2008, 2 referrals were made to the Oregon Medical Board for incorrectly reporting forms. The Oregon Medical Board found no violations of “good faith compliance” with the Act and did not sanction any physicians for “unprofessional conduct regarding the Act.”

Why have other states not followed suit? Only one state has passed similar legislation since Oregon passed its Death with Dignity Act. (Washington State recently passed its Initiative 1000 in November 2008.) The Death with Dignity Act has not been without opposition from the federal government. On November 5, 2001, then Attorney General John Ashcroft, declared in a letter to Asa Hutchinson, the chief of the Drug Enforcement Administration, that assisting a terminally ill patient to commit suicide is not a “legitimate

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medical purpose” for federally controlled drugs. He said, “Any physicians who use drugs to help patients die face suspension or revocation of their licenses to prescribe federally controlled drugs.” Following the letter was the issuance of the Ashcroft Directives directing the DEA to enforce and apply the revocation of the DEA registration of any physician who uses federally controlled substances to assist in suicide.27 The United States District Court, District of Oregon, upheld the Oregon Death with Dignity Act in a case against Attorney General Ashcroft.28 The case made its way to the United States Supreme Court in October 2005 with Attorney General Alberto Gonzales as the lead Petitioner. The case was decided in January 2006. The Court ruled in favor of the State of Oregon maintaining that the statute in place does not grant the U.S. Attorney General the authority to overrule state laws as to what constitutes an appropriate use of medications.29

On November 22, 1998, viewers of the CBS television program, 60 Minutes, watched in horror as Dr. Jack Kevorkian killed fifty-two-year old Thomas Youck by injecting him with poison to stop his heart. Mr. Youck was suffering from Lou Gehrig’s disease and had asked Dr. Kevorkian to end his life. Dr. Kevorkian complied. Youck was not the first person Dr. Kevorkian helped to die. However this time Dr. Kevorkian was convicted of second degree

27 John Ashcroft, “Dispensing of Controlled Substances to Assist Suicide.” Memo to Asa Hutchinson, Administrator, The Drug Enforcement Administration, 6 November 2001.

28 United States District Court, District of Oregon, State of Oregon, Plaintiff & Richard Holmes; Karl Stansell; James Romney; Jane Doe #1; Peter A. Rasmussen, M.D.; and David Malcome Hochhalter, PhD, Plaintiffs – Intervenors, v. John Ashcroft, in his official capacity as United States Attorney; Asa Hutchinson, in his official capacity as Chief of the Drug Enforcement Administration; Kenneth W. Magee, in his official capacity as Director of the Drug Enforcement Administration, Portland Office; United States of America; United States Department of Justice; and United States Drug Enforcement Administrator, Defendants. No. CV01-1647-JC, May 7, 2003.

murder and sentenced to jail for ten to twenty-five years. He was paroled in 2007 because of
own failing health. It is believed that with the aid of his “suicide machine” and other methods
Dr. Kevorkian, nicknamed Dr. Death, aided at least 45 people, possibly more, in ending their
lives. He had been tried and acquitted three times for the charge of assisting suicide in the
1990s. With Thomas Youck he crossed the line by not only administering the lethal injection
but videotaping Youck’s death and defying prosecutors to charge him. Dr. Kevorkian’s
purpose was to have America’s laws prohibiting euthanasia and assisted suicide overturned
instead the killing of Thomas Youck and the backlash that occurred caused irreversible damage
to his cause.\footnote{Ian Dowbiggin, \textit{A Merciful End: The Euthanasia Movement in Modern America}, (New York: Oxford University Press, 2003), xi-xii.}

Another more recent case to make its way to the courts was that of Terri Schiavo.

This case, that first made its way to the courts in 1993, took 12 years for resolution and
ultimately resulted in Terry’s death. A summary of the events by David Gibbs, the attorney
representing Terri’s parents is as follows:

On February 25, 1990, Terri Schiavo, a 26 year old female, collapses at home
alone with her husband, Michael. Oxygen flow to Terri’s brain is interrupted for several
minutes, causing permanent brain damage and Terri to slip into a coma. Terri improves
from her initial acute coma status and is taken to a Florida rehab center for a rehabilitation
recovery program. In February of 1991, Terri’s parents, the Schindlers, report that Terri
can say words like “no” and “stop” and that she enjoys outdoor trips in her wheelchair.
Michael Schiavo files several lawsuits against the insurance company and Terri’s
physicians and is awarded funds to be placed in a trust for Terri’s care and funds for loss
of companionship. In 1993 Michael Shiavo and Terri’s parents have a disagreement
about Terri’s care. The Schindlers want Terri moved to another rehabilitation facility for
therapy and Michael refuses. The Schindlers make several attempts to become Terri’s
guardians, the first of which is in 1993. All of their attempts will fail. During this time
Michael Schiavo obtains the assistance of George Felos, a leading pro-euthanasia attorney
in Florida, to find a way to remove Terri’s feeding tube. Unfortunately Terri has left no
advance directive to indicate to all what she would have wanted regarding her medical
care. In 1998 Michael successfully petitions the Florida Pinellas County Probate Court to have Terri’s feeding tube removed using a newly-enacted Florida law. This legislation declared that use of a feeding tube was a form of medical treatment which any person who is terminal or in a persistent vegetative state has a right to refuse. Judge Greer who presided over the case issues the order for removal of Terri’s feeding tube, ruling that there is “clear and convincing” evidence of Terri’s oral end-of-life wishes, that Terri is in a persistent vegetative state, and that she would not want to live with a feeding tube. Although Judge Greer has never seen Terri, he also rules that she is unconscious, unaware, and without cognition, conditions that Terri’s family consistently deny. On February 20, 2000 the Schindlers petition for a rehearing and ask Judge Greer to allow Terri to have medical testing to determine her capabilities and true neurological condition. The motion is denied. In April 2000 Michael moves Terri from her nursing home to the Woodside Hospice facility where his attorney, George Felos, has served as chairman of the board. On April 24, 2001 Terri’s feeding tube is removed for the first time. It is reinserted two days later by Florida Circuit Court Judge Frank Quesda after Michael’s testimony about Terri’s wishes is questioned. Judge Greer rules again on November 22, 2002 that Terri is in a persistent vegetative state and cannot be rehabilitated and resets the date for removal of Terri’s feeding tube. The feeding tube is removed for the second time on October 15, 2003 but reinserted on October 20, 2003. The Florida Senate has authorized Governor Bush to order Terri’s feeding tube reinserted while he reviews her situation and all similar situations in Florida. Pope John Paul II in a worldwide address on March 20, 2004 issues a declaration that he specifically intends for Terri Schiavo, stating: “I should like particularly to underline how the administration of water and food, even when provided by artificial means, always, represents a natural means of preserving life, not a medical act.” The case makes its way to the United States Supreme Court on December 3, 2004. The Schindlers receive permission to visit Terri on December 24, 2004. This is their first visit with Terri since her relocation to the Woodside Hospice in April 2000. On January 24, 2005 the U.S. Supreme Court rejects Governor Bush’s appeal of the Florida Supreme Court’s decision. Judge Greer then orders the feeding tube be removed from Terri and that hydration and nutrition by mouth also be withheld to begin on March 18, 2005. Terri Schiavo dies on March 31, 2005, thirteen days after the removal of her feeding tube.31

As we can see from the Terri Schiavo case the United States is still grappling with end-of-life issues. Her story is disturbing and leaves us with a desire to see the issue of euthanasia and physician-assisted suicide decided once and for all. The world looked on as the details of the case were reported by the media. Those who are for and those who are against euthanasia

and physician-assisted suicide weighed in on the matter. An 11th Hour Coalition, an ad-hoc group of religious and political organizations, was formed to gather in front of the White House and the Florida governor’s mansion to urge the President and the Governor to exercise their Executive powers to protect Terri from starving. The pro-euthanasia group, End-of-Life Choices, (formerly the Hemlock Society) began an ad campaign in Florida using Terri’s situation as a way to make their case and increase their membership. At the heart of this campaign was an increased awareness of living wills and/or to name a durable power of attorney for healthcare to spell out how extensive end-of-life care will be and who will make the decisions for continuing or ending treatment. Pro-life groups such the National Right to Life Committee and the Alliance Defense Fund have banded together to promote Pro-Life Living Wills, a legal document that starts from the principle that patients desire to live and don’t want lifesaving medical treatment such as food or water, as in Terri Schaivo’s case, denied to them.

Terri Schaivo’s brother, Bobby Schindler, began speaking on University campuses across the United States and now works full-time for the non-profit Terri Schindler-Schiavo Foundation which describes itself as an organization dedicated to ensuring the rights of the disabled, elderly and vulnerable citizens against care rationing, euthanasia, and medical killing. Bobby Schindler believes that the laws that set the groundwork for his sister’s death were motivated by the expenses of caring for the disabled and elderly. He makes the case that Terri’s situation was not just a pro-life matter but also a disability rights issue and that the care of the disabled should not be looked upon as a burden.32

Timothy Quill published an article in the New England Journal of Medicine in which he summarizes the facts of the Terri Schiavo case. While he states that he never examined Terri Schiavo, his review of her medical data leads him to the conclusion that Terri Schiavo was in a persistent vegetative state and that her cognitive and neurologic functions were not going to improve. Dr. Quill believes the courts got it right in Terri’s case. That while it is true that her life could have been further prolonged with artificial hydration and nutrition, the evidence as presented by her husband was clear that Terri would not have wanted to be kept alive in this way. It is unfortunate that Terri’s family could not reach an agreement as to what was in Terri’s best interest in this case. Dr. Quill’s conclusion is “that if a patient’s wishes are not clear, then in the absence of public policy or family consensus, we should err on the side of continued treatment even in cases of a persistent vegetative state in which there is no hope of recovery. But if the evidence is clear, as the courts found in the case of Terri Schiavo, then enforcing life-prolonging treatment against what is agreed to be the patient’s will is both unethical and illegal.”

Our current President of the United States, Barack Obama, was in the Senate in 2005 when the Terri Schiavo case was being debated. Of Congress’s involvement he has since remarked that Congress should not have intruded and that he should have fought for making sure that families make those decisions and not bureaucrats and politicians. As a candidate Obama was asked in an interview with the Oregon Mail Tribune in March 2008 his views on physician-assisted suicide. His response was, “I am in favor of palliative medicine in

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circumstances where someone is terminally ill. ... I'm mindful of the legitimate interests of states to prevent a slide from palliative treatments into euthanasia. On the other hand, I think that the people of Oregon did a service for the country in recognizing that as the population gets older we've got to think about issues of end-of-life care. ....."34 The debate wages on and both sides on the issue of physician-assisted suicide anxiously wait to see if the current administration will promote legislation in favor of physician-assisted suicide.

This issue has also left the medical community, physicians and healthcare administrators, at odds. In May 1994, the New York State Task Force on Life and the Law published a 217 page report entitled "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context."35 Representatives of the Task Force, physicians, nurses, and other health care administrators, members of the clergy, ethicists, and legal counsel, unanimously recommended that New York laws prohibiting assisted suicide and euthanasia should not be changed. The report states:

Assisted suicide and euthanasia would carry us into new terrain; American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those who autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

The distinction between the refusal of medical treatment and assisted suicide or euthanasia has not been well-articulated in the broader public debate. In fact, the often-


used rubric of the “right to die” obscures the distinction. The media’s coverage of individual cases as a way of presenting the issues to the public also blurs the difference between a private act and a public policy; between what individuals might find desirable or feasible in a particular case and what would actually occur in doctor’s offices, clinics, and hospitals, if assisted suicide and euthanasia became a standard part of medical practice. Public opinion polls, focusing on whether individuals think they might want these options for themselves one day, also offer little insight about what it would mean for society to make assisted suicide or direct killing practices sanctioned and regulated by the state or supervised by the medical profession itself.36

In the Executive Summary of this report there is much discussion of the clinical background. It is not unusual that a terminally ill patient or a patient facing severe pain or disability would suffer from depression and would consider suicide. It is the Task Force’s finding that when these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide. The Executive Summary ends with this statement: “When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient’s suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern about burdening family or others, hopelessness, loss of self-esteem, or fear of abandonment.”37

Dr. Patrick Dunn, Chair of the Task Force on Caring for the Terminally Ill, in Portland, Oregon, offers this: “.....if a patient asks for a life-ending prescription, it’s important to know whether he’s depressed, feeling isolated, suffering pain that treatment could help, experiencing a spiritual crisis a clergyman could address, feeling financial pressures, or fearing


37 Ibid.
loss of control. To effectively treat patients and allay their concerns, we must probe the meaning behind their requests.\textsuperscript{38}

Portland Psychiatrist, N. Gregory Hamilton, would like to see more data collected about patients who legally kill themselves such as gender, ethnic background, financial situation, health insurance status, or hospice utilization. His concern is that without this information we cannot know if a disproportionate number of poor minorities without health insurance are being assisted in suicide.\textsuperscript{39} The Annual Report on Oregon’s Death with Dignity Act prepared by the Oregon Department of Human Services currently captures this information. As the Washington State Initiative 1000 was just passed there are not yet any reports to determine how much of this information will be captured in their reports although the new law does require annual reporting by the Washington Department of Health that will be available to the public.

One segment of the population of concern is our elderly. Kay Redfield Jamison has written about a subject she knows all too well, suicide, having attempted it herself many years ago. In her book, Night Falls Fast – Understanding Suicide, she tells us that suicide rates in the elderly are alarmingly high and that “rational suicide and physician-assisted suicide, especially within the context of disabling or life threatening illness is less relevant to those who are younger”. Study after study has shown that the elderly are inadequately treated for depression. “In its severe forms, depression paralyzes all of the otherwise vital forces that make us human, leaving instead a bleak, despairing, desperate, and deadened state. It is a barren, fatiguing and

\textsuperscript{38} David Azevedo, 1998, Suicide is Legal, Now What?, Medical Economics Magazine (May 11, 1998).

\textsuperscript{39} Ibid.
agitated condition; one without hope or capacity...Life is bloodless, pulseless, and yet present enough to allow a suffocating horror and pain. Thought, which is as pervasively affected by depression as mood, is morbid, confused, and stuporous. It is also vacillating, ruminative, indecisive, and self-castigating....The horror of profound depression and the hopelessness that usually accompanies it, are hard to imagine for those who have not experienced them.\textsuperscript{40}

In 2005 the President’s Council on Bioethics generated the report, “Taking Care – Ethical Caregiving in Our Aging Society”. Report data indicate that between 2000 and 2050 the population of Americans age 45 to 64 is expected to grow modestly from 61 to 85 million while the population 65 and over is expected to grow from 34 million to 70 million with the cohort 85 and above more than quadrupling from 4 million to 18 million. This increased population of elderly is due to improvements in public health and preventive medicine and modern medicine’s success against many causes of premature death. While this society-wide increase in personal longevity is a remarkable human achievement it also creates new challenges. With the marvels of modern technology can also come the burdens of treatments that may range from minor to physical discomfort and pain, loss of mobility, and invasive treatments that can be short or long term. Sometimes the burden is more psychic than somatic. There is misery in being stuck long term in a hospital bed, removed from everyday life and unable to do the things one loves. Those with dementia may lose all understanding of the medical interventions performed and not understand that the caregivers are intervening for them and not against them. The goal of the report is to stress ethical caregiving for our aging society. Euthanasia and physician-assisted suicide are strongly opposed. The report instead

\textsuperscript{40} Kay Redfield Jamison, \textit{Night Falls Fast: Understanding Suicide}, (New York: Alfred A. Knopf, 1999), 21, and 104-105.
presents what it calls moral boundaries as rules to guide prudent caregivers in action and
grounds for foregoing life-sustaining care. The rules are as follows:

- No active killing or assisted killing of another, no matter how painful or
diminished a life has become
- No aiming at death as a purpose of action, whether by acts of commission or
omission
- No imposing excessively burdensome treatments on others
- No obligation to do what we cannot do in the role of caregiver, but the
obligation to see how much we can do without destroying or deforming
everything else in our lives

The grounds for forgoing life-sustaining care are:

- When the treatment itself is excessively burdensome for the patient
- When the treatment is useless
- When a better death is possible in circumstances where death is proximate (for
example by allowing an irretrievably dying patient to remain at home in the
company of family rather than go to the hospital)\textsuperscript{41}

\textsuperscript{41} The President’s Council on Bioethics. \textit{Taking Care: Ethical Caregiving in Our Aging
CHAPTER 3

COMPELLING ARGUMENTS FOR AND AGAINST EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

There are several compelling arguments for assisting in the death of a patient whether by euthanasia as practiced in the Netherlands or physician-assisted suicide which is the current practice in the States of Oregon and Washington. These arguments center around self-determination also recognized as patient autonomy – freedom to make your own decisions; mercy – the relief of pain and suffering; and nonabandonment – commitment to the patient.

The argument of self-determination is the argument for freedom and the protection of an individual’s liberty in being able to make important decisions about their lives for themselves according to their own values or conceptions of a good life and in being left free to act on those decisions. Dan W. Brock, Professor of Philosophy and Director of the Center for Biomedical Ethics in the School of Medicine at Brown University explains that “self-determination is valuable because it permits people to form and to live in accordance with their own conception of a good life, at least within the bounds of justice and consistent with not preventing others from doing so as well. In exercising self-determination people exercise significant control over their lives and thereby take responsibility for their lives and for the kinds of persons they become.”

We would all agree that there is a desire to retain dignity and control to the extent possible during the last period of life. Therefore, Brock continues “if

self-determination is a fundamental value, then the great variability among people on this question makes it especially important that individuals control to the extent possible the manner, circumstances, and timing of their dying and death."²

The argument for mercy needs little explanation. The dying process can often be cruel and can lead to devastating pain and loss of bodily functions and mental capacities. Who wouldn’t want relief from this kind of pain and suffering? The argument for mercy therefore is often the most compelling argument for euthanasia or physician-assisted suicide and is looked upon as a good consequence for patients whose lives, while they are dying, are filled with severe and unrelievable pain or suffering. Brock argues, “When there is a life-sustaining treatment which, if forgone, will lead relatively quickly to death, then doing so can bring an end to these patients’ suffering without the recourse to assisted suicide or euthanasia. For patients with no life-sustaining treatment that can be withheld or withdrawn, however, assisted suicide or euthanasia may be the only release from their otherwise prolonged suffering and agony.”³ Is it not more humane to end life quickly and peacefully which may be accomplished with euthanasia or physician-assisted suicide than to let the patient linger in such unrelievable pain, especially if this is what the patient wants? Many physicians in the United States would agree that pain is sometimes not adequately managed at the final stages of life when disease has taken control of the patient’s body. Some physicians express discomfort with prescribing large amounts of narcotics for fear of hastening the patient’s death and lack of a publicly accessible means for assessing the amount of the patient’s pain therefore causing many patients

² Dan W. Brock, Life and Death: Philosophical Essays in Biomedical Ethics (New York: Cambridge University Press, 1993), 206.

³ Ibid., 215.
to suffer pain that could but is not relieved. Providing adequate measures of pain relief should be a high priority and has long been one of the central goals of medicine.

The argument for mercy goes beyond the physical suffering and extends to those experiencing great and unrelievable psychological suffering as well. Suffering is not exclusive to the patient. Families and friends suffer as well. There is the emotional anguish at watching the suffering of the loved one often compounded with financial burdens and a feeling of helplessness in not being able to rectify the situation. There is also the hopelessness that comes with the realization that the outcome will be death. One only has to look at the Netherlands Postma case in which Ms. Postma agonized over the decision to give her mother the lethal injection. From all accounts Ms. Postma and her sister had pleaded with their mother to try new therapies and to work with the clinicians at her nursing home to adapt.⁴ Likewise the Terri Schiavo case in the United States illustrates the emotional turmoil of Terri’s husband Michael and her parents which drove a wedge into their relationship and left them in disagreement over Terri’s course of treatment. Michael Schiavo was faced with mounting debt as the insurance claims for Terri’s care were denied. His and Terri’s family’s lives were in turmoil for fifteen years as Terri’s case was fought in the court rooms and publicized by the news media.⁵

The third argument in favor of euthanasia and physician-assisted suicide, nonabandonment, follows from the first two. Nonabandonment suggests a relationship with an


open-ended commitment over time. Neither party knows where this commitment will take them over time. This argument should be a norm for physicians and health care professionals with the ethical requirement that physicians try to respond to autonomous requests from their patients, especially when the requests concern extreme suffering in those who are already dying. Timothy Quill and Margaret Battin summarize how the arguments of autonomy, mercy and nonabandonment work in the best interest of the patient with the following:

Patient autonomy is clearly a central point in considerations of assisted death, since it is the patient’s life and death that are at stake in those decisions. However, assistance in dying, if it is to involve physicians, cannot be solely a matter of patient choice; it must also be a response to medical distress, to actual or imminent suffering. The nature of the patient’s suffering and why it is intolerable to the patient must be understood by the physician, who must then try to respond as a matter of mercy and in fulfillment of his commitment not to abandon the patient. Thus autonomy, mercy, and nonabandonment go hand in hand: for the physician to participate in assistance in dying, it must both be the patient’s choice and help the patient avoid suffering that is intolerable or about to become so.

Many of us have heard the argument for death with dignity which euthanasia and physician-assisted suicide offer. It is important to us how we die because it is important to us how we will be remembered by others. The possibility of a predictable escape from suffering if it becomes overwhelming is important to many patients, especially those who have witnessed bad deaths in loved ones toward whom the medical profession was unable or unwilling to be responsive. Quill and Battin further argue that this fear is probably the driving force behind the desire for legalization of physician-assisted suicide. The physician should communicate to a patient early on in a patient’s terminal illness that the physician is not afraid of the dying

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7 Ibid., 8.
process and should use this conversation as a means of educating the patient of available options such as palliative care in addressing pain. "Patients who know that their doctor is a committed medical partner and that acceptable medical options are available to address their fears and concerns, will then have the freedom to spend their time and energy on other more vital matters as they are dying. Those without this knowledge and commitment are left to wonder fearfully how their final weeks and months might unfold."8

Brock states that there are three reasons for restricting the performance of assisted suicide or euthanasia to physicians only. The first reason is that physicians would inevitably be involved in some of the procedural safeguards necessary to a defensible practice of assisted suicide or euthanasia, such as ensuring that the patient is well informed about his or her condition, prognosis, and possible treatments and ensuring that all reasonable means have been taken to improve the quality of the patient’s life. The next reason is that physicians have access to and knowledge about (or can gain that knowledge with training) the necessary means and methods for carrying out assisted suicide or euthanasia effectively and can be instrumental in avoiding failed attempts by the patient to take his or her own life that only worsen the patient’s condition. The final reason given by Brock is that by limiting who is given authority to perform legalized assisted suicide or euthanasia so that those persons can be held accountable for their exercise of that authority we have put into place one necessary protection

against any abuse.\textsuperscript{9}

The Netherlands with its thirty years of experience with euthanasia is presented by proponents as a case in point for the legalization of physician-assisted suicide in the United States. The due care criteria of the Netherlands Euthanasia Act require that the physician must:

- be satisfied that the patient’s request is voluntary and well considered
- be satisfied that the patient’s suffering is unbearable and that there is no prospect of improvement
- have informed the patient of his or her situation and further prognosis
- have come to the conclusion, together with the patient, that there is no other reasonable alternative
- have consulted at least one other independent physician, who must have seen the patient and stated in writing that the attending physician has fulfilled the criteria listed in the previous four points
- have exercised due medical care and attention in terminating the patient’s life or assisting in the patient’s suicide

In addition there is an article stating that a written request for euthanasia drawn up by the patient in advance may be effective should the patient no longer be able to express his or her will when the time comes.\textsuperscript{10}

Central to the arguments for euthanasia in the Netherlands is the argument for patient autonomy. The right to die is the central justification for the legalization of euthanasia. It is argued that no one is in a better position than the patient of knowing when pain has become unbearable. Dr. Guy A.M. Widdershoven, Professor of Health Care Ethics at Maastricht

\textsuperscript{9} Dan W. Brock, "Voluntary Active Euthanasia," \textit{Hastings Center Report}, (March/April 1992): 11-12, 14-17, 19-21.

University and president of the European Association of the Centres for Medical Ethics in a discussion on patient autonomy and Dutch euthanasia practice writes, “Whereas the physician should corroborate that the patient’s suffering cannot be treated, and that the situation is without prospect of improvement, only the patient can determine whether it can no longer be endured. Prominent ethicists in the euthanasia debate have supported this line of augmentation.”

The Dutch however have a specific view of patient autonomy. As Widdershoven explains, in Dutch health care practice, patient autonomy is not primarily seen as the right to decide for oneself without external influences. “This notion of autonomy, which can also be described in terms of negative freedom, does play a role in health law in the Netherlands, which emphasizes protection of the patient against medical infringements. Yet, in medical practice a different notion of autonomy is to be found. The Dutch expect patients to act in a responsible way. In the euthanasia debate, the prevailing notion of autonomy is ‘responsible autonomy’. Thus, elements of positive freedom are crucial to the debate. The focus is not on freedom to make one’s own decisions, but on deciding in a way which shows consideration of others.” Patients are to take into consideration the consequences of their requests. With the freedom of choice for death vs. life comes responsibility and the expectation that the patient has given consideration to all other health care options before choosing euthanasia.

Euthanasia however requires the active participation of the physician. In the

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12 Ibid., 87-88.
Netherlands the central value of beneficence along with a paternalistic stance of the physician clearly plays a role in the decision for euthanasia. Primary to the decision is what the physician considers to be good for the patient. The physician’s view of the situation is crucial and is regarded as the more important one if there is a conflict between the views of the physician and the patient. The physician has to be convinced that euthanasia is the only alternative left. Euthanasia is acceptable only if the physician is convinced that suffering cannot be allowed to continue.

The “due care criteria” of the Netherlands Euthanasia Act requires that at least one other independent physician must see the patient requesting euthanasia, verify the patient’s prognosis, and that the other points of the due care criteria have been met in deciding whether euthanasia is justified. Therefore this role of consulting physician is a significant one in the euthanasia process which goes beyond mere professional advice based on knowledge of the disease.

There must also be an element of trust at play within the values of autonomy of the patient and beneficence of the physician. We can draw from this the argument of nonabandonment. Mutual dialogue is a requirement and is expressed as one of the due care criteria of the Netherlands Euthanasia Act in which it is stated that the “physician must have come to the conclusion, together with the patient, that there is no other reasonable alternative.”13 The expectation is that the physician will be there to help and support the patient and can be relied upon to be there for the patient in hard times. Widdershoven makes the observation that with the issue of euthanasia, trust not only means that one can be sure that

the physician will not misuse his power. First and foremost it means that one can be sure one
will not be left alone in a hopeless situation. "Concerning end-of-life issues, fear of
abandonment is more pervasive in the Netherlands than the fear of unwanted interventions by
the physician. Patients express the need to be cared for, and not to be left alone to die."14

Understanding the Dutch people provides insight as to why there is such a dependence
on the physician by the patient. The Dutch historian, Han van der Horst, tells us that there is
no public display of grief. Instead the Dutch people keep a stiff upper lip and show that they
are in complete control of themselves. Van de Horst suggests that feelings may be expressed
in a controlled environment, for example to someone in a professional capacity.15 The
physician is someone that the patient knows and trusts. The strength of this relationship
between physician and patient lies in the physician’s ability to alleviate suffering.

While euthanasia may be the end result of a carefully thought out medical process, the
Dutch medical profession insists that euthanasia must be the last resort. A request for
euthanasia is seen as a cry for help to relieve pain and suffering, the fear of being a burden to
family and loved ones, the fear of dying alone, and the fear of dying an undignified death.
These factors need to be considered in any request for euthanasia. It is only when suffering
can no longer be relieved that euthanasia should be considered an option.

There are two characteristics of the Dutch health care system that lend support to
euthanasia as a valid medical procedure. The Dutch health care system is accessible to all and

14 Guy A.M. Widdershoven, “Beyond Autonomy and Beneficence - The Moral Basis of
Euthanasia in the Netherlands” in Euthanasia and Palliative Care in the Low Countries, ed. Paul

15 Han van der Horst, The Low Sky: Understanding the Dutch, (The Hague: Nuffic, 1996), 237-
238.
guarantees full insurance coverage for end-of-life and palliative care. This insurance is
mandatory for all except those with incomes over a stipulated high level. A safe assumption
would be that patients will be under no financial pressure to end their lives. Second, the
Netherlands now has a good level of palliative care. In the past, the Netherlands was often
criticized for its presumed lack of palliative care. In the beginning of the euthanasia debate
palliative care was often ignored. In more recent years, however, much effort has been made
to improve palliative care, partly in response to the international critique.¹⁶

As stated above, euthanasia should be a last resort. The physician should always look
for reasonable alternatives. The consulting physician (second physician in the euthanasia
process) must confirm that options for palliative care have been explored. Even the best
palliative care, however, may not prevent a patient from deciding that his pain is unrelieveable,
his suffering has gone on too long, and his dignity is slipping away. For these patients
euthanasia needs to be an available option.

There are also compelling arguments against the practice of euthanasia and physician-
assisted suicide. When evaluating the autonomy argument the question becomes just how
autonomous is the request for euthanasia or physician-assisted suicide. Requests are likely to
come from patients experiencing severe emotional distress as well as severe pain whose
judgment may be clouded by the side-effects of medical treatment. Even if a patient has full
mental capacity just how informed is he of his diagnosis and prognosis or alternatives such as

¹⁶ Johannes J.M. van Delden, M.D., Ph.D., Jaap J. F. Visser, L.L.M., and Els Borst-Eilers,
M.D., Ph.D. “Thirty Years’ Experience with Euthanasia in the Netherlands, Focusing on the Patient as a
Person” in Physician-Assisted Dying: The Case for Palliative Care and Patient Choice, ed. Timothy E.
Quill, M.D. and Margaret P. Battin, Ph.D., (Baltimore: The Johns Hopkins University Press, 2004),
213-214.
palliative care? Clinical depression and inadequate pain relief are significant factors in the requests for euthanasia or physician-assisted suicide. Opponents of euthanasia and physician-assisted suicide believe that if the patients’ mental health and physical pain are adequately attended to the requests for euthanasia and physician-assisted suicide would not be necessary.\textsuperscript{17}

Autonomy is an argument to the freedom to make one’s own decisions. This argument is based on the patient being able to freely choose his course of treatment or non-treatment, including the choice to end life. The idea being that the power to choose death vs. life has been bestowed upon the patient and it is his right to choose death. However, it is the physician who has the power to grant or deny euthanasia or physician-assisted suicide as a medical treatment. Therefore the physician still maintains the decision-making power over the patient’s autonomous request. The process of euthanasia or physician-assisted suicide is not truly autonomous because it involves the interpersonal dynamics of the doctor/patient relationship.

While as a society we should be concerned about the rights of the individual we must also be concerned about the rights of the community and the protection of those rights. We need protection of our relationships with others and of ourselves in order to develop fully as individuals. As Margaret Somerville warns “it could well be that the greatest danger of overusing euthanasia in the future, were it introduced, would come from an overemphasis of communal claims, (for example, cost saving in health care) at the expense of individual rights.

Such an outcome would be ironic if the introduction of euthanasia were seen as necessary, as often claimed by advocates, to respect and promote individual rights.”

A physician is traditionally looked upon as someone whose duty it is to promote and restore health. Therefore the acts of euthanasia and physician-assisted suicide are inconsistent with the physician’s role as healer. One cannot have a conversation about physician-assisted suicide without also discussing the Hippocratic Oath and its purpose. What do the words, “do no harm” and “I will keep them from harm and injustice” and “Into whatever houses I may enter, I will come for the benefit of the sick”, mean? Is the paragraph “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect…In purity and holiness I will guard my life and my art”, in contradiction with the act of physician-assisted suicide and euthanasia? Leon Kass, a physician and previous chairman of the President’s Council on Bioethics, argues that euthanasia and physician-assisted suicide go against the moral foundations of medical practice. Kass further describes the activity of healing the sick as requiring certain virtues such as moderation and self-restraint, gravity, patience, sympathy, discretion, and prudence. He also discerns positive duties of the physician addressed to the patient’s vulnerability and self-concern and including the demands for truthfulness, patient instruction, and encouragement and argues for the importance of negative duties, formidable as absolute and unexceptional rules. The most important of these rules, “Doctors must not kill.”


The ethical role of physicians is to help patients heal, not to hasten their deaths. There is a real concern among physicians that merely by making physician-assisted suicide and euthanasia available options some patients will be caught up in the process that truly don’t want to end their lives but feel as though they have an obligation to do so. These patients are not really tired of living but feel that others are tired of them. Is this then a truly autonomous request when made by a patient in this depressed state of mind? Can we be certain whether or not the patient truly wants to die or is simply bowing to the felt desires of family or others?

Kass also makes an argument to the slippery slope effect of allowing physician-assisted suicide and euthanasia. Patients with diminished capacity, ambivalent about life, or depressed will be in danger of having decisions about their deaths made for them, perhaps by someone who may benefit from their death. “Once this practice gains acceptance who will be around to notice when those who are elderly, poor, disabled, weak, powerless, retarded, depressed, uneducated, demented, or gullible, are mercifully released from the lives their doctors and next of kin deem no longer worth living?”

James K. Boehnlein, Associate Professor of Psychiatry and Assistant Dean for Curriculum at Oregon Health Science University adds that “the use of the prescription pad or lethal injection to hasten death in terminally ill patients is an inappropriate use of medical knowledge and technology, reducing the moral stature of the medical profession in both

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symbolic and realistic ways. It diminishes the responsibility of the physician and the medical profession to assist the patient in the process of dying.”

Unlike the Netherlands, the United States does not have a system of universal health care. There are implications for cost control in our era of managed care where there are increasing incentives for doctors and health care organizations to limit the amount of medical care that is delivered. Since comprehensive care for dying patients is not universally available in the United States, patients and their families can face painful decisions about whether or not one week or one month more of expensive medical care is truly worthwhile or whether that money is best spent on the surviving younger generations of the family.

Sissela Bok, formerly a Professor of Philosophy at Brandeis University and currently a Senior Visiting Fellow at the Harvard Center for Population and Development Studies, has written extensively on the subject of euthanasia and physician-assisted suicide and argues that we take “great and needless risks in moving toward legalizing euthanasia or physician-assisted suicide” and “that such measures will not deal in any way adequately with the needs of most persons at the end of life, least of all in societies without adequate health care insurance available to all.” The act of killing would not necessarily be truly merciful for the patient making a request for euthanasia or physician-assisted suicide. As Bok points out “some might die as a result of an error in the prognosis for their disease; others might die just before a new treatment for their disease would have allowed them to recover as when penicillin first came

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into use. Others might die who did not really wish to die, given the difficulties of knowing whether the request is genuine, and even if genuine, is in the best interest of the patient."

Wesley J. Smith, Attorney for the International Anti-Euthanasia Task Force, cites the story of Kate Cheney from the October 17, 1999 Oregonian as a case in point against physician-assisted suicide:

Kate Cheney age 85 had terminal cancer and may have had dementia. Kate’s daughter was unhappy with a psychiatrist’s evaluation of Kate so she asked for and received from Kaiser Permanente a second opinion. This time Kate saw a clinical psychologist vs. an MD psychiatrist. The clinical psychologist also recognized Kate’s memory problems but determined she was competent to kill herself and approved the writing of a lethal prescription. An ethicist/administrator for Kaiser also gave the ok. It appears that Kate was worried about not being able to attend to her personal hygiene. The family needing a rest from taking care of Kate placed her in a nursing home for a week. This pushed Kate into wanting immediate death so as soon as she returned home and the family was gathered she took the poison and died. In Kate Cheney’s case the poison that killed her cost Kaiser $40. It would have cost the HMO $40,000 to care for her properly until her natural death. Oregon Medicaid which rations health care to the poor, pays for assisted suicide.24

George Lundberg, M.D., former editor of the Journal of the American Medical Association, believes that physicians are against physician-assisted suicide because the dynamics of health care have changed. Physicians are out of sync with patients because they don’t know them as well as they did years ago. Dr. Lundberg is a proponent of hospice and the withholding of treatment. “Physician-assisted suicide need not be done intravenously or

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intramuscularly or by prescription for pills. It can be accomplished simply by the agreement of everyone involved to withhold fluids and then wait.\textsuperscript{25}

In 1995 a study was conducted among five major medical centers in the United States that looked at the discrepancy between how patients at the end of life ought to be treated and how too many were in fact being treated. The results were disturbing and showed that only 41\% of patients in the study discussed with their physicians their prognosis or how the patient felt about CPR. Physicians misunderstood their patients’ preferences regarding CPR in 80\% of the cases. Physicians also failed to implement patients’ refusals of intervention such as do not resuscitate in about 50\% of the cases. Even when specially trained nurses worked to improve the patient-physician communication in areas of pain control, advance care planning and other patient needs, the intervention failed to make a dent in serious deficiencies in patient care.\textsuperscript{26} The authors of the study further concluded that the picture they gave of the care of the dying was not pretty and that they would prefer “to envision that when confronted with life threatening illness, the patient and family would be included in discussions. Realistic estimates of outcome would be valued, pain would be treated, and the dying would not be prolonged. That is still a worthy vision.”\textsuperscript{27}


\textsuperscript{26} SUPPORT principal investigators, “A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT)”, \textit{Journal of the American Medical Association}, vol. 274, no. 20 (November 22/29, 1995) : 1591-1635.

\textsuperscript{27} Ibid., 1597.
CHAPTER 4

WHY EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE SHOULD NOT BE VALID HEALTH CARE OPTIONS IN THE UNITED STATES

As patients and consumers of health care we have many legal rights guaranteed to us under the Omnibus Reconciliation Act of 1990. These rights include the right to see and copy our medical records, the right to obtain copies of tests, the right to expect the privacy and confidentiality of our medical records, the right to seek second opinions, the right to register complaints, the right to full disclosure if being asked to participate in clinical trials or research studies, the right to refuse medical treatment at any time, and the right to be informed about and consent to any treatment.¹ Euthanasia and physician-assisted suicide are not among these rights and are not yet considered valid health care options in 48 of our 50 states. Oregon and the state of Washington have both legalized physician-assisted suicide and residents of these states may choose physician-assisted suicide if they meet the requirements of the law and have fulfilled the necessary steps for the request as mandated by the law.

There are many reasons why the other 48 states in our union should not follow in the footsteps of Oregon and Washington. The fact that the United States does not have a system for universal health care should weigh heavily against the legalization of euthanasia and/or physician-assisted suicide. Our current President, Barack Obama, has made the availability of health care coverage for all a priority during his administration and the issue is currently in

debate among our lawmakers in Washington, D.C. The truth, however, is that it hasn’t happened yet and no one knows what this health care solution will look like if and when it does happen. One does know that being uninsured certainly limits one’s access to quality health care services and potentially leaves the uninsured in a position of helplessness when cost is figured into the decision making process regarding life and death. Most doctors refuse to accept patients without health insurance and private hospitals will only accept patients in life threatening emergency situations because the law requires that they do so. Certainly a universal health care system will help to level the playing field but only to the extent cost of care is not allowed to prevail in decisions regarding treatment options and leaves room for long term care. Otherwise the uninsured may be no better off than they are right now when it comes to long term care options for terminal illness.

Currently health care is linked with one’s ability to pay for it. Those with good financial resources will often receive better health care and have more options available to them than those with lesser resources. Even with health insurance there is no guarantee that the best resources will be made available. We have all heard of insurance claims being denied and have dealt with the rising costs of coverage. Health care is a business and just like all other businesses strives to operate at a profit. Cost of care was one of the factors in the Terri Schiavo case. Michael Schiavo was faced with mounting debt as insurance claims were denied.\textsuperscript{2} To be sure euthanasia will cost less than many medical procedures or long term care as the case of Kate Cheney illustrates. The prescription that ended Kate’s life cost her HMO a

\textsuperscript{2} David C. Gibbs, \textit{Fighting for Dear Life: The Untold Story of Terri Schiavo and What it Means for All of Us}, (Minneapolis: Bethany House, 2006), 56-58, 177-180.
mere $40 in comparison to the $40,000 it would have cost to care for her until her natural
dead.³

Dr. Brendan Sweetman, Professor of Philosophy at Rockhurst University, uses the
practical argument against euthanasia. According to the practical argument euthanasia leads
to human misery because of the abuses it will likely bring with it. One of the abuses is the
subtle pressure the elderly ill may face from family, friends, and medical staff or they may feel
cultural peer pressure. Their decision for euthanasia may look like it was freely arrived at but
they may opt for euthanasia because they do not want to be a burden on their families.
Sweetman is also concerned about unscrupulous doctors adding to the pressure on the elderly
patient.⁴

Sweetman expresses concerns that the legalization of euthanasia and physician-
assisted suicide may lead to changes in the ethics of the medical profession and would
challenge the current practice of physicians as reflected in the Hippocratic Oath. If euthanasia
were legalized a doctor’s level of concern for the health and welfare of the patient would be
limited up to the point where euthanasia becomes a serious option which soon becomes the
sensible argument.⁵ When a patient begins to think that a doctor is not doing everything he can
to help him the trust between the patient and the doctor begins to erode. If euthanasia or

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⁵ Ibid., 184.
physician-assisted suicide become widely established a serious breakdown in trust could develop for the medical profession.

The ethical role of physicians is to help their patients heal, not to hasten their deaths. Therefore, the actual practice of euthanasia or physician assisted suicide may place a moral burden on the shoulders of the physician that he is not trained to cope with. There has been little research into what the psychological effects might be on the physician who complies with the request for euthanasia or physician-assisted suicide. Stephen Potts in his article for the Houston Law Review makes the observation that “euthanasia advocates seem very confident that doctors can be relied on to make the enormous efforts sometimes necessary to save some lives, while at the same time assenting to requests to take other lives… but it is a confidence seriously undermined by the shocking rates of depression, suicide, alcoholism, drug addiction, and marital discord consistently recorded among this group.”

In May 2008 a documentary entitled “Struggling in Silence: Physician Depression and Suicide” produced in part by the American Foundation for Suicide Prevention reported that every year approximately 300 - 400 doctors take their own lives and that more physicians commit suicide than do members of any other profession. Dr. Charles Reynolds, professor of psychiatry at the University of Pittsburgh School of Medicine, who appears in the film and co-authored a 2003 paper on physician suicide that was published in the Journal of the American

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Medical Association reports that undiagnosed and untreated depression is the root of the problem. Substance abuse is also listed as a contributing factor.\(^7\)

In a study supported by a grant from the Dutch Ministry of Justice and Health, Welfare and Sports from November 1995 through February 1996 on the emotional impact on physicians in the Netherlands from hastening the death of a patient, Paul J. van der Maas and his colleagues interviewed a random sample of 405 physicians and found that 42% of the physicians reported feelings of discomfort in cases of hastening death (euthanasia, assisted suicide, alleviation of pain or other symptoms with high doses of opioids, and life ending without an explicit request from the patient), most frequently referred to as emotional (28%) or burdensome (25%). Feelings of discomfort were highest for euthanasia (75%). The study also showed that of the 110 physicians who had performed euthanasia previously, 45% reported that their most recent cases of euthanasia were just as difficult. While the survey showed that a vast majority of physicians would be willing to continue to perform euthanasia or assisted suicide, 5% had doubts about performing euthanasia. These doubts concern the consideration of treatment alternatives, the amount of time and latitude involved in the decision-making, and possible pressure by others on the patient to be euthanized. The report was released on April 23, 2001 as euthanasia was being legalized in the Netherlands.\(^8\)

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The acceptance of a euthanasia culture could bring with it a very negative effect. Euthanasia could lead to an erosion of our respect for human life or as Potts warns a "further erosion of our attachment to the sixth commandment. ["Thou shalt not kill"][9]. What value will we place on human life when we determine it is acceptable to end life because the quality of one’s life is not sufficient to make life worth living? “What will we say to the terrorist who justifies killing as a means to his political end when we ourselves justify killing as a means to a humanitarian end?”[10]

From the earliest of times we have been taught that suicide is wrong and it is a sin against God. Therefore assisted suicide, euthanasia, and physician-assisted suicide are wrong because they involve the taking of a human life which is not ours to take. The Catechism of the Roman Catholic Church states, “Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of Life. We are obliged to accept life gratefully and preserve it for His honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.”[11]

Bishop James McHugh in his message, Death and Dying Issues, reminds us that:

Human life is our most precious gift, and in many ways our most fragile possession. The sanctity of human life and the dignity of the human person then are fundamental principles in dealing with contemporary moral problems. These principles have a history in the scriptures and in the life experiences of the early Christian church, but they are especially important today when the “justifications” for certain violations of

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10 Ibid.

human life and human dignity are based on the greatest good for the greatest number or
the assumption that in certain difficult situations, a specific evil becomes permissible.
These principles are especially important in building a societal respect for human life at
every stage of its existence from conception onwards.\footnote{12}

The Catholic tradition is not the only faith to speak out against euthanasia and
physician-assisted suicide. On May 7, 1998, religious leaders who served eight faith
communities in southwestern Michigan gathered at Congregation Shaarey Zedek in Southfield,
Michigan to take the unprecedented step of signing an interfaith letter against physician-
assisted suicide. The signatories are members of the Religious Leaders Forum, a group of
Christian, Jewish, and Muslim leaders who participate in interfaith dialogue and speak out on
issues of joint concern. The content of the letter is as follows:

Mindful of our leadership positions in the Christian, Jewish, and Muslim faith
communities that we serve in southwestern Michigan and aware of the physician-assisted
suicide phenomenon which occupies the attention of our community, we take this
unprecedented step in issuing a joint statement against suicide.

- We believe that life is a gift from the divine Creator, temporarily entrusted
to us as faithful guardian of this sacred trust.

- Our shared traditions speak against the use of physician-assisted suicide as
an acceptable means of confronting end-of-life decision making.

- Those who promote this last, fatal escape as a “right” should remember
that such a “right” may quickly become an expectation and, finally, even a
“duty” to die. We fear eventually some individuals and families will be
forced to put financial concerns above the needs of loved ones.

- Because we value the dignity of each person, we call upon our
communities to extend their compassion and care to the chronically ill and
the dying. While this care includes relief from suffering through medical
solutions, it also involves any psychological and spiritual support needed
by the suffering. This care is also to be extended to the families and
caregivers of the dying.

• We believe the dignity of the human person is of an inestimable value in our faith traditions. These values are at the heart of the current discussion on the self-determination of the time and place of one’s death. Knowing that people of good will disagree on serious matters, we call upon all parties to conduct the communal dialogue with respect and to refrain from personal attacks and ridicule.

We call for calm reflection and prayer, within the disciplines of our faith traditions, to come to the knowledge of what is required as stewards, not owners, of human life.\(^{13}\)

You do not have to be a person of faith to understand the serious consequences to the human spirit by hastening death. Margaret Sommerville refers to the human spirit as the “intangible, immeasurable, numinous reality that all of us need access to in order to find meaning in life and make life worth living; that deeply intuitive sense of relatedness or connectedness to all life, especially other people, to the world and to the universe in which we live. The human spirit is the means through which we generate the feeling of belonging to something larger than ourselves. Hope is the oxygen of the human spirit and without it our spirit dies.”\(^{14}\) Even the terminally ill can have hope, mini-hopes as Sommerville describes them, to stay alive long enough for a child’s wedding, to see a grandchild born, to visit with an old friend, or to see the sun rise again. Euthanasia removes hope from the horizon and takes away from us the gifts that the terminally ill and elderly offer through the essence of their being.\(^{15}\)


\(^{15}\) Ibid.
Death with dignity does not need to involve the acts of euthanasia or physician-assisted suicide. Instead Rabbi Daniel A. Roberts tells us that “the concept of death with dignity must be conceived differently: as allowing our beloved to die with the knowledge that we will be with them, that we will minimize their pain, that we will not take heroic measures to extend their life beyond their allotted time, nor will we do anything to shorten it as long as there is hope.”  

Another concern should euthanasia be legalized is the impact it may have on medical research. Medical research continues to find new treatments and cures for diseases once thought terminal. As Bok pointed out there will be some that opt for euthanasia just before a new treatment for their disease becomes available that could have saved them. A long term effect of the acceptance of euthanasia is the loss of possible continued research into many diseases that carry with them a terminal diagnosis. On the monetary scale if it is cheaper to opt for euthanasia, why spend millions on medical research and drug therapies? Why search for improvements in end-of-life care and better methods to reduce and control pain? We can thank those who suffered through their illnesses to the end for the medical advances we have today.

Perhaps one of the strongest arguments opponents of euthanasia point to is the slippery slope argument. Proponents point to the Netherlands as a case study to prove that euthanasia can and does work and that the slippery slope has been avoided. But has it? Dr. Herbert Hendin, Professor in the Department of Psychiatry and Behavioral Sciences at New York

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Medical College, tells us that the Dutch have indeed traveled along the slippery slope. Over
the past two decades Dutch law and Dutch medicine have evolved from accepting assisted
suicide to accepting euthanasia, from accepting euthanasia for the terminally ill to accepting
euthanasia for chronically ill individuals and has now evolved from the acceptance of
euthanasia for the physically ill to euthanasia for those that are in psychological distress. The
Netherlands has also transitioned from voluntary euthanasia to the practice and conditional
acceptance of non-voluntary and involuntary euthanasia. As recent as 2004, advocates in the
Netherlands proposed allowing euthanasia to be extended to children under the age of twelve
that are terminally ill with no hope of recovery and in pain.

The first euthanasia case to reach the Dutch Supreme Court was the Schoonheim case
in 1983 in which the existing criteria for euthanasia at the time, continuous and unbearable
suffering of a physical and spiritual nature, was found to be lacking in the euthanasia of Ms.
Barendregt. Instead the euthanasia was justified on the basis of psychological suffering. Dr.
Schoonheim testified that he felt conflicted between preserving the patient's life and alleviating
her suffering and that he had acted out of a situation of necessity. He was not found to be
criminally liable.

The Chabot case was another landmark case heard by the Dutch Supreme Court in
1994. Dr. Chabot provided the patient, Ms. B., a 50 year old female who was depressed due to

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18 Herbert Hendin, 2004, The Slippery Slope: The Dutch Example, Nightingale Alliance, 26


20 Margaret Otlowski, Voluntary Euthanasia and the Common Law, (Oxford: Clarendon Press,
1997), 393.
several traumatic events that had occurred in her life, with the necessary medications to end her life just seven weeks after first meeting her in 1991. This time the Supreme Court held that for a request of assisted suicide or euthanasia to be justified on “necessity” grounds, the patient’s suffering need not be physical, the patient need not be terminally ill, and purely psychological suffering can qualify a patient for an act of euthanasia. The court decided not to impose any penalty against Dr. Chabot.\textsuperscript{21}

The test case for the newly passed euthanasia law, the \textit{Sutorius} case, was heard by the Dutch Supreme Court in December 2002. Dr. Philip Sutorius was convicted of assisting in the suicide of an 86 year old man who was “tired of living”. Dr. Sutorius helped a former Senator, Edward Brongersma, to take his life in 1988 by providing him with a lethal cocktail of drugs. Dr. Sutorius was found guilty for his assistance in Mr. Brongersma’s suicide but did not receive a jail sentence because the court felt he had acted out of compassion for his patient and because the court viewed this as a test case. However, the court did rule that being tired of living did not constitute unbearable suffering.\textsuperscript{22}

In April 1995, Dr. Henk Prins, was convicted of giving a lethal injection to a baby girl born with spina bifida. Prins said he acted at the express request of the parents. A Dutch Court found Prins guilty of murder but refused to punish him for the crime. “According to the court, Prins made a choice which – given the special circumstances of the case – can reasonably be considered as justifiable. The court further expanded the limits of the accepted euthanasia


guideline, allowing babies to be killed if the child is said to be in unbearable pain which is not being controlled and the parents repeatedly ask that the baby’s life be ended."23

There is also no way to know how many cases of non-voluntary euthanasia have occurred in the Netherlands. Even though physicians are to report all cases of euthanasia, voluntary and non-voluntary, there is no real way to capture this data. Soft data has been presented by the Remmelink Commission through their examination of death certificates and questionnaires to physicians but there is no way to provide concrete evidence from this data that the Netherlands has not traveled the slippery slope. John Griffiths states in a briefing session at the House of Lords in 2003, “One can quarrel with these data, of course, but then one is simply left with empty hands: no quantitative evidence at all one way or the other as far as the ‘slippery slope’ argument is concerned.” 24

Potts also expresses concern that once voluntary euthanasia is accepted we will evolve to the non-voluntary and then the involuntary. Following the developments of terminal care from the CURE mode to the CARE mode and then with voluntary euthanasia progression to the KILL mode and the slippery slope representing the CULL mode, his model is as follows:

CURE: The central aim of medicine
CARE: The central aim of terminal care once patients are beyond cure
KILL: The aim of the proponents of euthanasia for those patients beyond cure and not helped by care


CULL: The feared result of weakening the prohibition on euthanasia.\textsuperscript{25}

Nancy Dubler, Esq, and David Nimmons summarize the argument against euthanasia for the United States this way:

We cannot lose sight of the fact that permitting death in a society like ours raises deep ethical concerns. If we as a society acquiesce in the commonplace termination of life, we have taken a profound moral step away from the sanctity of life. It is no accident that the only place to have indulged in the social experiment of assisted euthanasia is a society like the Netherlands – a racially and economically homogeneous country, where socialized medicine gives everybody access to basic care.

But America is not the Netherlands. We are a pluralistic nation of haves and have-nots, profoundly stratified by class and color, where thirty-seven million people have no health insurance, and tens of millions more go without proper care. So long as we have no universal access to health care, so long as people have to pay for it, so long as we have a fee-for-service system, some people will refuse care for economic reasons and not as a matter of broader personal values. It may seem unnecessary to add that the people who will refuse care will probably be the poor, and the poor are disproportionately women and minorities.

In this society, allowing physicians to help people end their lives has a real danger. To permit active euthanasia under our healthcare system would be to make physicians the “executioners” or “enforcers” of our society’s inequitable distribution of resources and unfair healthcare policy. When people must confront a choice between staying alive and driving their whole family into poverty and homelessness; where, already, people routinely don’t seek care or refuse it because of economics; where we view healthcare as a privilege and not a right, and ration it depending on class and skin color; where we historically have done poorly in protecting our most vulnerable citizens: in such a nation, euthanasia becomes a particularly horrific, and inappropriate, prospect. Until we have healthcare for all, we cannot ethically or humanely seek a policy of assisted euthanasia for some.\textsuperscript{26}

Having access to universal health care does not remove the dangers of the legalization of euthanasia or physician-assisted suicide. Should we move in the direction of a single-payer


\textsuperscript{26} Nancy Dubler, Esq. and David Nimmons, Ethics on Call: A Medical Ethicist Shows How to Take Charge of Life-and-Death Choices, (New York: Harmony Books, 1992), 171-172.
national health care plan we may find that what we truly want in end-of-life care will not be made available to us because it is not deemed to be medically necessary. There may be hard choices to make on what to cover in a plan and what to leave out. It could be argued however, that our current system of health care through private insurance, for those of us who have it, already allows for the rationing of health care every time a claim is allowed to be denied by the insurance company as in the case of Terri Schiavo. Therefore any plan for universal health care whether single-payer or public will need to address end-of-life issues and the costs of care during a terminal illness to end-of-life. As the case of Kate Cheney revealed to us, the cost to end her life was certainly less than the cost of providing her care until her natural death. But not all cases of euthanasia and physician-assisted suicide are related to costs of care. The quality of life during a terminal illness is also an issue as is depression. Therefore managing pain relief should be a high priority and a central goal of medicine as should counseling for depression to not only the patient but the patient’s family as another way to offer support throughout the patient’s remaining days.

So where does this leave us? It leaves us with the ability to devote time, money, medical knowledge, continued research, and other resources into further advances in managing end-of-life care through better pain control, palliative care, and hospice. We can exercise our rights and make our wishes known with the tools we have at hand with advanced directives. The medical profession can be more diligent in the recognition of our wishes by acknowledging the advanced directive. We can expand the availability of palliative care and hospice care to make sure that the focus of care is quality of life.

The success of any palliative care model will depend upon the commitment of the medical community to integrate it into everyday practice. The Center to Advance Palliative
Care’s (CAPC) 2008 report card shows that the nation gets a grade of C for its overall access to hospital palliative care. According to the Dartmouth Institute for Health Policy and Clinical Practice, approximately ninety million Americans are living with serious and life-threatening illnesses. A serious illness is defined as one that requires daily and/or continuing treatment by a certified health care provider. This number is expected to more than double over the next 25 years due to our aging baby boomers. Those patients living with a serious illness often experience inadequately treated symptoms, fragmented care, poor communication with their physicians, and strain on the family caregiver.27

Palliative care is focused on improving quality of life for the seriously ill patients. It can effectively address the inadequacies stated above. Patients benefit from well-controlled symptoms and improved patient-physician communication. A hospital palliative care program can enhance the efficiency and effectiveness of hospital services.

Hospice is also a philosophy of care and can work effectively with palliative care. Its main purpose is to improve quality of life at its end stage. Hospice neither hastens nor postpones death. Hospice does not cure the disease but works to relieve disease related symptoms. Hospice care looks to treat the person rather than the disease. Most hospice care in the United States is given in the home but it can be provided in a hospital, a nursing home, or a hospice facility. The problem with most hospice care is that it is not started soon enough the mindset being that a recommendation for hospice means the patient, family, or health providers are giving up. Barriers to hospice care center around this “giving up” stigma and financial considerations. More resources should be made available to expand hospice services

throughout the United States, to provide training to the multidisciplinary team needed to run a successful hospice program, and to make hospice more financially accessible to our patient base.

The DC Hospice Collaboration publishes a brochure that lists responses to the question of what Americans would want if they had six months to live. Here is what they said:

- Someone to be sure my wishes are fulfilled
- Choice among the types of services I could receive
- Pain control tailored to my wishes
- Emotional support for me and my family
- An opportunity to put my life in order
- Spiritual support for me and for my family
- Hospice care provided no matter where I am living
- A team of professionals like physicians, nurses, and counselors to care for me
- The ability to be cared for and to die in my own home or a family member’s home
- Continuity with the same caregivers, no matter where I am staying

Hospice can provide the care that Americans need at the end of their lives without a loss of personal dignity. Euthanasia and/or physician-assisted suicide is not the answer.

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