Active Euthanasia and Assisted Suicide

Pat Milmoe McCarrick
March, 1992

Although the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in its 1983 report, Deciding to Forego Life-Sustaining Treatment, described the words and terms “euthanasia,” “right to die,” and “death with dignity” as slogans or code words—“empty rhetoric,” (I, U.S. p. 24), the literature reviewed for this Scope Note continues to use these terms. Therefore, to discuss the termination of a patient’s life by a physician at the patient’s request, the phrase active euthanasia is used, and the supplying of a means by a physician whereby a patient can end his or her life is referred to as assisted suicide.

Euthanasia, either as the “good death” from classical Greek or “mercy killing” to end unbearable suffering in the dying, has long been a topic of interest in western civilization (III, Brody 1989). In recent years, public awareness of this discussion about control over the time of one’s death has been informed by a series of well-publicized events. They include the November 1991 rejection by a vote of 54 percent to 46 percent of the Washington state Initiative 119, which would have allowed option of requesting one’s physician to “aid-in-dying” for adult patients in a “medically terminal condition” (V, Gross 1991); two medical journal articles describing physician’s actions in helping bring death to two patients (V, Anonymous 1988; V, Quill 1991), Dr. Jack Kevorkian’s assistance in the suicide of three women (V, Belkin 1990; V, Wilkerson 1991) and the best seller status of a how-to book on committing suicide with opiates obtained from a physician (III, Humphry 1991).

Dr. Edmund D. Pellegrino (V, 1991, p. 3118-19) presented opposing views about active voluntary euthanasia as follows:

Those who favor voluntary euthanasia argue that it is a beneficent and compassionate act; it respects autonomy by preserving the patient’s control of the manner, method, and timing of death; it takes the matter outside the reach of “medical power” (accessed in this Scope Note’s bibliography at V, Fletcher 1973; V, Nowell-Smith 1989) and scrupulosity and it prevents the injustice that allows some patients to choose death by refusal of life-support measures, while denying others the right to do so by active euthanasia....
The opponents of active euthanasia argue that it undermines the value of, and respect for, all human life (V, Kass 1989; V, Coyle 1990; V, Singer 1990). They fear that guidelines cannot avoid sliding down the “slippery slope” to involuntary euthanasia and selective devaluation of the lives of the most vulnerable among us.... If euthanasia is legal, it is predicted that patients will feel subtle pressure to conform so as to relieve the economic and emotional burdens they impose on family and friends.

Euthanasia, its opponents further argue, is socially destructive: it undermines trust in physicians, desensitizes society to killing, and imperils the ground already gained in legitimating passive euthanasia (IV, Wolf 1989).

Physicians were not particularly involved with a patient’s death until after World War II when participation grew in proportion to the growth of technology. Since the complex, life-sustaining equipment that could forestall death was located in a hospital, death itself became almost completely medicalized. (V, Dagi 1991). For terminally ill persons who would like to die a painless death, either by their own hand or with assistance, physicians have almost a monopoly on obtaining strong drugs for distribution to patients (V, Abrams 1990).

Active euthanasia for human beings is not legalized anywhere in the world (V, VonDrehle 1991). It is classified as homicide or murder in all fifty states and in Great Britain, Canada, Australia, and the Phillipines (V, Nerland 1989). Twenty-six states in the United States prohibit assisted suicide by statute (V, Rosenblum 1990).

In 1969 in the Netherlands, a physician named Jan Hendrik van den Berg, published a short book, *Medical Power and Medical Ethics*, in which he said that physicians should accept the consequences of technical power and be willing to kill their patients who were suffering, dying, or vegetative (translated and published in English in the United States, III, van den Berg 1978). A court case in Leeuwarden, the Netherlands, in 1973 first called attention to a physician performing active euthanasia. In October 1971, the physician-daughter gave an injection of morphine to her mother (a wheelchair-bound, incontinent nursing home patient), who died several minutes later; the daughter said that the mother had repeatedly and insistently requested to be killed. Charged with killing her mother, the court decision said that the charges against the physician were proven and punishable: they gave her a one-week prison sentence and ordered that it not be carried out unless she was guilty of some punishable act before the end of a one-year probationary period (III, Gomez 1991).

In the almost two decades since this case, physicians in Holland have performed active euthanasia under guidelines established by the government’s Commission on Euthanasia (I, Netherlands 1985) and those drawn up by the Royal Dutch Medical Association (II, 1986) for terminally ill patients who repeatedly request death, but they are supposed to report their actions to a public prosecutor’s office which investigates to see that all the requisite steps have been observed (V, Lilienthal 1991).

The Dutch government-appointed Remmelink Commission states that of 9,000 requests made annually to physicians to perform euthanasia, only 2,300 cases of euthanasia (1.8 percent of the 130,000 annual deaths) and 400 cases of assisted suicide occur each year. This commission’s study indicates that the following life-terminating actions are taken without explicit request (the first three are described as normal medical actions) and that these actions are usually inevitable: intensification of pain and symptoms treatment with a minor shortening of the patient’s life as a side-effect, discontinuing or not beginning a life-prolonging treatment, the active termination of life at a moment when vital functions already have begun to fail, and the active termination of life at a moment when the vital functions are still undamaged. The lack of a request for euthanasia...
makes the decision process more difficult; the justification in both cases is unbearable suffering and necessity. The physician must strictly observe the requirement of a written report. (I, Netherlands 1991).

The Dutch medical society’s guidelines for physicians are: a) voluntariness, b) a well-considered request, c) a durable death wish, d) unacceptable suffering, and e) consultation among colleagues (II, Royal 1986). Physicians in Holland have not experienced legal difficulty after performance of active euthanasia (V, Lilienthal 1991). For the most part, material included in Scope Note 18 has been chosen from work published since “It’s Over Debbie” (V, Anonymous 1988) appeared in early January 1988 in the Journal of the American Medical Association.

I. GOVERNMENT DOCUMENTS


The Minister of Justice and the State Secretary of Welfare, Health and Cultural Affairs established the commission January 17, 1990, and Prof. Mr. J. Remmelink, Procurator-General at the Supreme Court of the Netherlands, was named chairman. The report says that jurisprudence defines the term euthanasia, but legislation does not, and that common usage and physicians use the term for dissimilar situations. The commission chose the 1985 government commission’s interpretation: euthanasia is the deliberate termination of another’s life at his request. The commission looked at various surveys to provide current statistics on euthanasia.


The 15 member commission was established in 1982 to submit recommendations for future government policy on euthanasia and abetting suicide, particularly with regard to writing and implementing laws. The summary has highlights of the recommendations (and says that the complete report contains three parts: recommendations, comparative legal study of the law on euthanasia in other European countries, and the commission’s hearing records).

A majority of the commission recommended that euthanasia should be available under certain circumstances and conditions, performed only by a medical officer “using proper medical methods,” and that a requirement for “penalty free euthanasia” would be that “the patient must be in a hopeless emergency condition” (p. 2). They viewed physician assisted suicide to be the same thing under the same conditions. Involuntary active euthanasia was recommended for irreversible loss of consciousness when normal treatment has stopped.

The report says that in all cases the cause of death form must note the occurrence of euthanasia. No physician with problems of conscience should be obliged to satisfy requests for euthanasia or aid in suicide, but the commission thought the patient must be given information on organizations or physicians who “are willing to offer their cooperation” (p. 8). Only pharmacists, their assistants, or others associated with a pharmacy, can prepare and supply products intended for the termination of life which must be given directly to the “concerned medical practitioner.” Pharmacists do not have the task of judging whether the conditions for penalty free termination of life are met (p. 9), but they may choose not to supply such products.

While declining to use the term euthanasia, the report thoughtfully and at length discusses the dilemmas faced at the end of life and describes distinctions such as acting and omitting to act, ordinary and extraordinary care, or killing and allowing to die. The commission concluded that legal prohibition of active killings should be sustained.

II. ASSOCIATION STATEMENTS


“The intentional termination of the life of one human being by another—mercy killing—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth.” What is termed “active euthanasia” is a euphemism for the intentional killing of a person; this is not part of the practice of medicine, with or without the consent of the patient. Legally, a person who kills another person under these circumstances is guilty of homicide. A motive of mercy is not a defense (p. 2).


The society took two positions, each with a brief rationale: “1. A physician should not provide interventions that will actively, directly, and intentionally cause the death of a patient. 2. The current legal prohibition of physician assistance in active voluntary euthanasia and suicide should not be changed.”


The 15 brief chapters include discussions on the end of life, causes for requests to die, autonomy, and the rights and responsibilities of physicians under British law. The Working Party concludes that active intervention is different from non-treatment and should remain illegal; current law should not be changed. They say that neither doctors nor any occupational group should be placed in a category that lessens responsibility for their actions, and that any physician who intervenes to end a person’s life should face the closest scrutiny under the law. Patients should not be able to require doctors to collaborate in their deaths.


Saying that there is “hardly any difference in moral respect” (p. 5) between euthanasia and assisted suicide, the Central Committee “considers the physician to be the only competent person to perform a life-terminating action” (p. 7). If a physician is opposed to performing euthanasia, the committee recommends that the patient be put in contact with another physician at the earliest possible time.

Concerning minors, the committee holds that the physician should always consult parents about a child’s request for euthanasia, but that, “with a view to the child’s own good, this does not imply that the parents have the power of decision” (p. 14).

The Central Committee concludes its recommendations with some notes on reporting euthanasia after the death. The committee writes that it is incorrect to report such deaths as natural and advocates openness in order not “to obscure fields of tension between the legislation and the practice of aid;” it would modify both government directives and government forms to add “performance of euthanasia” and its context, and these forms would not be given to the Registry Office. The committee opines that the physician who complies with its requirements may “reasonably expect not to be in fact prosecuted” (p. 14). The committee urges changes in prosecution policy and modification of the Act on the Disposal of the Dead (p. 16).

The guidelines agreed on by two groups of physicians and nurses in Holland in 1986 are divided into seven sections: preamble, definitions, considerations relating to appropriate medical care standards, euthanasia in practice, a position on conscientious objectors, possible juridical consequences and conclusion. They are very similar to those of the Royal Dutch Medical Association (see above).

III. BOOKS


The bibliography contains author and title indexes, and in the main subject index offers an annotated compilation of books and articles about euthanasia and suicide.


A collection of 19 articles published in various journals provides views on active euthanasia and assisted suicide. It includes an interview with Dax Cowart, who requested assistance in dying almost 20 years ago, and who still says that he would have preferred death.


The Bergers have collected essays offering views on the “right-to-die” in various religions and the following places: The Netherlands, England, Japan, India, and Africa.


A collection of works by various authors, the volume surveys the history of western thought on the questions of euthanasia and suicide. Brody wanted to reexamine contemporary debate in the light of the historical record.


The editors gathered essays to commemorate the 50th anniversary of Britain’s Voluntary Euthanasia Society. The first part of the book offers works for and against euthanasia; the second part describes the voluntary euthanasia movement. The appendix includes the 1969 and 1983 British bills on active euthanasia, and a sample advance declaration form.


Physician Gomez went to Holland to study euthanasia practices and says that he found a scarcity of information about regulatory mechanisms governing euthanasia. He thinks that informal regulatory criteria are probably unenforceable. He discusses the background and describes euthanasia deaths in 26 individual cases, evaluating each of them. Dr. Gomez writes that irrespective of how much the patient asked for directed euthanasia, the physician involved does more than simply accede to a request. It is Dr. Gomez’s view that for the Dutch, the matter of euthanasia is so private that significant abuses would likely go undetected by public authority.


After describing how he assisted in his first wife’s death when she was terminally ill with cancer, the author says this book is written for those who want personal control over their death. He discusses various means and methods to achieve suicide.

Kennedy, Ludovic. EUTHANASIA: THE
Kennedy discusses voluntary euthanasia in Great Britain and the Netherlands and includes sample forms from the Voluntary Euthanasia Society in London. He says that all acceptable methods of euthanasia in Holland are in a manual published by the Dutch Royal Society of Pharmacists which was approved by the Dutch Royal Society of Medicine.

The book presents a New York Times reporter’s account of a woman with Lou Gehrig’s disease who wishes to die three years after diagnosis. In the end, she is taken to her home from the hospital and given an injection by a physician who then disconnects her respirator. He leaves and another physician then comes to declare the death. The author calls it a “negotiated death” with two doctors who were not her physicians.

The author examines the law and practice of euthanasia in both the United States and the Netherlands in order to study trends that may shape policy in Canada.

The discussion of euthanasia is divided into six parts: four personal case narratives, a brief historical perspective, views of the major faith traditions, a question and answer section, essays on whether euthanasia is justifiable, and essays concerning public policy for euthanasia.

Professor Rachels discusses worldwide traditions against taking life, and offers his view that there is a great difference between having a life and merely being alive. He thinks that there is no moral difference between letting a patient die and killing the patient. Chapters in the book include ones on the morality of euthanasia and on legalizing euthanasia.

Attorney Risley is the founder of Americans Against Human Suffering, set up in 1986 to change state laws to permit physician aid-in-dying for the terminally ill. The book discusses existing law in the United States and the Netherlands, the Death with Dignity Act that his group prepared and how it would work, as well as their efforts to place the law before the state legislatures in California, Washington, and Oregon.

The authors summarize kinds of euthanasia, analyzing such concepts as justified and unjustified, voluntary and involuntary, and active and passive. They discuss euthanasia and society, and include seven different kinds of euthanasia. Suggestions for legislation and public policy concerning euthanasia are provided as well as 56 case histories.

The body of the book contains a series of case histories which Dr. van den Berg included to illustrate his view that a new medical ethics attitude is needed. The author says that a new code of ethics not based on the Hippocratic oath is inevitable given the power of technology to prolong life. He thinks that physicians must be willing to kill the suffering, deteriorating, dying, or vegetative patient, and asks families and nurses to support such a decision made by a physician who “acts in the patient’s interest” (p. 85).

IV. SPECIAL ISSUES/SECTIONS

Section IV contains groupings of journal articles
that appeared together as a body of work on euthanasia; within each issue, authors have been arranged alphabetically.


Callahan states that to directly kill in the name of mercy, or to assist in suicide, is a man-made evil. Calling it a social act since another person must assist, he says legalization gives social sanction to the act. By adding a new category of acceptable killing—legalized active voluntary euthanasia—he thinks that in the future there will be no way to deny euthanasia to anyone who requests it or to incompetents who are suffering, even if not requested.

(excerpts, see III, Gomez 1991).


The author opposed the Washington state initiative saying that any public policy permitting active euthanasia appears to remove the aid-in-dying decision and execution from all legal oversight. He thinks that the public confuses the problems of forgoing life support with the problem of active euthanasia. Legalization would sweep away the old order of things, and physicians would have to decide if they will provide aid-in-dying, requiring standards and self-regulation.


Pointing out that a 2,000 year old taboo is under attack by proponents of euthanasia and physician assisted suicide, Dr. Kass says that doctors should not be licensed to kill. Physicians must promote wholeness and healing, death must never be intended. With active euthanasia, death is primarily intended. He points out that the euthanasia movement calls it inhumane not to help a person die; the author says it may be inhumane, but it is not inhuman.


Admiraal, Pieter V. Justifiable Euthanasia, pp. 361-70.

The Dutch physician best known for performing active euthanasia discusses his experience with patients who request it and the reasons they come to this request. He thinks of passive euthanasia as abstention.


The authors think that voluntary euthanasia is the cause for approximately 6,000 deaths per year in the Netherlands.


Four Pro Vital lawyers discuss the Penal Code of 1886.


A Belgian physician who opposed active euthanasia by physicians says it is not popular outside the Netherlands.


Dutch physician Segers includes ten questions he used in polling 132 old people and draws the conclusion that the majority are opposed to the legalization of euthanasia.


Boisvert, Marcel. All Things Considered...Then What?, pp. 115-118.

Husebo, Stein. Is Euthanasia a Caring Thing to Do?, pp. 111-114.

Recalling two cases in Norway, he says that it would have been better to give an injection in one case. In a few situations he thinks physicians should offer active euthanasia.

Lynn, Joanne. The Health Care Professional’s Role When Active Euthanasia Is Sought, pp. 100-102.
Dr. Lynn is against active euthanasia since many have a fragile hold on life and would then avail themselves of this option. She recommends good palliative care so that public policy can continue to condemn active euthanasia.


Scott, John F. Lies and Lamentation—A Solid No to Euthanasia, pp. 119-121.

Van Der Meer, C. Euthanasia: A Definition and Ethical Conditions, pp. 103-106.


Callahan, Daniel. Can We Return Death to Disease?, pp. S4-S6.

Callahan thinks the increasing longevity of all, but particularly sick children, the very old and mentally ill, or the mentally retarded, has caused a fear of medicine and its progress. He opposes active euthanasia and assisted suicide, but expresses a need to “dampen” medical progress and to accept death and decline.


The author holds that the intrinsic wrongness of killing the innocent, even with the victim’s consent, has shaped the laws and mores of western civilization.


Noting that society is “secular and increasingly diverse,” he sees a need for mutual respect but thinks that a general state-enforced prohibition of euthanasia is not justifiable in secular terms. He writes that unless there are duties to third persons, the state would not have the moral authority to stop competent persons from contracting for euthanasia.


Dutch cardiologist Fenigsen describes euthanasia in the Netherlands over the past two decades and thinks that there is evidence that active euthanasia is practiced on people without their knowledge. He forsees an “army” of benevolent or casual killers if there is legalization of euthanasia.

Koop, C. Everett. The Challenge of Definition, pp. S2-S3.

He urges use of terms such as “kill,” “suicide,” and “imminent death” to make the meaning clear since he thinks a euthanasian ethic would develop when the physician healer becomes the killer.


Describing the California initiative to legalize euthanasia, he says that although it did not make it to the ballot, polls indicated that 70 percent of Californians supported the concept.


Rigter says that euthanasia in the Netherlands violates the law, but that judicial decisions show that physicians are not prosecuted if they follow the strict guidelines set up by the Royal Dutch Medical Association and the State Commission on Euthanasia.


In his view “exceptional cases” exist when a discretionary professional could assist in the final stage of irreversible and fatal afflictions which are compelling and justify active euthanasia.


Attorney Wolf thinks that legal prohibition of active euthanasia has had major benefits for the development of “tolerable law and practice for termination of treatment.”

V. ARTICLES/CHAPTERS

Abrams., Frederick R. Physician Participation in

Dr. Abrams points out that physicians’ assistance is requested by patients who want to commit suicide since physicians have a “virtual monopoly on medications.”


Dr. Angell discusses the pros and cons of a physician purposely terminating a patient’s life. She suggests that those who favor legalizing euthanasia, but would not perform it, should rethink their position. She stresses that a patient must be competent and favors rules similar to those promulgated by the Dutch physicians groups. She would deny active euthanasia to an incompetent patient even if an advance directive advocated such action.


Attorney Annas provides information on two Michigan cases which indicated to Dr. Kevorkian that assisted suicide was legal in that state. Assisting in the death of Janet Adkins, Kevorkian was charged in December 1990, but charges were dismissed less than two weeks later. In January 1991, an injunction was issued to restrain him from using his machine again. Annas thinks that his machine to deliver killing drugs was seen as medical in nature which was why the court removed accountability and responsibility.


A short essay by a medical resident who describes being called in the night to see a 20-year old young woman dying of ovarian cancer. At her comment, “Let’s get this over with,” he decides to give her an injection and she soon dies. Letter writers responded to the essay, presenting views both for and against the action.


Barry holds that laws opposing active euthanasia are in place to prevent the despairing, weak, confused, and disturbed from harming themselves or being manipulated. He notes that the elderly already have the highest suicide rate. He says legalization would give physicians absolute control over the lives of the medically vulnerable.


Dr. Jack Kevorkian describes his suicide machine and the death that he arranged for Janet Adkins. Ms. Adkins accompanied by her husband and her friend met him and requested over dinner that he help her die since she feared her early symptoms from Alzheimer’s disease. Within a week, Kevorkian arranged her death; she pressed a button which delivered thiopental and potassium chloride in sequence from a machine the physician had rigged.


Dr. Benrubi presents an argument for allowing euthanasia in certain limited cases: when technology and treatment begin to fail, when the patient is sicker, and when without the earlier technical interventions, the patient would have died. He says that there would have to be stringent safeguards to protect the patient, and suggests the development of a “specialty of physicians who alone would be empowered to perform this procedure” (active euthanasia).


While stating that suicide is a choice for an untenable life, Dr. Butler urges care in any right-to-die decisions made by a state.

The authors say that the medical community found the 1990 Kevorkian assisted suicide case clearly unacceptable, and that the debate over euthanasia and assisted suicide should shift to a careful examination of the needs and values of patients. This study would be in a context that recognizes the limits of medicine and the inevitability of death. They think that the issues should not be obscured by inflexible rules. Letters carry physicians’ reactions to the article.

Cate, Stephanie. **Death by Choice.** *American Journal of Nursing* 91(7): 32-34, June 1991.

A hospice nurse writing under a pseudonym tells of a patient who constantly begged his wife to end his misery. The nurse indicates that the patient was in despair, the wife nearing collapse. She told them that the medicine he took kept him from seizure; if he stopped it, he would undoubtedly die. The patient died of seizures 12 hours after refusing his medicine.


Two psychiatrists say that it is good to discuss openly the part that physicians have in euthanasia and assisted suicide issues in order “to regain the humanism many feel has been lost in an era of rampant technological health care.” They think that insufficient attention has been paid to the attitudes of the terminally ill. The authors warn that the controversy should not be confused with the equally important debate concerning resource allocation to the terminally ill.


The Supportive Care Program of the Pain Service at Sloan-Kettering Cancer Center in New York evaluated 90 terminally ill cancer patients for euthanasia or suicide requests: about 20 percent discussed suicide and two did commit suicide, and four patients asked for euthanasia. Coyle thinks that ethical and medical discussion neglects the role played by symptoms and fatigue. Efforts to manage the former and support the family may alleviate the desire to hasten death.


Dagi discusses the art of dying as it was perceived by Christians in the Middle Ages, and urges that health care personnel be aware of their own beliefs and thoughts about death and dying to be able to assist patients to achieve their private needs.


Pointing out that termination of treatment issues should not be confused with termination of life by assisted suicide, he thinks that physicians should not be involved in mercy killing. If a state act requires it, there should be certified thanatologists who would assist in suicide, but not physicians.


The author provides a description of the current situation with regard to voluntary active euthanasia in Holland. He offers definitions, conditions that need to be met, euthanasia statistics, and the legal background concerning such acts.


The news story discusses the American Medical Association’s specific resolution against assisted suicide and active euthanasia passed in July 1991 and the British Medical Association’s September 1990 view that physicians would be ethically justified in assisting in the deaths of terminal patients to release them from intolerable pain and distress.

Engelhardt writes that there is a growing interest in voluntary euthanasia due to recognition of individual rights and limited state authority. He discusses the state’s role, saying that institutions may set their own policies, and he thinks that patients should be aware of a hospital’s moral standards. He says that coercive state force to prevent competent persons to assist in suicide or voluntary euthanasia appears to be negative, and that others should come to terms with views that diverge from their own.


Philosopher Fletcher writes that he has defended euthanasia since the early 1930s, contending that any sane society would want to exercise rational control over ending human life. In 1954 he published a defense of “voluntary medical euthanasia” and goes on to ask if the end can sometimes justify the means. Fletcher thinks that all types of euthanasia (active or passive) are morally the same and that euthanasia is by definition voluntary.


Four physicians who write often in the field of medical ethics, question the authenticity of the “It’s Over, Debbie” (V, Anonymous 1988) article and go on to say that if it is true, the physician committed a felony (premeditated murder) and acted unethically and unprofessionally since he had never seen the patient prior to his decision to give a shot that would bring death. The authors found this conduct inexcusable, and go on to say that it is incomprehensible to them that the journal would publish such medical malfeasance which they say goes to the moral center of medicine. Physicians licensed to kill will “never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty” (p. 2140). They think that if the community legalizes active euthanasia, persons other than physicians must be found to perform the act.


Fowler writes that the first ethical code ever adopted by American nurses as well as those adopted by the American Nurses Association and the American Medical Association contain prohibitions against physician and nurse participation in the administration of capital punishment because killing is intrinsically incompatible with their trust relationship with patients.


Commenting on California’s failed attempt to place on the 1988 ballot an initiative to legalize physicians’ participation in active euthanasia for terminally ill patients who request it, the author holds that the term right-to-die is flawed since nothing in medical or nursing tradition indicates that such a right exists. She urges that pain control become a matter of priority.


Gillett makes the generalization that in the debate about euthanasia, medical intuition is against it and philosophers are for it. He thinks that moral weightings and the tendency to pause
in life and death decisions are not an adequate basis for medical ethics; the intent to kill is at odds with the private and personal compact between patient and doctor.


The article reports the vote count and background issues on ballot Initiative 119 concerned with legalizing euthanasia in the 1991 election in Washington state.


After discussing the sanctity of life on both religious and nonreligious grounds, and the principles of autonomy, virtue, and the common good, he says that individual cases cannot be converted into a public policy. He thinks that the burdens of the individual should be compared to the burdens and benefits to society and to the medical profession.


Heilig surveyed physicians in the San Francisco area where 70 percent of the 330 doctors who responded thought that active euthanasia should be a legal option for patients with terminal illnesses. He says that this closely agrees with the 66 percent of the general public who favor active euthanasia. Of the 231 physicians who agreed with the legal option for active euthanasia, 54 percent said that they themselves might be willing to help patients die.


Calling voluntary active euthanasia ethically indefensible in the cases of “Debbie” or Janet Adkins, Jecker says that she supports Dr. Quill’s assistance in the suicide of his patient “Diane” (V, Quill 1991). The author says that their relationship had become personal; that the physician’s ethical role in active euthanasia is contingent on his relationship to the patient.


Jonsen says that physicians’ knowledge and competence are irrelevant to active euthanasia; they may know more efficient methods of killing, but it does not make it part of their business, noting that anyone with a skill can put it to an inappropriate use (e.g., a locksmith who becomes a burglar). He writes that being a physician does not have any feature which exempts the profession from the “judgments, sanctions, and blames that fall on any human being who kills another” (p. 196).


Calling active euthanasia practiced by physicians an idea whose time has come, he argues that it is a bad idea which must not come now or ever. Dr. Kass says that the theories most prominent in medical ethics literature today are those of autonomy and of general benevolence and compassion (love). He thinks that in euthanasia insistence on voluntariness cannot be maintained. Legalized killing will damage any doctor-patient relationship. He indicates that neither autonomy nor the patient’s freedom are the ethical principles restraining physicians’ powers—it is the power of human life itself. If doctors become technical dispensers of death, Kass writes, they abandon their patients and their duty to care. He concludes that physicians must offer encouragement and humanity to serve the good of their patients and the moral health of society.


The physician who assisted in three suicides in Michigan in 1990 and 1991, urges the establishment of medical clinics called “obitoria” where terminal patients can opt for death under controlled circumstances. He thinks physicians should be involved beyond termination to harvest organs and perform human experiments under irreversible general anesthesia.

Three physicians reply to Thomasma’s earlier essay (V, Thomasma 1988), disagreeing with his views. They review the resurgence of interest in euthanasia and express their opposition to legalization of active euthanasia. They think that any voluntariness would soon become involuntary, and conclude that professional medical virtue demands opposition to legalization of active euthanasia.


Lachs thinks that active euthanasia of those without mental life is morally right; that an organism without significant conscious activities is morally neutral. He believes that there are only a few carefully limited cases where active euthanasia could reduce suffering, and that the medical profession should make decisions about terminating life on a case-by-case basis in open, public procedures with public accountability.


Three Dutch citizens discuss physician assisted death in the light of their Jewish faith. Rabbi Lilienthal says that he has found it impossible to formulate guidelines for himself and his congregation. He concludes that there may be no correct answer, only an awareness of the dangers. Public Prosecutor Joop Al writes that the euthanasia policy in Holland was developed because judicial authorities were aware that euthanasia was performed, but physicians seldom reported it. Only physicians are allowed to perform euthanasia. The third writer, a philosopher, is against euthanasia holding that life should not be tampered with, less there would be no end to the killings. She describes euthanasia as a “craze” with “deceptive, superficially progressive, pseudo-humanitarian propaganda” (p. 151).


The authors consider current trends in euthanasia, the German euthanasia movement from the 1920s on, and the growth of interest in euthanasia in the United States from the founding in 1938 of the Euthanasia Society of America.


Saying that the question of whether active euthanasia is a public or private matter is essential, Minogue points out that arguments for or against it may be expressed in theological or nontheological language or a mixture of both. Until recently, euthanasia was viewed as public harm and illegal. If it changes, he suggests a very limited form wherein guardians could not participate beyond signing authorized active euthanasia wills.


Dr. Misbin offers a comprehensive discussion of the questions that were raised by Initiative 119 in the state of Washington, and presents various views that were expressed concerning the legalization of active euthanasia. He is opposed to such a measure, thinking the risk of abuse is too great to justify abandoning a rule observed since Hippocratic times. He says the best response is to offer better terminal care.


This article provides a brief history and legal background of euthanasia from classical Greece and Rome, and ancient Judaic and Christian views through the Middle Ages and Renaissance period in Europe. She compares criminal sanctions and public policy in present day Japan and Holland. The author recommends decriminalization of active euthanasia in several small incremental steps. She would first have it an offense of homicide upon request (based on German law); then assisted suicide should be decriminalized, and finally, homicide upon request should be decriminalized.

Nowell-Smith strongly criticizes the active voluntary euthanasia portion of the Working Party’s report saying that opponents’ positions were not fairly presented. He thinks that physicians should not be compelled to act against conscience.


Defining both assisted suicide and active euthanasia, the general counsel of the American Medical Association writes that if a physician were to think assisted suicide appropriate, a patient might not feel free to resist. He says that it short circuits the dying process; much more thought should be given before physicians involve themselves and compromise their role as healers.

O’Rourke, Kevin D. *Value Conflicts Raised by Physician Assisted Suicide.* Linacre Quarterly 57(3): 38-49, August 1990.

Father O’Rourke provides a background of euthanasia in the Catholic view through the centuries, and says that assisting a suicide is an act of euthanasia with the intention to cause death to eliminate suffering. He thinks that rational suicide is founded on the illusion that persons are totally in control of their lives and destinies.


Writing for the annual Contempo issue, the author says that euthanasia is the most intensively discussed and divisive topic in medical ethics. He summarizes current arguments pro and con about euthanasia, and asks a series of questions that he says will be debated in the months and years ahead.


After providing a brief history and background of the active euthanasia movement in Holland, he writes that the Dutch Medical Association allows terminally ill children to die even if their parents oppose euthanasia. He states that other cases have been accepted by Dutch judges, including paraplegia, multiple sclerosis, and gross deterioration at an advanced age.


Post says that in America, the health care system is curative, and the culture is “extreme” in its desire to eliminate suffering. He thinks that pain management should be a priority and that caring in a basic sense requires enduring encouragement.


Dr. Quill describes a long-term patient who developed leukemia and chose not to be treated. To ensure control over her dying, “Diane” wanted to be able to take her own life in as painless a manner as possible. After referring her to the Hemlock Society, she requested barbiturates. Dr. Quill prescribed them and made sure that she knew the dosage for sleep and the amount needed for suicide. After a few months of various treatments, she chose to commit suicide; he reported the cause of death as acute leukemia. The doctor questions if her dying alone was benign, and wonders why she had to be alone for the last hour of her life.


This early article is often cited and included in recent collections on active euthanasia. Philosopher Rachels questions whether there is any moral difference between active and passive euthanasia, and offers reasons why active euthanasia can be preferable to prolonged suffering.

Rosenblum, Victor G. and Forsythe, Clarke D. *The Right to Assisted Suicide: Protection of...*
Autonomy or an Open Door to Social Killing?  

The article discusses common law and case law in assisted suicide and says that 26 states prohibit it by statute. The California Court of Appeals would permit Elizabeth Bouvia to commit suicide if she chose to do so, but Ms. Bouvia opted not to request it. The authors recommend that once a patient is identified as one from whom nutrition and hydration can be withdrawn, that a lethal injection would be a better method of accomplishing the same desired effect.


Roy thinks that illusions exist in voluntary euthanasia. The author says it is questionable that the voluntary character would be upheld if it were legally and socially acceptable, or that social barriers against involuntary euthanasia would not begin to crumble if voluntary euthanasia were legalized. He theorizes that there would be more litigation and that society could link legalized euthanasia with discrimination or racism. Roy concludes that it would beg for ideal hospitals, ideal care givers, and ideal families and that great vigilance should surround those who administer beneficent death.


Drs. Singer and Siegler provide background and say that imprecision in language abounds in the debate about euthanasia. They urge better pain management, not euthanasia, adding that some elements of suffering and mental anguish are not physical and cannot be eliminated from the dying processes. They conclude that legalized euthanasia is dangerous for vulnerable patients and for the integrity of the medical profession. Physicians must refuse to participate and censure those who do.


After describing the debate on active euthanasia and its potential benefits, Dr. Lynn notes that in caring for over 1,000 hospice patients, only two of them seriously and repeatedly requested physician assistance in active euthanasia. The authors say that cost containment is a driving force in the current American health care system and that if voluntary active euthanasia were legal, patients would choose euthanasia to avoid bankruptcy or inadequate care. They also think that physicians might give less attentive care to the dying. Better symptom control and communication with the patient and family about forgoing technology decisions are needed, according to the authors.


Thomasma discusses different forms of euthanasia including “social euthanasia” which he describes as euthanasia of the uninsured ill who do not have access to health care and are unable to benefit from life saving interventions. He thinks that death can be seen as a kindness for some dying people. Thomasma suggests that medicine’s aim in a technological age should be to preserve life as a conditional value to pursue higher values such as love, work, etc. The active euthanasia debate will force medicine, law, ethics, and religion to offer better answers to questions raised by technology, death prolongation, and lack of pain control.


The Dutch authors offer the results of a nationwide survey on euthanasia made at the request of the government to prepare for discussion of legislation (see I, Netherlands 1991). Three studies are cited: interviews with 405 physicians; a mailing to physicians of 7,000 deceased persons; and collection of statistics in 2,250 deaths. In 35 percent of deaths, high dosages of painkillers or non-treatment decisions shortened life; only 1.8 percent of deaths were euthanasia by lethal drugs. Of the physicians interviewed, 54 percent had practiced euthanasia at persistent requests of the
patient; of the general practitioners, 62 percent had done so. Thirty-four percent said that they had never practiced euthanasia, but could think of occasions when they would be prepared to do so; 12 percent said they would never act, but of this group two-thirds would refer a patient requesting euthanasia to a colleague. Followup letters offer more information concerning the Remmelink Committee report.


While noting that the process described in the earlier essay (V, Anonymous 1988) was “morally unacceptable” and that active euthanasia must be proscribed in principle, the author says it could be “abided in deed” for a limited range of cases.


Veatch says that euthanasia has contradictory meanings and that he avoids the term, using “active killing.” He writes that society must decide whether the physician’s role should be kept separate from hastening death, or whether someone else might take on the role of euthanizer to spare physicians. He concludes that the good of the patient will not justify mercy killing.


Reporting on the defeat of the Washington State Initiative 119, Von Drehle provides background material about euthanasia history, public opinion polls, and quotations from theologians and ethicists.


Dr. Wanzer calls assisted suicide and euthanasia the “final, responsible treatment” of helping life to end when the agonies of dying cannot be relieved. He ascribes to the guidelines of the Royal Dutch Medical Association for performing the act and says that laws would have to be changed to assist in suicides in states where it is illegal.


The suggestions made in this article were formulated at a meeting held in the fall of 1987 under the auspices of the Society for the Right to Die. Twelve physicians co-authored the work and say that physicians have a specific responsibility toward patients who are terminally ill. They urge timely discussions with patients, advance directives, medical education, and the formation of institutional guidelines on such subjects as the use of pain killers even if life were to be shortened. If all else fails, ten of the authors think that it is not immoral for a physician to assist in the rational suicide of a terminally ill person. They say that fear of litigation and criminal prosecution deters euthanasia advocates in the United States. Six months later, 11 letters to the journal from physicians and others discuss the article along with a reply from the original authors.


The news report describes Dr. Kevorkian’s assistance in helping two women kill themselves, October 23, 1991. Margery Wantz (a woman with a severe pelvic disorder) pulled strings to deliver first an anesthetic and then sodium pentothal; the second, Sherry Miller (who had multiple sclerosis) had a gas mask carrying carbon monoxide placed on her face.


The author in this note says that the choice by
the terminally ill to choose the time and manner of their death is protected by the constitutional right to privacy which is also extended to individuals whose assistance is necessary to achieve suicide. Guidelines are offered to ensure that the decision is both voluntary and competent.

**SCOPE NOTE 18** was prepared by Pat Milmoe McCarrick, a Reference Librarian at the National Reference Center for Bioethics Literature.