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# An Argument for the Legalization of Active Euthanasia

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HPM Seminar  
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## **An Argument for the Legalization of Active Euthanasia**

### **I. Introduction**

Throughout history, the American legal system has implicitly and explicitly forbidden the practice of active euthanasia by doctors. Many of the arguments against active euthanasia are worthy of consideration, and shall be discussed and analyzed in detail throughout the context of this essay. These arguments deal with concerns about the effect of active euthanasia on the medical community, the fear of a slippery slope towards “convenience killing,” and the prior legal precedent prohibiting the practice of active euthanasia. In opposition to these concerns, I argue that there is both legal justification and a moral obligation to legalize the practice of active euthanasia. As I will show, a number of Supreme Court cases provide the legal justification for legalizing active euthanasia in the United States. I will argue furthermore that the ethical obligation to promote a merciful and compassionate society further compels the legalization of active euthanasia in America.

### **II. Context and Background**

Euthanasia, meaning “good death” in Greek, is a hotly contested medical, ethical and legal issue. Euthanasia can be considered in two different forms. Passive euthanasia involves a patient or family making a decision to abstain from medical treatment necessary to continue life.<sup>1</sup> Under these circumstances, the agent of death is the terminal condition existing within the patient that is hastened by the removal of life-sustaining treatment. The other type of euthanasia,

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<sup>1</sup> David Thomasma, Glenn Graber. *Euthanasia: Towards and Ethical Social Policy*. p.2

currently outlawed in the United States, is referred to as active euthanasia. Active euthanasia involves the intentional termination of a patient's life through the direct action of a physician.<sup>2</sup> Active euthanasia is often confused with physician-assisted suicide, but the two practices are different in one important aspect. Physician-assisted suicide refers to the process by which a physician indirectly assists death by providing lethal means by which the patient may end his or her own life.<sup>3</sup> Active euthanasia, on the other hand, involves direct action by the physician to terminate the life of the patient, usually through the administration of a lethal injection. In short, passive euthanasia involves the removal of life-sustaining treatment, such as the removal of a feeding-tube from a comatose patient. Physician-assisted suicide involves the indirect assistance of a physician in a patient's suicide, usually through the intentional prescription of a lethal dose of prescription medication which the patient ingests with the intent to end his or her own life. Finally, active euthanasia involves direct action by a physician to end the life of a patient.

It is necessary at this point to distinguish why this essay will argue for the legalization of active euthanasia and not just physician-assisted suicide. The two procedures are, in many ways, very similar. Both involve the voluntary and intentional termination of the patient's life with the assistance of a physician. Often in this situation, a patient is too weak or not conscious and thus unable to self-inject the lethal drugs prescribed by his or her physician. For example, in a case discussed later in this essay, a patient suffering from late-stage ALS sought out a physician to assist in ending the patient's life. The physician provided a lethal dosage of medication, but the patient was too weak to physically inject himself with the concoction. The physician injected the drugs into the patient. Although he had legally assisted in suicide before, the physician was charged with homicide in this case because he, not the patient, administered the dosage. I argue

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<sup>2</sup> Thomasa/Graber p.5

<sup>3</sup> Thomasa/Graber p.6

that a patient should not be denied the right to a dignified and compassionate death on the basis that they are unable to physically perform a procedure. Active euthanasia allows the weakest and often the most desperate patients to experience a compassionate death with the assistance of their physician. To permit physician-assisted suicide while prohibiting active euthanasia discriminates against patients in the most severe stages of illness and disease that are unable to end their own suffering by themselves.

### **Court Rulings and Legal Principles**

In order to understand the controversy surrounding the legalization of active euthanasia in America, it is useful to consider some of the history and background of the United States legal system. A number of foundational principles and court decisions both directly and indirectly affect the current legal status of active euthanasia. While several of these principles support the legalization of active euthanasia, there are also a number of essential concepts that suggest that the legalization of active euthanasia is impermissible.

One principle in support of active euthanasia is the right to self-determination. The principle of self-determination has been affirmed as far back as early English law.<sup>4</sup> In the 1960 case *Nathanson v. Kline*, Kansas Supreme Court Justice Alfred Schroeder reaffirmed the principle of self-determination when he declared that all individuals are masters of their bodies and have the right to decide what will be done with their bodies, including what medical treatment they will authorize or prohibit.<sup>5</sup> Individuals have a right to choose their own treatment and act as the judge of their own best interest. Proponents of euthanasia would argue that this right extends to the ability to make decisions about how and when one wishes to die. The other American principle that strongly supports active euthanasia is the assertion of right to liberty.

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<sup>4</sup> Burnell. *Final Choices*. p. 207

<sup>5</sup> *Nathanson v. Kline*, 186 Kan. 350 P.2<sup>nd</sup> 1093

The right to liberty is a fundamental component of the American legal system. The right to liberty is protected by the 14<sup>th</sup> Amendment, which states:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.<sup>6</sup>

Under the 14<sup>th</sup> Amendment, States are prohibited from creating or enforcing laws that deprive individuals of life, liberty or property without due process of law. The due process clause of the 14<sup>th</sup> amendment also protects against unwarranted government interference, although the line between warranted and unwarranted interference has been debated through numerous court cases, particularly in physician-assisted suicide cases discussed later. Nevertheless, the right liberty is crucial in the argument for legalizing active euthanasia. However, not all of the principles of the American legal system work in favor of legalizing active euthanasia.

One of the principles working against the legalization of active euthanasia is the interest of the State in protecting and preserving life. The government has a legitimate interest in preserving life and dissuading suicide. Obviously, this principle works in direct contrast to active euthanasia, which does not necessarily promote suicide, but does intentionally extinguish life. American society also rigidly upholds the dignity of the medical profession. Many argue that by permitting the practice of active euthanasia, the government compromises the integrity of the medical community. Regardless of whether or not this is a legitimate claim, the integrity of the medical community is another important principle to the discussion of euthanasia.

Several other principles relate to the discussion on active euthanasia, but do not specifically favor prohibiting or allowing the practice. For example, the principle of non-

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<sup>6</sup> 14<sup>th</sup> Amendment. <http://caselaw.lp.findlaw.com/data/constitution/amendment14/>

malfeasance or benefice requires all individuals to act towards good and avoid harm. On one side, practicing active euthanasia causes harm by ending the life of a patient. On the other hand, supporters of euthanasia argue that patients are harmed when they are forced to live out the final days of their lives in excruciating pain and humiliation. Similarly, the doctrine of best interest plays into both sides of the euthanasia debate. When applied to the medical profession, the doctrine of best interest is simply the declaration that when there are several methods of treating a patient, the physician should choose the course that is most beneficial to the patient. Many argue that ending the patient's life is never the best option, so active euthanasia directly contradicts this principle. However, others see euthanasia as a means of compassionately ending a patient's life when other means of treatment become futile or inappropriate.

Two important court cases on physician-assisted suicide highlight how these abstract legal principles provide concrete decisions and rulings. Both cases were heard and decided in the Supreme Court simultaneously, resulting in two strong anti-euthanasia opinions being published on June 26<sup>th</sup>, 1997. The first case, *New York v. Timothy Quill*,<sup>7</sup> highlights some of the common elements of the case history on active euthanasia, even though the case itself actually focuses on physician-assisted suicide. Dr. Timothy Quill, a New York physician, asserted that the prescription of lethal medication to terminally ill patients would be consistent with the medical profession, but was unlawful under New York's ban on assisting suicide under New York Penal Law § 125.15. Quill further asserted that it is inconsistent to allow a patient to legally refuse life-sustaining medical treatment while simultaneously prohibiting a physician from prescribing life-terminating medication. The Circuit Court of Appeals agreed with Quill, and ruled that New York's statute prohibiting assisted suicide was unconstitutional. However, a Supreme Court

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<sup>7</sup> Dennis C. Vacco, Attorney General of New York, et al. v. Timothy E. Quill. 521 U.S. 793

ruling reversed the decision, holding that it is consistent with the U.S. Constitution for New York to treat assisted suicide differently from the refusal of lifesaving treatment.

Though the case does not deal directly with active euthanasia, *New York v. Quill* affirmed that a legitimate difference exists between passive euthanasia and physician-assisted suicide or active euthanasia. The stance that a significant difference exists between assisting in terminating life and allowing a patient to die has been upheld in a number of cases, and is one of the primary obstacles to the legalization of active euthanasia. Another key issue, the tension between liberty and state interest, is the focus of *Washington v. Glucksberg*, another physician-assisted suicide case heard and decided on the same day as *Quill v. New York*.

The case of *Washington v. Glucksberg* centered on a 1975 Washington statute that criminalized the causing or assisting of a person in committing suicide. Plaintiffs brought suit, seeking a declaration that Washington's state ban on physician-assisted suicide was unconstitutional in that it violated the 14<sup>th</sup> amendment due process clause. In addition to a guarantee of fair process and protection from physical restraint, the due process clause provides heightened protection against government interference with certain fundamental rights and liberty interests. Plaintiffs asserted that these fundamental rights and liberties included a right to commit and assist in committing suicide, and both the District and Circuit Court agreed, ruling in favor of the plaintiff. However, the right to liberty is not absolute, and in their decision to reverse the Circuit Court, the U.S. Supreme Court ruled:

The assisted suicide ban was rationally related to a legitimate government interest because Washington sought to preserve human life and also uphold the integrity and ethic of the medical profession. Additionally, Washington's statute sought to protect vulnerable groups, such as the poor, elderly, and disabled from abuse, neglect and mistakes. Finally, the Court held that

Washington's ban on assisted-suicide effectively prevented a broader license to voluntary or involuntary euthanasia.<sup>8</sup>

The Supreme Court ruled that Washington's statute criminalizing assisted suicide was authorized for three reasons. First, the Court ruled that the State has a right to protect and promote human life and dissuade suicide. Secondly, the Court ruled that the State has a duty to protect vulnerable and powerless groups, including the terminally ill and dying. Finally, the decision also echoed the importance of the State in protecting and upholding the medical profession. Ultimately, the Court ruled that the State had a legitimate interest in physician-assisted suicide that justifiably interfered with the liberty and privacy of both the patient and the physician.

While the cases of *Quill* and *Glucksberg* focus on physician-assisted suicide, the case of Jack Kevorkian tackled the issue of active euthanasia directly. Dr. Kevorkian was a practicing physician with a medical license in Michigan and California. Kevorkian strongly believed in the patients right to a merciful, compassionate death, writing a series of journal articles advocating for medical experimentation on consenting convicts during executions. In 1990, he began posting newspaper advertisements for the "thanatron," a homemade machine designed to assist in the termination of a patient's life through a series of lethal injections.<sup>9</sup> A woman named Janet Adkins, upon reading Dr. Kevorkian's advertisement, contacted the physician regarding his machine. Ms. Adkins was suffering from the onset of Alzheimer's disease, and feared living out the rest of her life as a shell of her former self. On June 4<sup>th</sup>, 1990, Ms. Adkins met with Dr. Kevorkian in his car, where Dr. Kevorkian performed the procedure to terminate the life of Ms. Adkins.<sup>10</sup>

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<sup>8</sup> Washington, et al. v. Harold Glucksberg et al. 521 U.S. 702

<sup>9</sup> "Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign". *Frontline*. WGBH.

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Four days after the assisted suicide of Janet Adkins, Dr. Kevorkian was charged with murder in an Oakland County Circuit Court and prohibited from assisting in suicide. However, six months later, on December 12<sup>th</sup>, the charges against Kevorkian were dropped after District Court Judge Gerald McNally rules that the Michigan statute regarding physician-assisted suicide is unclear. One year later, Kevorkian attended the deaths of two more women, one suffering from multiple sclerosis and one from severe pelvic pain. Consequently, in November 1991, the Board of Medicine revoked Kevorkian's license to practice medicine in Michigan and, one year later, the Michigan Legislature passed a ban on assisted suicide. The State of California followed suit, suspending Kevorkian's medical license on April 27<sup>th</sup>, 1993. However, in May 1994, the Michigan Court of Appeals declares that the ban on assisted suicide was passed unlawfully and thus did not stand as state law, and Kevorkian was acquitted of charges relating to the deaths of four patients. The charges were reinstated in December of 1994, when the Michigan Supreme Court upheld the constitutionality of the ban on assisted suicide.<sup>11</sup>

On November 22, 1998, Dr. Kevorkian attended an interview on 60 minutes. During the course of the interview, Dr. Kevorkian presented a video recording in which he assisted in the death of a patient named Thomas Youk. Suffering from the final stages of ALS, Youk was unable to administer Kevorkian's lethal injection on his own, so Dr. Kevorkian administered the dosage for him. Consequently, Dr. Kevorkian was charged with murder on the grounds that he not only assisted in suicide, but that he actually acted as the agent of death. Youk was the first incidence of active euthanasia recorded by Dr. Kevorkian. Though previously acquitted of all former charges of physician-assisted suicide, Kevorkian was convicted of second-degree

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<sup>11</sup> "Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign". *Frontline*. WGBH.

homicide and sentenced to ten to twenty-five years in prison for his involvement in Thomas Youk's death.<sup>12 13</sup>

The Kevorkian case disrupted many of the traditional attitudes towards euthanasia and served as a springboard for public debate on this issue. In October 1995, a team of Michigan medical experts and physicians announced their support of Dr. Kevorkian and attempted to create a set of guidelines for the "merciful, dignified, medically-assisted termination of life."<sup>14</sup> In February 1996, a study published in the *New England Journal of Medicine* explored Oregon physicians' attitudes towards physician-assisted suicide in Oregon and Michigan, where Kevorkian practiced. 73 percent of physicians agreed that competent, terminally ill patients have a right to commit suicide. Sixty-six percent said that physician-assisted suicide would be ethical in some cases, and 60 percent said it should be legal in some cases.<sup>15</sup> Though Kevorkian was convicted and tried four times for physician-assisted suicide, all four juries acquitted him of the charges. Kevorkian's influence did not remain within the confines of Michigan. In the wake of the Kevorkian controversy, Oregon residents passed the Oregon Death With Dignity Act, a 1994 statute effectively legalizing active euthanasia.<sup>16</sup> With some of the context and background in mind, I now wish to move into the argument for the legalization of active euthanasia.

### **III. Legal Argument for the Permissibility of Active Euthanasia**

The legal justification for the institution of active euthanasia as a legitimate medical practice is grounded in U.S. case history. At this point, I wish to explore a number of cases that provide a legal support structure for the legalization of active euthanasia.

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<sup>12</sup> "Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign". *Frontline*. WGBH.

<sup>13</sup> Burnell. *Final Choices*. p. 254

<sup>14</sup> *Frontline*. WGBH

<sup>15</sup> Melinda Lee. *Legalizing Assisted Suicide – Views of Physicians in Oregon*. *NEJM*. February 1, 1996. Volume 334:310-315

<sup>16</sup> <http://www.oregon.gov/DHS/ph/pas/ors.shtml>

## Liberty

The principles of liberty and government interest are at odds in the debate over active euthanasia. As seen in the case of *Roe v. Wade*, neither of these principles is absolute. In the case of *Roe*, it was determined that the government had a legitimate interest in the preservation of human life that overruled a right to privacy and liberty. However, the privacy of the woman is still respected and acknowledged to a degree when it was determined that the mother has a right to an abortion for up to three months of the pregnancy. The vital distinction between *Roe v. Wade* and active euthanasia, of course, is that the Courts determined in *Roe v. Wade* that until the second trimester of pregnancy, a fetus is not considered a person, and thus does not fall under the protection of the government. Except in extreme cases such as a patient irreversible coma with permanent brain damage, it would be difficult, if not impossible, to argue that a patient requesting active euthanasia is not a person. Thus, the case of *Roe v. Wade* by itself is not sufficient to justify the legalization of active euthanasia. At this time, I merely wish to point out that *Roe v. Wade* exhibits the Court's judgment that the government's interest does not outweigh the right to liberty absolutely.

The issue of liberty is further explored in the case *Gonzalez v. Oregon*. In 1994, Oregon became the first State to legalize assisted suicide when voters approved a ballot measure enacting the Oregon Death with Dignity Act (ODWDA), which exempts from civil or criminal liability state-licensed physicians who, in compliance with specific safeguards found in ODWDA, dispense or prescribe a lethal dose of drugs upon the request of a terminally ill patient. The drugs prescribed by physicians under ODWD are regulated under a federal statute, the Controlled Substances Act (CSA). The CSA allows these particular drugs to be available only by a written

prescription from a registered physician. In normal circumstances, the drugs are prescribed for pain alleviation.<sup>17</sup>

The ODWD did not pass without intense controversy and uproar, particularly from the politically conservative demographic. In 2000, members of Congress argued to Attorney General Janet Reno that the ODWD was under the jurisdiction of the federal government because it utilized medications regulated by the Controlled Substances Act. Reno responded that the purpose of the CSA is not to allow the federal government to interfere with legitimate State supported medical practices, nor does it allow the federal government to dictate what a State may interpret as a legitimate medical practice. Therefore, ruled Reno, Congress had no case against the state of Oregon.<sup>18</sup>

Upon the election of President Bush in 2000, Janet Reno was replaced by Missouri Senator John Ashcroft as U.S. Attorney General. Unlike Reno, Ashcroft agreed that the federal government had a legitimate interest in the Oregon Death With Dignity Act. On November 9, 2001, Attorney General Ashcroft issued an Interpretive Rule determining that using controlled substances to assist suicide is not a legitimate medical practice and that dispensing them is unlawful under the CSA. Ashcroft also ruled that the Attorney General may revoke the right of a physician to prescribe medication if it is determined that the physician's registration is inconsistent with the public interest. Two days later, U.S. District Court Judge Robert Jones issued an injunction against Ashcroft's ruling until April 2002, when each side could present their argument.

In 2002, each side presented arguments for and against government interference under the Controlled Substances Act. Justice Robert Jones ruled in favor of the State of Oregon, declaring

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<sup>17</sup> Oregon Death With Dignity Bill Timeline. <http://www.oregon.gov/DHS/ph/pas/docs/History.pdf>

<sup>18</sup> Death With Dignity Timeline.

<http://www.deathwithdignity.org/media/documents/Oregon%20Death%20with%20Dignity%20ActTimeline.pdf>

that the government lacked the authority to overturn the state statute. Ashcroft attempted to appeal to the U.S. Circuit Court, but his motion for to retry the case was denied. On November 9, 2004, Ashcroft petitioned the U.S. Supreme Court to review the Circuit Court decision. On October 5, 2005, the Supreme Court heard arguments in the case. The Court, however, judged in favor of the district court in siding with the State of Oregon. In their ruling issued January 17<sup>th</sup>, 2006, the Supreme Court claimed that the Government maintains that the prescription requirement delegates to a single executive officer the power to radically alter the balance between the State and Federal Authority. The text and structure of the Controlled Substances Act shows that Congress did not have such a far-reaching intent to alter the federal-state balance and the congressional role in maintaining it. The power of the Federal government, ruled the Court, must be balanced with the liberty of the state of Oregon to legalize physician-assisted suicide. Again, the government is shown to be limited in its' right to control private end of life decisions.

### **The Preservation of Life**

The major argument against active euthanasia, however, is not usually an attack on liberty. Rather, critics argue that active euthanasia flies in the face of a society focused on the preservation and protection of life. Often set up as a slippery slope argument, critics contend that the legalization of active euthanasia is not only a violation of the medical profession; it is a dangerous step towards a culture of death and involuntary euthanasia. However, the U.S. legal system has already accepted death as a part of society, and reinforced the acceptance of death in the case of *Gregg v. Georgia*. A 1976 Supreme Court case, *Gregg v. Georgia* determined that “the punishment of death does not invariably violate the constitution”. In fact, “the imposition of the death penalty for the crime of murder has a long history of acceptance both in the United States and in England. The common-law rule imposed a mandatory death sentence on all

convicted murderers”.<sup>19</sup> The validity of “legalized killing” is not only mentioned in *Gregg v. Georgia*. The Court, *in re Kemmler, supra, at 447*, reiterates:

The punishment of death is not cruel, within the meaning of that word as used in the Constitution. It implies there is something inhuman and barbarous, something more than the mere extinguishment of life.<sup>20</sup>

The Court declares time and time again that the punishment of death is not cruel and unusual, and that it does not violate the Constitution. This reasoning is declared as far back as 1890, in the case of *Trop v. Dulles*, where Chief Justice Warren wrote:

Whatever the arguments may be against capital punishment, both on moral grounds and in terms of accomplishing the purposes of punishment...the death penalty has been employed throughout our history, and, in a day when it is still widely accepted, it cannot be said to violate the constitutional concept of cruelty.<sup>21</sup>

The death penalty is a longstanding form of punishment in the U.S. Legal System.

Though other cases debate the constitutionality of various methods of execution, no case disputes the conclusion of *Gregg v. Georgia*: that the punishment of death is not unconstitutional.

If the U.S. legal system has accepted the death penalty as constitutional, then it follows that actions that cause death are not always unconstitutional. It is peculiar to consider that death is permitted for the sake of punishment, but not for the sake of mercy. It is even more unusual that during the process of lethal injection, a physician must be present throughout, yet requiring a physician to oversee a procedure designed to induce death does not compromise the medical profession. What is even more troublesome for the critic of legalized active euthanasia is that while the death penalty has been accepted

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<sup>19</sup> *Gregg v. Georgia*, 428 U.S. 153 (1976)

<sup>20</sup> *In re Kemmler*, 136 U.S. 436 (1890)

<sup>21</sup> *Trop V. Dulles*, 356 U. S. 86 (1958)

since the time of our founding fathers, America has fallen down a slippery slope. Indeed, the death penalty is still reserved for the most extreme cases with the utmost precaution. When the procedure of lethal injection is carried out, thousands of dollars are spent to ensure adherence to ethical and safety guidelines. If the death penalty has been in effect for hundreds of years, and yet still follows such intensely monitored guidelines, it would seem that fears of a slippery slope argument about legalizing active euthanasia are unfounded.

Some may argue that the correlation between the death penalty and active euthanasia is not appropriate. While the death penalty involves the termination of life without consent, active euthanasia involves a decision by the patient to end his or her own life. The cases of Gary Gilmore of Utah and Charles Walker of Illinois make this distinction difficult to uphold. In both cases, the individuals were condemned to death for the crime of murder. Anti-death penalty activists pushed to change the punishment, but were overruled when both Gilmore and Walker requested that the sentence be carried out.<sup>22</sup> Eventually, the Courts upheld the death penalty in both cases. The decisions were influenced at least partially by the requests of the convicts that the sentence would be carried out.

At first glance, the cases of Gilmore and Walker may not appear analogous to a patient requesting active euthanasia, but the two situations are actually quite similar. In both cases, the individual prefers death to their current situation, either spending life in prison or continuing to suffer from a disease. In both cases, death is likely in the foreseeable future, either through execution or the natural course of disease. Finally, in both cases, the individual can either continue suffering, by sitting in prison or continuing

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<sup>22</sup> David Thomasma. *Euthanasia*. p.4

to battle the disease, or hasten their own death through artificial means. The primary difference between the two cases is that in the case of the convicted felon, they can choose to end their own suffering and face execution, while the terminally ill patient must continue to endure their own pain until the disease finally kills them. If a criminal charged with murder is allowed to choose death over the suffering of life in prison, then a patient suffering from a terminal disease should be allowed to choose death over days or weeks of agony and pain.

The second argument against the absolute preservation of life is grounded in the fact that patients already have a limited right to die. The removal of life sustaining medical treatment by a patient is permitted under the U.S. Constitution.<sup>23</sup> The rationale behind this ruling is that no person is ever required to accept medical treatment, including life-preserving medical treatment. Passive euthanasia often manifests in the removal of a feeding and hydration tube, but includes the refusal of a patient to continue any necessary medical treatment. Quite often, passive euthanasia involves excruciating pain at the end of life, as the disease destroys the already weakened body of the patient. Active euthanasia is simply a more merciful and compassionate extension of passive euthanasia. The distinction between legalized passive euthanasia and illegal active euthanasia is illusory.

### **Public Opinion**

Public policy should be shaped by public opinion. After all, the representatives creating public policy are designated to act in the interest of the public that elected them. Recently, public attitudes have grown more accepting of active euthanasia and physician-assisted

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<sup>23</sup> E. Emanuel, "Review of Ethical and Legal Aspects of Terminating Medical Care". American Journal of Medicine 84 (1988) 291-301.

suicide. A number of parties advocated the initiative, including former Washington governor Booth Gardner, the National Death with Dignity Center, Compassion & Choices of Washington, and Compassion & Choices of Oregon. Opposing the bill was the Coalition Against Assisted Suicide, an organization composed of physicians, nurses, disability rights advocates, hospice workers, the Catholic Church, and right-to-life activists. The initiative effectively legalized physician-assisted suicide in the State. In summary, the legislation:

Would permit terminally ill, competent, adult Washington residents medically predicted to die within six months to request and self-administer lethal medication prescribed by a physician. The measure requires two oral and one written request, two physicians to diagnose the patient and determine the patient is competent, a waiting period, and physician verification of an informed patient decision. Physicians, patients and others acting in good faith compliance would have criminal and civil immunity.<sup>24</sup>

Amidst controversy, the initiative passed in February 2008, when voters approved Washington Initiative 1000 by a 57.8% majority.<sup>25</sup> Physician-assisted suicide has also been upheld in Montana, where a District Court ruling stated that competent, terminally ill patients have the right to self-administer lethal doses of medication as prescribed by a physician. Physicians who prescribe such medications will not face legal punishment.<sup>26</sup> Including Oregon, there are currently three states that allow the practice of physician-assisted suicide. Public approval of physician-assisted suicide is becoming more and more prevalent. The overwhelming support for physician-assisted suicide acts as an indicator about public sentiment towards active euthanasia. If public policy is meant as a reflection of public interest, then the legalization of active euthanasia should be on the near horizon.

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<sup>24</sup> "Initiative Measure 1000 "The Washington Death with Dignity Act"". *Secretary of State of Washington*. 2008-01-24.

<sup>25</sup> "November 4, 2008 General Election". *Washington Secretary of State*. November 13, 2008.

<sup>26</sup> Montana third state to legalize assisted suicide. MSNBC. <http://www.msnbc.msn.com/id/28085809/>

A 2007 Associated Press survey polled Americans on their attitudes towards physician-assisted suicide. The poll asked whether it should be legal for doctors to prescribe lethal drugs to help terminally ill patients end their own lives. The survey showed that 48 percent of Americans believe the practice should be legal, while 44 percent believe it should be illegal. 68 percent agreed with the statement “there are circumstances when a patient should be allowed to die”, and only 30 percent agreed with the statement “doctors and nurses, in all circumstances, should do everything possible to save the life of a patient”.<sup>27</sup> This data suggests that the American public is becoming more sympathetic towards the intense suffering and loss of dignity suffered by some patients at the end of life. Perhaps the significant advances in medical technology and artificial life extension have redefined public understanding of how death and dying should work. Another theory is that American culture has become more open-minded towards bio-medical practices that were considered taboo forty or fifty years ago. Whatever the reason, public support for euthanasia appears to be on the rise, as indicated by voters in Montana, Washington and Oregon and public opinion surveys nationwide.

#### **IV. Answering Objections to the Legalization of Active Euthanasia**

##### **Effect on the American Society**

Many of the arguments against euthanasia are based on concerns about the implications on American society. This slippery slope argument asserts that by allowing active euthanasia, the government risks creating a “death on demand” culture in which patients are voluntarily or involuntarily euthanized for unacceptable reasons. Active euthanasia, critics argue, distorts the value of life and opens the door to “convenience killing” by overburdened physicians and hospitals. In his argument against euthanasia, bioethicist Edmund D. Pellegrino writes

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<sup>27</sup> American’s Split on Doctor Assisted Suicide. <http://www.msnbc.msn.com/id/18923323/>

“Euthanasia and assisted suicide are built on the premise that some lives are not worth living...this is why the preservation of life is, and had been, in the state’s interest”.<sup>28</sup> Pellegrino argues that if society accepts the termination of some lives, then it must follow that some lives will be depreciated in value. Therefore, it is necessary to preserve a culture of life in order to protect vulnerable groups like the sick and disabled who possess an apparently lower quality of life.

Certainly, in any well-constructed, functional society, the goal of the government should be to promote rather than destroy life. When the government justifies the intentional killing of patients, it sends a message that the sanctity of life is contingent and variable. Active euthanasia, argues critics, will lead to a disregard for human life and a movement towards destruction and death.

While the government has a duty to promote life, it should not value life as necessarily paramount. An important difference lies in distinguishing between a culture of life and a culture of mercy. In a culture of life, the duty to maintain life reigns supreme. Human life is valued above all else, including patient choice. In a culture of mercy, however, life is valued but not held as supreme. Individual circumstances must be considered in the choice to administer or continue life-sustaining treatment. In the example of the suicidal individual, mental issues are often distorting reason. If an individual is not rational, they may not be able to make clear and justified decisions about whether or not to end their own life. A culture of mercy would work to preserve this individual’s life against their wishes because they are not necessarily in a position to make decisions in the best interest. On the other hand, allowing a patient to decline life-

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<sup>28</sup> Edmund D. Pellegrino. “The False Promise of Beneficent Killing”. *Regulating How We Die*. P. 87

sustaining treatment at the end of a terminal illness actually does work in the best interest of the patient, and is thus acceptable in a culture of mercy.

### **Hippocratic Oath**

One of the fundamental arguments against active euthanasia appeals to the Hippocratic oath. Physicians traditionally take the oath upon graduating medical school, and in doing so swear to “neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect”.<sup>29</sup> In his 1989 article “Neither for Love nor Money,” Dr. Leon Kass argues that this vow must be taken as a prohibition on active euthanasia. He writes:

The prohibition against killing patients...stands as the first promise of self-restraint sworn to in the Hippocratic Oath, as medicine's primary taboo [...] The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and therefore, also what the Oath calls the purity and holiness of life and art to which he has sworn devotion.<sup>30</sup>

According to Kass, the duty of the physician to preserve life does not come from the autonomy of the patient or the physician’s own compassion. Rather, the physician is bound to the Hippocratic oath and thus prohibited from practicing euthanasia. To do otherwise would compromise the deep ethical restraint previously accepted to by the physician.

The Hippocratic oath is certainly a deeply respected and vitally important tradition of medical education. Of all the professions that require ethical intent and action, medicine is arguably the most important. However, allowing the practice of active euthanasia does not destroy the Hippocratic oath: it merely alters it, as a number of medical advances and shifting

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<sup>29</sup> "The Hippocratic Oath: Modern Version". *Doctors' Diaries*. NOVA. Retrieved 2010-02-08.

<sup>30</sup> Leon Kass. *Neither for Love nor Money*. Public Interest. Winter 1989

attitudes have done in the past. In a 2001 interview entitled "Euthanasia Sets Sail," Dr. Philip Nitschke argues:

Over time the Hippocratic Oath has been modified on a number of occasions as some of its tenets became less and less acceptable. References to women not studying medicine and doctors not breaking the skin have been deleted. The much-quoted reference to 'do no harm' is also in need of explanation. Does not doing harm mean that we should prolong a life that the patient sees as a painful burden? Surely, the 'harm' in this instance is done when we prolong the life, and 'doing no harm' means that we should help the patient die. Killing the patient--technically, yes. Is it a good thing--sometimes, yes. Is it consistent with good medical end-of-life care: absolutely yes.<sup>31</sup>

Dr. Nitschke does not oppose the Hippocratic oath. However, he understands that as medicine evolves, so must the oath. As he points, in order to fulfill the original oath in its entirety, the medical profession would have to prohibit women from practicing medicine, and doctors would not be allowed to "break the skin," preventing any type of invasive surgery. The medical profession should be regulated by an oath, but this oath should not hinder the growing medical field. Furthermore, Nitschke argues that practicing active euthanasia follows the oath's declaration to "do no harm." By comfortably and compassionately ending the patient's life, the physician eliminates much of the harm associated with the suffering and pain at the end of life.

The Hippocratic oath is a necessary component of medical education. An oath to act ethically compels the doctor to uphold the dignity and prestige of the medical profession. However, as Nitschke points out, an oath cannot remain stagnant while the medical community changes. An oath is a reflection of values, and as values change, so must the oath. The value that medical education should be exclusive to men, for example, changed as the rights of women increased. Similarly, as attitudes towards the end of life decisions change, the oath must

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<sup>31</sup> <http://euthanasia.procon.org/view.answers.php?questionID=000198>

accommodate this alteration in values. The main value of the Hippocratic oath, “to do no harm,” can remain in place perpetually, but definitions of “harm” may change as the medical profession grows.

### **Slippery Slope Argument**

Many of the “slippery slope” fears about active euthanasia involve references to abuse of the legalized procedure in Holland. Contrary to popular belief, active euthanasia is not legalized in Holland. The procedure has been justified through case law for the last thirty years, but there is no statute officially legalizing the practice of euthanasia. Instead, judgments about individual cases of euthanasia are decided by recommendations from the Netherlands Office of Medical Inspectors, who determines whether or not the procedure was ethically justified under the particular circumstances.<sup>32</sup> Another popular belief is that Holland is ravaged with involuntary and forced euthanasia. There is no empirical data to support these conclusions. A study published in the *Netherlands Journal of Medicine* found that in a review of 158 cases of physician-assisted suicide, 85 percent of cases were elderly patients suffering from end-stage cancer, while 15 percent of patients were suffering either from AIDS, multiple sclerosis, and other neurological diseases that cause paralysis. In 65 percent of the cases, it was reported that the patient was clear-headed and/or had repeated the request several times.<sup>33</sup> In only ten percent of the cases was euthanasia prompted by a physician suggestion. Finally, in 7 percent of the cases, the family suggested euthanasia.<sup>34</sup> In all cases, however, the ultimate decision was left up to the patient. The often cited claim of abuse of euthanasia in Holland is unfounded by data and evidence.

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<sup>32</sup> Buiting, H.; van Delden, J.; Onwuteaka-Philipsen, B.; Rietjens, J.; Rurup, M.; van Tol, D.; Gevers, J.; van der Maas, P. *et al.* (Oct 2009). "Reporting of euthanasia and physician-assisted suicide in the Netherlands: descriptive study." *BMC Med Ethics* 10 (1): 18.

<sup>33</sup> Buiting, H.; p. 18.

<sup>34</sup> M.Simons. "Dutch Survey Casts New Light on Patients Who Choose to Die" *The New York Times*, 11 September 1991.

Even without reference to the Netherlands, one can see that American society may permit the compassionate death of terminally ill patients without turning the medical profession into an organization of murderers. American society has already accepted the use of the death penalty for hundreds of years, and yet the criminal justice system still rarely resorts to the severe punishment. Like the death penalty, active euthanasia, even when legalized, can be sufficiently regulated for use in only the most extreme conditions. Reasonable use of safeguards and guidelines can protect the medical profession and American society while allowing patients to pass away in peace.

One of the crucial fallacies of the slippery slope argument is erroneously citing euthanasia as a floodgate to killing the weak and disabled. In her argument against legalizing euthanasia, Edmund D. Pellegrino writes:

Euthanasia is built on the premise that some lives are not worth living. It is inevitable that lives so designated will be depreciated. These will usually be the lives not only of the sick and dying but of the handicapped, the disabled, the aged, and infants or those at the margins of society (the homeless, the aberrant, the retarded) that is, the candidates for “assistance” in dying.<sup>35</sup>

According to Pellegrino, allowing euthanasia will “inevitably” result in depreciating the lives of mentally and physically disabled individuals. This depreciation, in turn, will lead to undue influence or even coercion for these individuals to end their lives. However, I question Pellegrino’s reasoning for drawing an inevitable link between depreciated lives and the physically and mentally handicapped. I recently spoke with a woman named Sarah Everhardt. Sarah is a ski and sailing instructor. She is also a quadriplegic. Sarah does not see her life as “depreciated.” On the contrary, she despises the “societal attitudes that a disabled life is pitiable

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<sup>35</sup> Edmund D. Pellegrino. “The False Promise of Beneficent Killing”. *Regulating How We Die*. P. 87

and it's best to just put us down because we will never be 'whole' active members of the community and we lead lives of suffering and misery".<sup>36</sup> If Sarah's life is seen as depreciated, it is not a result of her own attitude towards life.

It would appear, then, that the "depreciated" value of a handicapped life does not stem from the handicapped individual. Rather, it seems Pellegrino uses the ignorance of society towards mentally and physically impaired individuals in order to justify prohibiting active euthanasia. Merciful deaths for terminally ill and dying patients should not be denied because of socially constructed perceptions of inequality. Perhaps by legalizing active euthanasia, American society and Mr. Pellegrino himself would have to come to terms with the fact that a life is not depreciated simply because of some physical or mental impairment.

### **Active Euthanasia and Medical Technology**

America has been known for years as the pinnacle of medical innovation and technology. Thousands of breakthroughs have been made to extend human life beyond the original boundaries. Historically lethal and insufferable diseases are now more tolerable than ever before. Innovations to reduce pain and suffering in patients are met with worldwide approval. Morphine, for example, is widely considered the gold standard in relieving otherwise excruciating pain in a wide variety of cases. On a day-to-day basis, painkillers are ingested for a wide range of conditions. Each year, Americans purchased millions of dollars worth of Tylenol and Advil painkillers. One of the primary goals of the medical technology, it seems, is the reduction of pain and suffering in patients. Active euthanasia is the next step in pain management and compassion in medicine. By allowing patients to take control of the circumstances of their death, active euthanasia relieves the suffering and loss of dignity often associated with the final moments of

life. No one seems to object to technologies that improve quality of life and reduce suffering, yet objections are raised when medical technology is used to improve the quality of death and dying. This logic makes no sense. If a physician is allowed to do everything he or she can to bring comfort and dignity to the patient during life, then the physician should be allowed to do the same while the patient passes away. Legalization of active euthanasia allows this to happen regardless of the physical capability of the patient.

## **V. Conclusion**

End of life decisions are often emotionally charged and driven by passion rather than reason. Such emotion is understandable and should be included in matters of such great importance. However, it is vital that policy decisions are not based solely on fear of slippery slopes or concerns about the abstract effects on the medical community. It is equally important to consider those who benefit from a policy, as well as the magnitude of the benefit relative to the cost. In the end, the debate over active euthanasia depends on the benefit of relieving suffering and the possible risks of allowing doctors to end the lives of patients. As this essay has shown, the legal justification for active euthanasia already exists. It is only a matter of time before the United States recognizes the importance of compassion in end of life policies and legalizes active euthanasia.

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