Euthanasia: The Most Humane Impulse

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Abstract

The concept of euthanasia has been present in societies well before the development of the Hippocratic oath, which is an oath taken by physicians swearing to practice medicine honestly. The stringent belief on what constitutes as medical honesty has drawn most physicians away from euthanasia, which is the reason that euthanasia still remains illegal in the United States. The terms assisted suicide, physician assisted suicide, and euthanasia are often confused. The American Medical Association defines euthanasia as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy, which is the definition that will be used for the purpose of this paper. Assisted suicide is defined as helping a person kill him or herself. The only difference between euthanasia and assisted suicide is the acting agent. Proponents argue that the legalization of euthanasia will give terminally ill patients the authority and dignity that they deserve when it comes to end-of-life decisions. They believe that having the option of ending your life will increase the general quality of life. In contrast, critics argue that the legalization of euthanasia will create a slippery slope where physicians will forget their moral boundaries. This paper will begin with the history of euthanasia, and then cover the legal status of euthanasia in the United States and the Netherlands. The next section of the paper will concentrate on the condition on these areas after legalization, which will then lead into the various arguments for and against euthanasia.

Keywords: euthanasia, physician-assisted suicide
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The History of Euthanasia

Euthanasia originated in ancient Greece and Rome before the rise of Christianity (Life Resources Charitable Trust 2011). The idea of voluntary and involuntary “mercy killings” was tolerated in these ancient civilizations because there was no definitive belief in the inherent value of human life. Even though the Hippocratic oath prohibited doctors from giving deadly drugs to anyone, the majority of physicians in that area opposed prolonging death rather than abiding by the oath. It wasn’t until the rise of Judaism and Christianity that human life was viewed as “sacred,” thus making any form of suicide a sin. Peter Glover, a writer specializing in cultural affairs, claims that the “Creator, God himself is opposed to euthanasia,” and that the legalization of euthanasia in society is what would cause dreadful uncertainty and suffering (Glover 2006). It was not until 1935 when the Voluntary Euthanasia Legislation Society was founded that there was a growing interest in the option of euthanasia. Shortly afterwards, the Nebraskan Senator John Cornstock was the first to introduce the Voluntary Euthanasia Act. Even though the act was never voted on, it was a defining moment in the history of euthanasia since it led to the creation of the first national hearings on euthanasia. These hearings were the first time in history that laypeople, physicians, and government officials were all able to sit at the same table to discuss the wide range of issues concerning aging, terminal illness, the doctor-patient relationship, and defining death. Since then there has been a tremendous amount of progress when it comes to discussions about euthanasia; however, since euthanasia is such a controversial issue, a consensus has yet to be reached. The current policies on euthanasia fail to address the constant suffering of millions of terminally ill patients, which is an infringement upon their personal
rights and quality of life. The legalization of euthanasia with stringent regulations similar but not identical to those in the Netherlands will provide a pragmatic and humane solution.

**Active Euthanasia versus Physician Assisted Suicide**

There are two different types of euthanasia known as active and passive euthanasia. Active euthanasia is when the “death of the patient is caused by a lethal injection and passive euthanasia, also related to physician assisted suicide, is death due to inaction,” (Gay 2012). According to the founder of The World Federation of Right to Die Societies, “Physician assisted suicide entails making lethal means available to the patient to be used at a time of the patient’s own choose, whereas voluntary active euthanasia entails the physician taking an active role in carrying out the patients request.” Supporters of physician-assisted suicide (PAS) argue that it allows patients to change his or her mind up to the very last minute. On the contrary, according to Dan Brock, the author of several different articles regarding active euthanasia for the Hastings Center claims that active euthanasia is actually a safer option for patients. Through active euthanasia, the physician would have until the very last moment to discuss topics of motives and options with the patient. Furthermore, even though PAS offers the freedom of timing, there is still the risk of error. The lethal drug would have to be administered while the patient is still well enough to swallow or hold down substances, and it is because of this fear that some patients act earlier than they need to. Dan Brock ends his article by saying that, “If a patient knows that a physician can always intervene, the act of assisted death may be permanently postponed as opposed to when a patient self-administers drugs.” Even though there are many differences between active euthanasia on the pragmatic level, they are more alike than different from a moral standpoint; therefore, active euthanasia and PAS are often used interchangeably.
The Legal Status of Euthanasia

The United States

Legislative. The Hippocratic oath prohibited doctors from giving deadly drugs to anyone, which is primarily why some physicians oppose euthanasia, and this is why it still remains illegal in all fifty states. Oregon, Washington, Montana, and Vermont are the only states that have legalized assisted suicide. There are forty-six states that consider assisted suicide to be illegal through common law, and there are absolutely no laws on euthanasia under the federal government (Dworking 1998).

Oregon was the first state to legalize physician assisted suicide through the Death with Dignity Act of 1997, which gives all terminally ill citizens the right to self-administer lethal medications, prescribed by a physician explicitly for that purpose. Washington, Montana, and Vermont have also legalized physician-assisted suicide by adopting the Death with Dignity Act. Under the Death with Dignity Act, patients are required to fulfill a series of regulations before they are allowed to go through with the process. Some of these regulations include the following: making two oral requests to a physician, including a written request, and consulting with two different physicians regarding diagnosis. To qualify as terminally ill under the Death with Dignity Act, “a person must have an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.” Oregon has demonstrated that if laws can be drafted carefully then they can very well avoid putting patients in risk. Experts opposed to physician assisted suicide have conceded that the Death with Dignity Act has actually forced physicians to be more mindful of the different
options that their patients could have rather than misusing the power they have at hand. The Death with Dignity Center has the task of creating annual reports, indicating how many people were prescribed with lethal medication, and how many of them followed through with their own request. According to the report for 2012, out of the 115 people who requested lethal medication, less than 50 percent followed through with it due to the risk of error. A majority of those 50 percent were unable to self-administer the legal medication due to the lack of digestive abilities.

Judicial. One of the most famous cases regarding assisted suicide is *In re Quinlan*, in which a 21-year-old was declared to be in a vegetative state. After a couple of months, her parents requested the removal of the ventilator, and they had to bring this matter to court when the doctors refused. The New Jersey court denied the request; however, the New Jersey court declared that Quinlan’s right to privacy included her right to be removed from the ventilator. Unfortunately this case was the only case in favor of euthanasia for years to come. Some other famous cases include *Cruzan v. Director of Missouri Department of Health* and *Bush v. Schiavo*, in which the patients were kept on a ventilator because of the absence of “clear and convincing evidence” that the patients wanted to be withdrawn from treatment. The case that mostly everyone is familiar with is that of Dr. Jack Kevorkian who assisted in over one hundred deaths. Dr. Kevorkian was convicted of second-degree murder for administering a lethal drug to Thomas Youk upon his request, who was suffering from Lou Gehrig’s disease. Lou Gehrig’s disease is a neurodegenerative disease that impacts the nerve cells in both the brain and the spinal cord, the degeneration of the motor neurons leads to a slow and painful death (Amyotrophic lateral sclerosis Organization). Dr. Kevorkian had videotaped the procedure, proving that he had only
assisted Youk upon his own request. Even after serving six to seven years in jail, Kevorkian spent the rest of his life advocating the legalization of euthanasia (Trial of Dr. Kevorkian 2013).

**Conditions after legalization.** Since the legalization of physician assisted suicide in certain areas of the United States, medical and government organizations have been closely monitoring the implications of this legalization on all aspects of society. As always, there is a massive amount of polarization in the results. This process has been relieving for many patients and families who were fighting to end this suffering. On the other hand, critics of euthanasia are still skeptical about the integrity of doctors and insurance companies in this process. Even though euthanasia remains illegal in all fifty states of the United States, physician assisted suicide is legal in four. Oregon was the first of the three to legalize physician-assisted suicide through the Death with Dignity Act in 1997. Since it’s legalization a total of 1,050 people were prescribed with lethal medications, and 673 have actually died from ingesting the medications prescribed. In the year of 2012, 115 patients were prescribed with lethal medication, and 77 out of the 115 ended up ingesting the lethal medications (Death with Dignity National Center 2012). Even though the amount of lethal drugs being prescribed is increasing every year, the amount of people dying through physician-assisted suicide in Oregon is minimal compared to the total amount of deaths in the state. Another major concern of euthanasia critics is that lethal medication could be forced on the poor, uneducated, uninsured, or otherwise disadvantaged; however, annual reports prove just the opposite. In fact, there is a higher correlation between education and assisted suicide. Kathryn L. Tucker, a director for Compassion and Choices along with a Death with Dignity analyst found that those with a baccalaureate degree or higher were
7.9 times more likely than whose without a high school diploma to choose physician-assisted dying.

**The Netherlands**

**Legislative.** Euthanasia is legal in the Netherlands under the Termination of Life on Request Act, which was passed 2002. In the Netherlands both euthanasia and physician assisted suicide are lawful since they both require the same criteria; therefore, in the Netherlands when euthanasia is mentioned, physician assisted suicide is also included unless stated otherwise. Since 1985 the Dutch Supreme court has defined euthanasia as, the “intentional terminating another person’s life at the person’s request.” In 1881 the Penal Code was enacted which stated that euthanasia is an “offense punishable by up to twelve years of imprisonment, for a person to cause the death of another person at his or her request”(Dresser 2010). This arbitrary prohibition of “mercy killings” was not questioned until in 1973 when a physician aided her own mother to death after multiple explicit requests. The physician did receive a short sentence; however, the Dutch court soon upheld that he or she had not committed murder. Even though this case was in and out of the court it had raised many questions within a widely Christian country about the role and limits of medical care. In 1982 the Health Council finally decided that a State Commission should be organized to not define euthanasia, and set some parameters for physicians. It was while these parameters were being discussed that the Dutch Supreme Court decided on their first euthanasia case, which was performed on a ninety-five year old who had a combination of deteriorating eyesight, hearing, and speech. (Burghart 2005). The physician was acquitted from prosecution. During this time the Royal Dutch Medical Association was also taking steps toward maintaining societal stability and control of euthanasia. They emphasized that euthanasia should
only be allowed within a physician-patient relationship, and they also encouraged physicians to report their cases. In 1998, the Ministry of Justice in coalition with the Royal Dutch Medical Association created a national procedure for reporting, which included a “multidisciplinary review committee, consisting of a lawyer, a physician, and an ethicist.” This committee was the one to assess whether there were any serious violations of the euthanasia criteria. After about twenty years of trials and tribulations the Dutch Government decided to pass the Euthanasia act on April 1st, 2002, which allowed physicians to make end of life decisions at the “request of a patient who was suffering unbearably without hope of relief” (Burghart 2005).

**Judicial.** There were actually very few legal precedents regarding euthanasia in the Netherlands. This was the case of a fifty-year-old woman who was suffering from cancer herself, and had lost her first son to suicide and her second son to colon cancer. Ms. Netty’s psychiatrist, Dr. Boudewijn Chabot decided to respect her wishes by administering a lethal injection. Even though euthanasia was practiced in Holland, it was not entirely legal, which lead to the psychiatrist being charged with murder; however, the Supreme Court of the Netherlands eventually found the doctor to be not guilty (Paris 2002). It is this case that took euthanasia one step forward in the Netherlands. The case that really developed euthanasia in the Netherlands is the Robert Latimer case. Robert Latimer was a Canadian wheat farmer who was convicted of second-degree murder in the death of his daughter Tracy Latimer. Due to an interruption in Tracy’s supply of oxygen during her birth, she suffered from cerebral palsy, which led to severe mental and physical disabilities. On October 24, 1993, Tracy was found dead with high levels of carbon monoxide in her body. Further investigation led to the discovery that Robert Latimer had acted on Tracy’s wishes because after undergoing over one hundred surgical procedures in her
lifetime Tracy had just been scheduled for another hip replacement, and rather than suffering endlessly she decided that it was best for her to end her life (Paris 2002).

**Condition after legalization.** Euthanasia and physician assisted suicide have been legalized in the Netherlands for over two decades. Similar to Oregon, their society of Medical Ethics produces a report on how many people died from one of these methods during the year, and which condition each person was suffering from. In the years of 2005 through about 2010 the euthanasia rates in the Netherlands were stable; however, recently, this stability has changed. The Medical Society of Netherlands has determined that patients suffering from high psychiatric issues will also be subject to euthanasia. Due to this, the number of people who utilized euthanasia in the Netherlands skyrocketed; the number has reached to some 3,000 people on average. There have been multiple conclusions made stating that euthanasia has spiraled out of control in the Netherlands since it has gone from voluntary to non-voluntary and from terminal illnesses to psychiatric disorders as well; however, there are still stringent regulations in place that make it difficult for the euthanasia procedure to actually take place. Also, non-voluntary euthanasia only takes place if the patient has lost more than 50 percent of their cognitive abilities, in which case immediate family members are allowed to make a decision for their family member (Landers 1990).

**Arguments against Euthanasia**

**Sanctity of life**

Overtly religious people who argue against euthanasia often use the sanctity of life argument, which is the principle that all human life is sacred and of value and should not be
violated. The sanctity of life is an individual moral conviction; it is a concept that one believes. It is the moral conviction that all humans, at every stage of their life, including every religions, race, physical and behavioral characteristics, ability, disability are to be seen to have “immeasurable worth and inviolable dignity”(Keown 2009). The famous enlightenment philosopher Immanuel Kant made the claim that human beings should be treated as an end in themselves and not as a means to something else. The fact that we exist means that we have value, regardless of any illnesses or disabilities. The idea of assisting someone in their own death simply because they see no hope in their life is perceived to be a sin, since life is a gift given to everyone by God, which is the non-secular argument for sanctity of life. Furthermore, it is stated in the Bible that our lives are not our own, and we do not have the right to “dispense with it.” This argument is also presented in the form of respect, which argues that if a person choses to end their suffering in the form of ending their life then they are being disrespectful to their worth or value as humans.

Slippery Slope Argument

One of the biggest concerns of anti-euthanasia advocates is that the legalization of voluntary euthanasia creates a slippery slope in which physicians would start forgoing the distinction between killing someone who wants to die versus killing someone because they think the patient should be dead. Many legislators also believe that health care costs will motivate physicians to kill off more patients to make more money. A majority of policymaker’s reference to the Nazi’s, and state that they engaged in a large amount of involuntary euthanasia, meaning that we should not trust the moral sense of doctors. More than anything people fear that the legalization of euthanasia would create an imbalance in power. From this perspective, doctors
will be allowed to “play God,” and this would in turn pressurize the more vulnerable patients to end their lives (Moreland 2010). When a person is on their deathbed, it is almost natural for them to have feelings of worthlessness; they begin to feel like burdens on not only their friends and family but on society in general. Furthermore, the last few months of a patient’s life are usually the most financially taxing, and being able to shorten this period of financial scarcity, some patients may view this as their chance of giving back to their family. The slippery slope argument states that it is virtually impossible to ensure that all acts of euthanasia are truly voluntary, and eventually the elderly, lonely, or sick people would feel pressured into early death (Smith 2006).

**Arguments for Euthanasia**

**Quality of Life**

The quality of life argument is what the proponents of euthanasia use to counter the sanctity of life argument. The length of our existence is inconsequential or insignificant if the remaining life is unbearable and painful. Failing to grant someone’s request for help to end their suffering easily and quickly is inherently immoral. Patricia Hewitt, a member of the Dignity in Dying organization which is a non-profit organization that has led the legal defense and education of the Oregon Death with Dignity Law for over twenty years, says that euthanasia should not even be a question of the sanctity of life versus the quality of life because ending someone’s suffering should just be viewed as a humane impulse of kindness. She goes as far as to say that, “we are gentler to our pets than to our fellow humans in facilitating an ultimate release from suffering when needed.” Even though most anti-euthanasia people correlate the
quality of life with income, quality of life actually references to the general well being of individuals and societies. The general indicators of the quality of life created by the World Health Organization revolve around social environments, physical and mental health, education, leisure time, and belonging. Even though the effectiveness of medication is increasing, there are still some diseases that cannot be cured and they cause patients to basically become a “vegetable”, meaning that they cannot perform any of the daily tasks that a “normal” human being would be able to. Why not end that person’s suffering rather than make them live everyday knowing that they will not be able to lead a normal and fulfilling life? Huntington’s disease is a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems. In a disease of this type, a person completely loses the very basic abilities, which are second nature for most of us. For most “normal” people, it is impossible to understand what it is like to feel captivated in your own body. John Keown, the author of several books regarding euthanasia policies and arguments once stated that, “a doctor who is unconcerned about the quality of life is inhumane; and the real enemy is not death but inhumanity.” He also contends that once a person’s life falls under a certain threshold, it is simply not worth living since life is more than just surviving.

**Autonomy**

Autonomy or the principle of individual decision-making is highly valued in the United States. Even though we don’t have the specific right to die, we do have the right to live, which doesn’t necessarily mean just the right to exist. Despite knowing that death is the opposite of life, “dying is still a living process, and we should be able to decide how we want to go through with it” (Journal of Medical Ethics 2012). In fact, any libertarian would argue that if a particular action
serves the best interest of the people concerned and in turn doesn’t violate the rights of anyone else, then the act should be morally acceptable. Additionally, the Fourteenth Amendment to the Constitution assures individuals the right of choice. It is legal for any terminally ill patient to make the choice of withdrawing treatment, and it almost seems contradictory according to Dr. Walters, a graduate from Cornell University, to “not permit terminally ill patients from hastening death by means of additional medication given with physician assistance.” The thing to really focus on here is that there are some people in this world that will follow the rules and their moral instincts, but there will also be the few who do what they think is best for them, meaning that no matter what, euthanasia will be taking place somewhere; therefore, isn’t it better to legalize it and regulate it? Effective regulation of euthanasia will be time-consuming and costly, but effective regulation is the only practical route. The government would have to implement full-scaled investigations of the patients psychological background, along with an at length search of the patient’s disease (Muhlenberg 2010).

It is crucial that society restructures its view on death because if we no longer viewed death as a bad thing, then so many of the objections to euthanasia would no longer be objections. Our society collectively views death as something bad and something that we should avoid at all costs. However, death shouldn’t be viewed as something terrible in every case because sometimes people truly have nothing left to live for, because they have no hope for recovery, they have given up on most of their relationships, and they are just ready to be freed of the suffering. Therefore, death wouldn’t be depriving them of anything at all (Lanza 2009). Death should not be seen as something morbid, instead it should be seen as something liberating for the people who are in constant pain. For example, Thomas Youk, who was suffering from Lou
Gehrig’s disease, was permanently paralyzed due to the lack of his motor neurons, and Tracy Latimer who by the age of fifteen had already undergone over 100 surgical procedures were given freedom from their pain.

**Understanding Empathy**

Many psychologists such as Jean Decety a Professor of Psychology and Psychiatry at the University of Chicago contend that euthanasia and other practices like it remain illegal in many parts of the world due to the lack of empathy in people. Despite having many definitions, most psychologists tend to define empathy as, “the ability to share and understand what another person is thinking and feeling, and to respond with care to others in need.” The development of empathy varies drastically from nation to nation. Non-developmental factors such as temperament and parent-child relationship quality have a large impact on the empathy of a child. Multiple studies show that children born in foreign countries are more empathetic because of the conditions they grew up in. Unlike many kids born in the United States, kids born in foreign countries are exposed to all spectrums of life at an early age. An example of this is the Roots of Empathy Project created by Mary Gordon, an internationally recognized social entrepreneur, educator, author, and child advocate. This project started off in Canada, and has reached “over half a million children worldwide since then” (Gordon 2000). One experiment conducted by this organization examined reactions of children to videos illustrating the life of people with illnesses. The children, ages seven through ten, were divided into two different groups based on ethnicity and socio-economic status. After both groups were shown the video, the reactions were drastically different. The Caucasian group of children was either bored by the process or had questions regarding why the people they witnessed were so different from them. On the other
hand, the group of children from the Hispanic decent was immediately concerned with what they could do to help these people (Roots of Empathy Proceedings 2012). Children who grow up with a terminally ill person will have a completely different understanding of what it means to live a debilitating lifestyle. On the other hand are the kids who are sheltered from the bitter reality of the world who do not know of anything that could be so drastic as to lead to the end of your own life. Interestingly enough, most of the proponents of euthanasia have either lived with someone who has a terminal illness, or have seen a vast amount of suffering in their life. On the other hand, critics of euthanasia are generally highly religious people who are blinded by their religion, and have no understanding of the quality of life versus the sanctity of life. The act of perspective-taking is summed up by one of the most enduring definitions of empathy we have, formulated by Adam Smith as “changing places in fancy with the suffers.”

**Conclusion**

Euthanasia is both a highly controversial and complicated subject to discuss. Is it practical to allow physicians to move beyond the realm of the Hippocratic oath and be liable for taking a patients life on request? Do we as people have a moral obligation to assist those who are suffering? These are just a few of the many questions that a topic like euthanasia will leave people asking. There are many pragmatic concerns when it comes to euthanasia such as cost control and whether patients should even have this authority; however, the moral factors are far more significant when it comes to this topic.

Most of the arguments against euthanasia are made from the fear of risks; however, these perceived risks cannot outweigh the reality of the millions of terminally ill patients in the United
States. Several of these patients lack the simplest of abilities. Most cannot step out of bed or even dress themselves without assistance. Dr. Andy Garfield, who received her doctorates in Bioethics from Fordham University, conducted several case studies on terminally ill students came to the conclusion that most terminally ill patients have no aspiration to live. They would rather end their life than suffer from constant physical and emotional pain. Not only do they lose basic abilities such as walking, but they also lose their job and some of their primary relationships.

Euthanasia has been legal in the Netherlands for about two decades, and within this time there has been significant evidence of a slippery slope. They went from initially legalizing voluntary euthanasia, which then led to some form of involuntary euthanasia. Initially it was just terminal illnesses that were under the legal code, which was then expanded to include mental disorders as well. On the other hand, even though there is less evidence of a slippery slope in Oregon, which has only legalized physician-assisted suicide, many patients were unable to self-administer lethal medication. In order to provide the best solution, the United States would need to find a middle ground.
References


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# Grading Rubric for Final Paper

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<th>4 -- Advanced</th>
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## Uniform LSA Scoring convention

- 16 = 100
- 15 = 97
- 14 = 94
- 13 = 91

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