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Medical treatment and the good death: an ethical analysis of euthanasia, physician assisted suicide, and the right to die

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MEDICAL TREATMENT AND THE GOOD DEATH:

An Ethical Analysis of Euthanasia, Physician Assisted Suicide, and The Right to Die

by J. Christopher McMath, '96

Submitted in Partial Fulfillment of the Senior Scholars Program

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Abstract

Frequent advances in medical technologies have brought forth many innovative treatments that allow medical teams to treat many patients with grave illness and serious trauma who would have died only a few years earlier. These changes have given some patients a second chance at life, but for others, these new treatments have merely prolonged their dying.. Instead of dying relatively painlessly, these unfortunate patients often suffer from painful terminal illnesses or exist in a comatose state that robs them of their dignity, since they cannot survive without advanced and often dehumanizing forms of treatment.

Due to many of these concerns, euthanasia has become a central issue in medical ethics. Additionally, the debate is impacted by those who believe that patients have the right make choices about the method and timing of their deaths. Euthanasia is defined as a deliberate act by a physician to hasten the death of a patient, whether through active methods such as an injection of morphine, or through the withdrawal of advanced forms of medical care, for reasons of mercy because of a medical condition that they have. This study explores the question of whether euthanasia is an ethical practice and, as determined by ethical theories and professional codes of ethics, whether the physician is allowed to provide the means to give the patient a path to a "good death," rather than one filled with physical and mental suffering. The paper also asks if there is a relevant moral difference between the active and passive forms of euthanasia and seeks to define requirements to ensure fully voluntary decision making through an evaluation of the factors necessary to produce fully informed consent. Additionally, the proper treatments for patients who suffer from painful terminal illnesses, those who exist in persistent vegetative states and infants born with many diverse medical problems are examined.

The ultimate conclusions that are reached in the paper are that euthanasia is an ethical practice in certain specific circumstances for patients who have a very low quality of life due to pain, illness or serious mental deficits as a result of irreversible coma, persistent vegetative state or end-stage clinical dementia. This is defended by the fact that the rights of the patient to determine his or her own fate and to autonomously decide the way that he or she dies are paramount to all other factors in decisions of life and death. There are also circumstances where decisions can be made by health care teams in conjunction with the family to hasten the deaths of incompetent patients when continued existence is clearly not in their best interest, as is the case of infants who are born with serious physical anomalies, who are either 'born dying' or have no prospect for a life that is of a reasonable quality.

I have rejected the distinction between active and passive methods of euthanasia and have instead chosen to focus on the intentions of the treating physician and the voluntary nature of the patient's request. When applied in equivalent circumstances, active and passive methods of euthanasia produce the same effects, and if the choice to hasten the death of the patient is ethical, then the use of either method can be accepted. The use of active methods of euthanasia and active forms of withdrawal of life support, such as the removal of a respirator are both conscious decisions to end the life of the patient and both bring death within a short period of time. It is false to maintain a distinction that believes that one is active killing, whereas the other form only allows nature to take it's course. Both are conscious choices to hasten the patient's death and should be evaluated as such.

Additionally, through an examination of the Hippocratic Oath, and statements made by the American Medical Association and the American College of physicians, it can be shown that the ideals that the medical profession maintains and the respect for the interests of the patient that it holds allows the physician to give aid to patients who wish to choose death as an alternative to continued suffering. The physician is also allowed to and in some circumstances, is morally required, to help dying patients whether through active or passive forms of euthanasia or through assisted suicide.

Euthanasia is a difficult topic to think about, but in the end, we should support the choice that respects the patient's autonomous choice or clear best interest and the respect that we have for their dignity and personal worth.

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I also owe a debt of gratitude to the Independent Studies Committee for allowing me to undertake this project and to my many friends who encouraged me along this great journey. A special thanks to my roommate and good friend Michael Goode for supporting and tolerating me this year as I stressed over this project a bunch and to Andrew Glos for being there to bounce ideas off of at three in the morning.

CHAPTER ONE:

THE STUDY OF EUTHANASIA AND THE GOOD DEATH

Modern medicine has grown at a substantial rate in the past twenty years, with new medical technologies that now allow health care teams to successfully treat many patients who would have otherwise died of serious trauma, a variety of chronic and terminal diseases, or from debilitating birth defects. With these advances have also come many serious philosophical problems that are a constant source of debate between philosophers and health care workers alike. Many people can survive such ordeals, but the stress of the treatment may leave them in a limited physical or mental state accompanied by substantial pain with little hope for a full recovery. In many of these cases, the lives that remain may be of a questionable quality for the patient or may require the commitment of so many resources that it places a great emotional and financial burden on the patient and the family. The outcomes of such cases are of considerable concern to medical ethicists and those working within medicine.

The goal of the field of medical ethics is to attempt to answer questions brought about by these new medical advances and to give practitioners and patients and their families options to consider in difficult cases. Euthanasia is one of the central areas of medical ethics which has received much attention by philosophers. The circumstances the debate encompasses raise many key ethical questions, such as whether it is right for doctors to carry out requests of euthanasia in any circumstance, who should decide for patients who cannot decide for themselves, and whether euthanasia is wrong in general.

The ultimate question that I plan to deal with in this paper is: is euthanasia ever an ethical medical choice, and if so, under which circumstances is it a proper choice, and under which is it wrong? Is euthanasia an option to give a patient a death that is free of pain and to allow them to retain their dignity?

Before I go any further, I would like to have a working definition of euthanasia. The original meaning of euthanasia comes from the Greek, meaning a "good or easy death." Webster's Dictionary further defines it as "The act or practice of killing or permitting the death of hopelessly sick or injured individuals (as persons or domestic animals) in a relatively painless way for reasons of mercy."

I will use euthanasia to mean, any action or conscious omission that is carried out to intentionally end the life of a patient who wishes to die for a reason related to a medical condition they have. It may also be carried out because of a decision made by a second party about the quality of life of a patient who is unable to speak for themselves because they are either mentally incapacitated or are too young to make their wishes known. Euthanasia can either refer to an act of the withdrawal of lifesaving treatments or a direct action meant to bring about the painless death of a patient through a method such an injection or through the administration of additional intravenous medication such as morphine. For many people, euthanasia has come to be connected with only direct active euthanasia. I plan to use the term to mean any act that hastens the death of a patient, regardless of method.

The question has been posed by many scholars if there exists a moral difference between the use of different methods of euthanasia. Is there a difference between a physician who removes life-sustaining treatment and one who takes life by the provision of a lethal agent? There are people who feel strongly on both sides of the issue. The question of whether there is a legitimate moral difference between active and passive forms of euthanasia will a major focus of several sections of this paper since this distinction impacts many areas of the debate.

The subject of euthanasia has become a hot topic in medical ethics for several reasons. With the current advances in medical technology, people are living longer than ever before. Some medical conditions, such as infections like pneumonia, are very treatable, so people live longer and can develop more complex health problems later in life that can cause them a great deal of discomfort at the end of their lives.

Chapter One: The Study of Euthanasia and the Good Death

If someone has not died from serious medical problems earlier, then they are more likely to spend their final days in a hospital. Several years ago, more people died at home, surrounded by family, in a more natural fashion, in what could be termed a "good death." The patient had control of their passing, instead of being left to an existence of a questionable quality permeated by substantial intervention by medical technology. Infectious diseases were a large cause of death. Pneumonia was referred to by some, as "the old man's friend," since it allowed people to die painlessly before they developed more serious problems.[1] Today, due to modern antibiotics, most cases of life threatening infections can be controlled.

Cancer, heart disease, Alzheimer's disease and strokes are some of the leading causes of death in the United States. These conditions may kill their victims the first time they strike, but in many cases, they may chronically weaken a patient to the point where they require the use of life-support systems, are in substantial pain or have an extremely low quality of life. These patients and their families who have been affected by such afflictions often ask for an end to the pain and suffering of the medical condition.

Many of these complex medical and ethical issues arouse great debate between physicians and other members of the health care team, hospital ethics committee members, the family, clergy members and others involved in the case. Many who have written on the subject of euthanasia have sought to recommend guidelines to answer such questions of whether it is ethical to end the life of a patient who either has a condition that has rendered them mentally incapacitated or left them in a state of constant, harsh pain. There are many who feel that euthanasia can be used ethically when the situation warrants it, and there are those who are opposed to killing of any form, regardless of the situation. Cases such as the Quinlan and Cruzan cases and those of Baby Doe and Baby Jane Doe have been widely covered in the media and have brought a personal side to the philosophical arguments and have caused more people to think about the issues related to euthanasia. Circumstances also exist in the

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[1] Ramsey, Paul. Ethics at the edges of life : medical and legal intersections New Haven : Yale University Press, 1978.

Netherlands in which euthanasia as practiced by a physician is not prosecuted. Due to this fact, many people have to looked to Holland, both to defend a position on euthanasia and to argue why it would be abused if implemented on a wide scale in the United States. The practice of euthanasia in the Netherlands will be examined in detail in chapter six.

The patient rights movement and the euthanasia debate

As medical technology has advanced, so has education about medical care. Patients now want to know more about their own medical treatment and want to have more of a say in making their own decisions. In years past, it was commonplace for decisions regarding patients to be made in a quiet manner by the physician, with limited consultation with the family. Many people believed that it was bad to tell the patient the truth about his or her condition since it might make the condition worse.

Today there is more openness about treatment plans, and the majority of doctors routinely discuss treatment options with their patients and the patient's family. As a result, people demand to have more of a say in their own care. The notion of informed consent has become important in patient care, and it recognizes that a patient cannot decide for him or herself without being adequately informed by the physician as to the nature of his or her diagnosis, prognosis and potential treatment options. Written directives detailing the course of treatment for persons in the case that they are unable to decide for themselves have also become increasingly popular. These statements are referred to as advance directives, or living wills. These documents have been created to give specific outlines of care decisions to give the patient's family and treating physician ideas concerning their care should they become incapacitated. In many circumstances, these directives have served as a substitute for first-person consent by the patient. Many people have stated in such documents that they do not wish to be put on a respirator in the event that they are unable to breathe for themselves. Some have also stated that they do not want certain surgical procedures performed or want to refuse treatments that have no potential to help them make a full recovery and only prolongs a painful death. These refusals of care which are laid out in such advance directives or by the patients themselves can be the root of several philosophical problems. These refusals of life-saving treatments by either the patient or their families would, in many circumstances, constitute euthanasia. Who is responsible in this case? Is the physician potentially committing a moral injustice or is the act considered suicide by the patient? Also, do the living wills represent actual consent for refusal of care?

These refusals of care are the cornerstone of the right to die campaign. Cases such as the New Jersey Supreme Court case of Karen Anne Quinlan have brought many issues into the euthanasia and right to die debates. Many people contend that there exists a right to die and the patient has a right to request either the withholding of treatment or to have their suffering ended by active euthanasia. They also contend that the state has no right to interfere with decisions for comatose individuals made by families that are believed to be in the patient's best interest.

Many groups have contended that there is no right to die and that euthanasia in any form is wrong. Many of the people who argue that euthanasia is wrong do so from a religious point of view. They feel that life is sacred in all circumstances and can only be ended by God.

Another factor of the euthanasia discussion that has been widely covered in the media is physician assisted suicide. This occurrence brings up many tough issues and has people who feel strongly on both sides of the debate. Most people have heard of the activities of Dr. Jack Kevorkian. The retired Michigan pathologist has been present at 27 suicides of terminally ill patients as of December 1995, and vigorously supports the right for patients to seek PAS as an option when they have circumstances that they feel demand it. This study will examine PAS as it relates to the physician's role in health care decisions and will also ask if PAS can be included in the range of choices that the patient is allowed to make to end pain and suffering.

The development of the field of medical ethics

These tough questions regarding euthanasia are dealt with by scholars in medical ethics on a daily basis. Medical ethics is a discipline that is concerned with determining right and wrong actions in the practice of medicine. Those who study medical ethics examine various ethical problems within medicine that have often produced doubts for both practitioners and patients.

Medical ethics started as an academic discipline within applied ethics. Philosophers were not as concerned with actual patients as they were with writing and academic discussions. A story was written by a physician early in the development of the practice of medical ethics in hospitals who presented the case of a burn patient who wished to die to a class of medical students. He had been talking all week with the nursing staff and the family about this difficult case and they didn't know how to resolve it. He presented the case to the students and asked for their responses. They had many differing opinions as to what should happen, and provided some unique insights. He then said that he would go back to the family and tell them the new ideas he had received. The professor was extremely surprised and with some horror said, "you mean that case was of an actual patient?!"[2]

A need was developing for patients' rights to be given protection and for physicians and medical staff to become more educated in ethical issues related to medicine. Many scholars with backgrounds in philosophy and law were hired by hospitals and academic medical centers to consult on cases where the course of treatment was in doubt.[3] This new service is performed in the recently created field of clinical medical ethics. The philosophers who work in this field function as an integrated part of the heath care team, offering help to physicians and the patient and his or her family. The need for ethics consultations was also born out of the increase in patients' demands to be involved in a larger part of their own treatment. Patients wanted to be

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[2] Macklin Ruth, Mortal Choices. Ethical Dilemmas in Modern Medicine. (1988)
Boston, Houghton Mifflin, pg 86.

[3] Dubler, Nancy N. and David Nimmons, Ethics on Call, Taking charge of life-and-death choices in today's heath care system (1993) Vintage Books. pg. 40.

more informed of their treatment options and to receive education to be in a better position to be able to make informed choices regarding their own care.

Hospital ethics committees are also a relatively new development. Ten years ago only a small number of the nation's academic medical centers and teaching hospitals and a few private hospitals had ethics committees. Today, the vast majority of major medical centers and a large percentage of private, religiously affiliated and community hospitals have such committees.

These committees are often composed of clinical ethicists, lawyers, doctors and other medical staff with special training in ethics, plus the treating physician and staff that are directly involved in the case being currently discussed.[4] During the course of the committee meetings, various members will give their medical and philosophical opinions and suggest different options for the patient or family and treating physicians to consider. Often the family will be present at the meeting and can directly ask questions to the various members.

Medical ethics is also referred to in the literature as bioethics. This field deals with the study of morality within pursuits related to medical treatment and scientific inquiry. Topics in bioethics have traditionally included medical research, genetic engineering, animal rights as they related to medical and social research, and many aspects of medical practice and the rights of the patient. Other areas that are widely studied include protocols for clinical research involving human patients, reproductive technologies, organ procurement and allocation, suicide and euthanasia, rationing of care and the physician-patient relationship.

Medical ethics has evolved considerably in the past few years. It has grown to accommodate the tremendous growth of medical technologies. These technologies, while helping many people, have also created many philosophical problems. One such problem is resuscitation of very critically ill patients. When resuscitation attempts are successful, the life of the patient is saved, but, depending on the speed of the resuscitation and the time since arrest, the patient may have suffered irreversible brain damage due to a lack of oxygen to the brain

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[4] Dubler and Nimmons, Ethics on Call, pg. 47-48.

tissues. This lack of oxygen may have led to the complete destruction of several regions of cells that controlled the patients thoughts, memories and character. These patients remain biologically alive, but who they were as a person is, for all practical purposes, gone forever. What remains is a patient who may require life-support and has little or no contact with the outside world.

Once the technology has become available, we should ask if it should be used in all circumstances. In many cases, the patient's "life" has been saved, but a large part of who the patient was has been lost permanently.

Issues in the euthanasia debate

Euthanasia has many difficult issues that are associated with it. To be able to better understand the field, it is necessary to explore several different ideas. This work will explore such issues as whether there is a right for patients to choose medical care options that aim to relieve suffering but may lead to their deaths. Additionally, we need to evaluate the importance of quality of life in treatment decisions. There are some cases in which the death of the patient may not be directly imminent, but the level of pain and loss of dignity that accompanies such a life may be too great to endure. For patients who are permanently comatose, they are not suffering as such, but the level of dignity that remains and their lack of quality of life may make them candidates for euthanasia in one form or another.

Another patient group to be discussed are infants who have been born with severe anomalies that all but promise a life that is full of pain or one which lacks any human contact. With these problems and the inability for even the highly technical field of neonatology to treat some problems, we are forced to ask what should happen to these small patients.

Finally, instead of just addressing whether the patient has a right to choose a course of treatment that results in a speedier death, we need to ask if their is an allowance in professional and moral codes of ethics that would permit physicians to provide the means to a painless death, whether through the withdrawal of medical treatment, active forms of euthanasia or assisting a patient to take his or her own life through the prescription of lethal doses of medication.

Various forms of euthanasia including active provision of medication, withdrawal of treatment and assisted suicide have become major components of medical ethics. As the development of medical technology increases and as the population ages, these issues will continue to increase in importance. Medical treatment should not only include a concern for extending the patient's life, but should also consider the quality and level of dignity that such a life gives to the patient.

CHAPTER TWO:
INTRODUCTION OF THEORIES AND PRINCIPLES USED IN MEDICAL ETHICS

Medical Cases that require an ethical analysis are evaluated using several different philosophical theories and principles. These theories use a variety of methods to determine whether the act in question is morally acceptable. In order to help the reader understand the terms used in this paper, I will present a general introduction on the philosophical basis of medical ethics. The theories and principles presented here will be used in later chapters to evaluate different cases relating to euthanasia, so this chapter is an important one.

The first theory to be introduced is Utilitarianism. This widely used theory weighs the net happiness of all persons involved in a certain situation as produced by a certain action to determine the permissibility of the action in question. This theory forms a basis for many discussions of quality of life issues as they affect medical ethics and medical decision making. It has been criticized by some for ignoring the interests of some groups in favor of those with more power. Utilitarian calculations, might for instance, state that the deteriorating elderly should not receive medical care since they a makeup a majority of health care spending and funding is so limited and might benefit other groups.

The second theory that I will examine is Deontology. This theory was developed by the German philosopher Immanuel Kant, and relies on the Kant's Categorical Imperative as it's chief tool of evaluation. The Imperative takes individual actions, or maxims, and expands them to determine the goodness of the action if it were to become a widespread practice. There are also several principles that have come out of Kantian theory that affect medical ethics. They include the principle of respect for persons, also referred to as the second form of the categorical imperative, and the principle of autonomy.

Additionally, I shall introduce the Hippocratic Oath, a statement written by the Greek Physician about 400 B.C, and a theological argument that will be used to evaluate a majority of cases in this paper. The chapter will then explore some basic philosophical ideas such as principles concerning the quality and sanctity of human life, the morality of killing and why death is viewed as a moral evil. This section will attempt to answer such questions like why killing is wrong, and what features of a person's life determine whether it is ethical to invoke euthanasia.

Moral Philosophy and Medical Ethics

Ideas and principles from general moral philosophy are used as a basis for medical ethics. There are several moral systems that are used to debate medical ethical issues. A philosopher will generally have accepted a system of moral philosophy, which will then be used to evaluate cases. In the beginnings of their philosophical training, these scholars will study extensively the writings of philosophers that represent the different systems. They will systematically debate these theories and reject them until they find a system with which they most agree. Most philosophers are fairly consistent in the principles they use for decisions, so such people often become identified with a certain theory and may then be called a Kantian or a Utilitarian, etcetera. All philosophical systems, no matter how well they generally answer a set of questions, have some shortcomings, so philosophers who subscribe to a certain theory may encounter situations in which they believe the conclusions that the theory has reached are false. In those cases, some exceptions to the theory are often made. For the utilitarian, the theory may reach some conclusions that violate a patient's right to life and treatment, and for a Kantian, the categorical imperative may prohibit actions that are allowable under other major theories.

Unlike many areas of philosophy, medical ethics seeks to answer questions that affect the way actual day to day decisions are made. They have significance to real ethical problems

within medicine and are not purely academic issues, since they affect the outcomes of actual patients.

One example is the debate over how scarce organs should be distributed. There are many different methods that are used to decide who gets the organs that are available and who has to take the risk of dying while waiting to receive an organ. Some people have suggested that a protocol be set up that judges patients for their potential worth to society after they recover. Under this system, a college professor or an EMT who can save lives would be put ahead of a recovering alcoholic without a family for whom to provide.

This approach, referred to as social worth criteria, is related to a theory known as utilitarianism. This theory holds that an act is right if it produces more pleasure than pain. Utilitarianism is referred to as a consequentialist theory, since it believes that the results of the act, or consequence, are what is important morally.

Many feel this method is not right and is discriminatory. They have advocated a more egalitarian system where the organs are allocated on a first-come, first-served basis. They feel this avoids unfair biases relating to socioeconomic status. Some theories would state that the providers have equal duties to all patients and thus it is not right to make decisions based on worth to society.

The point is, what ever system we choose to accept, a choice has to be made in a real hospital for real patients. It is not just a policy for endless debate. There have to be choices made, regardless of the range of debate. Medical ethics attempts to answer such questions and give practitioners, patients and families educational information so they can make choices in the most ethical manner possible.

Utilitarianism

The first theory that is used by some in moral philosophy and ethical theory is called Utilitarianism. This theory relies on the belief that an act is right if it increases the net amount of happiness and an act is wrong if it causes a lesser amount of net happiness for all persons involved. Utilitarians also speak of the notions of pleasure and pain as primary considerations for ethical decision making. An act is right if it brings the greatest balance of pleasure or benefit to all persons in a certain situation, wrong if it brings a greater balance of pain. The founders of the theory of Utilitarianism are philosophers John Stuart Mill and Jeremy Bentham. Mill's work *Utilitarianism* laid out many of the early principles of the theory.

As said previously, Utilitarianism is a consequentialist theory and believes that the outcome of an act is what is important. Utilitarianism believes that there is no intrinsic goodness in acts in and of themselves, only in the outcome. Utility is named as the most important goal when evaluating acts.

Common objections to utilitarianism

This system at first glance, seems to be correct. It would seem that it is good to maximize the balance of happiness and minimize pain. But, whose happiness is valued and how do we decide whose happiness is the most important? How do we determine what result brings the greatest amount of net happiness in a given situation?

If I have three one hundred dollar bills and I give one to each of my three friends, they each experience a degree of happiness. What happens if I give all three to one friend, leaving the other two unhappy, but the first very happy? What is the amount of net happiness then? Does the great amount of happiness of one compensate for the unhappiness of the others?

The above questions show a common objection to utilitarianism, which is that it is often difficult to tell in a situation how resources should be distributed among persons to maximize the balance of utility. Is there a way to determine how to maximize happiness? What happens if I give one friend the three hundred dollars and don't tell the other two? They are not happier, but are not unhappy either.

One of the major objections to utilitarianism is that it is hard to measure pleasure and pain. How do we determine which acts maximize utility? Jeremy Bentham, a major contributor to the theory of Utilitarianism, created a method called the Hedonic Calculus to measure the amount of pleasure and pain for a given act, but it is still obviously difficult to measure such a quantity.

Utilitarian considerations will be used for many cases in this paper. In medical ethics, and specifically in questions of euthanasia, there are many cases where it is possible to determine what decision does create the best situation with a reasonable amount of certainty. There are situations, such as in a case of extreme suffering due to pain or in a case of irreversible coma, in which it can shown that the hastening the death of the patient would increase the utility of the situation. Utilitarianism is very important for such cases that are made on a quality of life basis.

A second objection to Utilitarianism is that it can lead to injustice for those at a disadvantage in certain situations such as the elderly, the sick or poor or ill infants who cannot speak for themselves. A handicapped newborn who is born with many birth defects would be a tremendous burden on it's parents.[1] The problems the newborn possesses would incur large amounts of medical expenses and the parents would have to take care of the child for a long time. Some utilitarian methods of calculation might suggest that utility might be maximized if treatment was withheld from the infant and he or she was allowed to die. The newborn wouldn't experience much pleasure and would be frequently in and out of the hospital. So if the child was allowed to die, then utility might be maximized.

Many people would be horrified at this conclusion. Many might argue that the newborn has an absolute right to life and cannot be refused care because of the parent's unwillingness to care for it. They might cite a parental duty that exists for parents to care for their children. Doctors also have a duty to care for their patients and they are not permitted to end care because the child would be a burden.

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[1] Beauchamp, Tom L. and LeRoy Walters, Contemporary issues in bioethics, (1989) Belmont, Calif. : Wadsworth Pub. Co. pg 48.

Act and Rule Utilitarianism

When moral theories are applied to a range of similar circumstances, the question arises whether the same judgments should be made for all equivalent situations. To deal with this question, rules for conduct for a class of actions may be created. These rules, known as moral rules, are binding for all acts that fall into the class of actions that the rule is intended to cover. This use of moral rules to cover a broader range of circumstances is known as a rule based theory. Even though this approach covers a broader range of circumstances, it still reasons from a utilitarian perspective, with utility being the paramount concern. For a rule utilitarian, stealing might be judged as wrong, since it detracts from utility in a larger number of circumstances than it adds to it. Even in the case of individual instances where a specific circumstance might add to utility, it would be rejected since it violates the moral rule against stealing. It could be argued that a parent who steals food for his or her hungry children is maximizing utility in that circumstance since the interest of preserving their lives outweighs any profit that the shopkeeper might lose on a loaf of bread, but the stealing violates the rule.

There are many philosophers who support a rule based theory of utilitarianism. The judgment that the rule makes holds in all circumstances regardless of consequences. An example might be a moral belief that it is wrong for a physician to lie to his or her patients. In rare circumstances, there might be those who would say that it is justified for the doctor to lie to his or her patient. The patient might have a heart condition and telling the truth might cause the patient's condition to worsen, so it might be believed that it is better to lie to the patient to increase the utility of the situation.

The strong rule utilitarian would not accept this. The moral rule says that lying is wrong and for the doctor to lie, even in this circumstance, violates the moral rule, since it has been established that in a greater number of circumstances, lying decreases utility.

One difficulty in forming rules for this theoretical structure is knowing how broad the category can be. There is very little to prevent the rule utilitarian from narrowing the defined class of actions to include actions that would be prohibited by a wider rule. For euthanasia, rules might be made that exclude euthanasia as violation of a prohibition against killing, or a class could be defined that only includes forms of euthanasia that beneficently hasten the deaths of patients who are suffering or are permanently unconscious.

Some might say that the moral rules imposed by the rule utilitarian are too broad and that decisions should be made on a case by case basis, not using a rule based calculus. If the act creates more net utility for the given situation, then it should be used. This belief is the foundation for a sub-set of Utilitarianism called Act Utilitarianism.

Under Act Utilitarianism, the physician with the heart patient, might be justified in lying since the outcome for the patient is better, even though the lie goes against the moral rule of not lying to patients. Using an act system, the act of lying to the heart patient would be justified since more utility is created for this specific situation.

The principles of beneficence and nonmaleficence

An idea that is connected to aspects of utilitarianism is called the Principle of Beneficence. This principle believes that persons have certain obligations to others to prevent harm and to promote goodness to attempt to maximize utility. The companion principle to beneficence is nonmaleficence, which states that people also have a duty to prevent harm. This is associated with the directive, "do no harm," which is argued by many to be a primary duty of the physician. With respect to the use of the principle of beneficence, Peter Singer writes that a duty exists to undertake a specific action to prevent something bad from happening unless something has to be sacrificed that is of comparable importance.[2] This would establish a

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[2] Childress, James and Tom L. Beachamp, Principles of Biomedical ethics, (1989), Oxford University Press, pg 190.

duty to do whatever would maximize utility in virtually any circumstance unless something has to be sacrificed that would lead to an outcome that is comparably bad. A common example that is often given is the duty to save a drowning child. The principle would say that if someone were at a beach and came upon a drowning child, they would have a duty to save the child unless the attempt to save it would bring about an equal or greater harm. If the rescuer cannot swim and risks drowning, then they are not required to put their life in danger, but if they can swim then they ought to save the child. This seems simple enough, but several problems arise with the further application of the principle.

Most people would say that everyone should save drowning children when and if they come upon them and if they are able to do. The problem arises when it is asked as to what level sacrifices should be made to prevent evils. There are many starving people around the world. The principle of beneficence might say that affluent persons have a duty to prevent this starvation. If people give 20 dollars a month, then they are sacrificing very little, and are doing some good. If they are obligated to give more, then it should be asked to what level are people obligated to give money to people they have never met. The principle might even determine that a duty exists to give all we have to prevent the starvation of others until we are just above the level of suffering that we have intended to correct. Do we have a duty to prevent all the harms that are in our reach? Do we have an obligation to reduce the utility of our lives to increase the utility of the lives of others?

The principle of Beneficence is an important principle for medicine. One of the primary duties that the physician has is to benefit his patient and to protect him from harm. It is widely believed that physicians have specific duties to their patients to maximize their benefit and minimize the amount of harm they sustain. Just as with the ordinary citizen, it can be asked as to what level the doctor duty bound to provide for his patient. Is he bound by duty to maximize utility, even at the cost to his own person? If he is obligated to prevent harm unless he sacrifices something of comparable importance? Should he sacrifice his money and time spent with his family to prevent the sickness or death of others? What about his own health? Clearly it can be argued that the death of patients is worse than time spent away from one's family. Utility would be maximized if the patient lived, even if the doctor never saw his or her family. As above, to what level of self-sacrifice is the doctor obligated to endure?

Michael Slote argues against the notion presented by Singer that one is obligated to give to others until the sacrifice is just above that of those who the person intends to help. Slote states that they are instead obligated to prevent serious evil or harm when they can do so without seriously interfering with their life plans or style.[3] This seems more reasonable. It might be easier to argue that a person has a duty to give a small amount of money to sponsor programs to deal with hunger, rather than giving a level of funds that brings the him or her near poverty, even if the later creates more utility. For the physician, it can be argued that he or she has a duty to make certain sacrifices as determined by the special relationship that she or he has with patients, but not to sacrifice nearly all that he or she has. Slote's version seems reasonable, but can be argued to be based on an arbitrary set of criteria. How much money does the Millionaire have the duty to give? How about the common laborer who makes much less? It is hard to determine how much of a sacrifice we are obligated to make. The solution seems to be that if we accept some form of utilitarianism, then we can use these principles to understand that we are obligated to make some sacrifices in our lives in an attempt to maximize utility.

For the physician, it can be seen that through the principle of beneficence, that he or she is obligated to prevent certain harms and maximize the benefit for the patient that is possible without reducing the utility of his or her life to an unacceptable level.

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[3] Childress and Beachamp, Principles of Biomedical ethics, pg 199.

Kantian Deontology

A second system of theories that is widely used in moral philosophy is referred to as deontological theory. Deontology literally means the science of duty. This theory relies on the belief that we all have certain duties that we are required to follow. These moral standards exist independently of utilitarian concerns and don't exist purely to satisfy ends. These acts are seen as good in themselves, not just because of the outcome of the act. Utilitarianism evaluates the goodness of the action by it's circumstances, not by the virtue of the action itself, whereas the deontologist feels that acts have an intrinsic worth apart from consequences.[4] There are also act and rule deontological theories like in utilitarianism.

Kant's deontological theory is referred to as a non-consequentialist rule based theory. The duties that are set out by Kant's theory are generally binding in all similar cases and are not evaluated on a case by case basis like an act theory.

In some circumstances, however, there may be two or more duties that seem to obligatory under the theory that conflict. In some circumstances we cannot follow both duties, so to resolve such a problem, we should follow the duty that is the strongest. There is a duty for the physician to tell the truth to the heart patient, but he or she also has a duty to treat the patient and to protect the patient from further harm. It must be decided which duty is stronger, the duty to tell the truth, or to protect the patient from harm. In the case when the patient might experience real harm or even death, then the physician's actual duty is to protect his or her patient even though it violates a duty to tell the truth.

The core of Kant's theory is called the Categorical Imperative. This idea states: "I ought to act in such a way that I can will my maxim should become a universal law." This says that we can only act in a certain way that we would also wish everyone else to act. We don't want

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[4] Beauchamp and Walters, Contemporary issues in bioethics, pg 49.

every one to steal, so we cannot either. Deontology is based on fairness. It is not fair for us to steal, when everyone else has to respect the law.

When evaluating an act using Kant's categorical imperative, the personal act or maxim is first stated. Then the personal maxim is expanded to a universal maxim, which includes all members of a group. If the two conflict then the contradiction of the two shows that the act is not permissible.

An example is: I will shoplift from stores, to satisfy an interest of mine. This statement is the personal maxim. The universal maxim is then: everyone will shoplift. These two cannot exist together. If everyone shoplifted, then there would be security cameras and police officers all over the store. Since the store would be losing lots of money, there is a high probability that the shoplifter would be caught. The two maxims are contradictory since they cannot exist together, so the act is morally prohibited.

Another set of classic examples that are used to show the contradictions in a set of maxims are those that a based on truth telling. If The personal maxim is: I will lie to gain advantage, then the universal maxim would be that everyone will lie. This cannot exist because if lying were widespread, then there would be no standard of truth, so no one would believe anyone and the lies would not be counted as true. The two maxims are thus contradictory.

Deontology affects medical ethics in several ways. First it means that doctors and health care providers have certain mandatory duties that they must follow. In addition to general duties that all persons have to each other, like telling the truth, not stealing, etcetera, there are also special duties that some individuals have to each other. According to Kantian theory, these duties are set forth by the nature of the relationships that people enter into. Certain relationships such as the doctor-patient relationship, that of employer to employee and between a parent and his or her child carry specific duties with them that are obligatory, as defined by the nature of the relationship.[5] A parent has a duty to clothe, feed and teach his or her own child, but he or

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[5] Beauchamp and Walters, Contemporary issues in bioethics, pg 51.

she does not have that duty to another child who is not his or hers, since the parent-child relationship falls under the category of special duties.

The Principle of Respect for Persons

The Categorical Imperative of Kant's deontology is often presented in a second form called the Respect for Persons Principle, also called the means-ends principle. This principle, which is widely used in medical ethics, states that one should never treat a person as a means only and that people should ultimately only be treated as ends. People should be treated as independent moral agents and should be allowed to pursue their own goals, not merely being an instrument for the development of someone else's goals.

It is true that we occasionally treat people as a means to get something in our daily lives, such as the procurement of commercial goods and services. An example that is given by C.E. Harris is when someone goes to the post office to get stamps, they treat the postal worker as a means to get the stamps, but they don't treat the employee purely as a means. They still respect the person's life and goals and don't treat them like a slave.[6]

For medical situations, we can ask if the decisions are being made with the patient as an end or whether the patient is being used to fulfill some other goal. For a patient who is taken off life-support to give bed space to another patient with a better prognosis, the more critical patient is used as a means for the health of the second patient. This action does not respect the first patient as a person, so it should be prohibited.

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[6] C.E. Harris, *The Ethics of Respect for Persons* , pg 141-145, Introduction to Ethical Theory (1991), Kenneth Rogerson, editor, Fort Worth Tx, Holt, Rhinehart and Winston Publishers Inc.

The Principle of Autonomy

Another principle that is widely used in medical ethics and is applicable to euthanasia in many instances is the principle of Autonomy. This principle is related to Kant's principle of respect for persons. The principle of autonomy states that people should be allowed to make their own decisions regarding the choices that are to be made for their welfare. The autonomous person is able to control his or her own destiny and does not have anyone imposing their ideas on the choices that they make. Persons are rational agents of unconditional worth, who must not be treated merely as conditionally valued things incapable of choosing for themselves.[7]

John Stuart Mill also wrote on a version of autonomy. In *On Liberty*, he discusses how autonomy is fundamental to the forming of a society. He states that utility allows people to make autonomous decisions and develop their lives and character, as long as they do not cause harm to anyone else. He says that development of individual character increases productivity in a society, which is beneficial to all. [8]

The Principle of Autonomy affects many areas of medical ethics. The right to die can be defended by the right to make one's own decisions. To not allow one to die in the circumstances that they have chosen is to violate that person's right to make autonomous decisions. To reject that person's considered judgments or to prevent his or her freedom to act on those considered judgments is not to respect his or her autonomous personhood.[9]

One distinction that should be made is that autonomy is not simply the respecting of the patient's requests in all circumstances. Autonomy exists when a patient is a fully functioning moral agent who can make rational arguments. If a patient is pathologically suicidal, they are not acting autonomously, since their psychological state impairs their ability to reason. To

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[7] Childress and Beauchamp, Principles of Biomedical Ethics, pg 61.

[8] Childress and Beauchamp, Principles of Biomedical Ethics, pg 62.

[7] Childress and Beauchamp, Principles of Biomedical Ethics, pg 62.

respect the patient's autonomy is not to allow them to commit suicide, but to help them to return to a state in which they can make rational decisions regarding the course of their life. Also, such a person is not acting with autonomy since they are not making choices that under Kantianism they would be allowed to make. Suicide is not a rational choice in most cases and is self-defeating, since it goes against one's self interest and duty to preserve one's life and develop one's life talents. Also, in an act of suicide, the patient does not respect him or her self as an end and uses their life as a means to accomplish relief from misery or suffering, so the action is a violation of respect for persons. Even if a patient is acting with full autonomy, they can still make improper choices, so respecting the patient's autonomy is no guarantee that the correct decision will be made. The physician still should strive to see that the patient has been offered and accepts, in most cases, the choice that serves his or her best interest.

The principle of Autonomy also governs aspects of the physician-patient relationship. The earlier question of whether it is ethical to lie to patients to protect them can be evaluated using autonomy. The principle would require that the physician tell the patient the truth so that they can make their own autonomous decision regarding their own treatment. It is also essential for the patient to be told the whole truth so they can make a truly informed decision.

The principle of autonomy cannot be used in cases where the person in question may not be in a position to make a fully independent choice. If they are either incapacitated, too young or not mentally stable, then decisions may have to be made for them. In some cases, it is possible for a representative to make choices for the patient that reflect what they believe the person would choose if could they make the choice for themselves. To act correctly, the decider should respect the patient's autonomy by acting in a manner that is consistent with the patient's history of decision making. However, in the case of infants, pathologically suicidal patients and other groups who would lack the ability to decide in any circumstance, it is not possible to attempt to guess how the person might act in different circumstances.

The Hippocratic Oath and the morality of euthanasia

The method used by Kantian theory is similar to that of the *Hippocratic Oath*. Both theories believe that there are fundamental duties that people have when they enter special relationships such as the physician-patient relationship. The *Oath* establishes a set of rules to govern the physician's professional conduct, the physician-patient relationship and other aspects of medical practice.

One of the most well known ideas connected with the Oath is the directive which instructs the physician to "Do no harm." Many people have connected this statement with the euthanasia debate and feel that it prohibits doctors in any circumstances from killing their patients. There are other passages that also discuss the ending of patient's lives. It says,

> I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrong doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.[10]

In the case of euthanasia, however, a conflict has arisen, do no harm may mean that the physician cannot kill his patient. But a physician also has a duty to alleviate suffering. These two duties conflict. Which is more important, the prolonging of life at all costs or alleviation of suffering? Which best serves the rights of the patient? Preventing harm may actually be done by providing euthanasia in some circumstances, since the patient would be harmed if they were allowed to suffer extreme pain. The *Oath* and the physician's role in euthanasia will be explored in greater detail in chapter nine, The Physician and Euthanasia.

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[10] Hippocrates, *Selections from the Hippocratic corpus, the Oath*, W.H.S. Jones Trans., pg. 5. Ethics in Medicine , Reiser, S. J, A. J. Dyck, and W. J. Curran, Editors,(1977),Cambridge, Mass. : MIT Press.

Theology and the ethics of euthanasia

Many people object to euthanasia and feel that under no circumstances, or in very limited circumstances, should euthanasia be allowed to take place. What is the basis for this belief?

These ideas, in many cases, rest on a firm belief in the absolute sanctity of life, regardless of quality. Many traditions feel that human life is important and should be valued above all else. Many religions originally stated that killing of any type was evil. The theologian St. Thomas Aquinas stated that life is a gift from God and to end it without permission is to offend the maker. God has given life and to end it by human hands is a crime. To answer problems encountered in justifying war and execution, the Church revised the statement to read that the killing of the innocent was always wrong. In war, the enemy is not innocent and killing the enemy, who also wants to kill the opponent, is similar to self-defense. Condemned criminals are not innocent and have according to certain principles, forfeited their liberty and right to life through the crime they have committed.[11] The Catholic Church supports a position that opposes widespread use of euthanasia, but grants the right of the individual to forgo extraordinary treatments that only prolong a certain, pain-filled death.

Euthanasia may also be wrong according to some theological arguments since it interrupts the plan that God has for each person. A person's life has developments all the way from birth to death that are subject to God's plan. For people to interfere with this plan is wrong and is "playing god."[12] However, in some circumstances, some actions that may be considered euthanasia may be allowed. If the patient is near to death, then if they are allowed to die, then this action is following God's plan instead of going against it.

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[11] Rachels, James, The End of Life, Euthanasia and Morality (1986)

Oxford, New York, Oxford University Press, pg 35.

[12] Hamel, Ron, Choosing Death. Active euthanasia, religion and the public debate (1991)
Philadelphia, Trinity Press International. pg 57-60.

Personhood and the euthanasia debate

Once we have decided that the life of a person is important and should be respected. how do we then decide what qualities are necessary in addition to biological function to make a life that is worth preserving? Does it take more than a heartbeat and spontaneous breathing to establish a life worthy of protection? Is biological life something we intrinsically value. or can it be ended when the person's identity has be lost?

How can we determine if someone is "alive", and if so. is the life of a quality that we value? Most people believe that killing a live person is wrong. If euthanasia is killing. than it would follow that it is wrong to euthanize a live person. How do we determine what constitutes personhood? If we can establish guidelines as to what the requirements for being a person, and thus deserving of protection, are. then we can decide in which cases euthanasia is wrong.

There is a principle that is supported by Kantian theory and the principle of autonomy called personhood. Under Kantianism, a being is defined as a person if they are a rational moral agent capable of making decisions. If we can define what gives a human being personhood, then we can make judgments on the elements of personhood that critically ill persons may lack that might allow euthanasia to be justified. For infants. the question arises whether they in fact possess personhood. They are unable to make autonomous decisions as of yet, but should be protected, since they have the potential to develop personhood later.

Also, if we believe that people have a soul, at what point has the soul departed from the body? Does an irreversibly comatose patient still have a soul. or have they "passed on," so the body can be allowed to die?

In several famous euthanasia cases. the ending of the patient's life has been denied by hospitals and courts since the patient was still able to breathe freely on his or her own. even though he or she had sustained considerable brain damage. The patients were left with little or no higher brain function and with no chance of recovery. but the centers in the brain stem which control breathing remained intact, allowing the person to continue to be "alive", at least in one sense. Did they still have personhood, or are there more factors that make someone a person?

Is this a type of life that we as an ethical society value, or does a life have to have another component for it to be worthy of protection? Do they have to possess higher brain activity for them to be a person or can the patient be just "a bag of organs," living but with no "life". Many would argue that the personhood has been lost when the person no longer possesses the mental faculties that made them who they were.

Many people would say that a person should possess a certain mental capacity for their life to be fully valued. The person should possess a character and enjoy the contact of others, at least in a limited sense.

James Rachels draws a distinction between the concepts of having a life and merely being alive. This argument is similar to the concept of personhood. He says that there are two types of lives, a biological life, that is when a being has a heart that beats and lungs that function and organs that can carry on day to day metabolic processes.[13] Ants can do this. Are the lives of ants equal to that of human beings? Most people would say no. Why are ants seen as lesser beings? Why do ants lack personhood? Possibly because they lack or only have in a limited quantity, what Rachels refers to as a biographical life. The biographical life is a collection of attributes, such as aspects of character, relationships with others, enjoyment of surroundings and a knowledge of life. Does an ant have character and a day to day plan, or does it act from instinct and biological function only? Does a person who has either lost or will never develop the ability to have a biographical life, or a meaningful existence really have a *life* or are they merely just alive?

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[13] Rachels, The End of Life, pg 24.

According to these principles, are there levels of evil when it comes to killing? Is it worse to kill your neighbor's dog than to step on a grasshopper in the yard? If it is worse, why is it worse? We can argue that the dog has more of a biographical life, thus he has more to lose if he is killed. Both creatures are alive and carryout biological processes. The dog, however, is more highly evolved mentally. Many dogs are able to exhibit some almost human like characteristics. The can show emotion, learn special tasks, in the case of service dogs for the blind, and many people believe that they have an ability to love. Does a grasshopper love it's fellow grasshoppers, or is it merely acting from instinct to get food and survive to reproduce to continue the species?

The reader may ask, what does the difference between the lives of a dog and a grasshopper have to do with euthanasia? The example is being used to show that there are different qualities of life that may require different levels of protection. There are laws against animal cruelty. There are no laws that prevent us from stepping on grasshoppers, even though a few people may feel it is wrong.

One idea might be that there can be degrees of personhood. The dog may possess some human characteristics, so it is "closer to being a person" than a grasshopper. This idea of degrees of personhood also explains the evaluation of critically ill patients who are mentally incapacitated. Some patients can show some response and enjoy a visit from their children, whereas many are cutoff from the world as a result of severe brain injury. As a result these patients may have different degrees of personhood. So if some people are judged to have severely diminished degrees of personhood, than maybe we can let them die, instead of continuing a life devoid of purpose and dignity.

Similarly, there are people with different qualities of life. A normal healthy toddler can run and play and enjoys the company of his or her parents. He or she can enjoy life and has a character. A 90 year-old patient in an irreversible coma has none of these features. They may be breathing on their own and have some basic thoughts, but they cannot speak, interact with others, or experience joy. Are there differences between the qualities of these two lives? Most people would say yes.

These differences will form one of the lines of argument for the majority of this paper. Life is not only important in a biological sense. It is also important in the quality of the existence of the participant. Once the joy is gone, once the mind no longer functions, once contact from others is gone, the life may not be worth living. Is such a life worth preserving, or should these people be allowed to die? Is it unethical to withdraw treatment from someone who has such a low quality of life?

Religious principles might indicate that quality of life is not a reason that is acceptable for euthanasia. The person's continued existence may serve to teach others or to serve a higher purpose.[14] I would argue however that the person should not be forced to suffer to satisfy someone else's ends and their life should only be continued as long as it is useful to them. As autonomous beings, people also have a right to determine the course of their own lives, so if they determine that the lack of quality in their lives is such that they want to forgo treatment, then they should have that right.

Death, killing and the sanctity of life

According to western moral tradition, most people if asked, would agree that the killing of the innocent is wrong. Of all the crimes that people are tried for in the criminal justice system, murder is one of the most serious. It is generally considered worse to kill a man than to steal his car. Why is it wrong to kill?

It is considered wrong to kill not only because it puts an end to their being alive, in the biological sense, but they are also no longer able to have a biographical life. They are unable to complete their life projects and are deprived of future pleasures and experiences.

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[14] From an interview with Father John Marquis, S.M., Catholic Chaplain of Colby College, November 5, 1995.

From a religious perspective, it is wrong to kill because it violates God's will. He, as the creator of all people, has the singular right to create and end life. If we kill, or hasten death, then we are infringing on his primary right to decide when life has ended.[15]

Many people have said that they don't believe that death is in fact evil. Some argue that the time after death is unknown and so it is irrational to fear it. It is also widely held in the Christian religion that the afterlife will be spent in heaven or Hell. Heaven is supposedly a beautiful, peaceful place, so why should we fear it? For those who are damned, the time after death would clearly be unpleasant. Some might say that death is evil since it is very painful. In fact, this is the process of dying, with death itself being only the end result. The dying is the source of pain, not the resulting loss of life. [16]

Conclusion

In many cases, different theories such as Kantianism and Utilitarianism may reach similar conclusions as to how a patient should be treated. The quality of life may be such that the patient wishes to die and if the act is carried out, it respects the wishes of the patient. Utility may also be maximized since suffering is ended and the family no longer has to watch their loved one suffer. In some circumstances, there may be cases where it appears that there is not a significant difference between the use of theories. In other circumstances, however, the respective theories reach very different conclusions. In some instances, the respect for the patient's autonomy may be contrary to a utilitarian conclusion where utility is not maximized by the treatment outcome.

In these cases, we have to ask what principles are the most important, such as autonomy versus quality of life. In many circumstances, both systems support a consideration, but not always. As we shall see in the next chapter, each theory is better at dealing with some

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[15] Hamel, Choosing Death, pg 57-60.

types of questions. In general, I will support conclusions that value the autonomy, (or potential autonomy) as the paramount concern. In some cases, this conclusion maximizes utility, but in some, the autonomy of the patient overrides cases where the perceived utility of the situation is contrary to what the patient wants or what is ultimately in their best interest.

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[16] Rachels, The End of Life, pg 40-50.

CHAPTER THREE:
CLINICAL JUSTIFICATIONS FOR EUTHANASIA

One of the major goals of this project is to attempt to answer the question of whether the use of euthanasia in certain circumstances is morally justified. If the practice is allowed in some circumstances, which reasons are good enough to justify the hastening of the death of a patient? This chapter will explore many common clinical and social justifications for the use of euthanasia that are often given by physicians, families, scholars in medical ethics and others.

There are many reasons that have been given that support the use of euthanasia. One might be the decision by parents to withhold treatment from a handicapped newborn on the grounds that it would be unfair to the infant and to the family who is to care for him or her to allow the neonate to continue to live. Another argument might be made by those who believe euthanasia is justified for patients who are in a great deal of pain due to a terminal illness. Many reasons that are discussed within the euthanasia debate are controversial such as euthanasia for the patient in extreme pain or for patients who are afflicted by such conditions as cancer or AIDS. There is often a contrast between what is legally allowed by law and policies advocated by individuals on ethical grounds. Some practices are now increasingly more accepted by segments of the general public such as active euthanasia and physician assisted suicide, even though they still remain prohibited by law in most states.

Pain as a justification for euthanasia

One of the first reasons that may come to mind as a reason to seek euthanasia is for a patient in an extraordinary amount of pain. In the case of euthanasia of pets, there is little doubt expressed by many people that it is humane to put a dog or cat to sleep who is in a great deal of pain. Some people also believe that the same is true for human patients, whereas others feel that euthanizing a human patient is still wrong even in the case of extreme pain. They cite the belief that a human life is sacred in all forms and thus cannot be ended for such reasons.

A case described in James Rachels' book, *The End of Life*, details the experience of the well known journalist, Stewart Alsop, who died from a rare form of cancer in 1975. He wrote about his experiences as a terminal patient while undergoing treatment at the Clinic of the National Institutes of Health in Bethesda, Maryland. His roommate during this time, who is referred to as "Jack", was dying of a malignant tumor in his belly which doctors estimated was about the size of a softball. The cancer was spreading to his bones and to other areas, so doctors knew that his time to live was short. Jack was in constant pain, which was only partially relieved by the potent medicines he was receiving. According to Alsop, Jack's young wife came to visit frequently and was very distressed by the amount of pain that her husband was in. She would talk to him and pat him methodically as one pats a small child, which seemed to help. At night after his wife had left, Jack's pain would increase considerably. He was being treated with an IV analgesic pain killer, but could only receive it every four hours due to dosing restrictions. After a few hours, the pain would return with a vengeance. Alsop writes that then either he or the roommate would call the nurse and she would explain that it was only a short time until the next dose. Jack would then be given codeine or a similar drug by mouth, but it would have little effect, only "like an aspirin being given to a man who just broke his leg."

Alsop often wondered how his companion could continue to go on like this. Jack was close to death and had no hope of recovery, as far as his treating physicians could tell. Alsop often found himself thinking that if Jack were a dog, his suffering would have ended a long time ago, since "no human being with a spark of pity could let a living thing suffer so, to no good end." [1]

This case illustrates the type of pain that can bring on requests for death, or for a family to petition for euthanasia. The patient is in constant pain, with a terminal condition and there is

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[1] Rachels, The End of Life, pg. 153-154.

no hope of recovery. When there is no chance for a cure and the patient is constantly and completely miserable, why is it wrong to accelerate an already certain death?

A utilitarian might say that the act would be justified since the patient is miserable, the family may be upset and the patient's life is not contributing anything to utility. From a utilitarian standpoint, the ending of a life with pain may be justified.

A Kantian interpretation could draw on the respect for persons principle and the principle of autonomy. If the patient wishes to die, he has a right to make that choice. It shows a lack of respect for the patient as a person to deny this request. If the act of not permitting the patient to choose death was universalized, then everyone, when faced with a painful death with no hope of recovery will be forced to live out their final days in such a state.

Many people might say that it is immoral to kill. As discussed in chapter 2, it is wrong to kill because it takes away the victim's chances for future enjoyment of life. In the pain case, there is no enjoyment of life. There also is little future for life. Death is a foregone conclusion, it is just a question of when.

The statement "thou shalt not kill" might be adapted to "thou shalt not commit murder." Murder is defined as wrongful killing. If the act is to end suffering when there is no alternative, then maybe a beneficent act of mercy killing escapes the imperative. This act would not be murder, since it is not wrongful killing, but is from an admirable motive.

A religious argument might be used to oppose euthanasia on the grounds of suffering. Theologians might say that a death brought about by euthanasia is a crime against God, since only He has a right to end a life. It might be argued, however that since God is a loving god, He would never want a human being to suffer so, and the patient would be allowed to choose death. Since God also provided for the development of modern medicine, it could be argued that He would not will a life to continue that is so full of misery.

Intensity of pain as it affects justification for euthanasia

The first question that might be asked if pain is to be accepted as a valid reason for euthanasia is how much pain must exist for it to be acceptable to end life for humane reasons. How can we will someone to constant suffering and misery and is it moral for physicians to continue to let patients experience unrelenting pain?

Utilitarianism holds utility as the only concern for decisions. The life of this patient is not adding to utility. In fact, the continued suffering is causing more pain and a decrease in happiness, not only for the patient, but also for the family and health care providers. The patient has nothing left to add to the world around him and thus it would maximize utility to end the patient's life. The greater the pain, the less the patient can reap any benefit from being alive. There are some patients who can have their pain controlled by medication and can spend their final days with family members around them and have some pleasure. But if the pain is so great the they are consumed by their discomfort, then there is no benefit derived from their continued existence.

The will and autonomy of the patient would be more important to a Kantian than a utilitarian. Those caring for the patient have a duty to respect the autonomy of the patient as a rational being. The degree of pain would only matter in so far as it affects the will of the patient. They have the choice as to whether they want to live on in pain or to die painlessly. If they can tolerate the discomfort and want to live, then their decision should be supported, and if they want to die because the pain is beyond what they can handle, then they should not be kept alive for someone else's ends.

Pain and suffering are not reasons that can justify euthanasia using theology. The patient's life is still under the jurisdiction of God and the patient's life should proceed according to the plans God has laid out. Modern medicine has often felt that suffering should be avoided in all cases. In religion, while suffering is not sought, it does have a place and a life cannot be ended simply due to suffering. The courage of the patient to endure suffering can be an example to others. Suffering is a part of life, so it cannot be a reason to end it. [2] [3]

Many would argue that one of the duties of the physician is to prolong life. Another duty the doctor may also have is to alleviate suffering. Which duty is stronger in the case of the patient in pain? How much pain is enough to justify euthanasia? In this circumstance and many others, there exists two or more duties which compete with each other. Which duty should be followed when both cannot be? Kantian moral theory states that an imperative should be carried out unless there is a duty with which it competes that has a higher priority. In such a case, the higher duty should be followed. In cases such as this, we can argue that the duty to end the patient's suffering would be stronger than the duty to prolong life at all costs.

Duration of pain needed to justify euthanasia

When pain is present, many might also think it is important to consider how long of a course of suffering is too much. Is there a difference between a patient who will die of a terminal condition in ten days versus a patient with six months to live? Is the life of the second patient precious enough to warrant them enduring a course of six months of suffering? Does the extra ten days for the first patient make a difference in the whole span of their lives? Is quality or quantity of life more important?

A utilitarian would say that the length of time is an important consideration since if the patient is consumed by the pain, then a course of six months detracts from utility far more than ten days. If they will be in agony for six months, then the time adds no benefit in the whole scope of the patient's life and utility would be maximized by a speedier death rather than a long drawn out one.

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[2] Hamel Choosing Death. pg. 57-60.

[3] From a personal interview with Father Jon Marquis, S.M., Catholic Chaplain of Colby College, November 5th, 1995.

Under the Kantian point of view, the course of discomfort is a similar concern to the intensity of pain. The concern for the patient grows with the length of suffering. As with increased agony, a prolonged course of pain demands that we respect the patient as a person with the right to make autonomous decisions. A patient who faces a long course of suffering should have the right to choose to die. If death is imminent then they can be allowed to die, since it is wrong to force them to endure a long course of suffering. It is their life to live so they should be allowed to die painlessly if they so choose.

One problem that arises in using pain as a justification for euthanasia is the problem of uncertain prognosis. In some cases of extreme pain, there exists the chance for a cure, however remote it may be. There are many that argue that if we euthanize a patient because of their suffering, then there is no chance for a cure. There have been isolated cases of miraculous recovery. If the patient is actively or passively euthanized, then, obviously, all chance is lost for a cure.

After evaluating pain as a justification for euthanasia, I that in some cases of extreme pain euthanasia may be justified. The patient has a right to determine what happens to him and if he is a competent patient making rational decisions, than his wishes should be respected. Some may argue that the pain can be controlled by medication. For this type of pain, if sufficient levels were given to end the discomfort, they might accelerate death or at the very least, lead the patient into a state where he is unaware of his surroundings. It is ultimately his life and he should not be kept alive as a means to make others not feel sadness because of his passing or to satisfy government positions established after pressure from right to life groups that have nothing to do with his care and do not know him. The concern of uncertain prognosis is an important one, so if the patient has the possibility to recover, then euthanasia should not be considered until the prognosis more clearly establishes itself.

Euthanasia for patients facing a long course of painful treatment

There are some patients that do in fact have a decent prognosis but wish to die because they cannot endure the suffering of the treatment and subsequent course of recovery. This is often the case of severe burn victims. Some patients have suffered burns over major parts of their bodies, and must undergo extremely painful daily treatments to remove the burned skin so that new skin can grow. These patients may be miserable and some believe that they cannot go on. They will eventually recover and lead at least a semi-productive life, but the road ahead will be difficult.

There is a famous case of a patient who was burned who expressed a clear and constant wish to die. He was instead denied this request and was treated without his consent as requested by his mother. He is alive today and has a wife, a house and a law degree. Even with these successes, he still believes he should have been allowed to die. Newspapers called Dax Cowart, "The man who was sentenced to life." He has also been referred to as, "the man who lives to defend the right to die."

He was looking at a piece of land with his father and they were parked over a leaky propane gas line. When they started the car, there was a huge explosion that killed his father and severely burned Cowart. As a result, he is blind, severely disfigured and had both hands amputated. He says that he is "acceptably happy." Still, he feels that he should have had the choice to die. He was treated against his will for fourteen months with a course of treatment that included being dipped in a Clorox solution every day and then having his burned skin vigorously scrubbed. He was in incredible pain during this period and repeatedly asked to die. After he was discharged from the hospital, he attempted suicide several times. [4]

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[4] Wicker, Christine, *Sentenced to Life*, Euthanasia, the moral issues (1989) Baird, Robert and Stuart E. Rosenbaum editors, Buffalo, NY, Prometheus books.

The question is: even though he is living a useful life, should he have been allowed to choose to die? Should he have had to endure the pain against his will or did he have a right to decide, even if the doctors and his mother thought differently?

Utilitarianism might say that the course of treatment is justified, since the outcome is positive if it ultimately outweighs the negative effects brought on by the extreme pain and questionable quality of life. The treatment may be hard, but at the end, the patient has at least a partially enjoyable life again. Dax Cowart after he was recovered, was able to live a mostly happy life, and bring joy to others. His mother did not have to experience the sadness of his death and the health care team would not feel that they let a person die who could be treated. It might be fair to say that the results of the treatment justified the painful course of events to get there since his survival resulted in net utility since his life would have brought great sadness.

Kantianism, on the other hand, is not only interested in results, but with the act itself. Cowart was treated against his will. He had the right as an autonomous being to make the decision to forego the treatment if he wished. He was informed of his options and expressed a clear wish to die. Denying his refusal of treatment went against his wishes and used him a means to an end for the benefit of others.

His mother used the treatment as a means so she would not have to grieve for the loss of her son. In doing so she gave little thought to the feelings of her son, and as one might guess, their relationship has never been the same.

It is possible that Dax might not have been able to rationally make decisions at that point. He was 25 years old, so he was legally entitled to make decisions apart from his mother, but his autonomy might not have been fully intact. His judgment might have been clouded by the intense pain that he was experiencing. Although his pain had ended, and he is now "acceptably happy", he still has stated that if he had his choice before his treatments were begun, he would have chosen to refuse.

In this case, I believe that the Kantian point of view is appropriate. The patient has a right to have his autonomy respected and if he is able to make rational decisions, he should have a choice. He should not be used as a means for others agendas.

Euthanasia in the mentally incapacitated patient

Another case where euthanasia may be justified is when a patient has no mental capacity due to an irreversible coma, severe stroke or severe birth defects. These patients possess little brain function and may very well have little awareness of their surroundings. Does loss of brain function, even though the body continues to live, justify euthanasia? How important is competent mental function to the definition of a life that is worth saving?

The patient, John Brown, is an 80 year old male that is found by paramedics unconscious on the floor of his kitchen. He is brought by ambulance to a major medical center emergency room. As he enters the emergency department, he goes into cardiac arrest. The cardiac resuscitation team, or "crash team", is mobilized and the patient is brought back to life using all the advances of modern medicine, including specialized cardiac drugs and a defibrillator to convert the arrhythmias in his heart.

He is alive, but due to his age and the time since arrest, has suffered excessive cortical brain damage. He cannot speak and only responds to painful stimuli. The person he was is gone. All the memories of the experience of his 80 years were lost during the arrest, so all that remains is a frail old man who needs a respirator to breathe and continual medical maintenance to keep his heart rate and blood pressure where they should be.

Mr. Brown is biologically alive and is alive by medical definition, but we can surely question whether such a life is worth maintaining. He will never improve, probably will not know his family, if he has any, and will be in a hospital bed for the rest of his life. Is it what he would have wanted?

The will of the patient is a definite concern under a Kantian system. The autonomy of the patient should be respected. If he might not want to go on like this, hooked up to machines, his body should be allowed to die. Also, his existence does not fit with a Kantian definition of personhood. He is not a rational decision making agent and cannot return to such a state, since the mind is gone, leaving only a body.

Under utilitarian principles, it might be argued that the life of this patient has effectively ended and thus he has no "quality of life" to be evaluated. He is not experiencing anything and is not adding to utility. A utilitarian would say that his body should be allowed to die, since the person he was is already dead. All he was as a person is gone. All that remains is a body, being kept alive by modern medical technology.

Should he be kept "alive" on machines, or due to the absence of mental function, should he be allowed to die a more natural death? Both Kantian and utilitarian arguments have shown that patients like Mr. Brown should not be kept alive, since there is no longer really a person to be kept alive.

Both theories support the correct conclusion. The patient has nothing left to live for. Only his body remains. Since he has lost the ability to reason and will never regain that ability, he is no longer what a Kantian would say is a person. Since he is not a person any longer, then it is not immoral to let him "die."

Quality of life concerns and euthanasia

Another patient, a forty year old woman, who is in a little better condition than Mr. Brown has continually requested to die. She were involved in a car accident six months ago and is now a quadriplegic and will be confined to a hospital bed for the remainder of her life. She constantly has to be turned over to relieve the pressure on her bed sores, cannot swallow and is fed by a nasogastric tube. A member of her family comes to visit her every ten days or so, and the remainder of the time she watches TV and is occasionally visited by a hospital volunteer who may talk with her for fifteen minutes. She has constantly requested to die. She has no chance to regain her motor function and has no one that can care for her outside of the hospital. Her only family is a seventy year old mother and a brother who lives five hours away and has two small children for whom to care. Is her low quality of life and constant boredom a reasonable justification for euthanasia? What standard of quality of life is humane? Does she have a right to this choice?

With utilitarianism, it is questionable whether her quality of life is so poor as to justify ending it. She does experience the minimal pleasure of human contact and is not in constant pain, at least not to the degree experienced by Jack in the case at the beginning of the chapter. However, she does experience some boredom and discomfort, so utility may not be maximized by her continued existence. Using a broad utilitarian calculus, we also have to think about all other persons involved. The hospital spends considerable resources on her and the costs of advanced medical care are rising ever year, so some people might suggest that she be allowed to die. Utilitarianism might also reach similar conclusions for less ill patients if rationing concerns are factored in, so utilitarianism might not be the best theory to use in this circumstance, since it is hard to weigh her quality of life against economic factors.

Under respect for persons, she does have a right to choose her own outcome. She is competent and is informed about her chances to live a more functional life. If we universalize denying her request that we would will that everyone in her situation would not be allowed to choose. Would we want, if we were in this situation to be denied that choice?

The problem arises, however, that she will live on for a long time and would require active intervention by a physician to end her life. The taking of her life would be active voluntary euthanasia. She cannot end her own life due to the paralysis, so some one else would have to. Under any theory, are we required by duty to end this patient's life?

Low quality of life is often a reason that many would accept as a reason to justify the use of either active or passive euthanasia. The patient may be somewhat mentally coherent, but may be completely bedridden, in constant pain and be unable to speak. Such patients may wish, due to the nature of their suffering to end their lives. Is a low quality of life and a desire to die an adequate reason for euthanasia?

This question is the core of the right to die debate. Does a patient have a right to die, and can a physician aid this patient in this act if they are unable or unwilling to take their own life? The right to die will be further examined in later chapters, but a brief analysis using the principle of autonomy shows that patients have a right to decide their fates. They should not be used as a means for others, either to satisfy psychological needs or to fulfill some other concern. It is a different matter, though, whether there is a duty for physicians to euthanize such patients. They would require active euthanasia in some cases, which requires more intervention than simply withdrawing a respirator.

In that case, death is not imminent, so the physician has to act in order for the patient to die. If the physician does not believe in euthanasia in non-terminal cases, then it is using the physician as a means, not as an end to say that he or she is duty bound to comply with the patient's request. In cases where death is imminent, the physician may have less of a problem, since their action is not the only factor in the death, whereas in this case, the physician is clearly responsible.

Treatment of patients with late-stage AIDS

There are many terminal illnesses that bring with them considerable suffering and hopelessness including many forms of Cancer and ALS which is mentioned above. Many of these illnesses have no cure and chronically weaken the patient until death sometime later. One terminal disease that is particularly dehumanizing in the later stages is AIDS.

Acquired Immune Deficiency Syndrome or AIDS, is a disease that has received widespread media coverage since the early 1980's. This immune deficiency is a result of the action of the human immune virus. (HIV) The target cells of this virus are the T-4 helper lymphocytes. These white blood cells provide a vital link in the human immune response and the destruction of these cells impairs the body's ability to defeat infectious diseases and opportunistic cancers. According to a study released by the World Health Organization, there are approximately 13-15 million adults living with HIV worldwide as of late 1994. In a country by country estimate, the United States is thought to have approximately 700,000 people known to be infected.[5] In many cases, these numbers are conservative estimates since there can be asymptomatic carriers of the disease who have no developed antibodies to the virus yet or do not know they are infected.

Once the retrovirus enters the host cell, it integrates its genetic code into the host cell's DNA and can then lie dormant for several years. When the virus progeny which have been replicated by the host cell's machinery are released, the patient's immune system experiences a dramatic decline in function that leads to death in several years from opportunistic cancers and rare infections that are normally held in check by a functioning immune system.

The disease is fatal in nearly 100% of cases. There are a few rare groups of patients who have puzzled researchers with their long term survival rates, but most people die within ten years of the onset of the active period of the syndrome. Due to the nature of the immune suppression caused by AIDS, opportunistic pathogens can cause many terrible conditions that lead to great suffering including Pneumocystis Pneumonia, which is caused by a protozoa in the lungs and AIDS Dementia Complex.

What is the proper treatment for the end-stage AIDS patient? Are there cases in which some forms of withdrawal of life-support or active euthanasia is justified for the AIDS sufferer, or should the patient receive only pain control and emotional support? Is the treatment of the AIDS patient different from that of a terminal cancer patient?

Some experimental treatments for AIDS patients such as the drug AZT, ß-interferons and experimental anti-viral medications are able to slow the progression of the onset of some

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symptoms, but there is no cure for the immune deficiency itself. Due to it's terminal nature, AIDS can be treated as other terminal illnesses are in our ethical analysis. In many cases, AIDS sufferers have documented their feelings regarding aggressive medical treatment at the end of their lives or have appointed a health care proxy in the event they are unable to choose. The discussion of end of life issues has probably been talked about at some point with friends and loved ones, so when the time comes to make a decision, families and practitioners will generally have some idea of what course of treatment the patient would choose.

Since AIDS is fatal and there is no cure, then it can be argued that, if requested by the patient, aggressive treatment can ethically be withheld. These treatments may be merely prolonging death and if requested, treatment can ethically be withdrawn. There are some sufferers who do wish to live as long as possible, despite the deterioration of their immune system and overall health. They have sought out experimental treatments that may be able to extend their lives for a few weeks or months. If the patient wishes to fight to live for a somewhat extended period of time, that is their right. Similarly, if the patient wishes to die peacefully, unencumbered by a respirator or feeding tube, they should also have that choice. Passive euthanasia in the event that the patient cannot sustain life on his or her own is acceptable, as long as it has been consented for voluntarily, or in the case of the incapacitated patient, if those who care for the patient and the spouse or family have decided that it is the correct choice in keeping with the patient's philosophy of life.

Once we have decided that these treatments and heroics can be ethically withheld from AIDS patients in the later stages, we are forced to ask if it is ethical to practice active euthanasia on AIDS patients. Does the nature of their disease give them symptoms that make active euthanasia preferable to pain control and more passive withdrawal of treatment?

The first argument that can be invoked to support the active euthanasia of AIDS patients in advanced stages of disease is that from a perspective of mercy. In some cases, the natures of

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[5] *Weekly Epidemiological Record*, No. 2, 13 January, 1995, The World Health Organization.

the opportunistic infections and cancers that AIDS patients suffer from may bring a great deal of pain. These symptoms can also be very dehumanizing and the AIDS patient may be constantly miserable as they endure a constant deterioration that leads to certain death. They will have lost a considerable amount of weight, may have tumors in the mouth or stomach or may be afflicted with numerous rare skin cancers. In these circumstances, we should ask if we were in the same circumstances, would we want to live or be released from such suffering. In many cases, it could be successfully argued that in the face of such a horrible range of diseases, that we would not wish continued suffering on anyone and the AIDS patient should be allowed to die a painless death if they so choose. One of the indications for active euthanasia is a condition that entails a horrible quality of life and is not immediately terminal. In the case of the respirator bound patient, active euthanasia through injection or other means is not necessary since the time to death is short. In AIDS, there are few technologies to withdraw and death is long coming. Antibiotics could be withheld but the ensuing infections might lead to a rapid but horrible death.

The second defense of euthanasia stems from the idea that the patient has the right to choose the course of his own life and death. If the patient has the ability to choose and is not suffering from physiological depression or AIDS related dementia, then they have the right to choose. If active methods of euthanasia are the only way to be delivered from suffering, then the patient has the right to choose them.

A third argument for euthanasia is based on the principle of justice. This line of reasoning would say that since the AIDS patient has no hope of a cure that they are not deserving of the commitment of resources when other patients with more favorable prognoses are in need of scarce care. This is not an argument that should be used. It might be used by some to argue for involuntary euthanasia of patients, but it cannot support a voluntary choice of death in lieu of a horrible existence at the end of the ravages of the AIDS virus. The AIDS patient is terminal but still has personhood, so to deny them care in the name of distributive justice violates the respect that they deserve.

Is there a legitimate difference between invoking active or passive methods of euthanasia for the end-stage AIDS patient? Does it matter whether they choose to die by withdrawal of treatment (apparently passive means) or from a high dose morphine drip. (active means?) In both cases, the patient has chosen to die because of the level of misery that they are experiencing. If the request is fully informed and fully voluntary, then there is no difference if the patient wants active or passive means. In many cases, they may choose a more rapid, relatively painless death over a period of suffering after treatment has been withdrawn. If they want the active method, then that is their right. The reasons for choosing euthanasia, the voluntary nature of the request, and the intent of the treating physician are important moral considerations, but the method used is not, as long as it is the correct decision.

AIDS is a syndrome contains a range of conditions that can leave the person in state where they constantly wish for death. If the request for death is a constant and voluntary choice and is for a valid medical reason, then it should be allowed. The person has been robbed of a considerable portion of their dignity already as a result of the deterioration of their immune system and we should allow them to die with as much of their remaining dignity intact as possible if they choose such a path.

Euthanasia for economics and the good of other patients

A very controversial reason that has been given to rationalize euthanasia is for economic reasons or for matters of rationing of medical care. The argument states that if this patient were taken off life-support and was allowed to die, then the resources currently being committed could go to another patient with a better chance for recovery. In a system with limited resources, some feel that money and staff could be better used to help patients with a reasonable prognosis than to care for patients who might live on for years, but not improve significantly. They have limited chance for recovery, and no awareness of their surroundings or enjoyment of life. Is it ethical to end the life of one patient, even in a coma or the like, for the benefit of another?

Some coma patients, in order for them to stay alive, must be in an intensive care unit. They may require high tech care that only the ICU can provide, with such advances as skilled nursing teams that can deliver one on one care, carefully calibrated respirators, cardiac monitors and pulse oximitry, a device used to measure oxygen levels in the blood. They may require careful readjustment of medications on a daily basis to maintain stable vital signs. Many of these treatments cannot be as closely monitored on a normal medical floor. If a patient were to be transferred from the ICU, then he or she would run a higher chance of dying, since he or she is not being as closely monitored as in the ICU. As a result, the patient may eventually go into cardiac or respiratory arrest since the vital signs and careful balance of medications cannot be monitored as accurately.

Is it ethical to remove these people from the ICU to a regular medical floor, where the level of technology and caliber of nursing is less, to die? This act might be construed as a form of euthanasia, since the action is deliberate. According to the definition of euthanasia that some scholars use, death has been hastened and not every means possible is being invoked. Is it ethical to do this to a patient that has a worse prognosis to save someone with a better chance? There are situations where this choice may be clear-cut. For patients who are permanently comatose or will die with or without medical intervention, it would be ethical to remove them from the ICU regardless of rationing concerns. In the case of patients who are ill and require high tech care, but are not immediately terminal with or without medical care, it is not ethical to remove them from the ICU to allow a patient with a better prognosis to use their scarce bed.

This is chiefly a utilitarian concern. These patients are not really increasing utility through their continued, limited existence. They may never improve, while another patient who requires the bed space may have a better chance to recover. Thus if we allow a patient with a better prognosis to be treated, then we may add to utility.

Under Kantianism, in certain circumstances there is a duty to support these patients. If they are moved to benefit another patient, then their worth as a person is not respected and they are used as a means to help another patient. If their personhood is still intact and they are able to rationally decide, it is not right to deny them care for the good of others. If they lack personhood, or the potential to develop or regain it at some point, then the duty to keep them alive is not as strong a someone who is either partially functional or has a good chance to recover their personhood.

The physician has a duty to care for his patient. If the practice of determining the course of treatment based on the needs of others was universalized, then medical practitioners would not only act in the interests of their own patients, but with others in mind as well, which violates duties set forth in the physician-patient relationship. The doctor is bound by duty by the nature of the relationship to be an advocate for his patient, and not to base the course of treatment on the interests of other patients.

The Kantian position is correct. Euthanasia is acceptable in some circumstances where the action is in the best interest of and according to the perceived will of the patient. If the action is from another motive, than euthanasia is not justified. It is not right to hasten the death of one patient for the interests of another. The patient has the right to expect the correct treatments and the doctor has the duty to care for the patient and to act in the interest of the patient, not in the interest of others. If physicians frequently made treatment decisions on the basis of other patients, the present patient would not be able to know that the physician was acting as an advocate for them and acting in their best interest.

Another economically related question is whether a patient who either is mentally incapacitated, or a critically ill newborn with a poor prognosis, or has a terminal illness, can be allowed to die to ease a financial burden on a family. The cost of a day in the hospital has steadily grown over the past few years. Today, a stay in modern medical center can cost up to one thousand dollars a day. [6]

Lengthy stays in hospitals can bankrupt families and put huge financial burdens on hospitals. Do we have a duty to provide for such patients even at the cost of bringing our own lives to a standstill because all the financial resources we have are being used to support a patient with a poor prognosis?

Making decisions based on economic concerns clearly violates respect for persons. The worth of the patient is not considered, only financial considerations. The termination of their life is used as a means to save money. If the decision was made on the basis of the wishes of the person, then ending the life might be justified, but it is not respectful to end life solely according to financial concerns. Also, if all treatment decisions were made solely on an economic basis, then there would be little concern for patient rights, only money.

This is a tough question, since the family also has the right not to be used as a means to support a patient. They have a right to continue their lives and the lives of many people should not be limited by the needs of one. The duties to respect the patient and the family also conflict here.

It is hard to think about limiting care on this basis. As a solution, we should make decisions independent of economic concerns. If the quality of life of the patient is such that they are worth saving and may be able to return to a cognitive state, then they should be financially supported. If they have little or no chance to recover, then the choice should be made to allow them to die, since an existence such as this serves little purpose, so it uses the family as a means to support an end with no benefit.

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[6] Dubler and Nimmons, Ethics on Call, pg 60.

Living wills as a justification for euthanasia

One final reason that has been given to justify euthanasia is when patients who are unable to speak for themselves have given advance directives at an earlier date through a living will. Living wills allow people, before they become sick, to declare their wishes as they apply to resuscitation; respirators and other life-support measures; and surgical procedures, if they should become unable to speak for themselves. Living wills also allow people to appoint a proxy to make decisions for them. Is it ethical to engage in euthanasia, whether it be through the unplugging of a respirator or denying a surgery, at the request of a person as laid out in an advance directive?

Most living wills are made out when the person is younger and in better health. They make out such documents so that they can communicate their current feelings on the level of medical treatment that they desire if and when they are unable to make their wishes known.

If someone was close to death, would they really want to die, or is it just a thought expressed when the person is well and does not know what it is to truly be ill? Can the living will be used as an accurate representation of the true wishes and feelings?

Property wills are often contested in courts by families. Members of the family may believe that the will either is not fair, or does not represent what the dying person would really want. Many wills are made many years before they are used. They may not be updated for years, so when they are read, the family may doubt the current validity of the will.

The same questions come up in living wills. The family may believe that the will is outdated and doesn't communicate what they believe their loved one would truly want. They also may not be emotionally able to deal with the requests put forth in the will. The will may ask for apparently simple procedures to be denied, which may be hard for the family to accept.

The requests in a will may also be difficult for providers. They may feel that such withholding of treatment is not rational and may therefore recommend against it. They may feel that by honoring such requests they are going against duties to treat. Also the health care team may feel that the person is not making an informed choice. They were not able to discuss the current situation with the patient, so they only have a statement using many suppositions possibly made years earlier.

Respect for persons mandates that we must respect people as rational beings and respect their wishes. If it is a true representation of the incapacitated patient's wishes, then the will should be followed. It is not a perfect solution, but if the will is the only source of consent from the patient then it should be respected. The question of the living will as true consent will be further discussed in chapter five.

Utilitarianism might be able to argue the situation is independent of the will of the patient, so the living will is not as valid as under Kantianism. The situation can be evaluated for utility, which might ignore the will of the patient, if acting against their will maximizes happiness for all people involved.

Conclusion

The goal of this chapter is to give the reader an idea of some of the common reasons that are often deemed acceptable for euthanasia, either active or passive, and the views that the major theories might state. These actions might not be carried out because of legal or emotional concerns, but it is important to ask from the point of moral theory, if the reason justifies the conclusion, which is ultimately the end of the patient's, at least, biological life.

In general, this paper will support decisions that place the patient's autonomy at the forefront. The patient, if they are reasoning as a competent moral agent has a right to decide his or her own fate. In cases where the patient is unable to decide, we should use a combination of the principles that we believe were part of the decision making machinery that they possessed when they were competent, and to decide in ways that maximize their best interest.

There are many reasons that are offered to support euthanasia. Many center on the right of the patient to choose the way the live and the way that they die. The first reason that was presented is the use of euthanasia for patients in extreme pain due to a terminal illness. This is a reasonable justification for the use of euthanasia. This reason is often controversial since in many circumstances there are no treatments that are keeping the patient alive to withdraw to bring death. The only method available is an active form of euthanasia. This method is opposed by many groups, but as will be argued in the two next chapters, the patient has a right to choose the way that he or she dies so the use of active euthanasia in this circumstance is ethical as long as it meets certain criteria so we can avoid abuses.

Another reason that is an adequate justification for euthanasia is for a patient who is permanently comatose and has little or no hope to recover to a cognizant state. These patients are no longer persons according to some accounts, so it is not unethical to allow them to die a dignified death. If the patient has asked not to continue to be treated in such a circumstance, then this wish should be respected.

The use of euthanasia purely on the grounds of rationing of scarce resources is an improper action. Euthanasia should only be practiced when it can be shown to be consistent with the patient's informed wishes or if it can be demonstrated that it is clearly in their best interest. The use of euthanasia to give care to other patients should not be allowed. There are patients who consume resources for whom continued 'life' is not in their best interest. This judgment should be made considering the patient's welfare however, not for the benefit of others.

Euthanasia is a difficult topic to discuss and it evokes many strong feelings. There are many people who stress that it is not an ethical practice, however the contrary can be shown. In certain carefully chose circumstances, if we fully consider the wishes of the patient and respect their quality of life, euthanasia can be an ethical medical choice.

CHAPTER FOUR:
THE DISTINCTION BETWEEN ACTIVE AND PASSIVE EUTHANASIA

> The intentional termination of the life of one human being by another– mercy killing– is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/ or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.[1]

This statement was originally released by the American Medical Association in 1973 and has since remained largely unchanged. It demonstrates that the AMA, which represents approximately 600,000 physicians across the country, expresses a clear feeling that there are moral differences between the means employed in different methods of euthanasia. The AMA statement expresses a prohibition of active means of euthanasia, that is an act that is done to intentionally end the life of the patient. The cessation of extraordinary means however is allowed in circumstances when death has been determined to be imminent. Why does the AMA statement draw distinctions between methods of euthanasia? Is there a difference between direct actions and omissions of medical care or are they nearly equivalent, since in both cases, the physician makes a conscious choice to hasten the death of the patient?

There is a great debate in the study of euthanasia that examines the difference between what some call passive, or indirect euthanasia and active euthanasia, also called direct euthanasia. This is also known as the debate of killing versus letting die. This chapter will examine different sides of the debate and attempt to answer whether there is indeed a significant, philosophically relevant difference between the medical use of active and passive euthanasia. The chapter will also explore whether the intention of the physician makes a

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[1] From *the Journal of the American Medical Association*, 1973, appears in, The End of Life, Euthanasia and Morality (1986) Rachels, James , Oxford and New York, Oxford University Press.

difference in acts of euthanasia and the differences between the withdrawal of ordinary versus extraordinary means as they affect the use of passive euthanasia.

Is the distinction between active and passive euthanasia relevant?

Are there moral differences that accompany different means of euthanasia? Some people will argue that under no circumstances, can steps be taken to hasten a patient's death. They feel that euthanasia in all circumstances is wrong, regardless of method. These feelings may be the result of religious convictions or a belief in the absolute sanctity of human life, regardless of quality. Others state that there are certain methods that are acceptable, such as removing a respirator or ceasing pulse elevating medications in a patient who's death is an inevitability. Withdrawal of these more extraordinary means is classified as passive euthanasia by some in the field, whereas some might say that these methods still take an active step with a conscious choice to hasten the patient's death.

Those who argue for passive methods over active ones claim that passive methods only remove the means that are keeping patients alive, without which, they would surely die. In such cases it is often argued that the disease or injury is principally responsible for the death, since when the lifesaving treatments are withdrawn, the disease is only allowed to take its natural course. Those who prefer passive euthanasia say it is more a more acceptable method than active euthanasia since they believe that the physician does not commit the actual act of ending the patient's life, but merely allows the disease to do what it will. In cases such as the removal of a feeding tube in the case of Nancy Cruzan, there are questions as to whether such an action is purely passive or whether it is in fact active. In such a case, nature does take it's course, but the physician also had a role in causing death. Additionally, there is the question whether the removal of the feeding tube is more passive since Nancy had little chance to recover and the tube was largely extraordinary since it contributed nothing to her recovery.

Scholars who reason from a theological perspective would declare that active euthanasia should be fully prohibited since the physician is directly taking life, which is an action for which only God is entitled. Passive euthanasia through withdrawal of extraordinary means is sometimes allowed under the belief that they are allowing God's will to take over. If the doctor actively kills the patient, then he has acted by himself. If extraordinary means are withdrawn, then the disease takes it's course, which is more natural. Theologians would say that withdrawal of extraordinary means is allowed, since the physician does not directly take the life and the life of the patient is allowed to progress towards the natural end determined by God, which is death. To actively hasten death is to defy the authority of God and act against His will.[2]

Active euthanasia can be defined as an act in which members of the health care team take active steps to end the patient's life. The terminology usually refers to the use of agents to directly end life such as a morphine overdose, whereas passive euthanasia is usually defined as the withdrawal of medical treatment to allow death to occur. An example of active euthanasia is when a patient is suffering a debilitating terminal disease such as Alzheimer's is injected with a lethal dose of potassium chloride. The patient may be far from death, but will suffer greatly along the way as the disease progresses, losing all of his or her memories and the ability to interact with others. He or she may not die for some time from the course of the disease, since there is no life-support to withdraw, thus an active method is required to end their life.

The line between active and passive euthanasia is a hard distinction to make, since many people believe that any act of euthanasia, regardless of the actual means that caused the death is in fact active. They argue that in any method, health care teams are taking active means to end the life of the patient, since, without the action of the caregiver, the patient would be still alive. The result of the action, whether active or passive, is the same, regardless of method. The intention of each action is the same, hastening of the death of the patient, and both actions have the same result.

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[2] Hamel, Choosing Death, pg. 67-70.

Several groups such as the AMA, The United States Nurses Association and the Association of Catholic Hospitals make very deliberate distinctions between active and passive euthanasia. The American Medical Association, as quoted above, has stated in several articles published in 1973, and 1982, that there is a distinction between the two forms of euthanasia. The AMA feels that under certain circumstances, patients may be taken off life support, when there is no hope for a reasonable cure, and be allowed to die. The AMA strictly forbids any physician to take any active steps to hasten or otherwise end a patient's life.[3] How can we decide what means constitute active euthanasia and what means are purely passive?

There are gray areas where it is difficult to determine whether the method of euthanasia in question should be classified as active or passive. Is removal of a respirator an active or passive act? It can be argued that the respirator is only maintaining a state brought on by a medical condition, so if it is removed, then the patient will die from her inability to breathe on her own, so the act might be a passive method. It can also be argued to be an active step since the death of the patient from asphyxiation is a direct result of doctor's action.

Besides examining the causality of the death of the patient to determine the active or passive nature of the method of euthanasia, we can also seek to determine the quality of an act of euthanasia by the type of medical care that is withdrawn. There are some people that draw distinctions between withdrawal of extraordinary means of treatment, those that are either very advanced, expensive or only benefit the patient minimally and ordinary treatments, those that are common and less expensive and generally are beneficial when seeking to define a distinction between active and passive methods of euthanasia. They reason that an action is more active if it withdraws ordinary means of treatment, since such means are required care and the patient would die directly from their denial. The withdrawal of extraordinary means would be more passive since they are not as required, or in some circumstances, not as successful, so after their withdrawal, the patient dies more from the disease state than the withdrawal of the medical care.

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[3] *JAMA*, 1973, appears in, The End of Life, James Rachels.

Differing philosophical views on active and passive euthanasia

There are several philosophers who feel that the moral distinction between active and passive euthanasia is not a useful one. They feel that both actions are carried out with the motive to end the patient's life, and that both end with the same result, which is the death of the patient.

James Rachels published a very influential article in the January 9th, 1975 issue of the *Journal of the American Medical Association* dealing with the apparent distinction between active and passive euthanasia.[4] Rachels presented an argument in the article and in subsequent publications which he called *the Bare Difference Argument*. He wrote that there is virtually no moral difference between active and passive methods of euthanasia and defended it on several grounds. He writes that active and passive methods accomplish the same result and therefore there exists no relevant moral distinction. Rachels states that if the decision to hasten death is the right one, then the means don't much matter. If it is wrong, then both forms are wrong, and if we accept euthanasia in one form, than it is wrong not to accept both methods. He also stated that active euthanasia should be accepted in certain circumstances since it is a more merciful action than letting a patient die from "passive" withdrawal of treatment over a course of days.[5] The course of death from passive withdrawal of life-support may be accompanied by pain and a slow death, where as active methods allow the patient to die quickly and painlessly. Why would it be preferable for a patient to die with more suffering rather than less? Why would a more merciful action be less ethical than one that leaves the patient to die in a great deal of pain?

One common objection to the rejection of the distinction between active and passive euthanasia that Rachels offers in the article is the belief that passive euthanasia is different from

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[4] *JAMA* , 1973, appears in, The End of Life, James Rachels.

[5] Rachels, The End of Life, pg 112.

active euthanasia since the physician doesn't do anything to kill the patient, whereas in active forms of euthanasia, the physician takes direct steps to end the patient's life. Rachels defends the rejection of this distinction by stating that in both cases, the doctor does do something to bring about the patient's death. In the apparently passive circumstance, the doctor does in fact decide to end the patient's life and acts by withholding treatment and actively doing nothing to treat the life threatening condition. The means to the end do not matter significantly since the results are similar.

Many other articles have been written in response to Rachels' ideas, both concurring and strongly disagreeing. If Rachels is incorrect, and there is a difference, what would truly make active and passive euthanasia different acts? What reasons are there that make killing a patient worse than merely letting them die? Putting medical questions aside for a moment, we can ask more generally if there is a true difference between acting to cause an event and failing to prevent the same outcome from transpiring.

An example that is used by Rachels in his book, *The End of Life* to illustrate the apparent difference between active and passive means is called the Smith-Jones Argument. Smith and Jones both have a six year-old cousin from whom they will inherit money if something should happen to the boy. They both intend to kill their cousin to receive their inheritance, but the boy's death occurs by different events.

In the first case, Smith is taking care of his cousin for the afternoon and the boy is taking a bath. Smith comes into the bathroom and holds his cousin under the water until the boy drowns, then makes it look like an accident. As a result of the boy's death, he inherits the money. Jones also is planning to kill his cousin and inherit the money. As he comes into the bathroom to hold his cousin under the water like Smith did, the boy is balancing on the lip of the tub and is reaching for a toy. He falls and hits his head, falls unconscious and drowns.

Jones stands ready to hold the boy under, should he surface, but the boy drowns without Jones actively doing anything.[6]

Obviously, Smith and Jones both acted terribly, but is one worse than the other? They both had the same motive, to knock off their cousin for money, and their actions both produced the same action, the death of the cousin. Does it matter that one intervened in a more active fashion, while the other simply allowed it to happen?

As will be argued by Tom Beauchamp later, I don't think that the Smith-Jones example is that useful in discussing actual euthanasia cases since the distinction it makes does not directly parallel the differences between active and passive euthanasia. It does however illustrate the important points in the debate, which are that there may not be a difference between using medical methods to bring about death and withdrawing care or not treating with the intention to allow the patient to die. Independent of decisions about euthanasia, people have a general duty not to kill, but do they always have the duty to save lives? In a pure sense, the duty not to kill is stronger than to save someone from death, although it could be argued that Jones had a duty to save his cousin since he was watching over him and he is a family member. It is a special relationship since he is in charge of the cousin. Smith has been worse by killing his cousin for money since he did it purposefully. Jones did have the intent, but did not participate as much.

In a medical example by contrast, the physician has intervened in both circumstances. In the active one, he or she has given the lethal dose and in the apparently passive circumstance, he or she has removed or withheld care for the express purpose of letting the patient die. A more equivalent example would be if Jones put his cousin in a swimming pool, knowing that he cannot swim and allowing him to die, and Smith held his cousin under the

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[6] Rachels, The End of Life, pg 112-113.

water until he died. In euthanasia, the physician creates the circumstance in which the patient dies, whereas Jones didn't save his cousin, but didn't make him fall in the water either.

Utilitarianism would judge the actions of Smith and Jones basically the same. Both men wished for the death of their cousin and both intervened to a degree, whether through act or omission to bring about his death. The outcome is the same, so the act is nearly equivalent.

Kantianism is likely to judge these actions nearly equivalently also. Since they are both from a non-beneficent motive, they both violate respect for persons and would not hold up under the categorical imperative. Both actions result in the death, and equally violate the cousin's right to life.

A theologian would defend the argument that an active act is worse than a passive action, even though both men are guilty of a moral injustice. Smith has acted in a worse manner since he has acted directly. Jones should still save the cousin who is drowning since he has the general duty to prevent the death of his charge, but Smith has actively killed the boy, which theologians would argue is a worse act, since only God can take life.

In a well known response to Rachels, Tom Beauchamp writes that contrary to Rachels, the distinction between active and passive is not always morally irrelevant.[7] He does grant that in some cases the distinction is not relevant, but thinks Rachels is not justified in claiming that it is always morally irrelevant. He says that the Smith-Jones case is not especially relevant to euthanasia cases and that decisions in a clinical arena are different than deciding between Smith and Jones since the intentions are non-beneficent and Jones' involvement is different from the method used in passive euthanasia.

Beauchamp begins his criticism of Rachels by describing differences in an actual euthanasia case that received national attention, that of Karen Quinlan where he believes that

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[7] Beauchamp, Tom L, *A Reply to Rachels on Active and Passive Euthanasia*, appears in Contemporary issues in bioethics, 3rd ed. Belmont, Calif. : Wadsworth Pub. Co. Beauchamp, Tom L. and LeRoy Walters, editors, pg. 248-255.

there was a difference between the use of active and passive euthanasia. Karen was in a deep coma that doctors believed was irreversible and her parents wished to remove her respirator to allow her to die a natural death. Her father made it clear that he did not wish to kill his daughter, he only wanted to allow her to die naturally. Beauchamp adds a second hypothetical example, that asked: what if Karen's father only wanted her to die a painless death and asked for the physician to induce her death through a morphine injection. Many people would say that the first case may be acceptable, while the second is not morally justified. What accounts for the apparent difference?

It can be argued that the apparent difference is a preconceived view that there is a difference between active and passive euthanasia. In the Quinlan case, the parents had decided that there daughter would not want to live on in such a state. They had decided that it was wrong to kill her, but acceptable for her to be allowed to die. If the methods are equivalent, then if the use of passive euthanasia gives her parents peace of mind, then it could be used since it has an additional positive effect. The point that Beauchamp makes proves that the Quinlan family felt that there was a difference, but does not prove that there is a relevant moral difference.

One defense that Beauchamp uses in favor of the traditional distinction is that the use of passive euthanasia in certain cases allows for the possibility of misdiagnosis, whereas if an active method were used it would produce death in 100 percent of cases. Beauchamp writes that part of Mr. Quinlan's reasoning for requesting withdrawal of life-support was to see if his daughter could live without machines. If he had asked for active means, he would be seeking his daughter's death, not testing to see if she would die a natural death.

This reasoning can be argued against as a defense of the distinction. I would say that Mr. Quinlan was definitely seeking his daughter's death, since he felt strongly that the quality of life that she was living was very poor and he had correctly recognized that she had no chance to recover. Even if she could live without the respirator, she still has a very poor quality of life and would still be a candidate for euthanasia.

Another argument that Beauchamp gives to defend the active/passive distinction is that active means can lead by a slippery slope to other undesirable effects. He thinks that use of active means in certain circumstances can lead us to expand the cases in which active means are deemed acceptable to the cases of "unworthy" or "undesirable" human life in a precarious position. [8]

Passive euthanasia can only be employed in certain cases in which the patient is near death and will die without a certain level of medical treatment. Active methods can be employed in all cases when the patient will not die if some extraordinary means are withdrawn or is dying a prolonged death. Beauchamp cites an extreme case, where early in pre-Nazi Germany, there was active euthanasia practiced on mostly non-Jewish German patients. It was expanded over time to include anyone who was deemed an enemy of the people. In this example however, euthanasia turned to cases of murder and genocide, since killing groups such as Jews, Gypsies, Homosexuals and others is not done for reasons of mercy, but because of hatred. In a more rational example, Beauchamp discusses the ramifications for a moral code allowing restricted active euthanasia. He believes that if this policy were developed, then the reasons that are deemed acceptable for euthanasia might expand over time and it might become common place to euthanize at risk groups such as unwanted newborns and the elderly, with the latter practice increasing as the numbers of aged citizens grow with every decade.

To respond to the arguments of Rachels and Beauchamp, I would say that there is not a significant moral difference between active and passive euthanasia when they are used in the same circumstances. For the cancer patient who will die soon, there is little moral difference between "pulling the plug" and giving an injection. Both are forms of euthanasia which cause death. I agree with many people that state that using different methods of euthanasia to accomplish the same end is the same. They often say that it is like "choosing your weapon."

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[8] Beauchamp, Tom L, *A Reply to Rachels on Active and Passive Euthanasia*, pg. 248-255.

Instead of drawing distinctions between types of euthanasia and stating that one is worse than the other, we should be examining the cases in which euthanasia is used. In the case of Beauchamp's concern that a patient may recover if passive means are employed, we need to ask if euthanasia is a correct choice in such a circumstance. If there is a degree of doubt about the patient's prognosis, then euthanasia should not be chosen, active or passive. The decision should be delayed until tests can determine the certainty of the possibility of death within a certain amount of time. For the Quinlan case, there was little doubt that Karen as a person was gone, so either method could have been used.

Beauchamp's objection to active euthanasia on the grounds that it will lead to a slippery slope into euthanasia for more circumstances cannot be proven. There is little evidence that the use of euthanasia in certain specific circumstances will lead to the use in other circumstances to support the killing of undesirable people. If euthanasia were accepted as a medical practice, it would be done only with the understanding that it would only be used in certain circumstances with many safety controls and levels of consent. Other medical procedures today are only performed in very specific circumstances and require patient consent or the consent of representative parties such as parents or family. An act with as many consequences as active or passive euthanasia would only be used in specific circumstances according to specific protocols.

An example that can be used to disprove the slippery slope argument is the use of organ donation protocols to allow individuals to donate their organs to be harvested after their deaths and given to needy parties or to science for research or teaching. There might be a similar concern that by allowing organ donation that we might embark on a slippery slope to a point where organ donation would be done involuntarily. There have been strict rules regarding organ donation and a signed card with a witness is required and only the organs indicated can be harvested. If active euthanasia was allowed, then similar methods could be used to determine the groups to be included and to protect against involuntary euthanasia for certain at risk groups.

Ethical theories and the active and passive debate

An example of the debate of active versus passive methods of euthanasia in a medical circumstance is for a cancer patient who is in a great deal of pain and will soon die. The patient will die regardless of treatment, but will die a few days earlier if the chemo is forgone. If an active method is used, then his pain will be ended immediately. There is not a significant moral difference between the two methods, but there may be a procedural difference between the two. If it is judged that the act of euthanasia is morally acceptable in these circumstances, in what circumstances is one form preferable over the other?

Using passive means, the patient would be denied treatment and the cancer would take its course, over several, possibly pain-filled days. If active means are used, the patient would receive a lethal dose of anesthetic and would die within minutes. Which act is preferable?

The active form is viewed by some as being worse than the use of passive methods. On the contrary, the active form can be argued to be much more humane in some cases, since the patient is not forced to suffer for a few days while the disease takes it's course, but is relieved of suffering immediately. Why is it worse to use an active method when the passive alternative results in more suffering and death is certain? Both methods have the same result, but the passive method forces the patient to endure a longer course of suffering. If the course of the treatment has already been directed to end the patient's life because of suffering, why is it more morally acceptable to let them suffer more over a course of days? How would the major theories evaluate this distinction, and which method would be appropriate for the cancer patient?

Kantianism uses the categorical imperative to determine whether actions are acceptable or are prohibited by universalizing an individual action so it is applied in all cases. In the active and passive debate, we can ask if there are circumstances in which we can will passive means of euthanasia to be applied but reject active euthanasia. It might be able to be argued by some people that active euthanasia should not be used in some circumstances since it can lead to the killing of groups who are not able to be ethically killed such as the elderly or the mentally retarded. It is also argued that there is a difference between active and passive since passive euthanasia leaves room for error whereas the death of the patient is certain using active euthanasia.

In these circumstances, it can be argued from a Kantian point of view that the use of euthanasia itself is under scrutiny, not the method used. If euthanasia is unjustified in a certain circumstance, such as if it violates the respect for persons principle or is contradictory under the categorical imperative, then it would be unjustified using either method. If the prognosis of the patient is questionable, then use of either method should be postponed until a decision can be made with greater certainty. The use of passive euthanasia for the non-terminal elderly or the retarded who have not voluntarily chosen death would be as wrong as the use of active euthanasia. If we examine active euthanasia in a circumstance, then examine passive euthanasia in the same circumstance, we can find very little difference. It the choice for euthanasia is wrong, then it is wrong using either method and if we can accept it since it respects the patient's dignity and will, then we can accept either method.

Kantianism evaluates actions from the intention, not just the outcome. Utilitarianism would state that an action is right based on it's outcome. For Kantianism, an action is right if it follows the will of the individual and avoids a contradiction using the categorical imperative. Under Kantianism, we cannot support a distinction between active and passive euthanasia, since both would be equally wrong, and if used correctly to respect the patient's dignity according to their autonomous choice, both are ethical.

Using a Kantian analysis, it may be better for the patient to die by active means in a circumstance where either method can be employed. The patient wishes to die, and out of respect for them as an autonomous being, we should grant a quick death once the decision has been accepted. Why use a method that causes additional pain? An active death is more respectful of the patient and also it could be argued that, if we choose euthanasia as an option, why choose a means that gives additional pain, if the intent is to end the pain? If the choice has been made to die, then the patient should be allowed to die as painlessly as possible. If death is the outcome anyway, then there is no evil to one that comes sooner rather than later.

In utilitarianism, utility is the only consideration in making ethical analyses. An act is believed to be right if it increases utility, wrong if it decreases it. If an act of euthanasia is increasing utility and thus is correct, then under utilitarianism, the means are not as important as the outcome. If an act is right, then the means used to bring it about are less important. In a medical circumstance, if a patient is experiencing severe pain or is comatose then the ending of a situation where the patient has little dignity and consumes resources with little hope for recovery may be thought to increase utility. Using passive means or active means are not an important distinction using utilitarianism, since both acts accomplish the same outcome.

A utilitarian analysis might also support an active method for this patient. The patient's happiness taken into account in the calculus of utility. A quick death would add more to utility since the patient's pain is over immediately, instead of being stretched out over a course of days. A slow death after the withdrawal of treatment would bring additional suffering and the family additional emotional pain as they watch their loved one wither away.

A religious view would not support the use of active means to relieve suffering. According to theological principles, there is a place for suffering in the human definition. There are elements of suffering that help to teach people and to define what we are as people. Theology says that we should not directly look for suffering, but when it is present, we should not act to immediately stop it, since it is part of the course of life that God intends. Also, we are not alone in the world and the contact of others and support of family and community for the dying patient can help to ease the pain.[9]

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[9] From a personal interview with Father John Marquis, S.M., Catholic Chaplain of Colby College, November 4, 1995.

Ethical duties of the physician and active euthanasia

How do the physician's ethical duties affect the difference between killing and letting die? If the physician can ethically undertake the act of euthanasia, is there an ethical difference between active and passive? There is still a belief that is held by some members of the public and by many doctors that it is wrong for physicians to kill. The use of passive euthanasia may be easier psychologically for many but is it morally different for physicians to engage in one or the other? As posed previously, physicians may also have a duty to alleviate suffering in addition to preserving life, so both types of euthanasia may be allowed in certain circumstances.

One reason that people feel that doctors should not use active means is that the Hippocratic oath instructs physicians to "do no harm." Some have interpreted active euthanasia as harm. It can be argued, however, that in some cases allowing patients close to death to live on in pain, or to let them die over a course of hours or days after lifesaving technologies have been withdrawn is letting harm come to them, so active means may actually decrease what can be defined as harm.

No matter what we decide morally, it is still psychologically easier to think of letting a patient die due to the course of the disease than to actively be the cause. This is partly due to the widespread moral belief that we hold that killing is wrong in general. If euthanasia is acceptable, in a case, such as a patient who is in terrible pain that is unrelieved by medication, why is it harder to think about using active means?

As stated above, it can be argued that there is not a significant moral difference between the use of active and passive euthanasia. For the physician, in circumstances where active and passive euthanasia are both possible, he or she can use either method. If the decision is a correct one and they are acting to alleviate suffering, then either form is acceptable. It can be said that in case where the passive withdrawal of treatment leads to a pain filled process of dying, that active euthanasia may be preferable. The physician has already decided to act, so the decision, not the means to carry it out, is what should be examined.

The role of the physician and euthanasia will be examined in more detail in chapter ten.

Intentions as they affect the moral judgment of euthanasia

In cases of euthanasia, is there a relevant moral difference between two actions whose outcomes are the same but start from different intentions? Does it matter what the intent of the doctor is who carries out the action if the action achieves a desired result? Is the intention of an individual more important than the outcome of the action or is the method used to achieve the action the most important?

One doctor has a patient who is suffering from a very advanced cancer and is a possible candidate for chemotherapy. Even with the chemo, the patient will only live a short time, since the cancer has spread to so many areas and he will be under a lot of pain. A side effect of the potent chemicals in the chemotherapy medication is that the patient will be very sick as the drugs fight the cancer. To get a high enough dose, the chemotherapy must be injected intrathecally, into the cerebrospinal fluid in the canal of the spinal vertebrae, which is very painful. The doctor decides that he does not want to subject the patient to more suffering for such a short difference in the length of his or her life, so he ceases treatment and allows the patient to die. The motive that the doctor had in ceasing treatment was to prevent further pain for the patient, not the hastening of death, which was seen as a possible but not directly consequence.

A second doctor has a similar patient, also with advanced cancer who might be able to live for a short time longer if she was given intrathecal chemotherapy. The doctor decides however that his patient also has only a short time to live and feels that the benefit of the chemo is not enough to justify its use. He decides that the patient would be better off if she was allowed to die, so he ceases treatment. The motive that the doctor had was to hasten the death of his patient, since he felt that death was preferable to continued pain.

In a traditional analysis, it might be said that the first physician acted correctly and the second doctor acted immorally, since their motives differed. For the first doctor, the death of the patient was a known side effect, but the ending of the suffering was cited as the primary intention. His action might be interpreted as a more passive method, since the cancer was the ultimate cause of death. The second doctor, had the intention of hastening the death of his patient, which would be viewed as less morally acceptable.

A radical example of a difference of motive with similar outcomes could be applied to non-beneficent killing. Intent is a very important component of the American criminal justice system. It is clearly worse morally and legally to kill someone because you dislike them versus killing them to save your own life. In the first case, you intentionally end their life, where as in the second example the primary intention is self-defense.

It is hard to evaluate cases of intention for euthanasia. Each physician had a different motive, but the course of their treatment was exactly the same. They have both foregone the chemotherapy treatment, but one did so to hasten the death of the patient, whereas the other physician wanted primarily to relieve the patient's suffering.

Utilitarianism is not likely to pay much attention to the intent of the action, only the resulting utility of the action. The patient is suffering and the withdrawal of treatment will end the suffering sooner and will also probably be easier on the family and the physicians, so it is a preferable action, regardless of intent. If the outcome of the action increases utility, such as with the death of the patient in pain, then it does not matter whether the intention was to hasten death or relieve pain.

Kant on the other hand, would think that the intention of the action is the primary concern, with the outcome being less important. The action is only right if the intent is correct. If the doctor wanted to help the patient to die to end suffering, then his action is correct. If he wanted to hasten the patient's death to advance his political cause, then a Kantian would say he has acted incorrectly. In the case of the intentions of the two doctors above, both have acted correctly since they are acting according to the patient's wishes and in the patient's best interest, even though one intends death and one intends to ease pain.

Theologians would argue that the intention is a very important criteria in judging the morality of an action. They would also argue that certain actions are acceptable and others are prohibited. The physician who's primary intention was to end the patient's life acted in more of an immoral fashion than the doctor who wanted to end the patient's suffering.[10] Both may be acting immorally, since theologians believe that only God should take life, but the doctor who did not list the death of the patient as the primary intent is less morally wrong.

I believe that the intention of the action matters only in circumstances where the outcome is not desirable or the interest of the deciding party is independent of the interest of the patient. For the above case, deciding to forgo further treatment was the correct choice. The patient had little to gain from the continued treatment aside from more pain, and would be better off if treatment was discontinued. It is hard to see why intent matters in these cases. Both doctors have the interest of the patient in mind. The patient wants to be released from suffering and they want to die to accomplish that goal. The patient's life was not preferable to a painless death, so the use of euthanasia to hasten death is an ethical action as is the withdrawing treatment to relieve suffering.

If the doctor who wanted the patient to die did so for personal gain, then it would be wrong. Even though the action and outcome are the same, the doctor would not be acting in the interest of the patient but in his or her own interest. If the doctor discontinues treatment because he wants more cases to make more money, he is acting badly. The doctor who wants to relieve suffering clearly acts in the patient's interest, where as the doctor who views death as the desired outcome may be worse morally if the outcome is not according to the patient's interest.

The Doctrine of Double Effect

A philosophical principle called the doctrine of double effect could be used to defend the physician who sought to end the patient's pain, but didn't seek to deliberately take the

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[10] Hamel, Choosing Death, pg. 67-70.

patient's life. This idea says that an act may be judged differently if there is another primary intention in addition to the one supposed. For the doctor, it might be said that the primary intent was to relieve pain, not the supposed intention of ending the patient's life. For medical ethics, both the AMA and Catholic ethicists have used double effect to justify certain actions, such as abortion in cases where the life of the mother is in danger. For Euthanasia, an example of double effect would be if a doctor gave high doses of morphine, an analgesic and a respiratory depressant, to relieve intense pain. The morphine relieves the patient's pain but high doses also slow the patient's breathing to such a level that he or she may go quietly into respiratory arrest and death. The justification that could protect the doctor from legal and perhaps moral prosecution is that the death of the patient was not the primary intention, but the control of the pain, with death being an unintended but known possible side effect. The doctor might say that to relieve intense pain in a terminal patient, high doses may be required, with the possibility of respiratory depression. The intent is primarily to relieve the pain, not to end the patient's life, even though it may come.[11]

The doctor who intended to primarily treat the pain of the cancer patient above might be judged differently than the other doctor using double effect, if hastening the death of the patient is believed to be immoral. The death of the patient was not the primary intention of the first doctor. His goal was to end the patient's suffering, but forgoing treatment had a double effect, the end of the pain and the death of the patient.

The doctrine of double effect is only useful in a limited number of circumstances where the intention of the action is from an admirable motive, but the means used to accomplish the motive are usually considered wrong. It is only relevant if we have decided that the primary action is immoral, like stealing, abortion, as in a common example for the doctrine, or murder. I argue in this paper that there are specific circumstances in which euthanasia is an ethical

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[11] Kuhse, Helga. The sanctity-of-life doctrine in medicine : a critique (1987) Oxford : Clarendon Press ; New York . Oxford University Press, pg. 83-93.

choice, so that if relieving pain is the main intention, and euthanasia is means to attain that goal, then the doctrine is morally relevant, since in many circumstances, the means to accomplish the intention is ethical regardless of a double effect calculation. For the case of death from respiratory depression due to excess morphine, it is ethical to end the patient's suffering, whether the primary intention is not prolonging life or relieving pain.

In other cases however, it can be argued that the intent does matter, since there can be a similar outcome that results from two different intentions. Opponents of abortion sometimes accept abortion as a means to save the life of the mother when the death of the woman is a reasonable certainty. Here the primary intention is not to perform the abortion and kill the fetus, but to save the mother's life. If it is believed that abortion is wrong, it might be accepted as a means to save the mother's life, since there is no other way, but not for it's own sake.

There are some people who might reject the use of double effect to justify an immoral action. They might state that it is not possible to separate the intention and the means to establish that goal. If one believes that abortion is wrong regardless of reason, then that person would say that no matter what, if an abortion is performed, then the person is responsible for the performance of the action. Similarly, if we believed that the hastening of the death of a patient was wrong using morphine, then if death resulted from morphine, then the doctor is responsible for the death. It could be argued that they knew that death was a strong possibility with the use of excess morphine, so when they used the morphine, they should have taken into account the possibility of the death of the patient and cannot blindly look the other way and hide behind the defense of double effect.

Ordinary versus extraordinary treatments

If we do in fact accept that the withdrawal of certain medical treatments is acceptable in some circumstances, which means are acceptable to forego, and which are not? How does the type of treatment that is withheld affect the quality of the action?

This debate is referred to as the distinction between ordinary and extraordinary means. Under the distinction, extraordinary treatments are viewed as morally optional, whereas ordinary treatments are required. Some argue that there are certain treatments that are obligatory, whereas others are merely prolonging an already certain death. Additionally, the distinction between ordinary and extraordinary medical treatment is used by some to determine active versus passive euthanasia. If we have rejected the argument that relies on acts versus omissions, maybe we can draw a distinction between the withdrawal of ordinary treatments and extraordinary treatments. The withholding of extraordinary treatments might be seen as a passive decision since it can be argued that these extraordinary treatments are doing little to help the patient recover and their use only prolongs an already certain death. By contrast, it has been argued that the withholding of ordinary treatments is a more active choice since they are more required treatments and death may come more directly as a result of the treatment withdrawal, instead of from the disease process, which might occur with the withdrawal of extraordinary treatments.

Extraordinary treatments are often judged as those which are rare, difficult to provide or expensive. In some circumstances, treatments are also judged to be extraordinary if they have little chance of being beneficial for the patient. Ordinary means are, by contrast, common, inexpensive and are generally beneficial. Of course, this terminology is not terribly precise since it does not state how uncommon, or how expensive a treatment must be before it becomes extraordinary.[12]

The lines between ordinary and extraordinary treatment have shifted considerably following the developments in modern medicine. There are now more advanced treatments than ever before, but some of these advances are also considerably more scarce and expensive. As technology advances, some treatments are frequently reclassified as ordinary as they become less expensive, more widely available and more effective in a larger number of cases. Today,

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[12] Rachels, The End of Life, pg. 96.

most people would not say an IV is extraordinary, however, when it was first developed, intravenous feeding was a very modern form of treatment, as compared to existing treatments of the time.

The Catholic Tradition as decided by pope Pius XII states:

> Normally one is held to use only ordinary means–according to circumstances of persons, places, times and culture–that is to say, means that do not involve any great burden for oneself or another.[13]

This statement shows that the Catholic church requires the use of ordinary means in all cases, but will allow the removal of extraordinary means in certain circumstances. The Catholic Church as also stated that when death is only being prolonged, that the extraordinary means that are prolonging the death can be withheld. There is a statement that says "the doctor must not kill, but does not always have to strive to keep [the patient] alive."

The decision as to whether a treatment that may be withheld is extraordinary depends on the circumstances. For a child with cancer, almost any treatment would be justified using certain principles, since, if it results in a cure, the child will be able to live the rest of his or her life cancer free. For the 80 year-old comatose heart attack victim in chapter three, almost any means are extraordinary, since he has little chance of recovery to any reasonable quality of life.

The course of the illness should be evaluated, not only the treatments. If the treatment will have useful effect to any reasonable extent, then a high level of treatment may be justified. If a patient is in a persistent vegetative state, then there is little that can be done, so most means would be judged as extraordinary, since they will have little effect on the patient's progress.

As introduced above, there are often differences drawn between the withdrawal of extraordinary and ordinary means. The removal of extraordinary means, such as a blood pressure elevating medications, may be constituted as purely passive euthanasia, since the cause of death is the patient's underlying condition. The removal, by contrast of ordinary means, such as an IV or a nasogastric tube providing nutrition and hydration might constitute active euthanasia, since they are generally thought of as required and could cause the death of a patient without an underlying condition.

Legal cases have often sought to sanction physicians for the removal of ordinary means, but have rarely prosecuted for the removal of extraordinary means. In 1981, in the case of Clarence Herbert, two of his physicians were charged with murder because it was discovered that as a result of a request to allow the patient to die, they had not only removed the respirator, but also the IV. The nurse had copied the patient's chart and given it to authorities because she believed that an injustice was being done by the removal of ordinary means. The judge in the case said there is not a difference between the removal of an IV and a respirator, even though the IV is thought to be more 'ordinary.' The judge wrote,

> Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.[14]

I don't feel that the conception of ordinary versus extraordinary medical treatment is that relevant to evaluation of cases of euthanasia. If the patient has either chosen voluntarily to die, or if it is determined to be in their best interest, the means that are withdrawn should not matter. If extraordinary means are withdrawn, then ordinary means should be too. It is not humane to prolong the dying process by withdrawing higher level treatments and allowing the patient to slowly die with IVs etc intact. If all classes of means are withdrawn then the death may be quicker and less painful. If we have decided that death is the goal, then it makes no sense to prolong the dying process by refusing to withdraw certain means on the grounds that they are not extraordinary.

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[13] Appears in *Choosing not to prolong life* by Robert M. Veatch in Bioethics (1976), Thomas A. Shannon, Editor, New York, Paulist Press, pg. 184.

[14] Rachels, The End of Life, pg. 102.

Do not resuscitate orders

When a patient is near death and wishes to die, or if in consultation with the family, the health care team decides that an incompetent patient is too sick to ever make a recovery to a functional state, or when resuscitation would only prolong a painful death, a do not resuscitate order may be ethically entered into the patient's treatment records. A DNR order stipulates that if a certain patient goes into cardiac or respiratory arrest, then they are not to be resuscitated and will be allowed to die. The DNR order might be considered by some to be a form of passive euthanasia in it's truest form. The physician has not done anything to hasten death, but has made a decision regarding the quality of the patient's life and elects to let the patient die if they should arrest. The physician is not causing the death, but makes a conscious decision to not resuscitate the patient in arrest. The arrest is allowed to proceed to its natural conclusion and the crash team is not assembled to provide what are definitely heroic means of treatment. The act of the physician is to not act. The DNR order is criticized by some since they may believe that it is wrong to deny patients resuscitation since physicians have a duty to save lives, and should not allow people to die without any intervention.

Religious theory may accept DNR orders in certain circumstances. It can be argued that the initial arrest was a step in God's plan for the patient to follow and to allow the person to die is to only allow them to proceed to this conclusion. Only extraordinary means are not used and the patient dies a natural death.[15]

I believe that we can ethically allow DNR orders to be used, provided that they are set up according to the wishes of the patient and/or his or her family. It is not ethical for the care providers to make independent decisions about the patient's life if there are means to clarify what the patient and the family want. Deciding for the patient should only be done in cases where the patient has no support group and it is clearly in their best interest. In cases where a

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[15] Hamel, Choosing Death, pg. 57-60.

patient is unstable, it is not ethical to decide for them independent of a request for DNR status, since it violates the patient's autonomy.

In many cases of critical illness, a DNR order is the right decision. An example would be an unstable ninety year-old patient in congestive heart failure who has experienced multiple cardiac arrests. Without a heart transplant, this patient will die. Due to their age, they are not a candidate for such a transplant, since they are not an acceptable risk for anesthesia. During each arrest the crash team has been mobilized and the patient has been brought back. It is clear that death is imminent, since the heart can no longer support the patient. Each resuscitation has progressively weakened the patient, and to constantly resuscitate only prolong the dying process. If the treating physician is acting either according to the patient's consent or the judgment of the family, in the case of the incompetent patient, the DNR is then an acceptable and humane choice.

Nancy Dubler, in her book, *Ethics on Call*, defends the DNR order by stating that CPR may not be a reasonable treatment in all circumstances. She points out that historically, CPR was invented on the battlefields of World War II for fit, 20 year-old soldiers who had suffered trauma. It was not intended for weakened elderly patients who have little hope of making a full recovery after the arrest.[16] She writes that resuscitation for these patients is not a doorway to extended life, but the entrance to a tunnel of prolonged dying.

Dubler cautions that there is a need, as I have stated above, to make sure that the DNR is being ordered either, according to the patient's or family's wishes, or in accordance with the patient's best interest. There have been cases in which DNRs have been made for patients whose circumstance did not clearly mandate DNR status, or for patients for whom there has been a judgment made about the usefulness of their lives by some third party. Dubler tells of a patient who she consulted on that had suffered a broken hip and had a DNR status given without discussion with the patient or her family. After investigation, a resident, answering the

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[16] Dubler and Nimmons, Ethics on Call, pg. 175.

question of why the patient was DNR for such a non-life threatening ailment, said, "Society has spent enough on this lady."[17]

The DNR is, in many circumstances, the most humane, and correct, choice for the patient. The use of the DNR is ethically permissible in certain circumstances, but only with safeguards in place that guarantee that the order is only used in the patient's best interest.

Conclusions

After an analysis of active and passive euthanasia, it can be concluded that in a majority of circumstances, active and passive euthanasia are nearly equivalent acts, and in some circumstances, active means may actually be preferable, since the patient avoids a long painful dying process. If euthanasia is deemed acceptable in a certain circumstance, then active and passive methods of euthanasia are both acceptable in that specific circumstance. If a patient is so critically ill that they will die if treatment is ceased, then it is morally acceptable to speed the dying process using active methods as well as passive ones.

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[17] Dubler, and Nimmons, Ethics on Call, pg. 180.

CHAPTER FIVE:
VOLUNTARY AND INVOLUNTARY EUTHANASIA

There are several distinctions that are important in evaluating the euthanasia debate. One of the most important is that between voluntary euthanasia, where the patient decides in some capacity to end his or her own life, and involuntary euthanasia, where the patient is not involved in the decision process to hasten his or her death. Some have referred to a third distinction, called non-voluntary euthanasia when the patient, by definition, cannot have a say in the process, such as infants or the irreversibly comatose who have not given prior directions regarding their care.

The discussion about voluntary and involuntary (and non-voluntary) euthanasia has many difficult issues associated with it. The question arises with voluntary euthanasia, particularly in active forms, whether the decision of the patient is nearly equivalent to suicide. The patient has clearly chosen to end his or her life, but may be unable or unwilling to do it themselves. The physician is then left with the dilemma whether it is ethical to carry out such a request. Those who oppose voluntary euthanasia might also ask who bears the burden of responsibility for the act, the patient, in choosing death, or the physician, for causing it.

It can be argued that if the patient is competent and acting with fully informed consent, that for the physician to deny such a request is to disrespect the autonomy of the patient. There are others who feel that doctors should not hasten the deaths of their patients and to carry out such requests undermines the role as healers that they have taken an oath to uphold.

Difficulties arise with involuntary euthanasia since if the patient does not or cannot decide, we are forced to ask who should make that choice for them. For simplicity of terminology, I shall include non-voluntary euthanasia in the broad definition of involuntary euthanasia, since I will mostly cover circumstances of a non-voluntary nature, in which the patient is incompetent to decide due to age or mental status, since in circumstances in which the family or physician would decide in favor of euthanasia against the patient's direct will would be judged as immoral in most cases since it clearly disregards the patient's right to autonomy. For cases in which the patient cannot decide, guidelines need to be established to determine who should decide and how to determine what actions are in the best interests of the patient.

This chapter will address the issues associated with voluntary and involuntary euthanasia and methods for defining and dealing with each. Does it make a difference if the patient decides or if the decision is made by others? If we did in fact conclude that euthanasia was wrong in all cases, would it matter if the patient had consented to the act?

Informed consent and the classification of types of euthanasia

Informed consent is an important issue in modern patient care. In the early history of modern medicine, the rights of patients to participate fully in decisions regarding their own care were limited. The physician would commonly either make a decision and inform the patient what treatments they would receive, or in certain circumstances when the patient was given options, an effort may have been made to steer the patient towards a certain treatment. As long as the patient verbally consented, the procedure could be carried out. Physicians have often defended this right not to disclose all information to a patient by stating that they are acting in the patient's best interest and to suggest further options of treatment would be to suggest "less than the best possible medicine."[1]

Today, as a result of the patient's rights movement and because of developments in the legal process, doctors are much more likely to further explain the treatment options that the patient has and allow the patient, with the advice of the physician as a resource, to decide on a course of treatment. For a procedure to be carried out, the doctor must have the voluntary consent of the patient. The patient, when fully informed, has the right to accept or refuse any treatment options, including the refusal of life-saving measures. The use of informed consent is

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[1] Macklin Ruth, Mortal Choices, Ethical Dilemmas in Modern Medicine, (1988)
Boston, Houghton Mifflin, pg 35-48.

necessary for both physician and patient. When a patient is given all the necessary information, including expected outcomes and potential risks and/or side affects, they benefit, since they know what to expect if they consent to the procedure. It is also in the patient's best interest to become as informed as possible so they can protect their autonomy and be given the right to make decisions regarding their own care.[2]

The doctor also benefits, since as long as he or she has disclosed all the information to the patient, the patient then knows what the risks of the treatment are and the doctor has less legal liability for possibly medically expected side affects of a procedure. Informed consent has become an important facet of legal cases in medicine. Doctors can be prosecuted for not providing enough information to the patient in cases when a procedure encounters problems. Even if the outcome of the case is a medically recognized possibility, it is the responsibility for the doctor to fully inform the patient. They are expected to tell the patient what is wrong (diagnosis), what is likely to happen (prognosis), and what all of the available treatment options are, including doing nothing at all.[3]

Informed consent is an important principle for euthanasia. The level that the patient is able to consent determines their responsibility for choice of treatment or omission of treatment that they have made. Also, to be acting with full autonomy, the patient must be completely informed so he or she can decide what course of treatment they feel is best for them. If they are not given all the options or their choice is influenced by their doctor, they are not making a fully independent and informed choice.

To evaluate the patient's choice for euthanasia, it needs to be determined if the patient who seeks death is acting in a truly informed and autonomous manner. The caregivers and

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[2] Dubler and Nimmons, Ethics on call, pg 90.

[3] Dubler, and Nimmons, Ethics on call, pg 91.

family need to determine whether the patient has weighed all their treatment options and whether the expected quality of life is so poor that euthanasia becomes a viable option. If the euthanasia decision is related to pain, are there treatment options that can help control the pain, or is the level of pain beyond the control of modern methods of analgesia?

It also needs to be determined if in such circumstances whether the patient is capable of giving informed consent. Are they able to think clearly and are they able to understand the options that are given to them? To determine if they can in fact give informed consent, we need to determine if they are capable of understanding what is being explained to them and if they are mentally competent to decide. First, we can determine that informed consent has been given if they have a certain level of intelligence and are thus able to fully understand their options. It is important for the physician to explain the terms of the disease in layman's terms because if the patient has little medical background, the understanding will not be compromised by the use of medical jargon.

Being informed is only one facet of voluntary consent. In addition to the patient having all the information to make the decision, they also have to be able to make such a choice. There are several places where informed consent can break down. First, the patient may not have the education to understand their options and give consent. If they take what the doctor tells them on blind faith without truly understanding, then they are not giving fully informed consent. Early in the formation of informed consent, there were some physicians that stated that patients could never be fully informed since the majority of them lacked the medical background to understand their disease and corresponding medical terminology. As a result it was argued that the physician was in the best position to decide for the patient's welfare since he or she had the training necessary to decide what was best for the patient.

Additionally, if the patient is not of sound mind, then they may not have their autonomy fully intact and are not in a position to make a clear choice. The patient can receive clinical treatment to help them return to such a state where they can make a voluntary decision. In order to determine if the patient is competent to consent, we need to rule out clinical depression or dementia. There is a distinction in the types of depression that may compromise the competence of the patient that needs to be made.

There are two types of depression that can be associated with terminal illness. The first is a clinical, or physiological depression. These depressive disorders are brought on by chemical changes in the patient's nervous system and may be increased by the onset of terminal illness. This type of depression is largely treatable and if managed properly, the patient may be able to return to a state in which they are competent to decide. The second type of depression is not as treatable by conventional methods and in some respects is to be expected given the circumstances. The terminal patient may experience feelings of hopelessness and fear associated with the disease. These feelings, may or may not compromise their ability to make rational decisions.

Terminal cancer patients with a poor prognosis may state that they wish to die because of the level of pain they are experiencing and because they have lost all interest in life. This choice may not be a rational decision but one brought on by a clinical depression. Their pain may be accompanied by physiological depression with feelings of hopelessness that may cause them to lose sight of the things they used to enjoy and the family members and friends who they love. If they receive some therapy and/or medication based treatment, and contact with loved ones, they may then decide that they want to fight the disease with all they have and make the most of their final days, instead of giving into the disease and asking for death.

There is a debate whether depression that is not of a chemical nature detracts from the patient's ability to give informed consent. There are patients who are terminally ill who wish to die. It is hard to decide sometimes where the root of these requests lies. In many cases the feelings of sadness are not a result of clinical problem and are justified considering the nature of the illness.

According to an article published in the August 1995 edition of the *American Journal of Psychiatry*, there is a concern brought forth by many physicians in the discussion of granting requests for euthanasia and assisted suicide that the desire to die may not be a true feeling and may instead be given by patients who suffer from a treatable clinical depression.[4] These physicians believe that if euthanasia were legal, it might be most commonly requested by the elderly, those afraid of illness and the [clinically] depressed of all ages.

They state that it is important to gauge the stability of the request over time since the request is irrevocable once it is acted on. The study states that of the 196 patients evaluated by the group, those with a desire for death, which comprise 17 % of the patients, 58.8% of these patients have the current clinical diagnosis of depression and 37.5% have a previous history of depression. The doctors also note that occasional desires for death were prevalent among the study group of 196 patients (44.5%), but of these individuals, the overall feelings were of a desire to carry on with life.

In cases where the patient is not capable of giving fully informed consent, who should decide for the patient and using what principles? The principle of autonomy is one of the most important ideas in protecting the rights of patients. They have the right to act in such a way that it follows the way in which they want their life to proceed. In many cases though, respecting the spoken wishes of the patient is not the same as respecting their autonomy. For patients who suffer from clinical depression or elderly dementia, their autonomy needs to be protected if they cannot decide for themselves.

If the patient has been fully informed about their medical condition and feels that either doing nothing else or asking for help in dying is the best option, then the decision can be considered truly a voluntary one. If they cannot decide due to altered mental status or age, or cannot understand what is being explained to them, then they are not acting with full informed consent, so we cannot consider their form of euthanasia to be fully voluntary.

It can be argued that one of the problems with some of the actions of the physician assisted suicide done by the retired Michigan pathologist Dr. Jack Kevorkian is that he has not gone through a thorough enough process of evaluation of the cases of patients who come to

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[4] "Desire for Death in the Terminally Ill", Harvey M. Chochinov, MD, et al, Appears in *the American Journal of Psychiatry*, Vol. 152, No. 8, August 1995.

him looking to end their own lives. Since he has failed to do this, he has not gained fully informed consent. He is not in many cases, respecting their autonomy by hooking them up to his "suicide machine." They may have become depressed and are in need of treatment, or they may be pathologically suicidal and cannot make informed decisions. If they were treated for this depression that often accompanies terminal illness, they might not choose death, but might want to make the most of the time they have left. Recently, Dr. Kevorkian helped a woman to die by carbon monoxide poisoning, who, by the coroner's report, may not have had an immediately terminal disease. She was reported to have metastatic breast cancer, but the Michigan coroner was unable to find significant areas of the metastasis of the cancer.[5] Kevorkian still had a willingness to help her die, even though the state of her condition had not been fully quantified and he made few attempts to counsel her and find out if she truly wanted to die. It might be argued that in some cases, he may be helping patients die to advance his cause for the legalization of physician assisted suicide. This was his 27th assisted suicide as of December 1995.

It might seem fairly clear cut as to where a patient is acting in a fully voluntary nature or not. In fact, there are several categories that lie between the patient who is capable of giving full consent for a procedure or authorizing the withdrawal of life-saving medical treatment. These degrees of voluntary consent are categorized by level of education, mental disability and in the case of the comatose, directions given in a living will.

The first category can be referred to as robust voluntary. These patients are able to act with full autonomy since they fully understand their disease progression and the medical and philosophical principles associated with such a choice. To be able to make a fully voluntary choice, the patient may either need a medical background, such a doctor or highly trained nurse, or have read a great deal about their illness. In Nancy Dubler's book, *Ethics on Call*, she tells of a terminal cancer patient who had no prior medical training, but was determined to

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[5] "After Kevorkian aided suicide, clash over how ill woman was" , Appears in the New York Times, NYT staff, November 10th, 1995, pg. A- 20.

live every minute that he could so he could be with his family and continue his studies and devotion to his faith. He read extensively and talked to many specialists about his condition and fully understood his prognosis and options.[6]

The next level of voluntary decision making is represented by the patient who is intelligent but has no medical background. He or she may understand a portion of what is being said but may have some misunderstanding. If the doctor does not provide further explanation and describe the patient's options in clear, non-technical language, then we cannot consider this patient to be making a fully voluntary decision.

The third level of patient is the patient who is not acting in a voluntary manner. This may be due to levels of mental deterioration from dementia to permanent coma or persistent vegetative state, that prevents the patient from having a full understanding of reality. There may be some instructions that have been left via an advanced directive or through a proxy, but the patient is not a voluntary decision maker since he or she cannot be given the instructions. The decision may be able to be aided by some help from the patient's previous instructions, but without the ability to fully discuss the medical condition in person, the patient is not acting voluntarily.

There are other cases of non-voluntary patients in which they have never been able to make a decision so there is no decision making history to draw on. These patients include newborns with no history of decision making ability or those with moderate to severe mental retardation. Such patients are able to talk with the physician their family but are unable to understand their treatment options so they are not able to act voluntarily and we have to choose for them.

The final category of patients are those who not acting voluntarily at the moment. These patients who are either uninformed or are suffering from a clinical depressive or schizophrenic

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[6] Dubler and Nimmons, Ethics on call, pg 121.

disorder have no ability to make choices. They do have a decision making history and have the capability to return to a voluntary state if given the appropriate treatment. These ailments must not be ignored, since if the patient is allowed to choose then we are not respecting their ability to make a voluntary choice independent of mental illness. Also, if we don't treat these patients, then we are not allowing them to use the decision making faculties that they have lost for the moment but have the potential to regain.

Informed consent is an important idea in determining the voluntary nature of a choice for the provision or withholding of medical treatment. Without considering the factors that can cause informed consent to break down and by not dealing with these problems, whether through psychiatric treatment or further explanation of ideas, we are not respecting the patient's right to make an autonomous choice.

Voluntary euthanasia

Once we have determined that the choice to not prolong death made by a patient meets the definition of voluntary we should ask how we can comply with such a request. What types of care should the patient receive to relieve suffering?

A terminal cancer patient who is competent to make decisions about her care may be given several treatment options. She can receive aggressive therapy including radiation and/ or chemotherapy that may extend her life for a period of time, or she may elect not to choose the chemotherapy and shorten her life a little. She may also ask to receive more active means that will allow her to die painlessly.

In this case the patient has been determined to be a competent person able to make rational decisions about her own care. She has been given many treatment options and should be able to choose what she wants, since she has a right to choose or refuse treatments as she deems acceptable. If she chooses to end her life and end the suffering of her condition through active or passive methods of euthanasia, she would be doing so voluntarily, since she is deciding with fully informed consent.

There are many arguments that can be used to defend voluntary euthanasia as a morally acceptable practice. Many cite the patient's right to autonomy as a primary reason to defend voluntary euthanasia. The life belongs to the patient first and foremost and to deny them this choice is to use them as a means not as an end. This might occur if those who are close to them cannot accept their death or due to coercion from physicians worried about litigation or those who are reluctant to let a patient die under their care.

As mentioned above, it is hard to grant voluntary euthanasia as a choice, since it is difficult to know when the patient is actually requesting a hastening of death with fully informed consent. A patient who is either depressed or has a depressed mental capacity due to the disease is not acting with full autonomy, and thus may need therapy or some other treatment to return to a state of full autonomy.

Involuntary euthanasia

Another patient has suffered progressive strokes and is incapacitated as a result. He is on a respirator since the strokes have damaged the centers of his brain that regulate breathing. He has a daughter and a son who have often come to visit him in the hospital and have expressed their concern to the attending physician that they fear that their father may be miserable and wonder what the best course of treatment is for him. Through exams, it has been shown that he is responsive to some stimuli and may know when his children are in the room. Even though he is awake and responds, to a degree, he lacks the mental capacity to communicate his wishes with them, since he cannot speak or write. Since he cannot communicate, he cannot discuss the treatment options given to him for an informed choice to be made. If we either decide to withdraw life-support or invoke active methods of euthanasia, we would clearly be performing involuntary euthanasia, since the patient is unable to give informed consent.

How should we decide what happens to this man? He has given no prior official directions as to how he would want to be treated in the event of an incapacitation. His children want what is best for him and don't want him to miserable, but at the same time want to respect what they believe he would want if he could communicate with them. What principles can we use to decide for others? Is it ethical to make choices involving death for others, or do only they have that right?

The first concept that is related to deciding for others is called substituted judgment. When we decide for someone else, we must decide what we think they would have wanted and try to be faithful to that ideal. [7] We need to think about what we know about the patient and try to ascertain what he would want. Did he ever bring up the subject of life-support in a conversation? Was he a religious man who strongly believed in the absolute sanctity of life, or did he want his life to continue only if it was meaningful and free of pain? When using substituted judgment, we still need to respect the patient's autonomy. They cannot give direct consent, but if we try to act in a manner that is consistent with what they would want, then we are still respecting their autonomy.

Often a patient may appoint a surrogate decider earlier in their life. They may feel that this person knows them well enough to be able to decide in the same manner as they would. It is important that the person making the decisions be close to the person and harbor no motives other than wanting to act in the best interest of the patient. The presumed autonomy of the patient is paramount to all other concerns in this case.

In many cases, there may be no one present that can decide in such a manner as to be faithful to the patient's presumed wishes. In the case of newborns, they have no history of decision making, so there is no precedent with which to refer.[8] In this case we must try to act in what we feel is the best interest of the patient. The hard part is to decide what principles are

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[7] Dubler and Nimmons, Ethics on call, pg 126.

[8] Dubler and Nimmons, Ethics on call, pg 127-129.

most important in formulating a "best interest." We have to ask, not what would this particular patient want, but what would any patient in a parallel situation want? For newborns, it might be argued that they have no wants as of yet. To answer this, we should do what we believe they would "want" were they old enough to decide. They have what can be called potential autonomy, since they will grow to become rational decision making agents.

The idea of the best interest and the principles that take precedence vary widely. For Catholic theologians, they feel that life is paramount, so the incompetent patient's life should be maintained. They argue that only God can take life and for humans to decide on the quality of life of another human being and take action to end that life is to "play God."[9]

For the utilitarian, the quality of life and type of treatment should be weighed to determine what situation would bring the most utility. Is the continued existence of a grossly deformed, incontinent newborn or an irreversibly comatose 80 year old beneficial to society, or to the individual who's existence lacks dignity and meaning? What is in the best interest of the patient and for all affected?

In circumstances where the patient is incompetent to decide and has left no explicit plans for their treatment, it is best to try to balance the original or potential autonomy of the patient and to act in such a manner that the suffering of the patient. No patient would want to suffer beyond a certain level and if they are permanently comatose, than there is no potential to enjoy life once again. For infants, it is difficult to decide, since infants presently lack autonomy but have the potential to develop it. We have to weigh the potential for an enjoyable life and the level of pain that is connected to the condition the infant has. We can, in some cases justify choosing euthanasia for others. If the level of pain or chance for recovery is such that it violates what we believe they would want, than it is an acceptable choice.

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[9] Hamel, Choosing Death, pg 57-60.

This is consistent with the Kantian notion of a best interest, which would have the best situation be one that respects the patient's wishes or the expected wishes of patient who has no history of decision making.

Living wills as a form of consent for euthanasia

In a gray area between voluntary and involuntary (also non-voluntary) is consent for either active or passive euthanasia from an advanced directive. These statements, commonly referred to as living wills, are documents that are written by the patient earlier in life before they become sick that detail specific treatment requests. These documents frequently have sections dealing with how the patient would want decisions to be made in the event they should become unable to make these requests known themselves. The wills often outline requests regarding continuance or withdrawal of life-support, use of invasive surgical treatments and resuscitation in the event of cardiac or respiratory arrest.

The living will is seen by many to be the next best thing to the patient being able to being able to decide in person. They argue that the patient's autonomy remains intact since the directive states the wishes of the patient. [10]

Clearly the non-competent patient who possesses a living will is not available to give direct information regarding their care, but they have given advanced thoughts as to how they would want to be treated. Since they are not able to receive direct information regarding treatment decisions, many would argue that they are not fully consenting patients since they have not been given all the treatment options regarding their specific case. Can their decisions be regarded as true consent since the wishes put forth in the will are only approximations as to how they might expect they would want to be treated?

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[10] Dubler and Nimmons, Ethics on call, pg 122-124.

The will may have been written years ago and may not reflect the true wishes of the patient. The physicians and family cannot ask the patient what they want, so sometimes wills are not followed or are interpreted to mean different things than for which they were intended. There also may be new advances in technology that did not exist when the will was made, so it is hard to decide how to act in these new situations.

An alternative to a living will that is not so restricted to specific circumstances is the use of an appointed proxy or what is referred to as durable power of attorney.[11] The proxy can speak for the patient and can respond to more circumstances than the written will. One problem with the use of a proxy is that he or she may not be completely faithful to the person's wishes, especially if they are a family member who may not support the person's request for refusal of care in certain circumstances.

The use of living wills as a form of consent for active euthanasia and withdrawal of extraordinary means is an acceptable method for patients who cannot communicate their wishes directly. There are problems since the will may not cover areas that are exactly like the current situation and may be a little outdated, but they still give more of an idea of what the person generally wanted and give family members and providers general principles with which to make reasonable decisions regarding care.

Conclusion

Voluntary and involuntary euthanasia are two forms of euthanasia that are commonly discussed. The distinction between the two forms is determined by the level of consent of the patient. If the patient is fully competent and can understand the treatment options given, then a request for euthanasia is a fully voluntary one and the patient takes primary responsibility for the decision. If the patient is unable to speak, or understand or is too young, then the act of euthanasia is classified as involuntary. This distinction is important to the euthanasia debate

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[11] Dubler and Nimmons, Ethics on call, pg 356.

since it raises many questions. For voluntary decisions, we can ask, if the patient has a right to make a choice that would bring the end of their life. For an involuntary euthanasia case, we need to decide what the patient would have wanted and what treatment, including no treatment or direct hastening of death, is in the patient's best interest.

Euthanasia is a difficult topic for which to come up with concrete answers. It is hard to think about losing loved ones, but if we fully respect them as people, we should let them determine the course of their own lives and to decide how they want to die. For those people who cannot decide on their own, we need to weigh the options and consider what they would want, and ask what we would want for ourselves, were we in their position. In the end, the choice we make should reflect the respect we have for their autonomy and the dignity of human life.

CHAPTER SIX:

COMBINATIONS OF TWO DISTINCTIONS:

ACTIVE VOLUNTARY EUTHANASIA

The last two chapters have dealt with two distinctions which are very important to the study of euthanasia. The debate over the distinction between active and passive euthanasia has many supporters on both sides. Some people maintain a strict belief that there is an important difference between the two, stating that active euthanasia is killing, whereas the use of passive euthanasia merely allows the disease or condition to take its natural course. The distinction between voluntary and active euthanasia is important since we need to determine if the patient is acting voluntarily and with full autonomy. If they are not, then we need to help them to return to such a state so they will be able to choose for themselves, or if they are unable to do so, then we need to establish guidelines to decide for them.

If we combine these two distinctions and retain at least a hypothetical difference between active and passive euthanasia, we get four categories of euthanasia: active voluntary euthanasia, passive voluntary euthanasia, active involuntary euthanasia and passive involuntary euthanasia. Whether there are legitimate moral differences between these categories, there remain certain procedural differences, so we need to determine how to utilize each type of euthanasia appropriately. Is the choice of active voluntary euthanasia an ethical one and is there a difference between active forms of voluntary euthanasia and passive ones? For choices made for incompetent patients, how can the active and passive forms of involuntary euthanasia be used ethically and how can policy be set to give patients a choice in the face of terrible suffering? The use of euthanasia in carefully chosen circumstances in the Netherlands will also be examined in this chapter, as well certain movements in the United States to attempt to legalize physician aid-in-dying such as occurred in Washington and California.

Active voluntary Euthanasia

There has been much controversy surrounding active voluntary euthanasia in recent years. This action can be defined as a situation when the physician hastens the death of a patient with the full knowledge and consent of that patient. In most cases of active voluntary euthanasia, the patient has continually requested to die and has initiated the discussion, not the physician or the family. One of the problems that active voluntary euthanasia encounters is whether there exists a significant moral difference from suicide, since the patient is clearly participating in steps to end his or her own life. Is it possible for the patient to consent to being killed, so the moral responsibility is passed to the person who takes the life?

An increasing number of people in the United States now believe that in certain circumstances, patients and their surrogates should be allowed to choose the type of medical care they desire. This includes the right to choose not to have their dying process prolonged and to have suffering relieved in case of severe pain.[1] This belief centers around the idea that people have a right to self determination and the right to determine what happens to them (respect for autonomy). They should be able to decide what aspects of life they desire and should be allowed to die with dignity, not dying in a hospital, tethered to machines with no mental capacity or semblance of decision making ability. Decisions regarding the direction of treatment require the patient to be of sound mind, so they can give an informed level of consent. If the patient has lost the ability to fully decide, then the action is not fully voluntary and cannot be considered to be the full responsibility of the patient.

While it is fairly easy to justify voluntary euthanasia based on the right of patients to make autonomous decisions, it is hard to decide whether the physician either has a duty to act and to relieve the suffering of his or her patient, or whether it is contrary to the profession to ask doctors to kill. The patient's choices should be respected, but so should the doctor's. He or she is also a deciding moral agent and should not be used purely as a means to end the life of

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[1] Brock, Dan, "Voluntary Active Euthanasia", (1992) *The Hastings Center Report*, Briarcliff Manor, NY, Vol. 22, Number 2, March-April 1992, pg. 10.

the patient. If the doctor feels that euthanasia is wrong and would not wish to perform it, then compelling the physician to do so is to use him or her as a means to another's end. In cases of legal abortion, doctors who do not wish to perform the procedure are not made to. In cases involving requests for death the patient might be able to be referred to another provider who will honor the patient's request with fewer personal reservations.

Active voluntary euthanasia has also been compared to physician assisted suicide by many scholars. Many people feel that there is little moral difference between the acts. The patient makes the ultimate decision in both circumstances and the moral difference between the participation of the physician is questionable. In PAS, the physician arranges the means and the patient carries out the final act. In active voluntary euthanasia, the physician carries out the final act through the will of the patient. In both circumstances, both parties are responsible to a degree. In PAS, some physicians such as Jack Kevorkian, have stated that they have only set up the means and that the patient has carried out the ultimate act. This does not excuse them from moral responsibility. The physician still has a direct causal relationship to the patient's death, since if the doctor did not provide the means to the patient for the express purpose of speeding the dying process, they would still be alive. Physician assisted suicide will be discussed in much greater detail in chapters nine and ten.

There have been several attempts to make active voluntary euthanasia and PAS legal in a few states. One such case was in Washington State through Initiative 119.[2] This initiative titled the "Death with dignity" initiative came very close to passing in Washington, which would have made active euthanasia and physician assisted suicide legal for patients for whom death is an inevitable conclusion. The supporters of I-119 collected 223,000 signatures, nearly 50 percent more than necessary. Early polls showed that almost two out of three Washington residents favored voluntary euthanasia for patients suffering from terminal illness. As the election approached, the opposition of 119 did not even have a listed phone number. No! on

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[2] Carson, Robert, "Washington's I-119," (1992) *The Hastings Center Report*, Briarcliff Manor, NY, Vol. 22, Number 2, March-April 1992.

119 was a mix of Catholic groups, right to life groups and some doctors, but was generally unorganized.

The supporters faced a tough challenge. They had to reduce difficult philosophical arguments to short, easy to understand campaign slogans. The words "death with dignity" and "A voluntary choice for terminally ill persons" were put on posters and placed everywhere. The word euthanasia was never used. The ballot was worded as such: "Shall adult patients who are in a medically terminal condition be permitted to request from a physician aid-in-dying?"[3]

The medical community in Washington was split in its view of 119. There were groups on both sides, Physicians for 119 and Washington Physicians against 119. The members of the Washington State Medical Association, in an internal vote as to whether WSMA should support 119 voted 542 for and 563 against. Even with the vote, WSMA refused to believe that close to half of Washington's physicians believed in aiding in the death of a terminal patient.

In the final months of the campaign for 119, the no campaign received money from many Catholic and pro-life groups and both campaigns ran TV commercials blasting the opposing side. On election night, the initiative led early with 70 percent of the vote for yes. As the night went on, more and more no votes came in and I-119 was defeated. The proponents of 119, while accepting defeat, stated that the national interest in the subject generated by the proposed initiative demonstrated that euthanasia is a topic that is important to many people.

Euthanasia in the Netherlands

In the light of discussions about the possible legalization of active voluntary euthanasia in some states to allow terminally ill patients the right to choose to die, we can examine a system where the practice is not yet fully legal, but where there are certain instances when a patient can choose to receive aid-in dying and the physician can avoid prosecution. This situation currently occurs in the Netherlands, where there are specific guidelines governing the

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[3] Carson, "Washington's I-119, "*The Hastings Center Report* .

use of active voluntary euthanasia. Many observers contend that abuses frequently occur and that depressed patients and those who lack full autonomy will continue to comprise a larger and larger percentage of the population who die after assistance from a physician in the case of a terminal condition. This worry about a slippery slope has been a principle argument to oppose the legal and moral acceptance of active voluntary euthanasia in the United States.

Are there significant abuses occurring in the Netherlands that would be a worry if euthanasia was allowed in a number of carefully chosen circumstances in the United States? Is a slippery slope argument for active involuntary euthanasia that includes the mentally ill, the elderly and the comatose reasonable?

According to Peter Admiraal, an authority on euthanasia and assisted suicide, there are up to five thousand acts of euthanasia performed in the Netherlands every year. Euthanasia is only offered to patients in the later stages of a terminal, usually malignant disease.[4] Extensive terminal care is offered to the patient, with euthanasia only being a last resort in the case of incurable pain or low quality of life that is unresolved by other medical treatments.

According to Admiraal, euthanasia remains broadly illegal and every doctor who practices an act of euthanasia risks prosecution. The doctor can escape prosecution in circumstances in which the patient suffers from severe pain and it is recognized that the doctor has a conflicting set of duties, those which compel him or her not to kill and those which dictate that he or she relieve the patient's pain. It is often decided that the physician acted out of necessity in order to satisfy the interest of the patient by ending his or her life, and thus has not acted illegally. Under Dutch law, there are several requirements for the doctor to avoid prosecution. The patient must be fully informed and in the opinion of the treating physician, must have no other options. A second opinion must be sought from an independent practitioner and a report must be submitted to the legal authorities where it is reviewed for its legality.

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[4] Admiraal, Peter, "Justifiable Active Euthanasia in the Netherlands," Appears in Euthanasia, the moral issues (1989), Buffalo, NY. Prometheus books, Robert Baird and Stuart E. Rosenbaum, editors, pg 125.

Admiraal states that few patients seek euthanasia in the early stages of disease. They usually wish to fight their disease and will not give up hope, even after the doctor has given them virtually no chance to recover. They usually will seek alternative treatments, such as hospice care, and will only choose euthanasia when their case is hopeless, when they are in unbearable pain and are constantly miserable. Several reasons that Admiraal gives that may contribute to a voluntary choice for euthanasia include constant weakness, incontinence, fatigue, shortness of breath, nausea and vomiting, sleeplessness and constant pain. Admiraal argues that in many cases, the existence of pain alone is not a medically justifiable reason to seek euthanasia. He states that there are many non-physiological states of depression that accompany euthanasia and that these combine with the physical pain to produce a state in which the patient has lost all control of his or her life and has suffered the loss of a majority of their dignity. It is in cases such as these, where continued existence only brings constant misery with both severe physical and psychological pain, that euthanasia should be considered.[5] The majority of these requests come from patients with incurable cancer (70%), chronic degenerative disorders of the nervous system (10%), and chronic obstructive pulmonary disease.[6]

In the Netherlands, the notion of euthanasia is discussed with patients long before they enter the later stages of disease. It is a decision that is made with the patient and his family, along with the care team and a pastor or other support staff. Euthanasia is never suggested to a patient, but when requested, after long planning and careful analysis, can bring a patient relief and allow them to retain some of their dignity.[7] Also, it is worth noting that euthanasia is most

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[5] Admiraal, "Justifiable Active Euthanasia in the Netherlands," Euthanasia, the moral issues Baird and Rosenbaum, editors, pg 127.

[6] De Wachter, Maurice, "Euthanasia in the Netherlands." *the Hastings Center Report*, Briar Cliff NY, March-April, 1992, pg 23.

[7] Admiraal, "Justifiable Active Euthanasia in the Netherlands," Euthanasia, the moral issues Baird and Rosenbaum, editors, pg 128.

commonly practiced by family doctors whom the patient has known for a long period of time, with the practice of euthanasia by doctors in nursing homes being much less prevalent.

Even though active voluntary euthanasia is not prosecuted in several circumstances in the Netherlands, there is in no way complete acceptance of its use. The Royal Dutch Medical Association (KNMG) has opposed the use of euthanasia for some time and recommended to the State Committee on Euthanasia that it be abolished on the grounds that the use of active euthanasia and assisted-suicide clearly intend the death of the patient. The committee recognized the doctor's right to oppose euthanasia, but upheld the provisions in the law and allowed doctors to refer a patient to a colleague who would participate in the action. Additionally, it affirmed the necessity for the choice to be fully voluntary and to only be carried out after a second opinion had been obtained to prevent the deaths of patients who either had a more favorable prognosis or were not acting with full autonomy.[8] It is important to note that the voluntary nature of the choice is of paramount importance and to many, the use of the term *involuntary* euthanasia is self-contradictory.

The use of euthanasia in the Netherlands can be used as a model to plan a U.S. system that would give patients greater control over their lives as death approaches and to allow physicians to respond to such concerns without fear of prosecution. Proponents of the Dutch system state these clauses in the law do much good and give patients a channel to retain some of their dignity in the face of impending death from a terminal illness. Opponents of such a system state that the numbers of patients who die due to actions of physicians is growing every year and argue that this illustrates that if a system was implemented in the United States, then many people would die for unjust reasons. As previously stated, there are approximately 5, 000 acts of euthanasia in the Netherlands per year in a country of 14 million people. Opponents point out that if the numbers remained constant that there would be an estimated 80,000 acts of euthanasia performed per year in the United States. In the Dutch system, there are strict guidelines to control when euthanasia is legal, and there are penalties when the bounds are

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[8] De Wachter, Maurice, "Euthanasia in the Netherlands." *the Hastings Center Report*, pg 25.

transgressed, which include a prison term of up to 12 years. In the development of a parallel U.S. policy, there could be similar requirements and similar punishments to ensure that it is used in a correct fashion.

Possible objections to the use of active voluntary euthanasia

There are many common objections to active voluntary euthanasia. There are those people who believe that it is wrong to take a life deliberately and believe that active voluntary euthanasia is killing. They don't draw a line between any type of killing of an innocent person. This line of reasoning would draw a distinction between active killing and withdrawal of life-support. As has been argued in a previous chapter, there is little moral difference between active and passive euthanasia. The motive for both actions is the same and they produce the same results.

Also, active voluntary euthanasia is different from killing patients for non-beneficent reasons. If euthanasia were equivalent to other forms of killing, the debate would not be very important. Murder is defined as wrongful killing. If euthanasia is done from a beneficent motive for the good of the patient, then it is not morally equivalent to murder since it may not be judged as wrong or is at least "less wrong". It can be argued that euthanasia is acceptable in certain circumstances such as for extreme pain or loss of higher brain function.

A case given by Dan Brock of the Hastings Center involves a patient on a respirator who is paralyzed from the neck down and wishes to die. If she were to be given euthanasia by doctors by removal of the endotracheal tube and sufficient amounts of morphine to make her comfortable, then the action would be done from a beneficent motive and following the patient's consent. In a second case, the quadriplegic woman's son stands to inherit money upon her death. He knows that her death is inevitable and is only a question of when. He fears that his inheritance will be spent entirely on hospital care for his mother, so, knowing that she will die anyway, extubates her and she dies.[9]

There is a clear difference between her physicians and the greedy son. The active euthanasia is done according to patient consent and is done from a beneficent motive. The son's action is not according to patient consent and is from a self-interested motive. It is clearly murder, while the case of euthanasia is not as such.

Some opponents of legalized active voluntary euthanasia believe that legalizing euthanasia in some circumstances places the procedure on a slippery slope that will lead to acceptance of voluntary active euthanasia for non-terminal or depressed patients. They often cite the example of the progression of the use of Euthanasia in the Netherlands, where physicians are not prosecuted for certain types of euthanasia.[10] They state that in the Netherlands, euthanasia was intended for a narrow range of circumstances where the patient was terminally ill and had full ability to give consent. Now, it is practiced in a larger number of circumstances, even though it is still broadly illegal. This is not a persuasive argument because those who make it cannot show with a reasonable amount of certainty that it would be used in a larger number of circumstances if legalized in the United States.

There are also people who are concerned that physicians would euthanize sick patients who are able to consent to euthanasia but do not. This is not a valid argument. If the practice is only accepted in cases where the patient consents fully to the action, then patients do not have to worry that, in the course of treatment, the doctor, believing it to be in their best interest, would substitute a lethal agent for a beneficial treatment against their will. Before other treatments can be given, consent must be obtained, so for an action with an outcome as serious as active voluntary euthanasia, it cannot be proved the procedure would happen any differently.

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[9] Brock, Dan, "Voluntary Active Euthanasia," (1992) *The Hastings Center Report*, pg 12.

[10] Admiraal," Justifiable Active Euthanasia in the Netherlands," Euthanasia, the moral issues , Baird and Rosenbaum, editors.

Some believe that the use of Active voluntary euthanasia would erode the physician-patient relationship since patients wouldn't know if the physician was acting in their interest or not. On the contrary, as Dan Brock argues in his article, "Active Voluntary Euthanasia," the use of voluntary euthanasia might increase the trust between doctor and patient, since it would prove that the will and autonomy of the patient are of paramount importance to the physician.[11] The patient would know that the physician values the quality and dignity of their existence, not only the goal of preserving life at all costs, even in the face of misery and suffering. If there were guidelines that clearly define that a patient must meet certain requirements to ensure voluntariness, then the abuse of such a policy would not be a reasonable objection. The patient has chosen not to prolong dying and the physician would acknowledge this. If the patient is required to be acting fully voluntary, then there is nothing to indicate that the physician would take matters into his own hands.

Another worry that is expressed in the debate over the legalization of active voluntary euthanasia is that it might lead by a slippery slope to active involuntary euthanasia for those patients who cannot decide about their own treatments. Opponents feel that if patients were allowed to decide in favor of death in the face of terminal illness, then surrogates deciding for non-consenting patients might want to choose active euthanasia for these patients. They have not consented to the act, so they argue, it is wrong to end their lives.

This worry is only legitimate if we believe that ending the lives of incompetent patients who have communicated either through a surrogate decider or living will is wrong. It can be argued that if it is accepted that patients have a right to choose death over a horrible existence devoid of dignity, then patients that cannot communicate have the same rights. They should not be forced to live for a long time in pain and suffering just because they cannot directly consent.

The use of active euthanasia for non-consenting patients would be subject to the same controls as voluntary cases. It should only be used for patients for whom death is inevitable and who have in some form given a previous request through a living will or proxy consent or

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[11] Brock, Dan, "Voluntary Active Euthanasia," (1992) *The Hastings Center Report*, pg 16.

for whom it can be determined through a thorough evaluation that an active method is clearly in their best interest. Safeguards would need to be established to protect against the use of active euthanasia for patients according to motives other than the interest in the welfare of the patient.

A final worry about the acceptance of active voluntary euthanasia is that there might be patients who elect euthanasia that may have a prognosis that is defined as terminal which does not turn out to be as such.

A case is mentioned in Francis Moore's book, *A miracle and a Privilege* of a patient who was very ill and was judged by doctors to be very near to death. She was in tremendous pain and wished to die. Her husband and son appealed to the treating physician to let their wife and mother die painlessly. The doctor refused citing a duty of physicians to preserve life, not to end it. Several months later, a woman had made an appointment to see Dr. Moore. In walked a very healthy woman with no signs of her previous illness. Afterwards the husband and son asked to speak to the doctor alone. Once they were alone, the two told him how wrong they had been and said they were extremely sorry for suggesting such a course.[12]

The answer to such a problem is to allow euthanasia only in cases where the death of the patient or prognosis for a very dim quality of life is nearly certain. Patients considering such a course should obtain second opinions as well as a psychological profile. Euthanasia would only be allowed for those who meet certain guidelines. In the Netherlands, as described above, those cases which are not prosecuted are within a very narrow area and must meet certain criteria with respect to the condition of the patient and their corresponding psychological status.

Active Involuntary Euthanasia

Once we have accepted the right of the competent patient to voluntarily choose euthanasia as an alternative to a painful death, we need to determine what rights incompetent

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[12] Moore, Francis D, A Miracle and a privilege: Recounting half a Century of Surgical Advance,

patients have regarding euthanasia and withdrawal of life-support. Active involuntary euthanasia is defined as an act made directly to end the life of a patient who is unable to or has not consented to be euthanized. These patients may either have not given clear consent through advanced directives or have no history of decision making to look to for guidance. Since they have not consented we have to choose for them and attempt to define the principles that will help us to decide what they would want and what is in their best interest. If we were to accept such a system, we would need specific guidelines to guard against abuses.

A well known case regarding active euthanasia was presented in the *Journal of the American Medical Association* from a letter submitted by an anonymous source. [13] The letter details a first-person account of the actions of a gynecology resident rotating through a large private hospital. He was sleeping during a night on call when the phone rang. On the other end of the line, a nurse said that a patient on the gynecologic-oncology unit was having difficulty sleeping and asked if the resident could he see her. The patient was a twenty year-old woman who was dying of ovarian cancer. The woman had been vomiting and had labored breathing. She required nasal oxygen to aid her somewhat ineffective respiratory effort. She had not slept for days and weighed only eighty pounds. Since she was not responding to chemotherapy, she was only being given supportive care. Her only words to the resident were "let's get this over with."

He left to the nurse's station and returned with a syringe containing morphine. He injected the syringe into the IV and told the woman sitting with Debbie to say good-bye. The patient went to sleep and within four minutes her breathing slowed and she died painlessly.

This is clearly a case of active involuntary euthanasia according to the above definitions. The morphine injection is given with the intent to end the patient's life. Even if the patient did want to die, the resident had never met her before, so she was not under his

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(1995) Washington D.C.: Joseph Henry Press.

[13] "It's over, Debbie", *The Journal of the American Medical Association*, Edited by Roxanne K. Young, 259, no 2 (January 8, 1988), Appears in Euthanasia. the moral issues (1989), Buffalo, NY. Prometheus books, Baird, Robert and Stuart E. Rosenbaum, editors.

treatment in any capacity. He had not received informed consent since he had not talked with her about her wishes and didn't even ask what "let's get this over with" meant. Since he had not talked with her or read her chart, he couldn't know if she was mentally competent to give consent to euthanasia. The only reason that it might even still be considered euthanasia and not murder is that the resident acted from a beneficent motive, which was to end her pain, and because her death was inevitable.

The action of the resident does not follow what could be considered acceptable use of euthanasia protocols. He did not consult the patient to see what she really wanted. The hastening of the death of such a patient should only be done with the agreement of the patient, attending physicians and family, not the actions of a singular sleepy resident. Without careful regulation of the use of euthanasia for the incompetent patient, we might embark on the theorized slippery slope to arbitrarily include the euthanasia of the elderly, unwanted newborns, or the mentally retarded who have no one to speak for them.

It can be argued that there are certain circumstances, with rigid guidelines and definition of terms, where active involuntary euthanasia is acceptable. These include patients with no hope of recovery who are in large amounts of pain. For an elderly end-stage cancer patient who has been incapacitated as a result of the disease process, active euthanasia may be the only humane choice. If treatment is withdrawn, it may still take weeks for the cancer to run its course. The patient has not consented, but it can be argued that this is what they would choose, since almost no one would wish to continue such a miserable existence.

Uses of non-voluntary Euthanasia in the Netherlands

To continue the discussion of the practice of certain types of euthanasia in the Netherlands, we can ask how they treat patients who are incompetent to decide, but may be clear candidates for euthanasia. There has been less discussion about non-voluntary euthanasia in the Netherlands, however, there are circumstances where some forms of involuntary euthanasia are practiced. It is recognized that there are circumstances where the speedy death of such patients is preferable to a prolonged course of dying. For newborns with severe abnormalities, there are circumstances where termination of their lives is considered. In a study, at least three of eight centers of neonatology allowed such a practice.[14] Additionally, euthanasia may be practiced in cases of clear documentation in an advance directive that is not more than five years old. For actions to avoid prosecution, they must be carried out according to demonstration of prior consent of after the determination that the decision is in the patient's clear best interest.

Passive Involuntary Euthanasia

Passive voluntary euthanasia is an act when a physician removes extraordinary life-saving means from a non-consenting patient with the intent to hasten the patient's death. This might be done in cases where the decider does not want to invoke active means or if the passive withdrawal of life-support will lead to death in a short time. As in other cases, it is hard to draw the line as to where the act is purely passive and when the action is closer to active, if the treatment that is withdrawn is more ordinary in nature and will lead directly to death. The withdrawal of a respirator, for example, is considered to be a passive method by some and is viewed by others as a very active means of euthanasia.

An example where passive euthanasia could be considered would be in the case of an end-stage pediatric AIDS patient. Due to his age, the patient cannot legally consent to have his care terminated, so the action would be non-voluntary. The breakdown of his immune system has left him vulnerable to many infections and he is in great pain due to opportunistic cancers and multiple infections. It is only a matter of time until he will be free of this suffering, since he obviously has no chance of recovery. The right decision would be to forego treatment and allow him to die. Aggressive treatment might give him a few more weeks of life, but they may

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[14] De Wachter, Maurice, "Euthanasia in the Netherlands." *the Hastings Center Report*, pg 24.

be accompanied by considerable pain. It is more humane to let him die sooner and to be released of the burden of such a miserable existence.

The only reasons to prefer passive euthanasia to active euthanasia might be due to wishes of the patient and the family. While it can be recognized that there is little moral difference in choosing one method over another, there remain some psychological and procedural concerns that need to be addressed. Some people might say that if the parents of the young AIDS patient do not want their child to actively be euthanized, then we should respect their wishes. The AMA stated that the decision regarding termination of extraordinary means was the decision of the patient and the patient's family.[15]

A utilitarian might argue that utility might be better served if the patient was allowed to die sooner instead of letting him die over a course of days from the effects of the AIDS Virus. While I believe that in this case it be better to employ active euthanasia so the boy won't suffer while the opportunist agents that have invaded his body as a result of the syndrome take his life, it may be hard for the parents to think about actively ending the life of their poor child, so it might be seen as better to use passive means since death is imminent whether the death is hastened with drugs or through ceasing treatment.

Conclusion

When making a decision for euthanasia as a result of a constant, voluntary request by a dying patient, or because of a quality of life judgment made for an incompetent patient, it is important to consider both the voluntary nature of the request and what effect the type of means employed will have on the choice. In this chapter, we have examined the choice for active voluntary euthanasia and have presented some examples to illustrate the ongoing progress of the recognition of patient's rights to choose euthanasia as a viable medical option, as well as evaluated the practice of euthanasia in the Netherlands. Additionally, we have examined the use of the three other forms of euthanasia that result with the combination of the two distinctions from chapters four and five, active and passive euthanasia and voluntary and involuntary euthanasia.

The use of active voluntary euthanasia through case illustrations and the case of its use in the Netherlands can be shown to be an ethical choice. If it is a fully voluntary choice, then the use of euthanasia in the appropriate circumstances, such as for the pain patient who also has considerable misery and loss of dignity, can bring a large measure of relief that is not possible through simple pain control methods.

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[15] *JAMA*. 1973, the End of Life, James Rachels.

The use of passive methods for the voluntary patient is also appropriate, if it is the choice of the patient, or the time to death and level of pain are similar to that which the patient would experience with an active method. In some circumstances though, an active method may be preferable, since the active method minimizes pain. If the choice for death has been made, then the choice that brings the speediest, least painful death should be chosen unless there are other contributing factors that lead the patient and the health care team to choose a passive approach.

Similarly, the use of active and passive methods for the patient who is unable to give consent, but has either indicated this choice through a living will or in the case when it is in their best interest, are not substantially different morally, but the use of active methods may bring additional relief of suffering for the patient who cannot consent, but is extremely miserable. We should also respect the family, and if the choice they make is for passive methods, then as long as such a choice is consistent with the patient's interest, then such a choice is ethical.

CHAPTER SEVEN:
TREATMENT OPTIONS FOR CRITICALLY ILL NEWBORNS

Until now, the conclusions of this paper have supported euthanasia in circumstances when the death of the patient is inevitable; for patients in extreme pain; and for those who remain in irreversible comas or in persistent vegetative states. These actions have been defended on the grounds that the autonomy of the patient should be a primary consideration in treatment decisions and should be respected. Euthanasia has also been argued in circumstances where the quality of life is such that the continued existence is not preferable to a painless death. What is to be done then, when the patient presently lacks autonomy and no decision can be reached since the patient has no history of such decision-making?

This is the case with newborns who are born prematurely or whose lives are complicated by life-threatening birth defects. Most babies are born normally but for the small percentage who encounter problems, we are forced to decide how to treat them, not knowing what they would want if they could speak. Is euthanasia ever justified in newborns, since they haven't even had a life yet? Are there circumstances in which it would be better to allow the infant to die, rather than to continue a life that may be of an extremely poor quality? What conditions would produce a life that is not preferable to a painless death?

Modern Advances in Neonatology

The field of neonatology, which is a relatively new subspecialty of pediatrics, deals with the treatment of newborns (neonates) who are critically ill. These patients can be afflicted with a variety of conditions such as Down's Syndrome; severe spina bifida; and Respiratory Distress Syndrome, also commonly known as Hylane Membrane Disease, which is the most common disease affecting premature infants. One of the most severe cases in neonatal care, anencephaly, occurs when the baby is born without major portions of the brain present due to neural tube defects that occurred early in the child's embryonic development.

Many newborns can be successfully treated in the neonatal intensive care unit (NICU) and can go home to lead productive, generally happy lives. For some though, the burden of their handicaps will be large and their lives may be accompanied by constant pain and/or time spent frequently in and out of the hospital. Where can a line be drawn when the preservation of the neonate's life is not in his or her best interest? Do newborns always have a right to life or are there some lives that may not be worth living?

As in many other medical specialties, there have been many major advances in neonatology that have allowed infants who were much smaller and sicker to be treated and live normal lives. Along with these successes, modern medical advances have also produced patients who are living with no prospect for recovery to a normal state. In an attempt to avoid producing patients who are living lives of such a poor quality, we must develop principles to help pediatricians and neonatologists to decide how to treat these small patients and to give parents some ideas with which to think about these difficult problems.

Ethical Dilemmas in the Neonatal Intensive Care Unit

The details of a case that I was involved in as an observer in an NICU will illustrate some of the problems and issues that often accompany the treatment of ill newborns.

An expectant mother is rushed to the emergency room of a large private hospital complaining that the fetus inside her has a lower than normal heart rate and is not moving with much regularity. Upon exam, the fetus is diagnosed as having fetal hypoxia, a low level of oxygen in its blood. The pregnancy had been proceeding normally up to this point and the gestational age of the baby is 40 weeks, full term. The baby is delivered by an emergency Cesarean Section to save its life, and upon delivery, the newborn boy is limp, blue and is not breathing. He is resuscitated by the pediatric team that attends on high risk pregnancies. Through a clinical score called the Apgar, which assigns a score of two to zero for each criteria of color, muscle tone, pulse, respiration and reflexes; he is given a score of only one at birth, two at two minutes, three at five minutes and four at ten minutes, out of a possible ten. The lower the score during this time, the less hopeful the prognosis often is for normal development.

After the delivery, the child is rushed to the intensive care nursery and is given a full work-up, including IVs, oxygen and a thorough evaluation by the attending neonatologist. His initial evaluation shows the baby boy to be breathing on his own, he but is only mildly responsive to stimuli. Some tests indicate probable brain damage due to the lack of oxygen available to the brain before and during delivery. Seizures have begun at three hours of life and he is being given anti-convulsent medications.

A CAT scan is performed and shows that there has been considerable damage to the cortical areas of the brain. Some of the areas of the brain tissues have died and have been replaced by fluid. The brain stem, which controls breathing and regulates blood pressure and heart rate remains intact. He is diagnosed as having cortical birth asphyxia. An evaluation by a consulting pediatric neurologist shows an electroencephalogram (EEG) scan of the brain's electrical activity that is severely diminished from that of a normal infant but above the level of true brain death. The neurologist has commented that the autonomic brain regions are functioning but the EEG "bodes extremely poorly for normal neurocortical development."

This child is alive by medical standards and can breathe on his own. He cannot swallow though and must be fed by means of a nasogastric tube, and there is only a slight possibility that this will change. He is cared for by nurses around the clock and his parents come to visit and hold him every few days. After a while, it becomes apparent that there is almost no chance that he will be able to function normally. The parents, the two neonatologists who cover the NICU, and the nursing staff wonder what can be done for this poor little boy.

What is the correct course of treatment for such a child? He is alive by clinical standards, but cannot interact, cannot swallow and probably has no awareness of his environment. Due to the stable function of his brain stem, he could live for years in this limited state. Is there any useful reason for his continued existence?

One of the neonatologists felt very strongly that he should be allowed to die instead of living a life devoid of human interaction. He is breathing, so the only way to hasten his death is to either withdraw feedings and allow him to starve or to take an active step to end his life. His life is not of a great quality, but he is not in pain either, so would an active course be justified? Is it cruel to withdraw nutrition and hydration, or is it acceptable, since it is highly probable that he cannot sense pain? Does he have a right to life, even in this limited state?

This case was very difficult for all persons involved. The parents had been anticipating the birth of a healthy baby for nine months and instantly, their dreams were shattered. The father said that he and his wife were now "essentially preparing for their son's death." There are many ideas that need to be taken into account in making decisions about care for a situation like this.

It is important to ask if the child has any reasonable prognosis for a recovery to a cognizant state and whether he will have the ability to be able to interact with anyone, or whether he live out the rest of his days in a hospital bed, tethered to wires and under constant supervision? The mental state of the parents is important too. The child is the primary patient, but the pediatricians and nurses should provide for the parents' welfare as well as the child's. Additionally, the utilitarian might want to figure in the parents' requirement to commit resources, economic as well as physical and emotional, to such a child.

After a few days, the doctors in the NICU wanted additional input into the case to help them further understand the issues involved, to help the parents to come to a decision, and to establish some support structures for the family to rely on in these tough times. A meeting of the hospital ethics committee was called and I was invited to attend. The committee was composed of several physicians, nurses, social support staff and ethicists. All the members had taken at least a short course in medical ethics offered by the medical center.

At the beginning of the meeting one of the neonatologists gave a case summary to the group and then asked them for input. Many options were given to the parents. Their son could continue to be cared for at the hospital, he could come home, or he could go into hospice care, where the workers would care for him and give the parents emotional support.

There are also different levels of medical care he could receive. He was presently being fed by a nasogastric tube in his nose. With this method comes the risk that the infant will inhale some of the liquid into his lungs and develop aspiration pneumonia, which can be fatal. Surgeons could implant a gastrostomy tube that would lead directly to the stomach, thus eliminating the risk of aspiration. The question was posed to the group as to how aggressively to treat this baby. Should he be given everything, or only basic care to keep him comfortable?

A Kantian analysis might show that the child should be allowed to die. He basically lacks personhood since he will never develop any rational decision making capabilities, so he has no future autonomy to respect. The best interest for the child is to let him die peacefully. He has no future so there is no reason to pursue advanced treatment since he may grow but will never develop beyond this semi-aware state that is mediated chiefly by the brain stem.

A utilitarian approach to this problem would also suggest that he be allowed to die. The continued existence of this child is not increasing utility and may very well be detracting from it. He will never experience joy or interact and will consume many resources, giving very little in return. His parents may experience minimal joy from his presence, but he will never know them.

It is hard to decide the outcome of this case from a theological point of view. It can be argued that he is a product of God's will. He will never develop neurologically, but is not in obvious pain. There are no means to withdraw that are traditionally thought of as extraordinary, although, it can be debated whether feedings are in fact extraordinary since he will not improve no matter the level of treatments given. Additionally, it is important to note that without the intervention of modern medical technologies, he might have died in the delivery room, so his death might not be contrary to God's plan.

This is a very difficult case to think about, especially after having seen the child first-hand. He looked so normal and cute and the nurses really enjoyed taking care of him. Applying the principles that I have outlined in previous chapters, I have come to the conclusion that this child should be allowed to die peacefully. His "life" serves no purpose since he cannot and will never interact with anyone, since he lacks the brain function to do so. He would have to be tube fed his entire life and will probably never improve. He should be kept comfortable and feedings should be withdrawn. Obviously this is very hard to think about, but I believe it is the right decision. He has no chance for any quality of life. He will die at some point from infection or from other causes since the family's finances cannot allow him to stay in the NICU forever, so it is better for him to die peacefully.

Some people might feel that he will suffer as he dies, but the neonatologist who was treating him explained to the ethics committee that he did not have the neural development to detect pain, so he would not suffer.

As of the time that I was last involved in the case (January 1995), the parents had elected to place their son in hospice care where he could be cared for by a staff around the clock. They felt that it would be hard on the family to have him home, where he would require constant care, and the NICU was too expensive and in some ways unjustified, since there was no treatment that the doctors could provide that would make him better. He was to be placed in a special nursery that had already been created for a second baby who had been cared for earlier in the same intensive care unit.

Treating Handicapped Newborns: the Baby Doe Case

Decades ago, before the majority of advances had occurred in neonatology, such as infant respirators, special heat lamps and the modern NICU, many handicapped and critically ill newborns never made it out of the delivery room. There was nothing that could be done to treat them, aside from keeping them comfortable. Today, there are many methods to keep all but the sickest newborns alive, at least for a period of time. Numerous surgical advances also have allowed doctors to correct many significant birth anomalies. But, being able to do something doesn't always mean we should. Some handicaps are so severe that the quality of life that the person would experience would be extremely poor.

Following these concerns, there have been several cases made famous by the media involving newborns for whom withdrawal of care was contemplated. The first, and probably most famous case occurred in Bloomington, Indiana in April, 1983. The infant, referred to as Baby Doe, to protect the parents, was born with a trisomy of the twenty-first chromosome, commonly called Down's syndrome.[1] This condition usually causes some degree of mental retardation, plus possible heart and liver defects and a host of other problems. Baby Doe also had an esophageal atresia, where there is no connection between the esophagus and the stomach and a tracheoesophageal fistula, where the lower end of the esophagus connects to the trachea, so stomach juices are allowed to backup into the lungs, potentially causing tissue damage and pneumonia. The atresia and fistula are fairly easy to repair with surgery, but since the Down's syndrome is a genetic disorder, it is untreatable. Without the surgery, the baby could not get food and would surely die. The treating pediatrician, James Shaffer recommended that the baby be transferred to Riley Children's Hospital in Indianapolis to have the surgery. A second pediatrician, Dr. Jeffrey Wenzler, concurred. The obstetrician who delivered the baby, Walter Owens, did not agree with the other two and posed several options to the parents, one of which included foregoing treatment and allowing the baby to die. Later Owens explained that he had a cousin who had a Down's child who had never been normal and had taken a large toll, emotionally and financially, on their family. He had required several surgeries, had not learned to walk until age four, had never learned to talk and was often destructive and aggressive. The young couple had spent a majority of their lives taking care of this child and had no more children afterwards.

After much difficult thought, the parents decided not to elect to have surgery performed on their son, since they felt that the quality of life that he would enjoy, due to the strong potential for mental retardation would not be what they would want him to have and that his

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[1] Lyon, Jeff, Playing God in the nursery (1985) New York, W.W. Norton and Co, pgs. 21-58.

condition would be unfair to the two children they already had. Baby Doe was instead placed in the corner of the ward and was kept comfortable with warmth and sedatives, but no food, until he starved to death. The nurses found this extremely difficult to endure and after a time, Baby Doe was cared for by private nurses since the ward nurses wanted no part of his death. One nurse said after Baby Doe's death," This is the most inhumane thing I have ever been involved in. I had all this guilt, just standing by, giving him injections and doing nothing for him."[2] The two pediatricians strongly opposed the parents' plan and threatened Owens that there would be a court order to treat the child.

This decision brought forth many people who disagreed with the parents and wished to get a court order to have surgery performed on the baby against the parents' wishes. There was an initial hearing held in the hospital where Owens, Shaffer and Wenzler testified. The judge noted in his ruling that there were two competing medical opinions and that the Does had the right to choose either of them. He subsequently ruled that the hospital would follow Owen's plan and the child would be allowed to die.

After the initial ruling, the case went through several town committees and the hospital lawyers then appealed the case to a higher court mediated forum. The case was first heard by a special circuit court judge who upheld the parents' right to decide for their child. State prosecutors then appealed to the Indiana court of appeals, which refused to grant an immediate hearing. The Indiana Supreme Court refused to order emergency surgery for the infant, but the reasoning for this decision is not known since the case was sealed to protect the parents' anonymity. Finally, a deputy prosecutor flew to Washington to file an emergency appeal with United States Supreme Court Justice John Paul Stevens. It was during this time that Baby Doe died. [3]

The impact of this case would forever change American medicine and the field of neonatology in particular. The way that sick infants were treated had been changed

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[2] Lyon, Playing God in the nursery, pg. 33.

permanently. Now some practitioners felt that they were in constant danger of being reported by someone who felt that the infants in their NICU were not being treated properly. James Shaffer said that he still couldn't believe that it had happened. "It was like a comedy of errors. One step after another. A judge decides that a family has a right to not have its baby treated. The child protection agency backs him up. But when a child comes in with a bump on the head the whole welfare department gets up in arms. This is an organization designed to protect children in the community from certain things. It seems to me that dying is one of those things."[4] He also said that he had several Down's patients in his practice and some were "pretty damn bright." They don't have to have a terrible life and it was hard to tell what Baby Doe's future would be like at birth.

During the case, several parents of Down's patients came forward to tell their stories. A case in *Should the Baby Live?*, by Peter Singer and Helga Kuhse, tells of a couple with a child with esophageal atresia that was surgically corrected. They say that their son has had many difficulties, cannot eat well and is constantly miserable.[5] However, there is a distinct difference between this case and Baby Doe's, since this patient's atresia was worse. For that patient, withholding treatment might have been justified due to the physical abnormality. In Baby Doe's case, the treatment was withheld because of the Down's Syndrome, not due to the correctable anomalies.

Were the parents correct to withhold consent for surgery for their son? Did they have the right to decide his fate? And also, is Down's Syndrome a condition that leaves a child in a situation where death is preferable?

There continue to be many advances in the care of the mentally retarded and those with Down's syndrome. There are new ideas about education to give the child a head start at an

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[3] Lyon, Playing God in the nursery, pgs. 38-40.

[4] Lyon, Playing God in the nursery, pg. 55.

[5] Kuhse, Helga and Peter Singer, Should the Baby Live? The Problem of Handicapped Infants (1985), New York, Oxford: Oxford University Press, pg 16.

early age to compensate for the expected developmental problems. These children can grow into adults who can be productive and be largely self-sufficient. There are also numerous support groups across the country that are available to help parents of children born with Down's. These groups have made it possible for individuals with the syndrome to take advantage of many opportunities such as special training for jobs, educational programs and the chance to participate in sports. The type of life that a child lives when they have Down's is different from that of unaffected individuals, but can still be worthwhile in the majority of cases, so the Baby Doe case sets a precedent that is not appropriate for the level of disability that most Down's patients have.[6]

Utilitarianism might in some analyses believe that the parents were indeed justified in their decision. The life of the infant would be difficult and he would possibly need more extensive medical care. The parents would have to care for him for many years and he might never be able to live on his own. He might also bring unhappiness to his brothers and sisters. However, for many children with Down's Syndrome, they are able to live mostly happy lives. They are usually happy children and as adults, although they have certain mental deficits, they can often hold simple jobs, so it is hard to decide whether their continued existence would increase or decrease utility, since the level of mental deficits cannot be known at birth.[7]

A Kantian analysis of this situation would probably yield the decision that the surgery should be performed. The child once he was old enough, would probably choose to be treated. It is somewhat difficult to justify this since due to the altered mental status that is likely with Down's Syndrome, Baby Doe might not be able to fully understand his condition when he was older and provide informed consent. He would at least be conscious and could interact, so he would possess some degree of personhood.

A theological analysis would say that this baby was part of God's plan. The surgery is a fairly routine procedure and thus could not be considered completely extraordinary means.

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[6] "What is Down's Syndrome?" The Mile High Down's Syndrome Association, 1995.
[7] Dubler, Nancy N. and David Nimmons, Ethics on call : taking charge of life-and-death choices in today's health care system. (1993) 1st Vintage Books ed. New York : Vintage Books, pg. 249.

This infant had a right to life and to deny him treatment because of the wishes of the parents is wrong and contrary to God's wishes.

I believe that Baby Doe deserved a chance. The majority of Down's syndrome children can grow up happy and free of pain. They may have some disability, but they can definitely interact with their parents and environment. It is hard to know what level of mental retardation the infant would have experienced, but there was a chance that he would have been able to function with a degree of success, so he deserved that chance.

Some people might argue that the parents had a right to decide for their child. In most medical situations, parents are allowed to make decisions for their children. It is assumed, however, that they are acting in their child's best interest and have no other motives. In the Baby Doe case, the parents were acting contrary to the right to life that their son had. In more extreme cases, some parents have abused their children, so they have forfeited rights to decide for their child's welfare. This demonstrates that a parent's role as a decider for their children is not absolute.

The Baby Doe Regulations

As a result of the national attention that the Bloomington case received, the Reagan Administration, through the department of Health and Human Services established a set of rules that came to be known as the *Baby Doe Regulations*. The initial statements said that federal funds would be withheld from hospitals where treatment was denied to infants due to handicaps. There was even an 800 number for people to call if they felt an infant in an NICU was not being treated because of its handicaps. There were even so-called "baby doe squads" set-up by the government to investigate hospitals where discrimination against handicapped neonates might be occurring.

Signs were placed in NICUs across the country that read "DISCRIMINATORY FAILURE TO FEED AND CARE FOR HANDICAPPED INFANTS IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW." [8]

Initial Impacts of the Baby Doe Regulations

After the first version of the regulations were released, many groups, including the American Academy of Pediatrics, sought to challenge the government on the rules. While the majority of the pediatricians did believe that at some level it was wrong to deny treatment to handicapped newborns, they also felt that the rules were too far reaching and that if they remained intact in the same form, they would be forced to treat some infants with handicaps so severe that they would have little prospect for a happy life, only for one filled with pain and suffering.

No significant beneficial results occurred from the establishment of the Infant hotline. There were only two serious calls that were followed up by the baby doe squads, and both of these investigations failed to show than an infant was being treated incorrectly.[9] There were however some negative side effects to the hotline. In Rochester, New York, one infant was removed against medical advice by the parents before his treatment was completed, since the doctors had felt compelled to treat the infant, and at Vanderbilt University Medical Center in Nashville, several doctors and nurses were required to take several hours out of their patient care duties to respond to questions posed by the government investigators.

In an interview with a neonatologist in *Should the Baby Live?*, the doctor tells a tale of how he felt compelled to resuscitate a newborn for an hour who was born without a larynx and possessed many other horrible congenital abnormalities. He said: "The sad part was that both parents in the delivery room watched this most sad ordeal. It was obvious to me that this was

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[8] Lyon, Playing God in the nursery, pg 41.

[9] Moreno, Jonathan D, "Ethical and Legal Issues in the Care of the Impaired Newborn", *Ethical and Legal Issues in Perinatology*, , no. 2 June 1987, pg 352.

in no way a viable child but I felt compelled to carry on this way out of fear that someone in the hospital would 'turn me in.' I am sure that you who sit in Washington are not faced with such difficult decisions at two o'clock A.M."[10]

The Baby Jane Doe Case

Another case that received national attention and helped shape national policy regarding the treatment of handicapped newborns was the birth of Baby Jane Doe which took place in Port Jefferson, New York, on Long Island in October of 1983. She was born with numerous birth defects that were judged by her examining physicians to be all but incompatible with any reasonable hope for a decent quality of life. She was born with a severe form of myelomeningocele spina bifida where an area around the spine does not close properly. This opening leaves the child very susceptible to infection and can cause serious mental deficits. The opening was very high on the infant's spinal chord, between the third and fourth lumbar vertebrae, so the possibility for disability was substantially increased. The location of the lesion indicated that she would be paraplegic and would have no rectal or bladder control. She also had hydrocephalus, a collection of the cerebrospinal fluid on the brain, which often accompanies myelomeningocele; and microcephaly, an abnormally small head which is almost always accompanied by severe handicaps. This combination of defects almost guaranteed that she would have substantial mental deficits. [11]

A neonatologist that was involved in the case stated that in his professional opinion, the child would not be able to experience emotion, would only minimally respond to stimuli, and would have little capacity to develop any cognitive faculties.

Initially it was recommended that she be transferred to the University Hospital at Stony Brook New York where surgeons could close the opening on the spinal cord and could implant

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[10] Kuhse, and Singer, Should the Baby Live?, pg 43.

[11] Lyon, Playing God in the nursery, pg 47.

a shunt in her brain to drain off the cerebrospinal fluid. The infant was transferred and the parents consented for the anesthesia for the operation. These procedures would lengthen her life considerably, but nothing could be done to treat the paralysis and profound retardation. But after talking to more doctors, clergy, social workers and family members, the parents decided that it was more humane, given the circumstances, to take a more conservative approach to their daughter's care which included only feedings, antibiotics and hygienic care of the exposed spinal sac. The parents felt that given the potential that their daughter had for an acceptable quality of life, this was the best decision.

The Stony Brook doctors supported the parents' decision, but apparently, someone on the medical staff did not. A phone call was placed by a concerned party to a Vermont right-to-life lawyer named A. Lawrence Washburn, who was known even by his fellow activists for being very zealous towards these types of cases. He was told that an infant was being denied life-preserving surgery, and even though he had never met the parents, talked to the doctors or seen the baby, he filed a suit in New York court to seek surgery for the infant. He was quoted as saying that "the infant, no matter her condition has a right to life the same as you or me." [12]

The first hearing was held on Long Island with New York State Supreme Court Justice Melvin Tannenbaum presiding. The baby was appointed a legal advocate, local attorney William Weber. Weber sought to establish that the baby did not definitely have brain damage. He testified that the head measurement of 31 centimeters was in the normal range for a baby girl (when in fact only 3 in 1,000 female infants have heads that small) and challenged the doctor's notions that she would live a life accompanied by serious mental deficits. The neurologists insisted in their testimony that microcephaly was a reliable indicator for brain malformation. The guardian, Weber, asked the judge in his closing arguments, if he was unsure of a decision, to please err on the side of life.

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[12] Lyon, Playing God in the nursery, pg, 46.

After deliberations, the judge ruled that the infant must undergo surgery. He cited in his ruling that he did feel for the parents' disappointment about their daughter's probable handicaps but felt that the infant was in immediate danger and needed surgery.

The parents' attorney, Paul Gianelli, appealed the decision and the appellate judge stayed the order of the lower court, pending a ruling by a three judge panel. The panel met and reversed the ruling of the lower court, citing the parents' concern for their daughter and support of responsible medical authority.

The New York Court of Appeals, the state's highest court upheld the appellate court's decision, but on the grounds that Washburn had no right to interfere in private and extremely difficult family matters. This remark was echoed by many of the judges, who felt that Washburn had interfered in something that he had no right to interfere in.

As the national attention given to the case continued to increase, the Reagan Administration, from pressure from right-to-life lobbies, sought to obtain Baby Jane Doe's medical records to determine if she was indeed being denied medical care because of her potential to be handicapped. A U.S. district court judge reviewed the government's suit and denied the request for the records, stating that the hospital's actions were not going against section 504, since surgeons would operate if the parents gave consent. The Baby Doe Regulations, which are based on section 504 of the Rehabilitation Act states that federal funds would be withdrawn from institutions that discriminated on patients because of the nature of their handicaps. The hospital did not refuse to treat the baby because of her spina bifida. Surgeons could not legally operate without parental consent, so it was not violating the rule since the decision fell to the parents. He also said that it was not the parents' fault since he believed the decision to be one based on a genuine concern for the child's welfare and future quality of life. The United States Court of Appeals also affirmed the lower court's decision.

After many court proceedings and substantial intrusion into the private lives of the parents of Baby Jane Doe by the national media, the case was closed due to decisions made by the parents. The infant had remained at Stony Brook Medical Center and had been developing pain related to the pressure that the cerebrospinal fluid was placing on her brain, so the parents elected to have a shunt placed to drain the fluid. The myelomeningocele had healed over with tough skin, making further risk of infection improbable. She was even judged by her doctors to be well enough to go home. Time would tell how she would develop neurologically, but it was still highly probable that she would still suffer from degrees of paralysis and mental retardation.[13]

This is a hard case to decide upon. At first, when her death seemed fairly certain to me, I felt that it was acceptable for the parents to make a compassionate decision based on expectations of a miserable quality of life for their daughter. I too felt that she would experience minimal joy and would have little happiness being incontinent, paralyzed, and bedridden for all the days of her life. As the case progressed, and the parents had authorized surgery for the shunt and the myelomeningocele had healed, it appeared that she might be a little better and that she should be given the chance to see if she would indeed have the degree of retardation that was predicted. It is very tough to tell what the mental status of the person will be when he or she is an infant. The drawback to this approach is that once she has developed, there is no further treatment to forego and she will have to live in this fashion for the remainder of her life.

I don't believe that any of the major theories would have any easier of a time answering this problem. A Kantian approach might say that she should not be operated on since she lacks the potential for personhood since she might not be able to interact with people as she grows or take care of herself at all. But it is hard to draw a line whether the infant has the potential to possess personhood. The level of her future mental function cannot be known reliably at birth, so it hard to make a decision. She may later develop a certain level of ability to interact and be able to decide for her own welfare, so she would then have personhood and it would be wrong to refuse treatment. Also, even if she did later possess certain mental functions, she still might choose to refuse surgery since, regardless of the level of mental deficit, her life would be of a very low quality. An autonomous person often might choose to refuse treatment in the face of

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[13] Lyon, Playing God in the nursery, pg. 40-53.

such a poor quality of life, so we might be respecting her potential autonomy when we refuse treatment on her behalf.

It is also very difficult to decide using a utilitarian method whether her life would increase or decrease utility. She may bring her parents some joy, but will be bedridden and won't be able to communicate. The uncertain prognosis makes it hard to make a utilitarian decision. A theological critique might argue that her birth was part of God's plan and that it is not our place to take her life. But also, why would God create a child with the potential for such a poor a quality of life such as this? And, are we interfering with God's will when we treat her with surgery or when we deny it?

The Effect of Baby Jane Doe on the Baby Doe Regulations

The court proceedings for this case had drastically reduced the influence of the Baby Doe Regulations. It was judged by the U.S. Court of Appeals that Section 504 of the 1973 Rehabilitation Act, on which the Baby Doe Regulations had been based, was principally created to guarantee fair practices in employment and housing for members of the handicapped community, not to compel treatment of severely handicapped newborns.

In the summer of 1984, new legislation was passed to deal with the shortcomings of Section 504 as it applied to the treatment of severely handicapped newborns. The new regulations, which were released on April 15, 1985, compelled physicians to treat handicapped newborns in the same manner as other patients, with a few exceptions. Medical neglect for these cases was defined as withholding medically indicated treatment from a disabled infant with a life threatening condition. These treatments included nutrition, hydration, medication and other treatments, which in the physician's expert medical opinion will be the most likely to be effective in correcting such conditions.

The exceptions are worded as such:

1) The infant is chronically and irreversibly comatose.

2) The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.

3) the provision of such treatment itself under such circumstances would be inhumane.[14]

One of the more important revisions that appears in the final version of the regulations is the term, "reasonable medical judgment." This phrase gives the physician more control in deciding the course of treatment for infants under his or her care and he or she is better able to defend treatment decisions. Additionally, the regulations allowed states to establish their own baby doe squads to investigate cases, instead of the federal government. Violations of these regulations would result in a loss of federal funds for state child and welfare protection agencies, so it would be in the states' best interest to monitor the cases themselves.

The new regulations are an improvement over the previous versions that were struck down in several courts of law but may still be too restrictive when it comes to withholding treatment because of quality of life concerns. The rules only allow termination of treatment in cases of irreversible coma, certain death or to prevent inhumane treatment. It still does not recognize that there are cases where a life of very low quality is not preferable to a painless death.[15] For cases of substantial brain injury, the infant is not in pain or in immediate danger of death and can live for many years in a limited state. The rules are still too restrictive in this respect. I understand that the rules exist to prevent cases such as Baby Doe's, but they can also force prolongation of lives such as that of the baby with birth asphyxia in the first case, when there is no hope of recovery to a reasonable quality of life.

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[14] Moreno, Jonathan D, "Ethical and Legal Issues in the Care of the Impaired Newborn", *Ethical and Legal Issues in Perinatology,*.vol.14, no. 2 June 1987, pg 346.

[15] "The Baby Doe Rule, Still a Threat", Moskop, John C. and Rita L Saldanha, appears in Contemporary issues in bioethics. (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters, editors, Belmont, Calif. : Wadsworth Pub. Co, pg 84- 89.

Deciding to forego treatment for Infants

In the light of the newer, more flexible federal regulations, are there guidelines that can be agreed upon by the professional community regarding circumstances of how and when infants should be treated? We can use certain principles and medical guidelines to make these decisions. What constitutes reasonable medical judgment on the part of the physician?

In his book, *Special Care*, Fred Froehock outlines several "treatment zones" for infants. Those who fall into certain zones would be judged as having a prognosis that justifies aggressive treatment, whereas some infants who fall into lower zones would be classified as not being candidates for treatment, since the severity of their afflictions bodes so poorly for a decent quality of life that it would be more humane to let them die a peaceful death.[16] Zone three, as Froehock describes it, includes infants who only have mild to serious medical problems that may require surgery or therapy in the NICU, but once they receive such care, can go onto live happy lives. For Zone three, treatment is compulsory since the infant is largely viable.

Zone one, by contrast, is a category in which infants have conditions so grave that no matter the treatment, they will die within a short time and treatment may even increase their pain. Surgery for these children is not justified and most means of treatment are extraordinary since they are of little help in treating the condition. Included in this category are Trisomies 13 and 18. These chromosome abnormalities, where additional chromosome segments cause extensive problems, can cause death within the first year and are largely untreatable. They cause severe deformities and serious mental retardation that are all but incompatible with a reasonable quality of life.

Froehock also includes babies that are under 450 grams birthweight and/or twenty-four weeks gestation in the zone of those for whom therapy should be foregone. These infants are just too small and underdeveloped to survive. In most cases, the lungs have not yet completely

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[16] Froehock, Fred M, Special Care, Medical Decisions at the Beginning of Life, (1986) Chicago, University of Chicago Press. pg. 43.

formed and in the majority of cases cannot support the infant in the outside world. The heart may still be forming, so the holes between the septa will not have closed yet. There is also a condition of preemies that is called persistent fetal circulation (PFS) that is of concern. This condition occurs when the circulatory system is not advanced enough to give the organs of the infant adequate perfusion for the outside environment. The infant's system is used to being supported by the placenta and umbilical cord, so it has not advanced to a state that can support the infant outside the womb.

Some of these problems can be repaired surgically, but the summation of the problems may be too grave for the infant to survive, so the majority of neonatologists would see these parameters as the threshold for a viable infant. The neonatologists interviewed in *Special Care* stated that for infants who are this small, the air sacs in the lungs are just too tiny. They will treat an infant this small if they are able to breathe well on their own or show other signs of hope. If not, then there is no hope for survival independent of a respirator. The threshold of viability continues to drop with increasing technology in the NICU, but beyond a certain point, there is nothing that can be done.[17]

For these babies, the staff of the NICU in *Special Care* says that they are always given supportive care even though they are not given aggressive therapy. They are kept warm and are fed, often given some oxygen, but are not fully resuscitated in the case of cardiac or respiratory arrest.

Zone two falls in between zone one, where treatment is not indicated and zone three where it is required. Zone two encompasses babies who are on the borderline for treatment. They have serious life-threatening problems, but if they are treated correctly, they may have a chance for a respectable quality of life. These babies are usually treated, but if they have a severe form of a disorder, such as a high myelomeningocele spina bifida, then they may be moved into zone one where all treatment but comfort care would be forgone. Some spina bifida patients can be treated, with a shunt implanted to drain fluid from around the brain and surgery

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[17] Froehock, Special Care, pg. 47.

for the lesions. They can also usually live a life accompanied by only minimal mental deficits and can develop the ability to walk with the help of braces.

A serious problem in newborns that sometimes falls into zone two where it is difficult to decide whether to treat is Necrotizing Enterocolitis. This a condition of largely unknown origin in which sections of the bowel tissue die and the infant's ability to absorb food is compromised. The problem, if caught early enough, can be corrected surgically, or if it is too severe, then the baby is not treated. Proper intestinal function is necessary for life, so if it is not there, then the baby has no hope of recovery.

For anencephalic babies born without major portions of their brains, there is no beneficial treatment to undertake. Many can survive for a short time and breathe on their own, but they have no identity and no ability to know the environment around them. They can just be kept comfortable until they expire. It is a relatively easy decision in terms of care. They will die eventually, but there is no "plug to pull", since they are not in immediate danger of dying.[18] It can also be argued that active euthanasia is not justified in cases of anencephaly. The infant possesses no higher brain function, so there is no sensation of deep pain and the infant will die in a short time of natural causes. Additionally, the parents, who have already suffered from the birth of this child would not choose to directly end their baby's life.

It is often in the best interest of other patients to keep anencephalics alive. There have been several landmark cases where anencephalics have been organ donors for other babies in need of heart or liver transplants. It is difficult to decide if it is ethical to harvest the organs while the infant is still "alive," but the organs will begin to deteriorate if the organ recovery team waits until biological death, thus depriving any other needy infant of a chance at survival. What is often done is that if the baby arrests, the neonate is resuscitated and then placed on life-support. The infant has then "died" and can be taken off life-support for the organs to be recovered.

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[18] Froehock, Special Care, pg. 34-56.

The case of anencephalic organ donation is a difficult topic. I think that many theories would say that the anencephalic has no human identity as such and thus is not "alive", so harvesting of the organs is morally permissible. I believe that it should be the decision of the parents of the anencephalic infant since it is such a sensitive topic. I do feel, however that it is a very wonderful gift to another family to donate these organs that can save another precious young life.

For infants who have suffered brain injuries as a result of anoxia or due to congenital abnormalities, that have left them in a persistent vegetative state, the method for formulating treatment decisions is similar to that for comatose adults. It needs to be determined if there is any hope for recovery to a cognizant, sapient state. If not, then there is no reason to support the infant. They have no quality of life and never will, so it doesn't make sense to commit resources to them. They should be allowed to die a dignified death and not live a limited existence, always tethered to machines.

In this area, we can ask at what level of mental retardation is further treatment contraindicated? As stated above, many Down's Syndrome patients can have a reasonable quality of life, so they should be treated. For some patients though, they will never talk or know their environment. They don't have a quality of life that suggests that treatment would be beneficial. The problem arises though that it is hard to know how a patient will respond to treatment and what the long term prognosis will be. Often the level of deficit cannot be known until later, when obviously, treatment cannot be withdrawn. For patients with significant brain injury as seen by CAT scan and/or EEG, further treatment may be not helpful. They have been deprived of the potential for an identity by the loss of oxygen to the cortex and continuation of their lives is of no benefit to them.

The second criteria that can be used to determine the child's potential for a reasonable quality of life can be based on the Apgar score. This method of clinical evaluation, as introduced above, relies on a score of one to ten to determine physical condition of newborns, with ten representing perfect condition. This method, developed by Virginia Apgar of

Columbia University, uses five criteria, with each item being scored from zero to two, to determine the health of the newborn. They are color, quality of respirations, pulse strength and quality, muscle tone, and reflex. Statistically, infants with Apgars below a certain level have a poor prognosis for normal neurological development.

These criteria can be combined to come-up with an appraisal of the chances of infant's survival to become a person who can interact and live without constant medical and mechanical support. I feel that this is a primary criterion. If they cannot live without a respirator then they have no real quality of life.

For infants who have little chance to make a recovery to a state that would give them a reasonable quality of life, the question arises how aggressively to treat them. Should they receive antibiotics, oxygen, or resuscitation if there is a minimal chance that they can be treated successfully and live to become functional individuals?

To answer my own question, I believe that the level of treatment that should be given is related to the long term prognosis of the child. If they have a good chance to develop into a person who can be independent, at least to a degree and free of pain, then they should receive every advantage that medicine can give them. For children who are borderline, they should receive intermediate levels of treatment until their prognosis more firmly establishes itself. For those who are left to a life of low quality, aggressive treatment is probably not in their best interest.

Another relevant question in treatment of newborns is whether stopping life-sustaining treatment is different from not starting it. In the eyes of the law, I believe that it is not legal to remove a respirator, but it is legal to not start one. Morally, I don't believe there is a difference. It is similar to the active/ passive distinction for euthanasia. The outcome of both decisions are the same, so if the motives are correct on both ends, then either action would be morally acceptable. In many circumstances, the infant has a slim chance to survive to adulthood. For these cases it is better to undertake treatment and wait and see if the child improves. If it turns out that there is no hope for recovery, then treatment can be humanely withdrawn. It is preferable to give the infant a shot at life rather than refusing treatment in questionable situations. To refuse is to deprive the infant of any chance.

Born Too Soon: The Treatment of Premature Infants

Infants are transferred to the NICU for many different reasons. As discussed above, some babies are born with life-threatening birth defects that require surgery and other therapies to give them even a fair shot at life. Others remain in the nursery only temporarily. They may have low blood sugar levels following delivery or other minor problems that the treating pediatricians may wish to monitor, but they are generally able to go home in a few hours or days after birth.

The third and most common category are those infants that are born prematurely. They have not spent enough time in the womb so they need more time to grow and develop. The NICU can provide an environment where they can be protected from infection and can be kept warm in special incubators that constantly monitor their body temperature.

Many of these infants stay in the NICU for a couple of weeks or months and are able to grow and develop and can then go home to become generally normal children. However, some babies face greater odds. Their lungs may not have developed to a satisfactory level, so they cannot survive in the outside world. When is the problem too grave for them to survive? When should treatment be withdrawn from such infants?

The Andrew Stinson Case

A famous case involving a premature infant illustrates the potential for medical care to be undertaken that cannot benefit the neonate in the long run and instead robs the infant of basic human dignity and the parents of the control of their child's life.

Andrew Stinson was born at a birthweight of 1 pound, 12 ounces at 24 and 1/2 weeks on December 17th, 1976. As detailed in a letter written by his parents to the hospital where Andrew was cared for, and later in a book called *The Long Dying of Baby Andrew*, he was born in an immediate state of misery with little hope to live.[19] From the beginning, the parents wanted a humane, painless death for their son. Instead, they found themselves at the mercy of a system where "the machines used to keep their ailing son alive were more sophisticated than the codes of ethics and law that governed their use."

Upon admission to the NICU of a major tertiary care pediatric hospital a week after his birth, Andrew's weight had declined to 600 grams from his birth weight of 800 grams. He was placed on a respirator against parental consent upon admission. Andrew subsequently suffered many complications as a result of the aggressive treatment he received and finally died five months later on June 14th, 1977.

Throughout the course of the treatment Andrew developed many therapy related problems including bronchopulmonary displasia, which is commonly called "respirator lung syndrome"; he suffered periods of poor oxygen perfusion (cyanosis) and low heart rates known as bradycardia; numerous infections; an iatrogenic cleft palate; fractured bones; and eventually as his lungs became extremely weak, he developed pulmonary artery hypertension and brain seizures. Through his treatment, Baby Andrew required many blood samplings and transfusions and had difficulty with his nutritional requirements, which led to the bone disease rickets. He also failed to grow and was in less than the third percentile for height, weight and head circumference.

According to the parents, many aspects of their son's care were decided without anyone asking them and they were treated as outsiders from the start. They say that through the case, the medical residents and students got to see some rare problems to broaden their education and the specialists had "some interesting consults", but little attention was paid to their feelings or to their son's. They were treated as though they were bad people for wanting a painless and dignified death for their poor son. [20]

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[19] "On the Death of a Baby", Robert and Peggy Stinson, Appears in Contemporary issues in bioethics, (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters, editors, Belmont, Calif. : Wadsworth Pub. Co, pgs. 276- 283.

[20] "On the Death of a Baby", Robert and Peggy Stinson, Contemporary issues in bioethics.

Decisions were frequently changed regarding Andrew's care. One attending physician had decided that if Andrew's breathing were to fail, that he would be placed on a ventilator. The parents opposed this, and were told that if they did not allow the practice, that a court order would be obtained. Then a new attending told them that Andrew would not be placed on a respirator after all. Then after a short time, a third attending physician said that he would again be placed on the respirator in the event of respiratory failure.

As if all the other problems weren't enough, the parents' were informed later that a consult from the neurology department had stated that there was a strong possibility that Andrew had significant brain damage. This had not been disclosed to the parents, like many of the other findings of the medical staff. Shortly after this finding, Andrew's ventilator tube came out of his throat and he began breathing on his own. The decision was made by the team, (without the parents) that if he stopped breathing at this point, he would not be reconnected to the respirator and would be allowed to die.

On several occasions, the mother had asked one of the attending physicians under what circumstances the respirator could be turned off. In one instance, he responded in a rage and said," What do you want me to do, go in there and put a pillow over his head?"[21] She commented in the letter that she found it strange since she felt that her son's death had been planned by the staff none-the-less by not reconnecting the respirator when it worked its way out.

This extensive description of a case that was wrought with many injustices shows just how important it is to be clear about issues regarding potential quality of life and the use of aggressive treatment for infants. One study states that only 3.4 to 4 babies per 1000 live births are born in the range of low birthweight between 500 and 1000 grams. Still, these babies

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Beauchamp andWalters, editors, pg 277.

[21] "On the Death of a Baby", Robert and Peggy Stinson, Contemporary issues in bioethics, Beauchamp, and Walters, editors, pg 281.

represent a large percentage of NICU patients.[22] It can be argued that after reading this case, the parents had the right to decide for their child and that the doctors violated several moral rules in denying them that right. I believe that foregoing treatment was in the baby's best interest, since the only outcome of the aggressive treatment plan was to further injure Andrew, producing further complications that were caused by the treatments themselves. Also, as was outlined in previous chapters, the doctors did not obtain consent for many of the procedures, or even discuss the treatment plans with the parents.

The Problem of uncertain prognosis in low birthweight newborns

The problem of making immediate decisions about premature infants is that it is hard to know how they will respond to treatment. When some preemies are born, they are limp, not breathing on their own, and are scarcely bigger than an adult hand. At that time, it may seem impossible for such a tiny being to survive. Another baby in the NICU in which I observed was born extremely prematurely at 26 weeks of gestation. (40 weeks is full term). When I arrived, she had already been in the nursery several weeks. She had required a respirator on a special setting to allow her lungs to develop normally, but after these treatments, she was able to successfully breathe on her own. She was growing but was still very tiny. When she was born, as is the case with many preemies, she was too weak to suck on a bottle or breastfeed, so she needed to be gavage fed by means of a tube. After a period of time, she was able to suck on a bottle and was getting stronger every week.

This case illustrates the problem of uncertain prognosis that is a frequent concern in many areas of medicine. This little girl might have been seen to be suffering from many problems when she was born, but with special care and time, she grew and was doing really well. This experience makes me believe in a wait-and-see attitude for many circumstances. In *Special Care*, one of the neonatologists discusses this problem. He feels that it is best to treat

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[22] "The Baby Doe Rule, Still a Threat", Moskop, John C. and Rita L Saldanha, appears in Contemporary issues in bioethics, (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters, editors, Belmont, Calif. : Wadsworth Pub. Co, pg. 287.

aggressively in most circumstances and to wait and see what happens. They feel that if a course of treatment doesn't work, then treatment can be withdrawn, but if we don't try first than there is no chance of recovery.[23]

Uses of Active and Passive Euthanasia for Newborns

As is the case in many areas of the euthanasia debate, the question arises whether there are certain methods of euthanasia that are more ethical than others for certain situations in neonatal intensive care. Is there a difference in the circumstances in which active and passive euthanasia may be considered to relieve the suffering of newborns who have severe birth defects or other problems?

For some cases, we can determine that it is in fact ethical to withdraw treatment from certain newborns due to an anticipated level of quality of life that is extremely unfavorable. In these same cases, are there any circumstances where we can consider the use of active euthanasia?

For many infants, there are circumstances where we can decide that it is humane and ethical to forego surgery or withdraw feedings and life-support. It is however, difficult to decide if active euthanasia is justified. I have defined in several areas of this paper that there is virtually no difference morally between active and passive euthanasia. In both cases, the physician is causally responsible and in both cases, death comes. The motivation to undertake euthanasia is more important morally than the method. Despite the lack of a moral difference, there remains a procedural and psychological difference, so there may be circumstances in which the use of one type of euthanasia is more appropriate than another.

For adult patients, active euthanasia is only justified in cases of extreme pain where the patient has given informed consent either verbally or through an advanced directive or proxy consent, or for incompetent patients where a second party has judged that it is in the patient's

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[23] Froehock, <u>Special Care,</u> pgs 44-45.

best interest. For infants, the prognosis is hardly ever certain. For Baby Jane Doe, it appeared that she would have been allowed to die when her parents refused surgery for her. Eventually, she had surgery to place a shunt in her brain to drain the cerebrospinal fluid and the spinal lesion healed on its own. If she had been actively euthanized at an earlier point, then she would have had no chance to recover and death would have been certain. Since she recovered, to a degree, then she deserved the chance to see how she would develop since not all those involved in her care though that she was completely doomed to a life of paralysis and perpetual infancy. Passive euthanasia in the form of forgoing additional aggressive medical treatment leaves room for error and unexpected recovery, if active euthanasia is used, then death is certain.

Also, through withdrawal of treatment, most infants who face a very poor quality of life would die within a short time span and could be kept comfortable, so active euthanasia is not really necessary. Additionally, many decisions for the infant's care are made in conjunction with the parents. Most parents would not choose an active form of euthanasia since they don't want to think that they are the direct cause of their baby's death and are only in fact allowing nature to take its course. Even though there is little philosophical difference between the two forms, it is important also to care for the parents' mental well-being, so we might choose more passive methods over directly active forms.

Do Not Resuscitate Orders for Infants

DNR orders have been discussed in earlier chapters. Are there certain circumstances when a DNR order should be considered for the critically ill neonate?

For adults, DNRs are considered for patients for whom death is inevitable or for irreversibly comatose patients. I believe that similar guidelines apply for newborns. For a newborn such as the baby above with birth asphyxia, a DNR would be justified. It would also be justified for anencephalic infants and for infants who have a host of genetic problems or congenital abnormalities that are judged to be incompatible with life. If their death is inevitable, then they should not be made to suffer any longer than they can live without heroic measures.

For infants who are facing a long course of treatment but are ultimately viable individuals with hope for a reasonable quality of life, DNR orders should not be allowed. Their lives and potential adult lives have worth, so they should get every benefit of medical care, including a full scale resuscitation.

Resuscitation can be considered to be extraordinary in some circumstances. If other means are not successful in prolonging a life or the prolongation of such a life leads to more pain and only extends the dying process, then the use of resuscitation is not justified.

Sanctity of Life Versus Quality of Life

One idea that impacts this discussion is called the Sanctity of Life Doctrine. This principle holds that human life is sacred, regardless of quality and that the taking of any human life is wrong. The Sanctity of Life Doctrine also believes that human life is more sacred than any kind of animal life. This might be used to justify the taking of the lives of animals for research purposes, since their death may save human lives.[24]

Why does human life take precedence over other forms of life? Some philosophers would say that it is because that human beings have self-awareness and an a concept of a whole life plan. If this is true, can certain animals that possess some amounts of these characteristics have more right to life than other animals? Infants who are born with considerable brain malformations may possess less potential for self-awareness than that of some animals, like chimpanzees, for example, who have been found to live in close family groups and to plan for a limited future. Then it would follow that a chimp might have more right to life than a comatose infant.

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[24] Kuhse, and Singer, Should the Baby Live? ,pgs 118-120.

Instead of full acceptance of the Sanctity of Life Doctrine, I believe that only infants who have a strong potential for a decent quality of life should be treated and allowed to live into adulthood. Infants who are treated should be generally viable children who can interact with people around them and experience emotions.

I definitely think that human life, in general, is sacred, and should be preserved if possible, but it should not be valued to the point that a life exists that is full of misery or devoid of human interaction. If a person is in and out of the hospital for their entire short young life and he or she requires multiple operations, with little hope for recovery, then we should ask if this is the type of life that should be prolonged.

Conclusion

The field of neonatology has advanced considerably over the years and is now able to successfully treat many infants who would have died a short time ago. It also enables physicians to keep all but the sickest infants alive, at least for a period of time. With these new advances, there is the potential for great joy, but also the potential for great misery if these abilities are not used correctly. We need to be clear about what types of lives we value and which infants should be saved and which should be allowed to die a merciful death. A certain level of quality of life should be striven for, which means that we should establish understandings as to how we should treat infants. Cases like Andrew Stinson's should be prevented. He had little or no chance to survive and he and his parents were victims of a system that had the capabilities to keep him alive but didn't ask if it should have.

On the other side of this issue, we also should also strive to protect infants who have a chance to live reasonable qualities of life but may be discriminated against by parents or practitioners who feel that their handicaps make them less than desirable. We need to prevent cases from occurring like that of Baby Doe, where an infant was allowed to die because parents and parts of a society judged that his handicaps were not compatible with the type of life that they valued.

CHAPTER EIGHT:
TREATING PATIENTS IN IRREVERSIBLE COMAS AND PERSISTENT VEGETATIVE STATES

Many patients across the United States exist in either long term comas or in a semi-conscious state where they are able to exhibit some reflex movements and respond to painful stimuli, but cannot experience any deeper pain or joy, called persistent vegetative state. They are frequently maintained using artificial feedings and respirators for long periods of time at great expense, even though they possess little or no hope of ever recovering to a functional, cognizant state. Before the advent of many of the newer medical advances, a large number of these patients would have died a peaceful death as a result of injuries sustained from serious accidents, or from the progression of critical illnesses. Now, the way that they die is under constant scrutiny by courts, ethics committees and medical staffs alike. Should it be a priority to preserve life at all costs, or is the quality of the patient's life the most important consideration? Is the continued care of these patients justified or should they be allowed to die, since by some accounts, they are not even persons any longer?

Several famous court cases presented by the media have often connected the care of the comatose to the euthanasia debate. Some scholars and physicians have argued that these unfortunate patients would want to die if they were able to communicate and should be allowed to do so. Courts have in several cases, such as the *Quinlan* and *Cruzan Vs Missouri* decisions, sought to establish the importance of demonstrating a required level of consent prior to consideration of the removal of medical treatment from such patients.

The majority of these patients, who are either in persistent vegetative states, are comatose, or suffer from clinical dementia, may be unable to communicate their wishes to their loved ones and to the doctors who care for them. Dementia can be defined as a loss in at least two areas of complex behavior such as language, memory, visual and spatial abilities, or judgment that significantly interferes with a person's daily activities, which can be caused by progressive terminal conditions.[1] In these cases, it is often hard to know what they would want. Some may have left instructions in living wills, but these may be challenged by care providers or grief stricken family members. Decisions for others who have not left explicit instructions may be based on the ideas of an appointed proxy or from the impressions of friends or family members.

An additional problem that complicates treatment decisions for comatose adults is that of an uncertain prognosis. This is a common objection that is brought up with regards to euthanasia and withdrawal of treatment. Their situations may appear hopeless, but there have been rare instances where people have awoken from comas after several years. If we choose euthanasia, especially an active form, then all hope for a cure is lost and the patient will certainly die.

Several cases of coma and persistent vegetative state have brought out considerable debate about whether there exists a right for family members or loved ones to refuse care for incompetent patients. Is there a limitation to the level of treatment that can be refused? Are there some treatments that are required care? Also, for patients who are comatose, we need to determine if there is a certain line beyond which their lives are not beneficial anymore and can be allowed to die, since in many cases, it can be argued that there is no person to bring back.

The Case of Karen Ann Quinlan

Several cases have helped to establish legal precedents for court decisions in many situations relating to the withdrawal of treatment of adults. One of the most well known is that of Karen Quinlan, which was decided by the New Jersey Supreme Court in 1976. In *re Quinlan*, Karen's parents petitioned the court to have their daughter's respirator disconnected after she had suffered irreversible brain damage and had entered a persistent vegetative state.[2]

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[1] "What is Dementia?" The Institute for Dementia and Brain Aging, http://teri.bio.uci.edu/aboutad.html.

[2] Koop, C. Everett, "The Case of Karen Quinlan", appears in Euthanasia : the moral issues (1989) Baird, Robert M and Stuart E. Rosenbaum, ed, Buffalo, N.Y. : Prometheus Books. pg. 35-36.

Karen was born to unknown parents and was adopted by Mr. and Mrs. Joseph Quinlan when she was four weeks old. She was active in her church and was described as being energetic, friendly and outgoing by her parents and high school friends. After she graduated from high school, she moved out of her parent's home and embarked on a different lifestyle which, according to friends, included frequent drug use of such substances as marijuana, amphetamines and barbiturates to suit her moods. Drugs were apparently to blame for her vegetative condition. On April 14th, 1975, she took some tranquilizers and drank at a bar to celebrate a friend's birthday. During the course of the night, she began to nod off, so her friends took her home and put her to bed where she passed out. After a period of time, her friends realized that she wasn't just drunk. Attempts were made to revive her using mouth to mouth resuscitation and an ambulance was called, but Karen never regained consciousness.

She was transported to the emergency department of the local hospital where attempts were made to stabilize her condition and she was subsequently placed on a respirator. It might be asked why she was ever even placed on a respirator in the first place given her condition. Dr. C. Everett Koop, who wrote an article about the case, notes that it is important to realize that doctors in the ER had little time to decide on a course of treatment and so there was no time to take a detailed history before placing her on the respirator. It was later determined that she had stopped breathing for upwards of ten minutes due to the potent combination of alcohol and tranquilizers. There was no time to consider her mental status before implementing emergency treatments. To take more time in considering her outcome would have denied any chance for her to recover. Additionally, many patients that present with Karen's signs and symptoms are treated in the same manner and are often able to make a full recovery with their mental faculties intact.[3]

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[3] Koop, "The Case of Karen Quinlan", Euthanasia : the moral issues Baird and Rosenbaum, pg 36.

The Quinlans continued to pray for their daughter's recovery, but after a while it was determined that she had little or no chance to recover to any reasonable quality of life. She had been in a coma for five months and weighed only 60 pounds and could not move or speak.

The case was presented to the country through the news media in September of 1975, when Mr. Quinlan sought to unplug the respirator that kept his daughter "alive." Doctors refused and Mr. Quinlan decided to sue for his daughter's right to die. He said " In my own mind, I had already resolved this spiritually through my prayers and I had placed Karen's body and soul into the gentle, loving hands of the lord. . . . It was resolved that we would turn the machine off." [4]

The case was initially decided on November 10th by Superior Court Judge Robert J. Muir, Jr. who ruled that Karen's respirator could not be disconnected by doctors. He stated three criteria that were used in the formulation of the verdict.

The first was that Karen was alive. While it was true that she was unable to make any voluntary actions or demonstrate any cognitive function, she could respond to painful stimuli and cried when pinched. The EEG showed that her brain function was above that of whole brain death, although she hung precariously in a gray area between life and death. Because of the minimal electrical activity in her brain stem, she did not meet the legal and medical definition of "death" which requires true brain death.

The second reason cited in the ruling was that although the law allows some medical decisions to be made not to start respirator treatments, once a respirator is in use, it is illegal to disconnect a respirator from a person who has not had brain death and if done, it would be considered homicide. Additionally, there was a belief that if doctors were to disconnect the

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[4] Koop, "The Case of Karen Quinlan", Euthanasia : the moral issues Baird and Rosenbaum, pg 36.

respirator, they would be liable for malpractice and considerable litigation might ensue following a decision to hasten Karen Quinlan's death.[5]

The judge stated that even though Karen was on the threshold of death, no humanitarian motives could justify taking her life and he ruled that there is no constitutional right to die that can be asserted by a parent for his incompetent, adult child.

There were several premises that were presented by the Quinlan's lawyers in the case for Karen's right to die that were disagreed with by the judge. The first was that medical science held no hope for Karen's recovery. The judge argued that in fact some doctors had stated that there was always a chance for recovery to a certain level and that it was difficult to know how Karen would progress. While it is true that some patients do improve, Karen had been in her vegetative state for several months at this point and statistics from one study suggest that almost no one has recovered after being comatose or existing in a vegetative state for an extended period of time.[6] Because of this, it was almost impossible for Karen to return to a functional, cognizant state.

The lawyers asserted that her family believed strongly that Karen would want the respirator turned off. This argument was supported by evidence from several conversations before she began using drugs. Some who sought to block the measure to remove the breathing tube stated that they believed in some circumstances that these feelings may not have remained constant since those early conversations and believed that there was no way to know how Karen would respond today. It can be argued that with a decision like this, it is usually as a result of fundamental personal philosophies and is affected fundamentally by how someone lives their life.

The third reason offered was that doctors had no duty to keep Karen alive. Dr. Koop agrees with the judge who stated that he believed that Doctors do have a duty to treat and that

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[5] Koop, "The Case of Karen Quinlan", Euthanasia : the moral issues Baird and Rosenbaum, pg. 36.

[6] Hoefler, James M, with Brian E. Kamoie, Deathright : culture, medicine, politics, and the right to die (1994) Boulder, Colo. Westview Press, pg 135.

when a patient enters a doctor's care, he or she believes that the physician will "do all within his human power to favor life against death."[7]

While in most circumstances the ethics of the medical profession dictate that doctors should favor life over death, in Karen's situation and in others like it, it can be argued that doctors should not strive to preserve life in general, but should only strive to protect those lives that have meaning and allow the patient to experience happiness and have human contact.

The lawyers also argued that the parents had the right to decide for their daughter's welfare. The judge contradicted this, saying that the decision made by the family can be based either on the beliefs of the patient or on the desires of the parents, and such a decision may not always be in the patient's best interest. They also cited the right to privacy that should allow the parents the right to decide. The judge said that the right to privacy governed decisions to maintain a lifestyle, not to end life altogether.

Yet again, Karen's situation is different from other medical circumstances. As a policy decision, it makes sense to impose certain controls to prevent abuses by second parties who may wish the death of a PVS patient for their own reasons. For the Quinlan case however, there is no chance to recover, so Karen has no interests to protect, so the family is correct in its decision to remove the respirator.

The final argument was that Karen's "life" was over and she was not experiencing anything worthwhile by being connected to the respirator. The judge countered that a respirator had become 'ordinary' medical treatment and did not rob the patient of her dignity. It is hard to agree with the judge. The type of life that Karen was living would be very hard for families to accept. Due to the substantial brain injury, Karen had little hope to recover. While it is true that she is not being physically harmed by the respirator, she still is not deriving any benefit from this life and is arguably already gone.

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[7] Koop, "The Case of Karen Quinlan", Euthanasia : the moral issues Baird and Rosenbaum, pg. 39.

After the initial ruling, there was much discussion about the judge's conclusion. The majority of the ideas in the media supported the judge's decisions and people felt that Karen was alive and that her parents had no right to let her die.

Later, the case was appealed to the New Jersey Supreme Court where the decision of the lower court was reversed and Karen's parents were given the right to disconnect the respirator. The people caring for Karen must have sensed that the second ruling might allow the removal of the respirator. In preparation for the decision, they had begun to wean Karen from her respirator. When the respirator was eventually removed, she was able to breathe on her own, so the court decision was nullified. She lived on in a semi-conscious state for eight more years, finally dying in June of 1985 from pneumonia.

The Quinlans never sought to discontinue hydration and nutrition from their daughter. Being devout Roman Catholics, they followed the Church's view that food and water were ordinary means and should be continued in a majority of cases. They did withhold antibiotics and the pneumonia that led to her death went untreated.

The Quinlan case brought forth many issues that the national media had never dealt with in such depth before. It is important to ask whether the correct decision was made in the court rulings and also to ask what should happen in subsequent cases of patients who exist in a persistent vegetative state.

Doctors believed that the brain damage that Karen suffered as a result of the dangerous combination of drugs and alcohol that stopped her breathing was altogether irreversible. The objections that were made by the state included an argument that the state's interest in the sanctity of life overruled the interest in Karen's right to refuse life-saving treatment. The state's lawyers also argued that Karen was alive and stated that this was demonstrated by her response to pain. They also argued that it could not be proven beyond a reasonable doubt that Karen would choose to have the respirator removed if she could articulate her wishes.

I believe that Karen's lack of potential for a long term quality of life of any reasonable quality mitigates any arguments about an interest in the sanctity of life or arguments that seek to ascertain whether Karen had indeed consented for the removal of the respirator. The EEG and the known level of brain damage show that she will never improve to a state where she can enjoy anything or where she can interact with anyone. Because of this state of existence, the removal of the respirator is justified. Karen, as her family knew her, was gone, so she could be allowed to die. It can be argued that to disconnect the respirator is to also respect her autonomy since according to her friends and family, she would not want to live in such a state, so she should be allowed to die.

Treatment of Patients in Irreversible Comas and Persistent Vegetative States

The Quinlan case had a profound effect in the way that the right to die is viewed. Several cases that were decided after the Quinlan decision drew on the support that was given to an individual's right to refuse treatment, and in the case of incompetent patients such as Karen, for loving family members to choose an appropriate course of medical treatment. After the Quinlan case, a precedent existed that allowed a more liberal policy when it came to termination of life-support for permanently comatose individuals. We need to determine in what circumstances it is justified to terminate treatment for these patients. What requirements must be fulfilled and what theories or ethical concepts can be used to justify such a practice?

Previous chapters have strongly argued that euthanasia is justified in cases of terminal illnesses that are accompanied by continual pain. In these cases, the individuals have a right to choose how they live and die, or to have choices made for them according to a living will or appointed proxy. Irreversibly comatose patients and those in persistent vegetative states are unable to detect pain since the cortex of their brains are unable to sense the neural impulses. Despite the lack of detectable pain that these patients exhibit, they are still potential candidates for euthanasia. Their quality of life is such that they derive no benefit from their existence and in all cases of significant permanent brain damage, they have lost the personality that defined their previous existence. For the Quinlans, there was simply no "Karen" to bring back.

According to some ideas developed in earlier chapters, it can be shown that it is an ethical choice to discontinue the treatment and end the lives of permanently comatose individuals. One of the first notions that is useful is the idea of personhood. This holds that all people are human, but not all humans are persons. They must possess certain qualities to be given personhood. First, they must be able to make rational decisions, at least to a degree, or posses the potential to gain or return to such a state in the case of infants and the temporarily comatose, respectively. Additionally they must be able to interact with people and exhibit certain cognitive abilities. Obviously, a permanently unconscious or vegetative patient cannot do so. For the mildly demented and mildly mentally retarded, it can be said that they still posses certain degrees of personhood, since they can interact with others, have personality and possess at least a basic understanding of their surroundings. For patients who have a chance to recover and come out of their comas, we cannot justify withdrawal of treatment since they may recover to a state they would possess some personhood, so it is wrong to kill them. For these patients who cannot recover, their lives are not useful anymore. They have no quality of life left to consider, so they can ethically be allowed to die.

An important idea that is necessary to consider when thinking about the termination of a life of a comatose individual besides prognosis is their expressed consent for the action. Did they express, either in a living will or in a previous conversation that they did not wish to live on in a state where they could not know the world around them, or did they express the opposite? Do they feel that life is sacred in all forms, or only in a form that was free of a dependence on medical technology? One of the reasons that there was difficulty in deciding the Quinlan and Cruzan case, which is described below, is that these patients had not left any explicit instructions about what they would want in such a circumstance. The only resources their families and the courts had to go by were conversations the patients had had with friends and family. A judge in the Quinlan case stated that a conversation of this nature was not reliable since it might express a feeling that was only being felt at that particular time and might change under different circumstances.

I believe that in the absence of a living will, conversations about forgoing treatment are fairly reliable sources of testimony. Most people don't radically change their feelings on the nature of this type of situation since it is based either on strong religious convictions or on the general philosophy with which they lived their day to day lives. While decisions can be made in this case from the beliefs of family members, a living will or prior statement from the patient in a competent state is helpful to establish their wishes. It is considerably easier to decide in the patient's favor if they have provided instructions. If they state that they don't want to live in such a state, then there is little doubt about their feelings and the corresponding action can be ethically undertaken.

As in many other areas of this paper, I believe that quality of life is very important in making treatment decisions related to euthanasia and the withdrawal of life-saving treatments. It is important to consider if the patient is in considerable pain or as in this case, if the quality of their life is so noticeably absent that their life is no longer of any benefit since they are irreversibly comatose. If the quality of their lives are such, then decisions can be made that are in the patient's best interest even if there is not specific documentation or evidence from conversations to prove that the patient would not want to live on in such a state. In the case of the irreversibly comatose however, they are for all practical purposes, brain dead, so the level of prior consent is irrelevant. They have lost their personhood and have no ability to ever return to such a state. Due to this, the level of consent is irrelevant, since they will never again have any quality of life.

Additionally, one of the reasons that the Quinlan and Cruzan cases have been so important is their representation of issues related to the right to die. These two cases are cited by many people when attempting to defend the right to die, whether the patient is conscious or not. As the courts correctly recognized, in certain circumstances there is the capacity for abuse when consent is not obtained from incompetent patients. For these two patients however, they had little to lose since doctors had judged there ability to recover as impossible. For some cases, it is important to obtain consent, but for cases in which the patient cannot benefit from continued treatment, it is irrelevant to obtain consent, since the patient's interests are so clear-cut.

Modern medicine should definitely strive to preserve life in general. The goal of medicine is to extend lives and to constantly expand the numbers of conditions that can be successfully treated. It should, however, be asked if all lives are of a quality that should be preserved. Instead of treating everything, it should be considered if the patient has a life that is worth living. For an irreversibly comatose patient for whom it has been shown that a return to a cognizant state is not likely, doctors should not strive to keep the patient alive in all circumstances. The patient has no ability to interact or to know what is going on around him or her, so there is no benefit for continued advanced medical treatment.

For many patients, a life tethered to wires and survival due to tube feedings and artificial respiration goes against everything they believed before the onset of their affecting condition. There are many people that contend that patients should be allowed to die with dignity and that artificial support is not what the patient would want.

A Kantian evaluation of the situation would support withdrawal of treatment for comatose individuals with no chance to recover. These patients arguably would choose death over a state such as this if they could speak. In considering categories of consent, there exists a type of consent called implied consent. In emergency situations, it is understood that patients would want their lives saved, so verbal consent is unnecessary. For situations of irreversible coma and PVS, it could be considered implied that a patient with no hope of recovery and no awareness whatsoever would want to die in order to prevent the drain of resources of their loved ones and to preserve the idea of them as a person that their families would want to remember.

A Utilitarian analysis would surely favor removal of treatments that sustain this limited form of life. This life is not increasing utility and is probably decreasing it since the person is using resources and lacks any dignity by being kept alive without any ability to enjoy life. Additionally, if the family, society and economic concerns are figured into the equation, then a utilitarian critique would surely favor the death of the patient.

A theological critique would allow the withdrawal of these extraordinary means for a patient for whom continued treatment only would prolong death. There is a doctrine that says that doctors should not kill, but do not always have to strive to keep patients alive. There are no treatments that can bring patients back who have entered a persistent vegetative state, so the medical technology that is maintaining the patient can be considered extraordinary and is allowed to be discontinued. In the case of feeding and hydration, it can be argued using some principles that these treatments are extraordinary since they do nothing to improve the patient's condition. With a theological view however, there is the belief that food and water are basic care, and cannot be terminated. In the case of Karen Quinlan, since her parent's were devout Catholics, they never sought to have her feedings removed since it violated church doctrine. As stated above, antibiotics were discontinued and lead to the pneumonia which took her life.

Determining what are extraordinary means in withdrawal of treatment

In considering withdrawal of treatment for irreversibly comatose individuals, some people believe that a distinction between ordinary and extraordinary methods of medical treatment is important. They state that it is more ethical to consider the withdrawal of extraordinary means than simply ordinary means. It is argued that ordinary means are required care and it goes against duties of the medical profession to withdraw such treatment. Often included in these treatments are IV s, nutrition and hydration, and antibiotics. As has been argued in previous chapters, the level of technology is not what makes a treatment extraordinary, since what was considered advanced before can become fairly common within a few years. The potential benefit that the treatment can offer the patient is what should determine whether the treatment should be used.

To determine how extraordinary a treatment is, we need to evaluate the quality of life and prognosis of the patient. For a patient who is not suffering to a great degree and who will recover, most means are not extraordinary and should be required. For patients who have little to gain from aggressive treatment, most means are extraordinary. In the case of patients in vegetative states, there is no treatment to make them well, so most medical care is extraordinary.

In the Quinlan case it was argued by those who fought for Karen's right to die that the respirator was extraordinary since she had little hope to recover to a cognizant state. For some cases when the patient's prognosis is at least somewhat positive, it is felt that some treatments are compulsory such as intravenous fluids, feedings and water. For some cases however, it can be argued that the patient has no chance to recover to an active state, so feedings and water, especially those of an artificial nature, are not compulsory.

The Case of Nancy Cruzan

Another famous case that has been important in the right to die debate has been that of Nancy Cruzan. *Missouri Vs. Cruzan* was the first right to die case to be heard by the United States Supreme Court. It centered around the fight of Nancy's family to seek the removal of a gastrostomy tube that had been implanted into her abdominal wall to deliver food directly to her stomach. Due to her vegetative state, she was unable to feed orally and thus if the tube was withdrawn, she would then die of starvation and dehydration.

Many people felt that some aspects of this case were different than that of *Quinlan* which had been decided thirteen years earlier. In the Quinlan case, the petitioners sought to remove a respirator, which was viewed by some to be within the range of extraordinary or heroic medical treatment, considering Karen's chances of recovery. The physicians at the Mt. Vernon State Rehabilitation Hospital where Nancy was being cared for stated that in some circumstances they would consider the removal of a respirator, but never the removal of nutrition and hydration, since they were part of what they considered to be "basic medical care".[8]

The case began on January 11, 1983, when Nancy lost control of her car on a road in Jasper County, Missouri. She was thrown from the car and was found lying face down in a ditch without detectable cardiac or respiratory function. Paramedics were able to restore her breathing and heart rate, but her brain had been without oxygen for approximately 15 minutes. She was transported to the hospital in an unconscious state and was diagnosed by the attending neurosurgeon as having sustained considerable brain injury due to anoxia, a lack of oxygen to the brain, and from serious cerebral contusions. She lay in a deep coma for approximately three weeks and then progressed to a state in which she was able to open her eyes and show some reflex muscle action. She remained in this semi-conscious state that her doctors termed persistent vegetative state, where she could exhibit some reflexes from the brain stem level but showed no cognitive function. Since she was unable to swallow as a result of the brain injury, a gastrostomy tube was placed in her stomach.

After a period of time in which she showed little signs of improvement, it became apparent that Nancy would probably never return to a state where she could enjoy a life of any reasonable quality or feed herself. Her family believed that because of the way in which Nancy had lived her active life, she would not wish to live on in this state. They felt she had no quality of life and should therefore be allowed to die. Nancy's parents asked the hospital staff to remove the gastrostomy tube that kept their daughter alive. The staff refused and said they would not even consider it without court approval.

The parents found a lawyer who would help them fight the hospital administration to allow Nancy to die with dignity and the family filed in state trial court. The Cruzans waited for many days after the preliminary court proceedings had closed for the decision. Finally it was decided that the feeding tube could be removed. The judge cited a belief in a constitutional right

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[8] *The Right to Die?* , Frontline, Public Broadcasting Corp., and Columbia University, 1989.

of a person to refuse live-saving treatment and determine the course of their own medical care. The judge also believed that her wish not to continue on in such a condition had been proven by a conversation with a friend in which she told her that she would never want to be hooked up to a bunch of tubes and "live as a vegetable."[9]

After a perceived victory by the Cruzan family, the case was appealed by the state due to debate within the hospital and media that had asked whether the decision to terminate Nancy's life was simply respecting her wishes or whether it constituted criminal homicide.[10] The matter was considered by the Missouri Supreme Court and was reversed by a divided vote. The core of the decision rested on the fact that the justices believed that consent for the withdrawal of treatment had not been satisfactorily obtained from the patient. They felt that the conversation with her friend regarding matters of life and death were "unreliable for the purpose of determining her intent and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf."[11] They also declined to use the right to privacy as a right to refuse medical treatment in every circumstance and denied the right of Nancy's parent's to decide the course of treatment for their daughter, stating that no one can make decisions on behalf of incompetent patients without clear and convincing evidence of the feelings of the patient. The court also explained that the parent's quality of life arguments didn't carry as much importance as the state's interest in the overall sanctity of life.[12]

After this decision was rendered, the parents and their lawyer, William Colby, had to decide what to do next. One option was to ask for the matter to be heard by the United States

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[9] Quill, Timothy, Death and Dignity. Making Choices and Taking Charge, (1994)New York. London, W.W. Norton and Co., pg 180-181.

[10] Hoefler, Kamoie, Deathright, pg 132.

[11] *Missouri Vs Cruzan*, Appears in Euthanasia : the moral issues (1989) Baird, Robert M and Stuart E. Rosenbaum, ed, Buffalo, N.Y. Prometheus Books. pg 181.

[12] Hoefler, Kamoie, Deathright, pg 132.

Supreme Court. The Court had never heard a right to die case, so their was doubt whether their case would be heard.

The Court eventually agreed to hear the case and the lawyer was given one hour to present the details of the case. After a period of deliberations, the court delivered its opinion. The judgment was split with justice William Rehnquist delivering the majority opinion of the Court, with Justices White, O'Connor, Scalia and Kennedy joining. A dissenting opinion was given by Justice Brennan, with justices Marshall and Blackmun joining. Justice Stevens also filed a dissenting opinion.[13]

The majority opinion stated that the court did recognize the right of an individual to refuse medical treatment through informed medical consent as recognized by common laws and through implied elements of the 14th amendment, which states that "no person can be denied life, liberty or property without due process of law." The court ruled that to invoke these liberties on behalf of an incompetent individual, there must be evidence that it is indeed the choice of the patient. In the case of Nancy Cruzan, who lies in a persistent vegetative state, it is difficult to determine whether the patient has clearly expressed such a wish to discontinue treatment. The Court argued that in the Cruzan case, it appears that the parents are acting in Nancy's interest, but not all patients in similar cases will have family members to decide for them, so standards need to be established that safeguard against the termination of life in circumstances where consent has not been proven. The interests in the case, since they involve life and death are extremely important and cannot be made hastily.

The opinion went onto say that close family members generally make decisions in a similar fashion of what the patient would choose, but not always and there is no way to determine whether the family's decision is the same as what Karen would make if she were competent to decide.

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[13] *Missouri Vs Cruzan,* Euthanasia : the moral issues (1989), pg 181.

The Court affirmed the decision of the lower Missouri court, stating that the court had not violated the constitution in requiring that the Cruzans present clear and convincing evidence that Nancy would want to die if she could be asked today. They also recognized the state's interest in preserving life. The case was then remanded back for a final decision to be made by the State of Missouri.

Justice Brennan, in his dissenting opinion let it be known that he believed that Nancy had a fundamental right to be free of medical technology that only prolonged her dying. He stated that she had no awareness of her surroundings and that the state's claim to the interest in the sanctity of life was not paramount to a patient's right to be free of medical technology and to die with dignity. He stated that Nancy Cruzan had a right to die without the state's involvement. Justice Brennan also wrote that the artificial nutrition and hydration (ANH) that Nancy received was undoubtedly medical treatment and was not only "basic care".

Justice Stevens, in his dissenting opinion also believes along with Justice Brennan that Nancy's right to die with dignity, free of medical treatment that only prolongs her death is not secondary to the state's interest in the preservation of life. He also stated that she did not lose her rights to liberty as guaranteed in the constitution with the advent of her unconsciousness. She has a right to die a dignified death and the state of Missouri has no right to interfere.[14]

The justice for the State of Missouri stated that no ruling would be made until further evidence could be presented that the patient would indeed consent to the removal of her gastrostomy tube in such a circumstance. After learning of the Missouri court cases and the Supreme Court decision, several of Nancy's friends came forth to testify on her behalf. Many testified that Nancy had indicated to them that she would not want to live on in a state such as this. Nancy's doctor, who had initially opposed the removal of the tube, also came forward

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[14] *Missouri Vs Cruzan,* Euthanasia : the moral issues, pg 205.

and, when asked if it was in Nancy's interest to continue living in such a state, said "no sir, I think it personally would be a living hell."[15]

In the light of this new testimony, the court ruled that sufficient evidence had been given that demonstrated that Nancy would wish to have her feedings discontinued so she could be free of such an existence. The feeding tube that had sustained her for eight years was finally removed and she died on December 26, 1990. It took eleven days for her to die of dehydration and starvation, but at the end, she was finally allowed to die peacefully. Under the terms of the ruling, no one could intervene to do anything more to hasten her death during this period.

There are many issues that are included in a discussion of the Cruzan case. The first is the question of whether the use of the feeding tube constituted ordinary or extraordinary means. I believe, according to definitions laid out in chapter four that the removal of the gastrostomy tube is not significantly different from the removal of the respirator in the Quinlan case. Both treatments are artificial measures, since the patient cannot maintain the bodily function in question without the medical technology. Because these treatments utilize higher medical technology, and do little to contribute to a cure and may merely prolong dying, they can be judged as being extraordinary. With the current state of treatment, neither Cruzan or Quinlan can hope to return to a state where they can function independently of the medical technology.

Second, the case asks whether patients have a constitutionally mandated right to refuse medical treatment. It can be shown, as argued by Justices Brennan and Stevens, that there is a right to certain liberties under the Constitution, one of which is the right to choose the course of one's life, and it follows, one's death. These liberties protect the right to make choices affecting one's life as long as those choices don't harm others. It can be argued that a family can be harmed by the suicide of a parent who provides for children in the family. However, in the case of a persistently comatose individual, no harm can come to anyone when medical

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[15] Hoefler, Kamoie, Deathright, pg 131.

treatment is withdrawn, since the person has no chance to return to a state where they can provide for anyone.

The third issue is the importance of obtaining proper consent from the patient before withdrawing treatment. The judge of the Missouri Supreme Court and subsequently the U.S. Supreme Court in its majority opinion ruled that the testimony that had been given by the family and friends of Nancy Cruzan had not clearly demonstrated consent to withdraw medical treatment. In some cases, where the individual does clearly have something to lose or has a chance to return to a cognizant state, it would be important to make certain that proper consent had been obtained. In the case of Nancy Cruzan, I believe that the tube could be withdrawn solely on the decisions of the family since Nancy would not want to live in such a manner. This is an accurate estimation. It is easy to argue that few persons would choose to live in a state where they had no ability to know the world around them. Such a person would also not want to burden their family if they were in such a condition that allowed them little or no hope to return to a cognizant state. Nancy had no quality of life to protect, so she would never refuse consent to disconnect the gastrostomy tube. The identity of who she was was lost during the fifteen or so minutes that her brain was deprived of oxygen after the accident. In such a case, the family can choose for an incompetent patient when the interests of the patient are so clear. There is no benefit for continued treatment, so the tube can be removed without proof from a conversation that specifically documents Nancy's wish to refuse treatment were she to enter a state where she had no cognitive function.

It is hard to gauge the effect of the Cruzan case. The Quinlan case arguably had more impact, since it was one of the first cases to receive national attention. The Cruzan Case had been stretched over an eight year period, so it did not have as immediate an effect. It did however set a precedent that showed that artificial nutrition and hydration are not always a basic form of medical care and can be withdrawn to allow someone to die a dignified death in circumstances such as Nancy's.

Deciding for Patients with Chronic Dementia

There are one and a half million patients suffering from some form of progressive dementia in the United States. There are approximately seventy causes, but the most common cause of dementia is Alzheimer's disease.[16] This progressive disease has a long course and is usually fatal with in eight years but can go for as long as twenty-five. The later stages of the disease includes a probable loss of the identity of the patient, and sufferers are frequently unable to remember important events in their lives or those who they were closest to, such as children and spouses. These patients require constant care since in many cases they cannot even complete the most elementary tasks. This disease is irreversible and there are few effective known treatments.

In a case like this, the patient is clearly alive, and can interact with people, to a degree, although some of their mental faculties are damaged due to progressive deterioration of portions of their brain. They cannot remember many specific things but can take part in daily activities with some level of enjoyment. In the later stages, it can be argued that their quality of life becomes extremely poor. Is there a point in the progression of Alzheimer's where euthanasia is a reasonable choice? Does quality of life become so poor that the patient would choose to be euthanized if they could make a competent choice at the time? Can an involuntary decision be made on behalf of the incompetent patient if a painless death is judged to be in their best interest?

In her book *the Least Worst Death*, Margaret Battin explores the alternatives of the care of patients suffering from progressive dementia.[17] She states that a policy that included Alzheimer's as a reason for euthanasia would have wide reaching consequences since this horrible condition affects so many. In such a case, active euthanasia would be the only method possible since the condition has many serious symptoms but is not directly fatal for some time.

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[16] Battin, Margaret P, The least worst death : essays in bioethics on the end of life (1994) New York : Oxford University Press, pg 145.

The action would also be involuntary since the patient cannot give informed consent for the action, beyond a certain point. An exception would be if there were guidelines published in a living will, or if suicide was undertaken shortly after diagnosis as was the case of the Kevorkian aided suicide of Janet Adkins.

In general, one of the principles used to defend euthanasia is the principle of autonomy under which the patient has the right to choose the timing and nature of his or her own death. It can be argued that the Alzheimer's patient lacks such autonomy since besides the ability to make simple choices, the patient is not able to choose a course of medical treatment. To be able to give informed consent, a patient has to be able to understand the medical means to achieve death and the concept of death in general, which the dementia patient may not be able to do. So, unless explicitly mentioned in a living will, autonomy cannot be used to justify euthanasia for the demented patient.

Mercy is another reason why many people accept euthanasia. Is the nature of Alzheimer's, AIDS Related Dementia Complex and other syndromes such that a merciful death is preferable to continued existence? In general, the middle stages of Alzheimer's are not pain-filled and the only significant symptom is the slow, progressive loss of memory. The end stages could be argued to be filled with suffering, as the patient is unable to remember his or her daily activities or loved ones, cannot play games or carry on conversations. Can the patient suffer, as such, when they have such deteriorated mental faculties but are not experiencing physical pain? How severe is the emotional pain of the loss of memories of loved ones, life experiences and the ability to carry on daily routines?

A possible argument that is presented by Battin is that Alzheimer's patients should not be cared for any longer beyond a certain point because they are of no use to society and will not improve. It might argue that there are patients who need care more than Alzheimer's patients

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[17] Battin, The least worst death, pg 145.

and that funds and resources should be committed to patients who instead have a chance to recover to an active state. This is the argument from justice.[18]

There are several policy options for these patients. We could 1) let these patients live until the end of their natural lives and endure the serious mental deterioration, 2) practice passive euthanasia on late-stage patients and give no heroic treatments, or 3) actively euthanize these patients.

One of the indications that I have cited to allow patients to voluntarily choose active euthanasia is for those who are in substantial pain and verbally consent. Active euthanasia may also be chosen for an incompetent patient in pain for whom it is in the best interest, as decided by a second party. The Alzheimer's patient is not suffering in the traditional sense, so it might be hard to argue for active euthanasia.

Passive euthanasia may be a reasonable option in a broader range of circumstances such as for terminally ill patients who are not in pain but who wish to die or for patients for whom life is of no benefit such as a patient in a persistent vegetative state. I believe that Alzheimer's falls into this category. There is little reason to actively euthanize such patients, either by removal of medical means or through a lethal dosage of medication, at least in the early to middle stages, but with their minimal quality of life, there is no reason to invoke heroic measures or advanced treatments such as respirators or aggressive resuscitation.

Active and Passive euthanasia for the Alzheimer's patient

In several cases, I have argued that there is not a substantial moral difference between active and passive euthanasia. They both accomplish similar ends and if death is the proper choice, then the method used is not morally relevant. There are certain procedural differences between the two forms of euthanasia however, and even though not substantially morally different, there are circumstances where one may be more appropriate than the other.

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[18] Battin, The least worst death, pg 152.

Indications for active euthanasia include painful terminal illness and long courses of disease where the removal of medical treatment as a means to achieve death would result in considerable misery in route to death. In the case of Alzheimer's and other severe forms of dementia that are inevitably fatal, it can be argued that one the patient has deteriorated beyond a certain point, that withdrawal of life-support is justified and is appropriate since the patient's course of disease is irreversible and they derive little pleasure from life since they may be unable to carryout any daily tasks or remember anyone from their past life.

It is hard to decide if there is a difference in the circumstances in which active euthanasia may be used. In the case of the patient who requires a respirator, there is little difference between removing the respirator and using a dose of morphine to depress the breathing, since both actions lead to immediate death and are a direct causal result of the physician's actions. Many adult children participate in the decisions regarding their aged parents with advanced dementia. In these cases, there may be a difference in their view of the use of active euthanasia, versus "letting nature take its course." The family may feel that it is wrong to take the life of their parent in the face of terminal deterioration of the brain, but may feel that they are acting humanely in letting their parent die with dignity through the use of passive methods of euthanasia. The family should also be respected in these treatment decisions, so if either of the two methods produces additional positive effects, such as peace of mind for children of ailing elderly parents, then it should be used, since either method can accomplish the same end. In these advanced cases, death may be preferable to a long drawn out dying when the patient loses their identity and dignity. There is not the level of physical pain present as in other terminal conditions, so the patient will not suffer as death comes.

Battin provides two scenarios that illustrate the effects of different treatment decisions for Alzheimer's patients. The first involves a situation in which several criteria have been developed to determine the decline of the mind of the patient. As the end of the disease progression nears, the family is brought in to try to elicit a response from the patient and to attempt to ignite some spark of memory of their past life. The patient is also asked a series of representative diagnostic questions to ascertain the level of decline of the cognitive abilities of the brain cortex. Once the patient is regularly unable to answer such questions and is unable to demonstrate several cognitive criteria on several successive instances, a decision is made to quietly and painlessly euthanize the patient with an lethal intravenous dose of medication. The patient has not consented, but does not know what is happening and is not afraid of the impending death. Under such a policy, the practice of euthanasia of Alzheimer's patients would dramatically impact the nursing home and residential care facility populations.

In the second scenario, the patient is going through the same mental deterioration, but no steps have been taken to hasten his or her death. Over the course of several years, the patient goes from a person who is able to interact and participate in some conversations, but is frequently forgetful; to someone who sits in bed all day, with little response; to a patient who is unable to walk, feed themselves, bathe or control their bodily functions. Death comes several years later with a cardiac arrest in the middle of the night that is not discovered until the next morning.[19]

In many instances, we might clearly choose a painless death for the patient over years of chronic deterioration that ends in a state where the patient cannot take care of themselves. There are several arguments that can be used to oppose this idea. For many areas of ethics related to euthanasia, a principle argument that is often invoked is the slippery slope argument. This rationale states that if we allow a certain type of euthanasia to occur for a certain range of patients, then over time we will allow the categories for euthanasia to expand and eventually there will be groups who are included for involuntary euthanasia that are not justified. Is active euthanasia of deteriorating Alzheimer's patients embarking on a slippery slope that might lead to widespread euthanasia of the non-consenting terminally ill, the mildly demented and the elderly?

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[19] Battin, The least worst death, pg 157.

If we did accept active non-voluntary euthanasia for patients who were beyond a certain level of cognitive deterioration, there would need to be strict controls imposed to prevent the expansion of the use of euthanasia to patients who are at an earlier stage of dementia or for patients who possess other conditions that society might judge as undesirable. In the abstract sense, the slippery slope is a concern but at a true policy level, if there were explicit guidelines that governed what conditions met the criteria, then abuses could be prevented.

It is difficult to think about active euthanasia for this group of patients. Passive euthanasia is easier to think about since to use a passive method, a certain level of deterioration has to have occurred already to a state where the body cannot maintain all functions independently of medical intervention. For active euthanasia, the patient can be stable with no threat of immediate death. In the progressively deteriorating Alzheimer's patient, there are no means to withdraw, so active euthanasia is the only option.

The argument from mercy might argue that it is inhumane to let persons live in a state where they don't remember loved ones, life events and are unable to understand their daily routine. The living will might be helpful in such a circumstance. The early Alzheimer's or AIDS patient can indicate what type of care they desire in the case of severe dementia. If they indicate that in the instance that they have no awareness of their environment and no ability to interact that they want to be euthanized, then it may be morally permissible since it respects their prior autonomy. As of yet, such a practice in most states would be illegal, but if reforms are passed that expand patient's rights regarding death choices, then maybe hard choices to be made for such patients will be easier to deal with.

Conclusion

There are many groups that are commonly included in the contemporary euthanasia debate. One of the most prominent are those who have suffered significant brain injury or are the victims of a progressive disease that has left them in a state of coma or persistent vegetative state. These patients frequently are unable to demonstrate any significant cognitive function or exhibit any voluntary muscle action. They are cared for using the most recent medical technology and in most circumstances can exist in this state for decades or more. These patients are frequently visited by loved ones, but they usually don't know when their family members are in the room. The patient's identity as we know it may be lost forever.

In this chapter we have explored the question of whether there is in fact an ethical rationale for justifying active or passive euthanasia for the comatose or demented patient. The cases of *re Quinlan* and *Missouri Vs. Cruzan* have helped us to see on a state and national level what the prominent issues are with regards to the withdrawal of more advanced medical treatments that would result in the death of the patient. For these patients, does a third party, such as a spouse or loving family have the right to decide on their behalf? Are there circumstances where it is ethical to choose without demonstration of previous formal consent from the affected individual? Additionally we have explored the issues involved in the care of the severely demented patient. What rights as persons do these patients have? Does the fact that they are able to function to a degree, even though their mental faculties are damaged give them a right to life, or is euthanasia justified on grounds of humane treatment after a certain point of deterioration?

These are all difficult questions to resolve. If euthanasia was set into policy for these patient groups it would have far reaching affects since the numbers of comatose and demented patients in care facilities across the country are large. As with many decisions regarding the end of the life of a loved one, these decision are very difficult to think about. Ultimately, when we have to make a decision, we should consider what they would have wanted and what is the best and most humane treatment. If a living will is present, then the patient's wishes should be followed or if there are reliable conversations to document certain wishes, then the ideas contained in them should be used to make the appropriate treatment decisions. In the absence of any consent, we have to make the hard decisions as to what is best for the patient and which options maintain the patient's dignity. The families of both Quinlan and Cruzan were acting in the correct manner since they had an appreciation for who their daughters had been and what they believed they would want in the face of such a tragedy. In the end, the decision that we make should reflect the concern for the type of life the patient is living and should maximize the balance between the interest in the sanctify of life and a quality of life where the patient can have contact with those whom they love and have the types of experiences that make life so worthwhile.

CHAPTER NINE:
TERMINAL ILLNESS, PHYSICIAN-ASSISTED SUICIDE AND THE RIGHT TO DIE

Many years ago, a large number of the people who died in a given year were children and younger adults. Communicable infectious diseases such as Pneumonia and Tuberculosis, infant mortality and major childhood diseases such as Polio were major causes of death in the western world. Today, a majority of these conditions have been virtually wiped out or are able to be successfully treated, so that the majority of the people who die are older, with three quarters of such deaths coming after prolonged illnesses from such conditions as progressive stroke, various forms of heart disease, and cancer.[1] Increasing advances in medical treatments have also enabled medical staffs to treat people with advanced disease who would have died much earlier. Also, today approximately 80% of deaths occur in hospitals, whereas in the early 1900's, most deaths occurred at home.[2]

Because of the shift in these patterns of death in the United States and many other major industrialized nations, it is becoming increasingly important to continue to refine ethical theories to deal with morally difficult situations. Modern medicine has brought forth many changes that have saved the lives of many patients who would have died much earlier. Of those lives that are saved, a great many are happy, independent ones. But some patients are left to suffer in a compromised state as death approaches, often accompanied by the pain and general misery of a terminal condition. Due to these terminal conditions, and the influence of several landmark court cases, there has been an active discussion in the media and the courts about whether there is a right to die, or a right to refuse medical care. Additionally, it can be asked if the patient has the right to choose and to be assisted in suicide by a physician. There are very strong feelings on both sides of the debate with some people believing that the dying patient is

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[1] Battin, The least worst death, pg 59.

[2] Hoefler, Kamoie, Deathright, pg 15.

better served by being allowed to choose a more rapid death, whereas some people worry that allowing a right to die will undermine the roles of the medical profession and lead to a devaluation of human life.

There is a large range of conditions that can produce situations that are wrought with ethical doubt. Many patients across the country who are suffering from incurable cancers are being treated with high dose chemotherapy and radiation with the goal of extending their lives as long as possible, even if for just a few weeks or months. Seniors with inevitably fatal heart conditions are constantly monitored in cardiac care units across the country and may be resuscitated numerous times, even though the chances of these patients recovering to a functional state are extremely small. Are there alternatives to these aggressive treatments for patients such as these? Are there conditions where an accelerated, painless death is preferable to continued treatment?

The Right to Forgo Life-Saving Treatment

Unlike the majority of cases for individuals who are comatose or exist in a persistent vegetative state, individuals afflicted with terminal illnesses generally can voice their own opinions with regard to treatment options. Since many of these patients are able to give informed consent, we need to consider if they have the general right to choose a course of treatment that results in death. Do terminally ill patients have the right to die? Also, in the face of a deteriorating condition, are there other reasonable options to end the patient's pain besides the use of euthanasia or the passive withdrawal of medical treatment such as hospice care or treatment that includes large dosages of potent medications?

As previously argued, a patient's autonomy is one of the most important considerations in formulating treatment decisions. This right to determine the course of one's life and, logically, one's death is more important than other interests such as the rights of other patients to obtain treatment over the patient in question or to satisfy economic concerns. Should their lives be extended above all interests or are there benefits to planning a course of treatment to reduce pain that may eventually lead to a shorter life?

Many people have also defended the right to die through an interpretation of the Fourteenth Amendment of the United States, which guarantees certain liberties, including an implied right to privacy. This right is argued to include the right to refuse life-saving medical treatment, and in some instances has been argued to include the right to choose active euthanasia and assisted-suicide.

There have been several cases involving requests to die that have helped shape the right to die movement. Many people say that there exists a right to die, but it has been argued in some court decisions such as the first Missouri Supreme Court decision in the *Cruzan* case that the state's interest in the preservation of life and the duty to prevent suicide overrides this right. In the case of *Satz v. Perlmutter*, Abe Perlmutter, a 73 year-old ALS patient requested to die due to the progression of his disease and the constant misery associated with being attached to a respirator. He could not move, or breathe without the respirator and even speech required an extreme effort. He was near the end of the course of his disease and would have died soon, whether the respirator stayed in or not. He tried to disconnect it once and tripped an alarm that brought people to reconnect it. He said to them, "no, I'm miserable, take it out, I want to die."[3] The trial judge who heard the case was worried that Mr. Perlmutter would suffer during the time that it would take him to die after the respirator was removed. He said, " It can't be any worse than what I am going through now."

The State of Florida, in its case to block the removal of the respirator stated four reasons for its case against Perlmutter's right to have the respirator removed: 1) The interest in the preservation of life, 2) a need to protect innocent parties, 3) a duty to prevent suicide, and 4) a requirement that it help maintain the integrity of medical practice.[4]

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[3] *Satz v. Perlmutter*, Contemporary issues in bioethics. Beauchamp and Walters, pg 256-57.

[4] *Satz v. Perlmutter*, Beauchamp and Walters, pg 256-57.

The court ordered in this case that the tube be disconnected from Mr. Perlmutter and he be allowed to die. The judge stated that Mr. Perlmutter had a right to privacy and a right to refuse lifesaving treatment.

In this case, I agree with the decision of the Florida Court of Appeals which affirms the decision of the trial judge who ruled that none of the criteria presented by the state overrides the rights of Mr. Perlmutter to choose on his own behalf. He has a right, using the Kantian principle of autonomy, as has been extensively argued in this paper, to choose his own course of treatment, even if it ends in a premature death. He is in a constant state of misery and has the right under the right to privacy to choose to die. Some people equate such a choice with an action of suicide, and as a result reject the right to refuse medical treatment. It is tough to know if this concern is valid. The issue of refusal of care and the choice of euthanasia as they relate to suicide will be examined later.

Objections to the Right to Die

- An objection that is often given in opposition to the right to die is that if we allow people to choose to die when they want to, some people who are not competent to decide might be allowed to make decisions that are not consistent with what they would truly want if they were acting with full autonomy, or with what is in their best interest.

It has been argued that those who are clinically depressed would seek death as a way out. In the Netherlands, there have been cases where clinical depression has been reported as a primary motive for assisted suicide or euthanasia. As I have argued in a previous section on informed consent that appears in chapter five, refusal of care or active euthanasia should only be allowed for those patients who demonstrate clearly that they are of sound mind. To allow a depressed patient to choose death is not respecting their autonomy. They are not thinking clearly and if they we given help to overcome their clinical, chemical-based depression, then they might come to different conclusions about how to deal with their suffering.

This is a valid objection and one that, at a policy level, would need to be safeguarded against. Before a request for death is allowed, a psychiatric evaluation should be done to determine if the patient's autonomy is intact and to decide if the decision that they are making is a fully voluntary one. This problem of requiring fully informed consent does not in and of itself preclude an ethical appraisal of the right to die.

• In some circumstances, patients might choose treatment options that don't appear to be in their best interest. Are we justified in overriding the wishes of a fully autonomous patient when they have made a decision that may not be in their best interest? Many people have argued that the right to autonomy includes the right to make decisions regardless of what others think. While this can be debated, we can agree that the patient has a right to choose and not to be coerced into making a decision. If they are able to make an autonomous decision but have chosen incorrectly, we should strive to given them additional information and counseling so that they will hopefully come to realize what is in their best interest and make the choice on their own.

In the case of children and those who may not have fully intact mental faculties, we are justified in using some paternalism to choose for them. They may not be able to understand or are too young, so they need protection and some decisions can be made that are judged to be best for them. Most young children, if given the choice to receive injected immunizations would not choose them, but we exercise a level of paternalism to encourage them to have the immunization since it is in their best interest.

•A criticism of the right to die that is given by Leon Kass of the University of Chicago in his article *Is there a right to die*? is that if we were to grant a right to die to patients in terminally ill states, then it would put pressure on the medical profession to provide the means of death and this provision of such means would lead to a devaluation of the concept of the sacredness of life that is so central to the profession.[5] This objection has been given by many

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[5] Kass, Leon, "Is there a right to die?" *The Hastings Center Report*, Vol. 23, no. 1, January-February, 1993, Briarcliff, NY, pg 37.

with regard to euthanasia. It relies on the belief that the physician's primary responsibility is to prolong life and to actively end lives is to contradict this role. One of the physician's roles is also as healer and reliever of pain, which is just as important by some accounts as the prolongation of life.

Instead of devaluing the medical profession, the respect of a right to patient self-determination can, when used properly, be used to enhance it. There can be an increased understanding of how to treat dying patients and we can encourage a belief in the importance of a standard of a certain quality of life, not only the prolongation of life at all costs.

• One of the largest objections that many people give when discussing a widespread right to die is the belief that by allowing terminal patients the right to choose death when they are miserable, the use of the right to forgo treatment will extend to other groups by means of a slippery slope and the sanctity of human life will be devalued. Kass states that there is a concern that advocates not only want to establish a right to die, but to encourage some groups then to exercise such a right and to "prepare for the practice of the termination of useless lives."[6] He worries that by allowing a belief in a right to die that the "hard-won ethic in favor of life," will be damaged and that children of parents who are not "dying fast enough," physicians disgusted with caring for incurable patients, hospital administrators and insurance companies attempting to minimize costs and those who feel that the resources of the young should not be spent on the "virtually dead" will campaign for the ending of these undesirable lives.

As with other slippery slope arguments, the possibility for the slide does not imply that it will happen. If there was an established right to die that was recognized by the medical and legal professions, the limits of its use could be defined as are many other medical protocols. An example that was provided in an earlier chapter is the development of protocols to allow persons to choose to donate their organs after they die. The choice of these patients is supported by autonomy and the decision should be respected after the patient's death. A possible abuse of this right to choose might be the establishment of a policy that requires people to donate organs. This requirement might go against many personal and religious beliefs and would violate respect for persons. There also might evolve a belief that there is a duty to donate organs or a belief in a slide to involuntary organ harvesting of the newly dead. An extreme example is given by the book *Coma*, by Robin Cook, in which undesirable patients are killed during surgery to take their organs since there has developed such a strong need. Obviously, this does not happen, and such a worry was not a deterrent to a policy that could help many people and give the power of choice to the person who may choose to donate.

Similarly, there might be a worry that there might be coercion to accept euthanasia or the use of involuntary euthanasia to satisfy rationing concerns or at the extreme end, to deal with the problem of over population. These possible abuses are not serious concerns, since if policy is developed to ensure voluntary decision making, then there will not be extreme abuses. Slippery slope arguments have not prevented organ donation that benefits others and these concerns should not prevent the right to die that can benefit the person who chooses it. The right to die could be abused like other rights, but if used properly, the benefits generally outweigh the risks.

Additionally, the concern that an individual right to die would extend to involuntary euthanasia is not necessarily a bad thing in certain circumstances. In some cases like *Cruzan* and *Quinlan*, the somewhat involuntary withdrawal of life support was in their best interest, so recognition of a right to die would help to prevent the continuation of lives that are either accompanied by relentless pain or are already over. For those patients who are not candidates for euthanasia, there would need to be controls implemented to avoid abuse.

Is there a duty to die?

One objection that has been used to oppose a widespread right to die is the belief that a perception would develop that there exists a duty to die for certain patient populations. It is argued that the elderly and the poor might be made to feel as a result of societal pressures, that

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[6] Kass, "Is there a right to die?", pg 36.

beyond a certain age and quality of life, they would be under an obligation not to continue their lives. They might be made to feel that they are too much of a burden on their families and on society, so they should not pursue aggressive treatment beyond a certain point.

In several cultures there are practices in which elderly members frequently commit suicide or refuse treatments in the face of impending death. In some Eskimo traditions, once elderly members feel they have outlived their usefulness, they will frequently leave the village and go out into the cold to die, never to be seen again. They do this not only to prevent a painful death as their health deteriorates, but also to relieve any burden that they may impose on the younger generations. In earlier centuries in Japan, the aged were taken to mountain tops to die and in areas of ancient Greece, the sick whom early doctors were unable to cure were offered suicide or euthanasia.

As in many areas of the discussion of euthanasia, there is the question of a slippery slope for this argument. This possible duty of the very ill and the extreme aged to die could be a step down a slope that might lead to the unregulated involuntary euthanasia of the elderly population and those with largely non-terminal illness. Is the slippery slope argument reasonable? Are we able to make choices to enact a policy in one area without it extending into a new range of possibly undesirable circumstances?

The possibility of the existence of a duty to die is a difficult subject to resolve. Certainly, the greater numbers of aged patients and pressures to reduce the amount spent on health care may contribute to this idea. A large percentage of the nation's health care dollars are spent caring for the elderly. There is a belief by some that in the event that there is a shortage of access to care, funds should not be spent on the old and the dying.

This belief is then internalized by older patients who may be made to feel that they have little right to be taking the resources that they are. In general, I believe that it is unethical to deny people care based on their age or other factors. This is chiefly because it does not respect them as persons. They are still competent, cognizant individuals who have a right to life.

Additionally, they have personhood and so it is wrong to euthanize them or to coerce them into accepting less medical care.

This duty to die can also be extended to a policy of health care rationing that includes exclusion of the elderly. Some argue that the elderly can no longer contribute to society and should be the first to be refused care when it is scarce. The majority of health care would be given to younger people who have the perceived potential to advance society to a new level. Margaret Battin argues that in many circumstances, the elderly have already made substantial contributions in the earlier phases of their lives and thus deserve support. In some cases, their previous contributions may be greater than the potential contributions of the young.[7]

If we are in fact going to assert a right to die, we have to be clear about what this means. The right to die would give individuals meeting certain medical and psychiatric criteria the right to choose the nature in which they die. They would be given the chance to refuse treatment that they believe only extends their suffering or to be allowed to consider active euthanasia or assisted-suicide in certain circumstances. If we accept these rights, we also have to accept certain responsibilities. There needs to be a thorough evaluation of the cases in which the right to die is appropriate so we can avoid abuses that might stigmatize the elderly or the sick who wish to fight their illness. They have the right to choose the course of their treatment and also the right not to feel that they are being coerced into a decision that they do not want. The right to choose the type of medical treatment also includes a right to choose not to die. The patient has the right to choose the timing of his or her passing, and has the right to be allowed to make such a decision independently.

Defenses of the right to die

In light of the above objections, we need to ask if there is indeed a right to die, and if it is a morally permissible action. As has been previously argued, patient have the right to decide

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[7] Battin, The least worst death, pg 61.

the course of their own medical treatment, even if it shortens the length of their lives. How would the major theories evaluate a right to die?

From a Kantian standpoint, we can defend a right to die in the face of suffering on several grounds. The first principle that can be applied is respect for persons. If we deny a patient the right to choose the course of treatment, then we are not respecting them as a person, but merely as a means to our own ends, whether it be to maintain a belief in a religious prohibition of a right to die or to keep us from grieving from the loss of a loved one. Additionally, we should honor their decisions through a respect for the principle of autonomy. If the patient is able to make rational, informed decisions and is thus acting with autonomy, then we should respect their wishes. However, respecting autonomy is not equivalent to doing whatever a patient asks, but is the action of respecting rational decisions that are made by a person who is able to give fully informed consent. When a patient makes a request to die, the informed voluntary quality of such a request should be examined to prevent suicide that is not the result of a rational, informed decision.

Using a utilitarian calculus, if we evaluate the specific act of the right to die due to a poor quality of life, in most instances we can allow voluntary death for a patient when the quality of life does not produce net utility when weighed against the interests of all involved. For a terminal cancer patient with only weeks to live who is miserable and for whom continued therapy only prolongs death, we can assert that they have a right to choose not to prolong dying. They may have a family, but the family derives little benefit from their prolonged dying and may be at peace once the patient has been released from her suffering, so their death will increase utility.

It can probably be assumed that from a theological standpoint that people do not have the widespread right to choose death. Several writers have stated that life is either a gift from God or only on loan to us from God, so in either case, it is wrong for us to end it ourselves. They argue that God is the only one that can determine when to end life and for us to do so is to "play God."

In some circumstances, it is hard to decide what is the will of God. In some cases, such as the use of aggressive treatment for certain illnesses that are ultimately fatal, we may have arguably gone against God's will in treating these patients using modern medical advances, since, if we reason along these lines, God has caused the condition and the untreated person would have died by God's will. If we treat aggressively, then we have gone against this will, so if we allow death to occur, then we are actually allowing God's original plan to continue. In some cases, a right to die may in fact follow God's will, since Catholic doctrine has stated that in some circumstances, extraordinary treatments are not required.

After evaluating the right to die with several theories, I believe that we can in many circumstances justify a right to die. Due to a belief in a possible slippery slope that might allow people to be coerced into making decisions for euthanasia or might lead to involuntary euthanasia, it is important clearly to define in specific language under what circumstances people have the right to die. It can be argued that there exists a right to die for patients when the course of disease is terminal and continued treatment only prolongs a painful death. In circumstances of progressive diseases that leave the patient with little or no function or dignity, such as ALS, and in cases where the patient may not be terminal for a period of time but is in continual pain and must experience painful treatment to fight a losing battle against disease, this right can also be supported. These parameters need to be firmly established to guard against patients who may be pathologically suicidal, uninformed or unable to understand the course of their disease choosing to die. We also need to have guidelines that prohibit the taking of lives through coercion from physicians or family members or through involuntary euthanasia without patient consent.

Hospice and Comfort Care as an Alternative to Euthanasia

Modern traditional medicine, also known as allopathic medicine, seeks to fight specific diseases using scientific principles and to extend patients' lives for as long as possible. It has shown remarkable progress in some areas over the years, but still cannot reverse some events, such as profound brain damage or heart failure. Some of the treatments to combat illness, such as invasive surgery or chemotherapy may cause additional pain and discomfort to the patient, while only extending lives for a short time. Some scholars feel that modern medicine is successful at treating specific illnesses, but is not especially successful at treating people as a whole. Doctors, to protect themselves emotionally and through the socialization of the medical profession, often become detached from their patients and cannot deal with the dying patient's emotional problems as well as their physical ones.

There is another philosophy of medicine that can be employed in the care of terminally ill and dying patients that places comfort and control of pain as paramount to the extension of life. This type of care is commonly referred to as hospice care, also called comfort care or palliative care. There are many hospices across the United States. It is a relatively new movement, having started in England in the 1960's with the founding of St. Christopher's Hospice in London.[8] In most hospices, the emphasis is on relieving pain and giving comfort to the patient in his or her final months or days. Emotional counseling is also available for the patient and his or her family. There is no treatment given to combat the progression of the underlying disease, which is chiefly the focus of traditional medicine. Using a comfort care philosophy, the whole patient is treated and priority is given to the quality of life and level of pain, even if it shortens the overall length of the patient's life.

Hospice care is often delivered in a residential facility or may be given in the patient's home. Care can be coordinated between the primary care physician and the hospice nurses and social workers. Hospice ideas can also be used in an acute care hospital, but this option is usually only offered by physicians when all aggressive treatments have failed, and the patient is near death.

In both traditional and comfort care approaches, there are certain trade-offs. In traditional medicine, more painful, more invasive methods are used with the goal of extending the patient's life a short time longer. In hospice, the length of the patient's life may be shorter,

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[8] Quill, Death and Dignity, pg 77.

but they will not receive painful aggressive therapy; instead, they will receive treatments to limit the level of their suffering. The shortening of the patient's life can be justified using the doctrine of double effect, which was discussed in chapter five, since the primary motive is to lessen pain, not directly to shorten the patient's life.[9]

According to Dr. Timothy Quill, there are certain definite advantages to hospice care for patients over traditional medical approaches. The same effort that is used to extend the patient's life can be directed at treating the patient's pain and improving quality of life for the time before death. Also, the patient is treated as a whole person instead of narrowly focusing on aggressively treating the underlying illness. Quill says that in the intensive care unit, medicine's most extreme circumstance, painful measures may be used to monitor the patient and keep death at bay for a short time. In the ICU, the disease is the primary focus. In the hospice setting, the person is given intensive patient care, which may be preferable for the dying patient even if death comes sooner. All measures that don't directly contribute to the patient's comfort are discontinued, even if they hasten death. [10]

For some doctors, comfort care is seen as a threat to traditional medicine. Their training has stressed aggressive treatment of disease and prolongation of life. It should be the patient's choice whether he or she wants to fight for every last minute of life, with some pain from treatment, or if they want to choose peace, with the loss of a little time. In regular settings, doctors have to worry about dosages of narcotics when treating those in extreme pain, since these drugs may hasten death or cause addiction. In hospice care, since alleviation of pain is the focus, larger dosages can then be given to deal with intense pain.

In some circumstances, hospice is a clear advantage to continued aggressive medical care. Withdrawal of treatment can be done in a hospital, but hospices seem to be better

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[9] Quill, Death and Dignity, pg 78.

[10] Quill, Death and Dignity, pg 78.

equipped to deal with the emotional aspects of the patient's dying process.[11] As with a euthanasia decision, where death is sought directly, hospice care should only be an option when death can be known with a reasonable amount of certainty. If treatment for the disease is discontinued and only pain control measures are used, then all hope for recovery is ended. Hospice may be a viable alternative to euthanasia for some patients. For those who do not wish to die immediately but want relief from extreme pain and are not afraid of hastening their death, then hospice is an alternative. The point of this paper is not to argue for euthanasia to be performed in certain situations, but to argue for the patient's right to choose it as an option at the end of their lives.

In some cases, hospice treatment may actually be double effect euthanasia. The patient may have decided to discontinue all treatment besides pain medication. The dosage required to alleviate pain to the point where the patient is comfortable may bring death fairly rapidly, so death is hastened, even though the primary motive has been to treat the pain.

In some circumstances, hospice is a method of treatment that can be highly effective and can allow patients to die with dignity and in a state that is relatively free of pain. The emotional counseling received can also be very beneficial to both patient and family. In some circumstances however, it is not enough. There are certain types of pain that are not relieved completely by medications. Emotional pain that is rational as a result of the disease process can also take a great toll on the dying. In many circumstances, hospice can provide a viable option to the patient who wants to be free of pain but does not want to die immediately. In other circumstances, it cannot deal with all pain, so the patient may still choose euthanasia or physician assisted suicide as the next step in their treatment.

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[11] Quill, Death and Dignity, pg 79.

The Right to Choose Assisted Suicide

There has been much national media coverage over the years on the subject of Physician assisted suicide. Most reports have involved the activities of Dr. Jack Kevorkian or Dr. Timothy Quill, who proscribed a lethal dosage of medication to a leukemia patient named "Diane". Quill was subsequently indicted by a jury but no formal charges were eventually brought in the case.

If we have decided that by the principle of autonomy patients have the right to choose to forego life-saving treatment, we can ask if this right should be extended to choose physician-assisted suicide, also called physician-aid-in-dying. Are there differences between a patient either consenting to the removal of artificial medical treatment or even voluntary active euthanasia and choosing physician assisted suicide?

The ideas that are used to justify choosing to refuse different types of medical care, namely the right to use autonomous decision making and the right to privacy, can be used to argue for the right to choose assisted suicide. If there exists a right to choose active euthanasia in some circumstances, then it can be argued that there exists a right to choose PAS in similar cases. I would support this choice in some instances but there need to be strict controls to regulate the practice and to insure that the consent is fully informed and that the choice is fully voluntary.

There are many people who argue that PAS is not substantially morally different from active voluntary euthanasia. In active euthanasia, the patient chooses to die and the physician carries out the request. In PAS, the patient chooses to die, and the physician provides the means, but the patient ultimately carries out the action. In both cases the patient has made the choice and the physician has been a causal agent in the action. There are some people that feel that PAS is very different than active euthanasia, since the patient takes his or her own life instead of the doctor. There is a stigma attached to the word suicide, whereas some people are willing to think about euthanasia or at least withdrawal of medical treatment. In my view, there is little moral difference since the suicide could not be performed if the physician had not provided the means in the first place. For a Kevorkian aided suicide, the lines blur even further. He has frequently been present during the suicides and has helped his patients with the action. In the beginning of his practice, Kevorkian used a device dubbed by the press as the "suicide machine." This contraption consisted of an intravenous line hooked up to three vials of fluid. One vial contained a harmless saline salt solution, one held a sleep inducing agent and the third was filled with a paralyzing agent to stop the patient's breathing. Kevorkian inserted the IV and started the flow of the saline. The patient then pushed a switch that changed vials to start the dispensation of the lethal agents. Kevorkian's involvement was pretty major in these circumstances, since he was present and provided more direct means to death, instead of purely giving a prescription for the patient to take at home.

Dr. Timothy Quill is the other major physician to be in the headlines for assisting in a patient's death. As mentioned above, he helped a leukemia suffer to die following a refusal of painful chemotherapy when it was determined that she had less than a 25% chance for long-term survival. He has defended this action and Diane's right to choose it on several grounds. He does support the patient's right to choose, but indicates that there needs to be a strict method to determine whether it is an appropriate choice in certain circumstances.

Quill also states that in some cases, PAS is preferable to active euthanasia since the physician and the patient are nearly equals in the process, with patient making the full choice and being at less of a risk for coercion that might make the decision less than fully voluntary.[12] This is a questionable distinction. In appropriately used cases of both voluntary euthanasia and assisted-suicide, the patient should be acting in a fully voluntary fashion. If not, then there is the same potential for abuse in either circumstance. Were the physician to offer pills to a potentially suicidal patient or provide excess morphine for the same patient, he would be guilty of the same injustice of not insuring the voluntary nature of the request. Likewise, if the patient consents voluntarily for euthanasia or takes excess medication proscribed by a physician in a

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[12] Quill, Death and Dignity, pg 159-160.

fully voluntary manner, then both instances are equivalent. PAS and voluntary euthanasia have the same potential for compassion and for abuse.

One of the first statements that Quill makes in his section on PAS in *Death and Dignity* is that PAS should only be an option when a patient has been confirmed to be suffering a terminal condition with no hope for recovery to a pain free state, where they can enjoy life in any reasonable capacity. As with euthanasia, the choice to utilize PAS is final. Quill also states that a patient has to have exhausted all comfort care options to be a candidate. He is a strong supporter for hospice based care, which can in many circumstances give the dying patient relief from pain and provides emotional support throughout the process. If such patients either do not receive adequate pain control from hospice care or have other legitimate reasons for wanting an immediate death, such as constant misery and an unwavering wish to die independent of clinical depression, then PAS can be considered.[13] We might additionally consider PAS for a patient who is experiencing an extremely poor quality of life, but will not die within a short period of time. These patients may be in extreme pain and passive euthanasia would not be an option since the disease could go on for a long period of time. In considering such patients however, we need to examine the prognosis to determine that the disease is incurable and gives such a miserable quality of life that continued existence would subject the patient to intolerable suffering.

Quill offers six criteria that must be fulfilled to consider PAS as an equitable medical choice. He states that he supports a review of the policy towards PAS, but wants it to be used only in circumstances when all other treatment options have been explored first and then only after a long process of thought and close consultation with a physician whom the patient knows well.

The criteria are as follows: Quill's requirements are in italics, with my comments following. All are from Quill's Book, *Death and Dignity*.[14]

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[13] Quill, Death and Dignity, pg 157.

[14] Quill, Death and Dignity, pg 161-165.

1) *The patient must, of his own free will and at his own initiative, clearly and repeatedly request to die rather than continue suffering.*

This requirement is based on the need for fully voluntary decision making. To be honored, the request for assisted suicide must be determined to be fully voluntary. There cannot be any coercion by the physician, family or hospital staff. This request must also be constant to demonstrate that the request is true and is not the result of temporary sadness or loneliness that may change with time or effective counseling or medication. Many terminal patients go through periods of sadness or depression. This depression may be physiological and can be treated. The only way that a request for assistance should be honored is if it is a rational, constant choice on the part of the patient.

2) *The patient's judgment must not be distorted.*

This is related to the above requirement. The patient, to insure that the request is true, needs to be free of clinical depression or dementia. These states can change the patient's viewpoint and may not be an accurate representation of the patient's autonomous feelings. If the treating physician is not qualified to diagnose either of the above states, he or she should seek a consult to establish whether the patient is competent to request aid-in-dying.

3) *The patient must have a condition that is incurable, and associated with severe, unrelenting, intolerable suffering.*

The use of assisted suicide should be restricted to conditions that are either associated with incurable ailments or for persons who are in extreme pain, or those who are not physically suffering but have an extremely poor quality of life such as an ALS patient. If there is a doubt regarding the patient's prognosis, a second opinion should be sought to determine whether there is a reasonable chance of recovery. The ailment does not have to be immediately terminal as long as the patient is acting voluntarily and there is not a reasonable hope for a cure.

4) *The physician must ensure the patient's suffering and the request are not the result of inadequate comfort care.*

PAS should be an option only when other support measures have failed. If the patient can live his or her final days in the care of a hospice where he or she can be pain-free and receive support, then PAS may not be reasonable. Once the level of pain has grown too great or the daily misery too much, then the right to choose PAS may be a reasonable one.

5) *Physician-assisted suicide should only be carried out in the context of a meaningful doctor-patient relationship.*

This is a key requirement. The patient should have a long-standing relationship with the physician, or at least have received a thorough evaluation and some counseling through several sessions before it becomes reasonable for the patient to request aid. Many critics of Kevorkian's methods have said that he acts unethically since he has no long-standing relationship with those whom he helps to die. The provision of drugs to bring death is a tough decision on the part of both parties and should only be made in the context of ongoing treatment for the illness. The patient should not seek out the physician solely for the purpose of helping death come. Quill criticizes the idea of clinics that would offer aid-in-dying to patients as their sole function. Also, a relationship between doctor and patient is useful since the physician has an interest in the patient and can help him or her to discuss other options besides assisted death to determine if the patient has fully thought out the decision.

6) *Consultation with another experienced physician is required.*

There can be many doubts when it comes to the professional judgment of one physician. In light of such a final decision, there should be a consulting physician to examine the patient to determine the extent of disease, to determine the voluntary nature of the request and to make sure that all treatment options have been satisfactorily discussed.

7) *Clear documentation to support each condition above is required.*

There must be documentation to establish the completely voluntary nature of the action and to absolve the physician of any claims of coercion or help in arriving at the decision to terminate the patient's life. Also statements should be made to distinguish the medical suicide from ordinary suicide for reasons not related to terminal disease progression.

In states where physician assisted suicide is legal, such documentation would be acceptable and patients and physicians could sign a consent form for the activity. In circumstances where the open use of PAS is not legal, such overt documentation would not be practiced, since if subpoenaed by a jury, the evidence provided by such documents could lead to the conviction of the physician under the charges of murder, manslaughter or other lesser crimes. In the case of Quill's assistance of his patient Diane, he has stated that he met all of the above criteria that he would advocate for a policy that allowed PAS to be legal except for the documentation of the agreement of the provision of the lethal dosage of medication. He was indicted for his role in the suicide, but the jury subsequently dismissed the charges. He stated that in Diane's medical records he documented her refusal of treatment for the leukemia but there is no mention of the suicide, to protect Diane and her family.

Is Physician Assisted Suicide an Ethical Choice?

After the presentation of Quill's criteria that should be met for the use of PAS, we need to ask if it is a morally permissible action. How would the major ethical theories evaluate PAS? In order to illustrate the types of cases that may be justified for physician assisted suicide I will present the case of Diane, the leukemia patient whom Quill helped to die.

Dr. Quill and Diane had an eight year relationship as physician and patient. She had experienced many previous health problems, including treatment for vaginal cancer as a young woman and a battle against depression and alcoholism in her later years. She had also come to rely on Dr. Quill as a source of emotional support as she fought to rebuild her life. She came to him on one occasion complaining of frequent tiredness and she presented with a sizable rash. On a hunch, he did a blood count and it yielded results consistent with leukemia. Both he and Diane hoped that it was an infection, but a follow up exam confirmed the finding and a peripheral blood smear showed myelocytes, a certain type of abnormal white blood cell her suffering for good. He did ask that she meet with him before she took her life so they could talk and make sure all of the options had been explored, and she agreed.

After a while, the bone pain, nausea, and persistent fevers consumed her days. She had to choose whether to be sedated or deal with continual pain. After a period of time, she came to see him and they talked. She told him she had decided that she could no longer tolerate the intense suffering and was ready to die. She thanked him for his concern for her level of suffering and said good bye. Two days later, Diane's husband called to say that she had died. She had asked her son and husband to leave for an hour and when they returned, she lay still on the couch, wrapped in her favorite shawl. Dr. Quill came and called the medical examiner to report that a hospice patient had died. When he inquired of the cause of death, acute leukemia was reported. It was accurate, but it was not the whole truth. To report the suicide would bring a coroner's investigation with a possible autopsy and possible prosecution for the doctor or the family. It was questionable if what they had participated in had violated several moral and legal rules, but Diane had been able to have control over the way she died and was able to retain her remaining dignity.

From a Kantian point of view, we might be able to argue that PAS falls within the range of treatments that the patient is allowed to choose. Autonomy would allow the patient the right to determine their own life. However, we need to differentiate the rational suicide for reasons of misery or certain death from other forms of suicide, since, at least by his own personal feelings, Kant believed that suicide in general was wrong, based mostly on religious grounds. Through deontology, we can defend suicide for medical reasons. We have defended the right to choose active and passive forms of euthanasia and by many accounts, assisted-suicide in justified circumstances is ethical since it respects the patient as a person.

Since Utilitarianism is a consequentalist theory that believes that the consequence of an action is the only important consideration, PAS could be thought of as an ethical medical choice if the patient's death produces more utility than their continued existence. The use of PAS would be no different from active euthanasia, since under utilitarianism they both have the same outcome. A distinction that may impact this case, which was made in the second chapter, is that of act versus rule utilitarianism. The act utilitarian makes decisions based on a utility calculus for the individual circumstance. For Diane's situation, the act utilitarian might accept her suicide since her painless death added to utility since she ended her pain, retained her dignity and her family did not have to witness her deterioration beyond a certain point. The rule utilitarian however might reject her use of suicide. Suicide as a class of actions can produce some effects that are negative to those involved. The suicide destabilizes society and can detract from the emotional and financial stability of the larger group. Even if Diane's suicide did bring results that bring greater pleasure to she and her family, the action will have violated a moral rule that prohibits suicide.

Most theological points of view prohibit the taking of one's own life, regardless of the reason. It is hard to know when this first became a common belief. St. Thomas Aquinas, a leading theologian in the eleventh century wrote that suicide was wrong since life is a gift from God and we don't have the right to end it. Despite this belief, there are several areas in the Bible where people commit suicide to prevent suffering that might be used to defend PAS. When Saul's armies were defeated by the Philistines and he was wounded in the stomach by an arrow, he asked his armor bearer to kill him with a sword to avoid torture. When he refused, Saul fell on his own sword and died. This decision by Saul is not judged as being wrong by the scriptures in this passage. After Saul's death, seeing that they had been defeated and knowing he would surely die or be tortured, the armor bearer also took his own life.[15] These suicides were only undertaken after it was apparent that all hope for victory was lost and to avoid torture. The same idea might be extended to rational medical suicide, since it should only be allowed after all effective treatments and palliative care measures have failed.

No matter the origin of the belief in the wrongness of suicide, today the doctrine of the Catholic Church prohibits suicide and most religious people, if asked would say that suicide is wrong, since God has given life and we have no right make the decision to end it ourselves.

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[15] Battin, The least worst death, pg 207.

But, like Saul, can we draw a distinction between suicide in ordinary circumstances and for those when all we have to look foreword to is misery?

While I do feel that in general we should strive to prevent ordinary suicide that does not stem from a request related to a poor quality of life, whether due to depression or for other reasons, there may be times when a person's life is not of a quality that the person should be forced to continue living. PAS is one method that can be used to end suffering to give a patient control over the course of his or her final days. It may not be substantially different from active euthanasia which has been defended for certain circumstances in earlier chapters.

Quill supports PAS in certain well regulated circumstances when all of the above criteria have been fulfilled. There have been several cases in the media that he objects to and he believes that these actions, such as the zealous activism of Jack Kevorkian, hurt the chances for patients to be given the right to choose the way they die by state or federal statutes.[16] The first objection that Quill raises with regard to Kevorkian's practice is that he lacks the background to effectively diagnose patients. He is a pathologist by training so he has not treated patients since very early in his career. Due to this fact, he cannot properly evaluate the patient's condition and he cannot determine whether they are competent to decide. He also fails to give patients other options such as comfort care. Quill says the he is primarily treating these patients out of activism, not out of singular concern for their welfare. Since he is pursuing the legalization of PAS, he is unlikely to offer other options. Since he does not in many cases have a long-standing relationship with the patient, he has little emotional investment in these patients and may see them principally as a means to accomplish his ends. With Kevorkian's method, there are few safeguards. In some cases, he has not fully certified the terminal nature of the disease or verified that the choice is fully voluntary. There was even a case that was reported in which he was helping a patient to die who changed his mind as the suicide was proceeding. He took off the mask which was delivering the lethal carbon monoxide gas and asked to stop the

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[16] Quill, Death and Dignity, pg. 124-125.

process. Kevorkian reportedly talked with him and convinced him that it was the right choice and told him to keep going, and the patient subsequently died.

Many people, myself included, feel uncomfortable with the methods of Kevorkian. He frequently helps patients die in a motel or in the back of his Volkswagen van, not in a hospital or hospice where other options can be discussed and the nature of the disease can be evaluated before the final decision is made. There is room for discussion about PAS, but it should be in a medical forum, not in the press as the result of the actions of a retired doctor who does not even possess a medical license. (It was revoked by the State of Michigan in 1991.) The activities of Kevorkian hurt the chances of assisted suicide to become a reasonable medical choice for dying patients who want to exhibit some choice as to how they will die. This section is chiefly about the right of the patient to choose assisted suicide as a means to escape suffering. The role of the physician in euthanasia and assisted suicide will be more extensively discussed in the next chapter.

Differences Between Rational Suicide and Other Types of Self-Induced Death

In the quest to justify PAS as a legitimate choice for the terminally ill patient whose pain cannot be completely relieved by comfort care, it is important to differentiate the right to choose death in the face of illness when death is certain, or in the case of a very poor quality of life versus a general right to commit suicide. In our culture, the term suicide has many negative connotations associated with it. This may be due largely to the Judeo-Christian belief that suicide is wrong. As mentioned above, even Kant broke from his primary philosophical method to argue against suicide, believing that it was a crime against God. He said, "This duty of self preservation is upon us until the time comes when God expressly commands us to leave this life. Humans are but sentinels on Earth and cannot leave until relieved by another beneficent hand."[17]

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[17] Battin, The least worst death, pg 216.

Also as previously argued, suicide in the Kantian sense violates the principle of respect for persons since the person uses him or herself as a means to escape certain circumstances such as physiological depression or loneliness. But, in the case of extreme suffering, to deny the person the right to die is to use them as a means to another end, instead of respecting their right to be free of intolerable pain that is unrelieved by hospice treatment.

Additionally, suicide as a general practice can be refuted by an interpretation of the Sanctity of Life Principle which holds that all human life is sacred. In previous chapters, this view of the sanctity of life has been accepted, except in cases where the patient's quality of life is severely diminished and in those cases in which continued care only prolongs an agonizing death. In the absence of terminal suffering or misery for a non-terminal condition where continued survival is not found to be preferable to the course of suffering, choosing one's death should not be allowed.

It is important to recognize that a medical condition might not be the only reason that can be used to justify rational suicide. An example of a rational suicide might be given by prisoners in the Nazi concentration camps who committed suicide once they learned the true nature of the death camps. They knew that their death was nearly certain and they only had torture and suffering to look foreword to. In many ways, their suffering might be judged as equivalent to that of a cancer patient, since they were victims of constant physical suffering and dehumanization at the hands of the Nazi S.S. and were in effect, terminal, since many of the Jews did not survive the Holocaust. Using the principles I have laid out, these people may have been justified in taking their lives instead of enduring constant torture that only lead to a nearly certain death.

M. P. Battin asks if there is a widespread right to suicide in her book *the Least Worst Death*. There is no law preventing suicide by an individual but aiding a suicide is illegal by statute in 36 states.[18] In some circumstances, we can argue that persons have the right to

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[18] Battin, The least worst death, pg 277.

In the case of the cancer patient, she has lived a long life and her life has little potential to contribute anything substantial anymore. She is physically suffering and wants to die. This request is rational given the nature of her pain and it has been shown to be of a constant nature, as demonstrated by her saving of the pain medication over a long period of time. Some people speak of a general prohibition of suicide and subsequently allowing certain exceptions such as in this case. Instead of making exceptions to a prohibition of a class of actions, we should seek to define a new class of actions. We can differentiate the rational suicide by a patient who has a poor quality of life and little potential to contribute to society or the concentration camp prisoners above and the non-rational, possibly pathological suicide. These people may be suffering from a loss of a loved one or have a psychological condition that makes them suicidal. In these cases, the person may not be acting with full autonomy, so their suicide is not a rational choice. The allowance of suicide in the second example would be wrong, since the person uses him or herself as a means to escape the pain of rejection. Additionally, such a desire to die may not be constant over a period of time, since after few years or months of time, the person may have better accepted the rejection.

A Kantian idea that also helps to distinguish between the medical and non-rational suicide is the idea of human dignity.[20] This principle says that all persons have a level of worth that they have as a part of their identity. This idea of worth should be defended. Dignity is also defined as a quality that makes a person worthy of respect. A decision should not be made that defames the person's dignity. In the case of the cancer patient, she is suffering and it can be argued that she has lost a great deal of dignity in the face of a prolonged death, so to allow her to take her life would be respectful of her dignity. The rational suicide, whether for medical reasons or others, such as the example of the death camp prisoners, if it is justified with a person who meets certain criteria and is acting voluntarily, can help to preserve dignity. If the person in the second case is granted the right to commit suicide, then they will not be respected

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[20] Battin, The least worst death, pg 282.

and their worth as a person will be decreased. The non-rational suicide clearly takes away the person's dignity in the face of an unjustified death.

Conclusion

The right to choose the type of medical care that a person is to receive or refuse has been an important part of the modern patient's rights movement. Previously, doctors practiced in a paternalistic manner, doing what they believed was best for their patients with little discussion. Little interest was given to the patient's ideas since it was presumed that the doctor knew best. Informed consent has become an important part of modern medical care and many people have argued that to appropriately treat the patient, the physician must obtain the patient's input. As a result of these changes in patient consent and the many advances of modern medical technology have brought forth many people that assert that there is a right for patients to choose their own treatment path, including a plan that leads to a premature death in the face of physical suffering or in a low quality of life. These rights are supported by a belief in the right to privacy and due process of law and by a common law right to refuse life-saving treatment.

Included in the right to die debate is not only the right to refuse treatment or choose active forms of death, but the right to choose physician-assisted suicide as an option in the event of incurable disease or extreme pain. There are several groups that have lobbied for the legalization of PAS and active euthanasia in states such as California and Washington. PAS is currently legal in Oregon, and in Michigan, Dr. Jack Kevorkian has narrowly evaded charges in the majority of the 27 cases in which he has been present in patient deaths, despite a law prohibiting PAS[21] Arguments for the lifting to the legal prohibition of PAS contend that it is not substantially different than other forms of beneficent treatments that hasten death, and some

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[21] His trial for the 1993 deaths of two patients, Merien Fredrick, 72 of Ann Arbor, Michigan, who had Amyotrophic Lateral Sclerosis and Dr. Ali Kali, 61 of Oak Park, Illinois. who had bone cancer, began on February 20th, 1996.[21]Kevorkian was subsequently acquitted since the jury believed that Kevorkian's primary motive was to relieve the patient's suffering, not to bring death.

even argue that it is preferable to euthanasia since the choice is more the patient's and as a result, there is less risk of coercion or abuse by physicians or families.

Several movements have supported alternatives to death in the face of terminal illness. The hospice movement advocates treatment for pain and emotional support in lieu of continued treatment to fight progressive incurable disease. In some instances, it can be argued that in the face of pain, hospice care can be used effectively to treat patient's discomfort and this option should be fully explored before a hasty decision is made to invoke euthanasia or seek assisted-death. In the some circumstances though, hospice care may not offer the level of treatment that is necessary and the patient may wish to choose death over a life of pain or continual sedation. In these instances, under controlled conditions, there are many arguments that successfully support patient's rights to choose a painless release from misery. The right to privacy and the duty to respect the autonomy of the fully voluntary patient who requests death supports the right to choose to die as a reasonable option in a limited number of carefully evaluated circumstances. The frequent objections to a right to die correctly express concern for a slide into policy that might support the involuntary killing of patients or the death of individuals that are not acting with full autonomy. If there are not controls to determine the correctness and voluntary nature of these activities, then there is the potential for great injustice. If these options are used correctly, however, they have the potential to give peace to many patients who would otherwise be sentenced to months or years of misery. We have a liberty right to protect our lives and we should have the same rights to determine when and how we die.

CHAPTER TEN:
THE PHYSICIAN AND EUTHANASIA

Previous chapters of this paper have supported the competent patient's right to choose euthanasia and physician assisted suicide in certain controlled circumstances. I have also argued that there exist certain cases in which it is ethical to hasten death for incompetent patients who are comatose, or are in circumstances where they are unable to consent due to the lack of a decision making history, but where the choice is in their best interest, as is the case with extremely critically ill newborns. In many of these circumstances, it is ethical to make decisions regardless of the level of consent, if it is judged to be in the patient's best interest. Once we have taken the position that it is ethical for patients to choose euthanasia in controlled cases, or for family members to decide for them, we have to ask if the physician or other health care members are ethically allowed to participate in the action of hastening the deaths of their patients. I have differentiated the taking of life for beneficent reasons for terminally ill patients and for those who are comatose with no hope for recovery, from the broad class of actions of killing for non-beneficent reasons or for reasons of self-interest. Even so, if the patient has the right to choose death as an alternative to suffering, is the physician allowed to provide it? Additionally, it can be asked if the physician is actually required in certain circumstances to provide aid-in-dying. Arguments might be made that if euthanasia is in the best interest of certain patient groups, then following the belief that the physician is bound by duty to provide for his or her patient's best interest, the physician may be obligated to provide euthanasia. In what circumstances, if any would a doctor be required to respond to a request for euthanasia or assisted suicide?

Many people have opposed euthanasia on the grounds that it would be contrary to the goals for which the medical profession stands. They state a concern that if doctors were allowed to practice euthanasia then they would become licensed killers and the respect that the medical profession has for the sanctity of human life would be lost. On the other side, there are those people that believe that compassion for the dying and a strong belief in quality of life should be an essential foundation for ethical medical practice, so the inclusion of euthanasia in certain controlled circumstances may be to the benefit of the profession, not a detriment.

Are the Hippocratic Oath and the practice of euthanasia incompatible?

One source that is often quoted when discussing the ethics of the physician in medical practice is the famous Hippocratic Oath. This document and the accompanying Hippocratic Corpus were written by the Greek physician Hippocrates about 400 B.C. and was until recently, routinely taken by all graduating medical students as they started their careers. It is no longer required at some schools due to personal or religious objections.[1]

A well known statement that is often associated with the oath, but is not actually in it, is the directive which instructs the physician to "do no harm". This directive follows from the principle of nonmaleficence that was presented in chapter two. Many people have taken this directive to be a direct prohibition against killing one's patients, which is not necessarily a conclusion that follows. For a patient who is terminally ill or is comatose, ending their life may not be letting harm come to them, since their death is either inevitable, in the case of the terminally ill, or has already ended for all practical purposes, in the case of the irreversibly comatose. Additionally, the patient who has substantial pain is arguably experiencing harm, so not responding to that pain may be letting harm come to them. As argued in the previous chapter, it is preferable under most circumstances for the physician to offer the terminal patient comfort care measures before considering euthanasia or assisted suicide, but once the patient's suffering has gone beyond a certain point or palliative care is not appropriate, as with those who exist in a persistent vegetative state, euthanasia that is performed by the physician may be called for.

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[1] The Use of the Hippocratic Oath, a review of 20th century practice and a content analysis of oaths administered in medical schools in the U.S. and Canada in 1993, Orr, Robert and Norman Pang. Http://ccme-mac4.bsd.uchicago.edu/CCMEPolicies/medcodes/hippo.

There are several passages of the *Oath* that deal with questions regarding euthanasia and physician assisted suicide. One states "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."[2] This would be judged by most as a direct prohibition against PAS and active euthanasia. One problem with this statement is that the prohibition may conflict with additional duties of the physician which are also implied by the *Oath*. Included is a requirement which stipulates that the doctor should make decisions that reflect what is in the best interest of the patient. This duty to protect the patient from harm and to alleviate suffering competes with the duty to refrain from directly seeking death. In the case of the pain patient or the permanently comatose patient, which duty is stronger, the duty to prolong life at all costs or the duty to alleviate suffering or respect dignity?

For the dying patient, it can be argued that the duty to alleviate suffering is stronger when aggressive medical interventions only prolong death. According to Dr. Timothy Quill, in some cases, rather than prolonging meaningful human life, medicine often prolongs a painful death when it follows what is perceived to be a directive from the Hippocratic Oath to prolong life in all circumstances.[3] The extension of the life of the dying patient is only desirable when the quality of life they enjoy is of a high enough quality to merit such aggressive treatment by the physician.

As Drs. Robert Orr and Norman Pang point out in their article concerning the changes in the Oath over the years, throughout the history of the oath there have been many versions of the text that have been recited.[4] There have been versions written to include the Christian faith instead of a polytheistic Greek structure, and even versions that word their stance on euthanasia and abortion less strongly than the original. However, the new versions still include a

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[2] The Use of the Hippocratic Oath, a review of 20th century practice and a content analysis of oaths administered in medical schools in the U.S. and Canada in 1993, Orr, Robert and Norman Pang. Http://ccme-mac4.bsd.uchicago.edu/CCMEPolicies/medcodes/hippo.

[3] Quill, Death and Dignity, pg 43.

prohibition of active euthanasia. A section of the new text from the *A.D. 1995 restatement of the Oath of Hippocrates (Circa 400 B.C.)* reads:

> I will follow that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither proscribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform any act or omission with direct intent deliberately to end a human life. I will maintain the utmost respect for every human life from fertilization to natural death. . . . .[5]

The complete text of this new version describes, in more specific language than the original, which actions the physician is required to carry out and which he or she is ethically prohibited from engaging in. The new statement still prohibits active euthanasia, PAS and more 'active' forms of withdrawal of life-support like the previous version. Even with this specific language, there is still room for interpretation when it comes to the role of the physician in life-and-death decisions for those who are comatose or terminally ill. There are some aspects of the statement that might be considered contradictory in the light of the view of medical treatment as outlined in previous chapters of my paper. The new version of the oath states that the physician should make decisions regarding treatments that are beneficial to the patient. In the next line, it has a strict prohibition of the use of medications or acts or omissions of medical means to end life. This is contradictory, to some degree. It can be well argued that omissions of care that are intended to bring about death can often be in the patient's best interest. Since the *Oath* instructs the doctor to act in such an interest, then it can be argued that the use of some methods of euthanasia is justified. I have also argued against a relevant moral distinction between acts of euthanasia and omissions of medical treatment, since they both lead to the death of the patient. As a result, it can be argued that in some cases, if the physician is allowed to omit certain forms

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[4] The Use of the Hippocratic Oath, a review of 20th century practice and a content analysis of oaths administered in medical schools in the U.S. and Canada in 1993, Orr, Robert and Norman Pang. Http://ccme-mac4.bsd.uchicago.edu/CCMEPolicies/medcodes/hippo.

[5] "A.D. 1995 Restatement of the Oath of Hippocrates," Http://ccme-mac4.bsd.uchicago.edu/CCMEPolicies/medcodes/

of advanced or basic care, then in the same circumstances he or she is allowed to let the patient die painlessly through more active methods such as a morphine drip.

In some circumstances, such as in the *Quinlan* and *Cruzan* cases; the suffering of Timothy Quill's patient Diane; for Andrew Stinson, the baby who was born 16 weeks premature and is mentioned in chapter six; and for many others, life may not be in their best interest. If the physician is supposed to act in the patient's best interest, then in some cases, this duty would be precluded by the widespread prohibition of euthanasia and PAS. Dr. Quill felt that Diane's choice for suicide was in her best interest since she no longer had any hope for a cure after her refusal of treatment for acute leukemia, and only had continual pain to look foreword to. Quill questioned his own moral position on the issue of providing the barbiturates, but in the end, he gave Diane the prescription and had decided that it was acceptable since she was suffering so severely. There are many instances where a speedy death without pain is in the best interest of the patient, so the physician may not be prohibited from providing it. There is a duty for the physician to prolong life for as long as possible, but in cases like Diane's, this duty is precluded by a duty to care for her welfare and to end her suffering, if she so chooses.

Another ethical problem is that the oath does not directly mention any concern for the quality of life that the patient enjoys. Many people would argue that such a concern should be a cornerstone of compassionate medical practice, so not allowing patients and concerned families to plan for the patient's comfort is not compatible with a mandated respect for the patient as a person. The last line of the above excerpt states that the physician should have the utmost respect for human life for human life from birth to *natural* death. In several instances, such as when patients are being kept alive on respirators and are being fed by gastrostomy tubes with no potential to return to any level of cognizant activity, or for patients who are in substantial pain due to progressive terminal illness, the death that follows may not be a natural one. These patients are in no way being allowed to die a natural death since they live only because of the constant aid of higher medical technology. For Andrew Stinson, a natural death would have occurred shortly after birth when his underdeveloped lungs could no longer support him. He was instead placed on a respirator and developed many problems related to his aggressive treatment regimen. In many cases, aggressive treatment is justified and should be pursued when the patient's chances for a reasonable quality of life are good. In other circumstances though, the patient should be allowed to die a deliberate, merciful, and natural death.

The *Oath* states: I will abstain from whatever is harmful or mischievous." This statement has a correct motive since it seeks to prevent abuses in some circumstances where the patient has not fully consented or when it is not clearly in their interest to die sooner rather than later. In such circumstances, euthanasia and PAS should not be allowed. There definitely needs to some safeguards to insure that physicians are acting responsibly, but on the other hand, there should also be some room for interpretation regarding end of life issues, when compassionate decisions can allow the patient to die with dignity and to be out of harm's way.

The Medical Profession and Euthanasia

Besides the perceived violation of the Hippocratic Oath by an action of euthanasia or assisted suicide by the doctor, many people feel that the involvement of the physician in euthanasia and assisted suicide breaks many codes of professional ethics. The American Medical Association, which represents approximately 600,000 physicians nationwide, has released several statements that denounce the participation of the physician in active euthanasia, which it refers to as 'mercy killing.' What is the basis for this prohibition? Is it justified for a doctor, under professional ethics, to kill a patient for beneficent reasons? Is the euthanasia decision different since it is from a beneficent motive or is it still an unjustified, wrongful killing? Does the duty of the physician to alleviate the patient's suffering override the duty to extend lives in certain instances? Are there certain methods of euthanasia that ethics codes deem more acceptable than others?

In a summary statement of the 1989 current opinions of the Council on Ethical and Judicial affairs of the American Medical Association, regarding the treatment of patients and the use of euthanasia, it was stated that the primary social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail.[6] It also goes on to say that in circumstances where the patient cannot choose or has not left any explicit instructions with family or physician, then a decision must be made by the family in conjunction with the doctor.

Despite the advancement of the treatment of the topic of patient autonomy and the right to refuse treatment, the passage below is still consistent with earlier statements in its preference for passive withdrawal of extraordinary methods over use of active euthanasia. It states:

> For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause any death. . . . Even if death is not imminent but a patient is beyond doubt permanently unconscious and if there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging treatment. Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or permanently unconscious patient, the dignity of the patient should be maintained at all times. . . . . Unless it is clearly established that the patient is terminally ill or permanently unconscious, a physician should not be deterred from appropriately aggressive treatment of a patient.[7]

This current statement clearly reflects new thought by the AMA regarding the issue of euthanasia and the patient's right to choose it in the environment of modern medical practice. In light of *Cruzan* and other cases, the AMA has revised its statement to include, in specific language, the allowance of not seeking to prolong death in circumstances of immediate terminal illness or persistent vegetative state, which can be argued to be nearly equivalent to permanent unconsciousness, along with the right to refuse treatment. The AMA, however still prohibits

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[6] "1989 current opinions of the Council on ethical and Judicial affairs of the American medical association." Prepared by the council on ethical and judicial affairs, American Medical Association Chicago. Illinois.

[7] "1989 current opinions of the Council on ethical and Judicial affairs of the American medical association." Prepared by the council on ethical and judicial affairs, American Medical Association Chicago. Illinois.

the use of active euthanasia or the participation of the physician in acts of assisted suicide. This "direct causing" of death is stated by the AMA as being dangerous to the core of the ethics of the medical profession, and yet, they are allowing physicians to participate in more 'passive' acts of euthanasia. These actions are viewed by some as only allowing death to take its course, when in fact they are not substantially different from more 'active' forms. In many cases of withdrawal of treatment, the physician arguably acts in a very direct manner to end the patient's life, even though he does not use lethal medicines.

Is it the motive of the physician which matters to the AMA or the method used to hasten death? Why is it deemed acceptable for physicians to relieve suffering through certain methods, but not to seek death directly? How can the medical profession and the courts differentiate actions with regard to humane treatment at the end of life, and determine the intention of the physician? Also how can such an intention be determined? How can we know if the primary motive was to hasten death or ease suffering?

If there is a difference to the AMA in the directness of the causation of death, how can an acceptable level of action to hasten death be determined and is it morally relevant to draw such a distinction regarding active versus passive methods? In several chapters I have argued that there is little or no philosophical difference between active and passive methods of euthanasia. There are circumstances where either method can be used appropriately. What should be examined is not the method of how the physician delivers the patient from his or her suffering, but the intention and the corresponding level of consent from the patient. The AMA should rethink its distinction between what it terms "removal of medical treatment to relieve suffering" and direct "mercy killing." In many cases, there are instances where these apparently passive methods of euthanasia are fairly direct. The removal of a respirator can be treated as a direct action with a death that occurs in a matter of minutes after its removal. It is just as active as a dose of morphine, and the morphine overdose may be more humane since the patient is not suffering as he or she dies and is not starved of air.

The AMA also needs to define the term "intentionally causing any death." If it embarks into allowing physicians to make certain decisions regarding the relief of suffering, then it should define what level of intervention into the dying process is acceptable or abandon the distinction between active and passive methods and its pretending that the removal of life-support is not a direct taking of life. It should also recognize that the removal of extraordinary means is an action that intends for death to come, instead of only seeking to end suffering. If it feels that it is not ethical for physicians to take life directly using drugs, then it should also reject the active withdrawal of medical technology. If it does in fact support the hastening of death for patients in certain circumstances, then it should recognize that there are cases where the use of active means can be appropriate. But if these methods are allowed then the circumstances should be carefully controlled and take place only in a hospital or clinic setting, not under the jurisdiction of the non-physician who lacks the proper training or motivation to judge what options are the best for each patient.

The American College of Physicians Position on Euthanasia

Another group that represents many doctors is the American College of Physicians. In its 1989 ethics manual for physicians, the organization devoted several sections to the conduct that it deems appropriate for physicians to partake in regarding removal of life-support, euthanasia and assisted suicide. It recognizes that with current advances in methods of care and patient's rights, that these circumstances are considerably more prevalent than they were years ago. It says that considerations about initiating or foregoing life-sustaining treatment arise most frequently in patients who are severely and critically ill, permanently unconscious or suffer from irreversible cognitive or physical impairment. These cases (about which the law varies from state to state) frequently present perplexing clinical and ethical challenges to patients, physicians and families.[8]

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[8] The American College of Physicians Ethics Manual (1989), the American College of Physicians, Philadelphia, PA, section 5.0.

There are several instances in its 1989 report in which the American College of Physicians discusses and supports the physician's role in certain types of euthanasia and withdrawal of life-support. The first is for comatose patients for whom recovery is unlikely. These patients are not terminally ill and do not meet the whole brain death definition for determination of death. They also do not experience deep physical pain. The document states that in the event that there is clear evidence of the patient's wish not to continue to live in such a circumstance, the physician has a duty to uphold such a request. The statement then discusses the withdrawal of advanced medical technologies such as respirators, renal dialysis and intensive care nursing for such patients. It also discusses the removal of antibiotics, and artificial nutrition and hydration when patients continue to live, such as were considered in the *Quinlan* and *Cruzan* cases, respectively. The board recognizes the difficulty of such decisions and supports the physician's right to make decisions regarding the patient's welfare in consultation with the family.

This is an appropriate statement regarding the treatment of patients in persistent vegetative state. These patients have little or no chance to return to a functional state and in accordance with the wishes of the family, the physician is allowed, and it can be argued, even required to terminate life, as such. The patient is already gone, and the physician has a duty to respect his or her patient's dignity.

One concern is the idea that the physician be given the final say in the decision. As has been extensively argued, the patient has a right to choose the course of treatment, even if it ends in death, and similarly, families of incompetent patients have a right to choose those options that are in the patient's best interest on their behalf. The physician has many obligations concerning other types of care, so he or she has a duty to uphold the patient's and family's wishes, at least for passive forms of euthanasia. The question of whether the physician is obligated to provide a variety of methods to hasten death when it is in the patient's interest or due to a request for death will be examined later.

The next group considered by the ACP are those patients with various cognitive disabilities including the severely demented, the unconscious with uncertain prognoses, and the mentally retarded. They indicate that they believe that in such circumstances, physicians should not make quality of life judgments in case they should lead to discrimination based on age, status of disability, or to satisfy economic concerns. The physician is obligated to care for such patients until such time that a consensus can be reached by the patient's previous statements or the family makes a decision, or their prognoses more firmly establish themselves.

This statement also reflects the principles for care that have been presented elsewhere in this work. The autonomy of these patients may not be fully intact, but they still retain a certain degree of personhood, so the physician has a duty to care for them as long as they do not develop any significant medical problems unrelated to their cognitive deficits.

Another situation that is discussed by the ACP is the use of the do not resuscitate order by the medical professional. The statement suggests that there are circumstances in which cardiopulmonary resuscitation is not recommended since it may be contrary to the patient's best interest. They state that the purpose of CPR is to prevent sudden death in patients who have a condition that is not terminal and where death is not expected with reasonable certainty. For certain terminal patients or the permanently unconscious, CPR is not indicated and a published DNR order can help guarantee that the patient receives the correct range of treatment and does not suffer needlessly. Because of the emergency nature of CPR and the necessity to make quick decisions in the event of a cardiac arrest or episode of respiratory failure, decisions regarding the use of the DNR order should be made in advance. When it is discussed with the competent patient beforehand and the order is found to be an appropriate medical decision, or it is decided that the use of CPR would merely prolong dying for the incompetent patient, then the use of the DNR order can be considered ethical.[9]

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[9] The American College of Physicians Ethics Manual (1989), the American College of Physicians, Philadelphia, PA, section 5.06a.

Regardless of the conclusion reached in the above active and passive euthanasia debate regarding the physician, the physician's use of the DNR order can be defended for certain patients. In circumstances where resuscitation would only prolong a painful death or comatose condition, it can be ethically withheld from the patient. Even the Hippocratic oath would probably not find fault since the physician does not actively hasten death, but only allows it to proceed to its natural conclusion since without the medical technology the patient would have died of the arrest. This is hard to resolve though, since some still might argue that the doctor has acted by not acting and that he or she has a duty to use CPR. The possibly resulting compromising condition and the effects of the resuscitation itself might bring the patient significant real harm. In the case of DNR, it is true that nature is taking its course, whereas with the removal of a respirator, the patient is alive, then the tube is removed and death occurs as a direct result of the action. The use of CPR on the other hand is definitely a heroic medical measure, so if the patient is in such a condition where resuscitation would only prolong death, then the physician is not only allowed to order it, but to see to it that, in the correct circumstances, CPR is not used.

The next step from the DNR order is the withdrawal of other advanced medical treatments such as respirators, renal dialysis, blood products and antibiotic administration. The organization recognizes the right of the patient to decide whether he or she desires the use of such treatments under a right to exercise autonomy, and for the incompetent patient, such decisions are allowed to be made for the patient, provided they follow appropriate channels with the family and with regard to the patient's wishes. Such decisions must either proceed directly as a result of an advance directive or from family members, in consultation with the physician, when it is recognized to be in the patient's best interest. In addition to the withdrawing of more advanced treatments, the ACP also recognizes that there are circumstances where the withdrawal of artificial feeding and hydration are ethical choices. They state that there is an emerging clinical and legal position, possibly as a result of *Cruzan* and other national cases, in which the use of such means are not entirely different from other forms of medical treatment. In the case of persons who are permanently unconscious, two conflicting notions exist. One is that in the case of a patient who has not made his or her wishes known previously, the doctor is not required to sustain the patient with such means since they have no capability to return to a functional, cognizant state. The opposing belief holds that by withholding fluids and nutrition, physicians are contributing to the death of non-terminal patients and this action sets a dangerous precedent for other groups of vulnerable patients. In deciding between these two positions, the physician must exercise his or her own judgment as to what is morally permissible and should seek guidance concerning the law in his or her locale.[10]

The majority of this statement reflects the principles that have been set forth in this paper. I have argued that in several cases, the withdrawal of life-support and the cessation of extraordinary means, either from an advance directive or as a result of the demonstration of a clear best interest for the patient is consistent with the ethical practice of the physician and supports a belief in respecting the patient's dignity.

In contrast to the statements made about the withdrawal of treatment by the ACP, the college follows the AMA's position active euthanasia as stated by the Council on Ethical and Judicial Affairs. It states:

> 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. . . . . 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. Physicians should draw a firm line between the foregoing of life-sustaining interventions, (sometimes called "passive euthanasia" and medical killing, (sometimes called "active euthanasia," mercy killing or assisted suicide.) Medical killing would involve the administration of a lethal agent (such as a deliberate overdose of morphine) to a patient with the clear intention of causing the patient's immediate death. Although a patient may refuse medical intervention and the physician may comply with this refusal, the physician may never intentionally and directly cause death or assist a patient to commit suicide. Active euthanasia remains illegal in all jurisdictions of the United

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[10] The American College of Physicians Ethics Manual (1989), the American College of Physicians, Philadelphia, PA, section 5.06a.

> States. Even if legalized, however such an action would violate the ethical standards of medical practice.[11]

This consistent belief in the difference between the omission of treatments such as respirators and the use of morphine or other similar agents to cause death is misplaced in discussing the conduct of the physician, as it is when discussing euthanasia in general. If the patient has a right to choose passive euthanasia, then he or she also has the right to choose more active methods. This statement says that the use of active euthanasia is clearly homicide, and it maintains a clear difference between such acts and omissions of medical treatment. This distinction is problematic since it would also be judged to be manslaughter or possibly even homicide for someone to remove a respirator with intent to kill apart from a medical concern, so in beneficent cases, if removal of the respirator is acceptable, then the use of morphine or similar agents should also be acceptable. In the case of a greedy adult child who removes a respirator from an ailing elderly parent to facilitate the release of inheritance money, this action would be judged as seriously as an active form of killing. Similarly, if the physician is allowed to remove a respirator from a beneficent motive, then they should allow the patient to die painlessly by active methods of euthanasia.

It can be argued that one reason that the AMA and the ACP maintains a prohibition of the use of active euthanasia by the physician is that such actions remain illegal in the majority of the 50 states. There have been several laws passed at the state level that deal with the use of living wills. These laws allow for the withdrawal of treatment according to a patient's wishes and leave some room for interpretation as to what means may be withdrawn. In addition, assisted suicide is allowed in Oregon and a law prohibiting assisted suicide has expired in Michigan and has allowed Jack Kevorkian to continue his activities, although he is not a licensed practicing physician any longer.

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[11] The American College of Physicians Ethics Manual (1989), the American College of Physicians, Philadelphia, PA, section 5.07.

The above statement still rejects the use of euthanasia independent of legal grounds and states "Even if legalized, however such an action would violate the ethical standards of medical practice." So what else makes the use of active euthanasia immoral besides the law, when the active withdrawal of medical treatments is acceptable under certain circumstances?

This statement, that the use of active euthanasia would be wrong independent of legal concerns is not a justified position to hold based on philosophical grounds. It may be more of a personal statement from the physicians who lead the group. It is legitimate for the AMA and the ACP to prohibit physicians from participating in currently illegal actions, but to state that, independent of legal concerns, there is a substantial difference between the use of active methods and passive methods is not grounded in sound moral theory. The physician has an obligation to provide for his patient's welfare, and in the case of the terminal cancer patient for whom active euthanasia is the only method of deliverance from suffering, it is wrong to deny that patient the right to die based on personal moral concerns. Additionally, if these groups allow active withdrawal of life-support, they should also allow active, humane euthanasia. If they seek to prohibit one method, they should not allow the other, since on moral grounds, independent of legality, active and passive euthanasia are nearly equivalent actions when practiced with similar motives under similar circumstances.

A concluding section in the manual of ethics of the ACP deals with what they view as the ultimate responsibility of the physician in the physician-patient relationship. They state:

> The primary responsibility of physicians is to apply medical knowledge to help patients identify and achieve their medical goals. Medical goals frequently sought by patients and [treating] physicians may include prevention of disease, cure of disease, prolongation of life, relief of symptoms, restoration of function, and at times, the withdrawing or withholding of medical treatment.[12]

The statement goes on to say that the nature of the physician patient encounter depends on the nature of the disease and prognosis, the values and preferences of the patient and physician, and the social, legal and economic constraints on possible choices. It requires that

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[12] The American College of Physicians Ethics Manual (1989), the American College of Physicians, Philadelphia, PA, section 6.0.

physicians take certain responsibilities in caring for patients in life or death situations. The physician should obtain the wishes of his or her patient regarding preferences in the event that the patient loses his or her autonomy, preferably documented in up to date advanced directives. The physician must also in the case of incompetent patients with no indications of previous preferences, seek to find appropriate decision makers to speak for the patient. The statement also says that the physician is obligated to respect the wishes of the competent adult patient or to respect statements made clearly in current living wills.

Both the statements from the AMA and the ACP have updated their language with respect to issues related to care for patients near the end of life. Both recognize the right of patients to choose their own care and also require that the physician be an active participant in the formulation of treatment decisions. The ACP statement leaves more room for more active withdrawal of treatment when it is in the patient's best interest. The prohibition of active forms of euthanasia, mostly influenced by the statements of the AMA are problematic, both philosophically and procedurally since they rely on a largely morally irrelevant distinction. If the ACP will allow fairly active withdrawal of treatment such as the discontinuation of respirators and artificial nutrition and hydration, then it is trivial to prevent the beneficent hastening of death by painless active means for patients with no reasonable expectation of a decent quality of life.

The distinction between active and passive methods of euthanasia as they affect the role of the physician in treatment will be examined in further detail later on in this chapter.

Major Philosophical Theories and the Physician and Euthanasia

The role of the physician and euthanasia has been commented on by many sources such as the AMA, the ACP and the Hippocratic Oath. They all prohibit the doctor from performing active euthanasia, but leave room for discussion of passive euthanasia, whether through specific language or from an interpretation from sections that direct the physician to care for his or her patient's welfare and treat in a manner that it consistent with the patient's best interest.

After evaluating the physician's role in treating the dying or comatose patient using codes of ethics, we can evaluate the physician's role in euthanasia using the major ethical theories of Kantian Deontology, Act and Rule Utilitarianism and from a Catholic theological prospective. These theories may be more successful in justifying the legitimate medical use of euthanasia and allow us to critique euthanasia independent of the AMA. Additionally, it is hard to know what percentage of the physicians whom the AMA represents feel this way. It may be a personal feeling by the leaders, or may represent fundamental moral imperatives.

Kantianism

One of the core beliefs of Kantian Deontology is a belief in the respect for persons and a respect for individual autonomy. Under Kantianism, we have shown that the patient has a right to choose to not prolong suffering. Using Kantian theory, does the physician have the right to hasten death when the patient requests aid in dying? The special duties that are inherent in the physician-patient relationship mandate that the doctor provide the appropriate level of treatment for his or her patient as defined by the Hippocratic oath and other codes of ethics. Does this responsibility also include the withdrawal of life-support, the provision of active euthanasia or the giving assistance in requests for rational medical suicide in the face of intolerable suffering?

Kantianism would clearly prohibit killing on a large scale, since the action violates the first and second forms of the categorical imperative. We cannot extend the killing of individuals to a situation where everyone will be killed to satisfy a certain non-beneficent interest. Additionally, killing people in general clearly violates respect for them as a person. For euthanasia and assisted suicide however, these circumstances are different from the widespread killing of the innocent or aiding the suicide of non-terminally ill persons. If the physician has a duty to respect the patient as a person and to uphold the patient's right to autonomy, then the respecting of a wish to die is consistent with the duties implied by the physician-patient relationship. Several groups would argue that there exists a duty for the physician to prolong the life of his or her patient as long as possible. This is true, but he or she only has this duty if the life in question is worthwhile and the patient is free of intense suffering or existence in a persistent vegetative state.

Under Kantianism, even if we were to reject the use of active and passive euthanasia for the conscious, terminally ill patient, we would still be able to rationalize the use of euthanasia for the permanently unconscious. As has been argued previously, these patients have lost all of the elements that previously defined their personhood. Even if it is wrong to kill a person, it is still acceptable to let these patients die since they are not persons anymore under a Kantian analysis.

It is true that we cannot rationalize the killing of innocents for non-beneficent reasons under Kantianism. Euthanasia however, is defined as the termination of the lives of those who have a painful medical condition or exist in a comatose state for reasons of mercy, thus euthanasia and assisted suicide cannot be considered under the same analysis as other forms of killing. Under Kantianism, the motive is one of the most important factors in determining the correctness of an action, and the use of euthanasia, when used correctly, is from a beneficent motive and represents either the informed will of the patient or the desire to carry out actions that are consistent with their clear best interest. If it is not possible to establish the best interest of the patient and the beneficent motive of the physician, than the use of euthanasia is unjustified. If these factors can be certified, then the use of euthanasia under certain circumstances can be justified using deontology.

Utilitarianism

As has been previously explained earlier in this paper, utilitarianism makes its ethical calculations on the basis of maximizing utility for all persons involved in a given situation. For certain circumstances, it can be argued that there are cases in which the death of the patient maximizes utility. In the face of intolerable suffering, or a permanent coma, the patient's continued existence does not add to utility and the interests of the family and society are harmed, as is the dignity that the patient had before they entered such a state. If, under utilitarianism, the patient can be allowed to choose euthanasia and assisted suicide, then under the same circumstances, is may be ethical for the physician to provide the means of death.

Under a broad utilitarian calculus, killing in general would be viewed as wrong since as a class of actions, murder and other types of killing detract from utility. Is the outcome of a euthanasia decision sufficiently different to be accepted apart from a prohibition of killing from a non-beneficent motive?

The suffering of terminal patients, critically ill infants and the existence of the comatose whose lives are devoid of dignity can be argued to be clearly decreasing utility. The correct action would be one that maximizes utility, which in this circumstance, would be satisfied by allowing the death of these unfortunate patients. Killing as a broad class of actions causes many harms and usually decreases utility. Murder deprives the victim of further enjoyment of life and deprives their families and society the joy of knowing them and reaping of benefits from their abilities. For the terminally ill and comatose, they can provide few if any of these benefits. The comatose consume resources and their continued existence undermines the dignity that they deserve, and the pain that is accompanied by terminal illness has negative effects on the patient and his or her family. In these states, they also contribute little to society.

Under these circumstances, the outcome of the actions of the physician who provides a beneficent request for euthanasia or physician assisted suicide maximizes utility, so they are allowed to undertake such an action.

One problem with the use of utilitarianism to justify the physician's participation in euthanasia is that the circumstances that the physician is allowed to provide the means for death might be broader than with other theories. In some cases, it could be argued that the involuntary euthanasia for those who are less than terminally ill or the temporarily comatose with or without their consent may maximize utility. But contrary to this, it can be argued that the patient has a right to control his or her own fate and to be protected against involuntary euthanasia unless they voluntarily choose it or it is judged to be in their best interest. In this circumstance, Utiliarianism should be rejected as a theory to determine the obligations of the physician regarding the use of euthanasia. The rights of the patient and a respect for autonomy should be the most important consideration here, not the balance of utility as it affects all persons involved. Kantian theory correctly supports a position in which euthanasia decisions are made that are in accordance with the patient's expressed autonomous wishes or with their demonstrated best interest.

The physician has a duty to uphold this right and utilitarianism might judge otherwise, saying that the euthanasia of the ill elderly or the very young maximizes utility, independent of patient consent or demonstrated best interest. There are situations where the compassionate hastening of death by the physician reflects a decision that increases utility. There are also circumstances where decisions that maximize utility violate the patient's right to life. Because of these concerns, utilitarianism may not be the most effective theory when used on its own to evaluate this problem. It is useful in making arguments that allow physicians to hasten death in the face of decreased quality of life, but it may also support decisions that don't view the patient as the center of treatment decisions, instead considering other patients, economics, and society at large. This is not consistent with ethical medical practice which requires that the physician be an advocate for his or her patient and to make treatment recommendations that are in the patient's best interest.

Theology and The Physician and Euthanasia

Theologians have stated time and time again that killing under a majority of circumstances is wrong. One of the chief reasons is that under several interpretations, God has given life and it is immoral to end it and to "play God." If killing is wrong as a class of actions under a theological analysis, are there any instances where the physician is allowed not to prolong life? There have been statements made by the Catholic Church that support the withdrawal of extraordinary means but denounce euthanasia. Where can the line be drawn where treatments can no longer be withheld?

In the Quinlan case, the parents, who were devout Catholics, never considered the withdrawal of the artificial nutrition and hydration that their daughter was receiving, since they believed they were part of basic medical care and were as a result, required. They supported the withdrawal of the respirator, believing it to be extraordinary, since it was not a treatment that would improve their daughter's chances to return to a functional state. In general, a theological view would support the withdrawal of extraordinary medical treatments that only prolong death, but definitely draws a distinction between active and passive euthanasia, and states that the only method to ease suffering that may be employed is the removal of extraordinary means. Theologians would clearly reject the use of any treatment that purposely seeks the patient's death, regardless of motive. Under such a view, active withdrawal of medical treatment would be prohibited, as would the provision of prescription pain medications that are known to be used by the patient to commit a medical suicide. This view is held chiefly because God is viewed as the keeper of life and only He has the right to take it. Such a position would deny the patient a right to choose death in the face of intolerable suffering, so it would prohibit the physician from providing the means of death in such a circumstance.

Philosophically, it is hard to argue against a theological position without a rejection of beliefs that the theory holds about God. If we assert that people have a right to choose death and that the ability to hasten death is included in the responsibilities of a compassionate physician, then we must reject a position which believes that God would prohibit humans from deciding the timing of their own deaths. If we believe either, that, God, as a loving being would allow doctors to beneficiently hasten death in certain circumstances, or in a Deist position where God takes less of a direct role in the lives of humans and instead regards the earth and its creatures as a mechanism that was set in motion many years ago which he only watches and does not participate in every moment, then we could support euthanasia and assisted suicide, and the physician's role, without going against religion.

It can be argued that there are few absolutes in religion. Most of the evidence for a belief in God's principles are from the scriptures, which are either interpreted by some religious sects as stories that are meant to teach morality, or are believed by some to be the literal word of God. Even regarding suicide, there are places in the Bible where there are circumstances where it's use is not unilaterally condemned, such as in the case of Saul and his armor bearer. Historically, the Church has held several positions that are inconsistent with later discoveries such as certain scientific theories and physical laws. The Church condemned Galileo and other astronomers' views of the planets and physical laws of motion. In modern times, the Pope has offered an apology since the physical laws that govern the universe that were set forth by such thinkers have become part of accepted facts. It is possible that the views of theologians may not represent the true views of God, who might not have an absolute view that directly seeking death is wrong, and as a loving god, might recognize that there are circumstances in which prolongation of life is not in the patient's best interest.

Passive Euthanasia and the Physician

The AMA in its 1973 statement regarding euthanasia, also called "mercy killing," stated that it prohibited active euthanasia, but it would allow the removal of extraordinary means and that this removal of such treatments is the choice of the family and they are free to receive advice from the treating physician. Is there any reason why the physician would be prohibited from removing treatment and allowing the patient to die by the use of passive methods of euthanasia? It has been argued that there is not a substantial moral difference between killing and allowing to die in previous chapters. If this is true, then is passive euthanasia killing too, making it unethical for the physician to remove life-support that will cause death?

Based on several criteria, patients are allowed to refuse consent to medical care and to choose to be free of medical treatment that only prolongs pain and suffering in the face of an inevitable death. In the case of Abe Perlmutter, a late-stage ALS patient whose case was described in the previous chapter, Perlmutter had the right to refuse the continued use of his respirator and the court who heard the case recognized this. The court also granted the physician the right to withdraw the respirator with Mr. Perlmutter's consent without prosecution.

If patients are allowed to choose passive euthanasia on certain grounds, then the physician should also be allowed to provide it. Both the AMA and the American College of Physicians, in different capacities, state that the patient is allowed to choose withdrawal or refusal of medical care. The ACP goes onto say that the physician is entitled to respect such a wish. This is consistent with the general principles of both the Hippocratic oath and several professional statements, since the physician has a moral and professional duty to provide for his or her patient's welfare. The oath states that the physician should do what is medically necessary to ensure that the patient is provided with the correct type of care. In the case of the patient who is acting with full autonomy and it has been shown that further medical treatment is contraindicated, passive euthanasia is an ethical choice.

Active withdrawal of medical treatment

Along the road to active forms of euthanasia is what could be termed "active withdrawal" of treatment. This could be used to include respirators and removal of nutrition and hydration. These acts, while not using lethal medications, are certainly an active decision by the physician and/or family to terminate the patient's life. It is hard in many cases to make a relevant moral distinction between active withdrawal of treatment and the use of morphine or other similarly 'active' methods to bring patient's lives to a close. In both cases, there is a direct correlation between the physician's actions and the death of the patient. In some cases, it can be argued that the disease has taken over once medical means are withdrawn. This was true in the case of pneumonia that killed Karen Quinlan after she was not treated with antibiotics for an extended period of time. For the respirator bound patient however, the withdrawal of the respirator produces direct death within minutes to hours. The physician is a direct causal force and the withdrawal of the respirator is not substantially different from the use of morphine to depress the patient's breathing until death comes. In both cases, the intent was to allow the patient to be free of suffering through a speedier death. Death should not be recognized as an absolute evil to be avoided at all costs, but an inevitable conclusion that will occur soon enough regardless of the level of action or omission. It is just a question of whether death comes with the patient's dignity intact and pain at minimum, or whether it comes after a long struggle to be free of terminal suffering.

After the classification of this new subset of passive euthanasia that correctly recognizes the active nature of many actions, there are few actions that remain as being purely passive. This is because in many circumstances, it is an active omission, not a passive action. The methods that remain are the DNR, in which the physician does nothing and the cardiac arrest truly takes the patient's life, and not starting treatments with the intention of letting nature take its course. In such circumstances as refusing surgery, it is a truly passive act, not an active action disguised as a passive method.

The Physician and Active Euthanasia

As a result of advances in the discussion of issues related to end of life decisions and due to national court cases, there has been increasing acceptance with regards to the participation of physicians in the humane withdrawal of medical treatment. It has been recognized on several grounds that the patient has the right to refuse medical care, either through competent informed decision making, or through an advance directive or proxy consent. Due to these advances in the rights of patients, the ability of the physician to relieve suffering and help patients to die with dignity has been increasing all the time. Laws concerning living wills have allowed physicians to legally terminate certain levels of treatment when clear proof has been given to support the patient's wishes. Despite these advances, there still remains a widespread prohibition, both by state laws and by groups such as the AMA, of the physician's ability to provide active aid-in-dying, whether through active euthanasia or physician assisted suicide. Many groups regard the obligation of doctors to respect patient's wishes with regard to refusal of treatment as an ethical and increasingly important practice. The use of active euthanasia and physician assisted suicide is still likened to criminal homicide by some groups, or worse, is given strong negative connotations connecting it to many horrible abuses of policy, including the atrocities of the Nazi regime during World War II. Why is there still this sanction against active forms of treatment at the end of life? Why do many people still draw a distinction between withdrawal of medical care and the use of more active methods, and is it an important one?

I have defended active euthanasia on many of the same grounds as passive euthanasia. There are several circumstances where I believe it to be a rational and ethical choice for a patient to make. Is it an ethical practice for a physician to engage in? Is the distinction at all valid for the physician?

In 1988, an anonymous source submitted an article to the Journal of the American Medical Association entitled, "It's over, Debbie." This article, detailed in an earlier chapter, tells, in a first person account, of how a sleepy resident rotating through a large private hospital gave a lethal dose of morphine to an ovarian cancer patient without having treated her ever before, simply in response to a confusing request of "let's get this over with." The article brought many responses and outrage from the medical community and prompted the release of many statements and articles saying that Doctors must not kill.[13]

In a notable article first printed in the *Journal of the American Medical Association*, Willard Gaylin, Leon Kass, Edmund D. Pellegrino and Mark Siegler present an argument that condemns both the actions of the resident who helped Debbie to die and the involvement of members of the medical profession in active euthanasia in general.[14] This objection to the conduct of the doctor and with regard to the involvement of the physician in active death is made on several grounds. The first objection is made on a legal basis. Gaylin, *et al* believe the action of the gynecology resident to be an action of premeditated murder. The use of active

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[13] "It's over Debbie", Anonymous, from Euthanasia the Moral Issues, reprinted from the *Journal of the American Medical Association*, 259, no. 2, January 8, 1988, AMA.

methods to end the life of a terminally ill patient still remains illegal in the United States. In some countries, with Holland being the notable example, there are provisions in the law to allow doctors to answer the patient's request for a planned death without prosecution if certain requirements have been met. There are many critics to this system, but many medical professionals in the Netherlands and families of terminal patients who have died have defended it on several grounds, stating that it gave their patients and loved ones a measure of control over their impending deaths and allowed them to die with dignity.

Obviously, I don't advocate that doctors break United States law and administer morphine to terminally ill patients while active euthanasia remains illegal, but just because something is illegal doesn't mean that it is necessarily immoral. An example is that in the 1920's, consumption of alcohol was made illegal in the United States, and today it is used in moderation by the majority of the public with few serious moral problems. (Although alcohol abuse is arguably a significant problem among some groups.) It can be argued that active euthanasia should not be legalized until a sound policy can be developed to insure that the action is carried out in an appropriate manner and only after requirements concerning patient consent and/or quality of life standards have been met. The illegality of the use of active euthanasia means that U.S. physicians cannot at present conduct these practices to give their patients relief, but it does not preclude consideration of new policies for the future.

The next objection to the role of the physician in euthanasia that is raised by Gaylin, *et al* is that the physician in question acted in a highly unprofessional manner. They contend that he acted in an incorrect manner since he had never met the patient before, had not studied her case, and had not talked to her physician or family before taking the decision into his own hands. This is a highly appropriate criticism. This situation is not an appropriate representation of how the process should be practiced. The physician did not consider if the patient was acting with full autonomy, he did not gain fully informed consent from the patient and did not

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[14] Willard Gaylin, et al, "Doctors must not kill," from Euthanasia the Moral Issues, reprinted from the *Journal of the American Medical Association*, 259, no. 14, April 8, 1988.

consider any other methods of pain control before considering euthanasia. Dr. Timothy Quill has outlined several criteria for physician assisted suicide that are presented in the previous chapter, that are also applicable to active forms of withdrawal of life support and active euthanasia. Included is the requirement for a long-standing relationship between the doctor and patient; careful consideration of other treatment options including aggressive palliative pain control; a second opinion; and the demonstration of the full autonomy of the patient. The physician in question fulfilled none of these requirements and the only reason that his action can be differentiated from murder at all is that he acted with the patient's level of suffering in mind. If there is to be any hope to allow physicians to respond to clear requests for death from competent suffering patients, there must be safeguards to prevent cases such as Debbie's from occurring.

In addition to objections on grounds of legal violations and professional misconduct, Gaylin, *et al* fully reject the use of active euthanasia in the medical profession. They uphold the belief that there is a difference between passive withdrawal of "useless medical treatments" and the active termination of a patient's life by a physician. They argue that the participation of the physician in euthanasia is contrary to the ethical foundation of the profession and that it violates ideas set forth by generations of physicians and moral philosophers.

Many of these objections have been raised above. The AMA and the American College of Physicians maintain a belief that it is unethical for physicians to administer active euthanasia, while it ethical to withdraw treatment that either reflects the patient's wishes or clear best interest. In most instances, I believe it can be shown that the use of active euthanasia also meets these requirements. If there is a duty to use treatments that best represent the needs of the patient, then the patient suffering from terminal cancer who has no means of medical care to withdraw that will allow death to come is best served by active euthanasia, if they so choose. The physician has a duty to uphold a certain standard of care and to use the appropriate treatments for the appropriate circumstances. If all palliative care has been exhausted, then it is in the patient's best interest to allow him or her to die painlessly. If the patient was respirator bound, then many would support the removal of it, so they should also support methods that will allow the patient to achieve a dignified and painless death.

Kenneth L. Vaux states in his article, *Debbie's Death–Mercy Killing and the Good Death,* that despite the fact the resident acted inexcusably with the use of morphine to speed Debbie's death, there always has been and is still a place for active euthanasia in medical practice.[15] There are circumstances where the patient is suffering so greatly or his or her life has become of such a low quality, that active euthanasia is acceptable. Vaux also states that with new medical technologies, these issues have only intensified. He writes:

> In recent years, the qualities that morally distinguish the living from the dying have been blurred. With our life prolonging techniques and medications, we have transformed death, we have taken it out of the acute, natural and noninterventional mode and made it more into a chronic, contrived and manipulated phenomenon. Deaths as inevitable as Debbie's have been protracted by a range of interventions, including chemotherapy, analgesia, the administration of intravenous fluids and nutrients and hospitalization itself. Logically and emotionally, we cannot intervene at one phase and then be inactive at another, more painful phase. We cannot modify nature and then plead that nature must be allowed to run its unhindered course.

Is there a duty to provide aid-in-dying?

In light of previous sections in which we have granted the physician the right to provide various methods to achieve death as an alternative to terrible suffering or for patients in persistent vegetative state, it needs to be asked if there are circumstances in which the physician is not only allowed to act, but is required to do so. As discussed above, there are some treatments that can bring the patient great harm, and if their benefit does not outweigh the level of harm that they bring, then their use is unjustified and should be prevented. In the case of aggressive resuscitation, if the patient is beyond the point where such treatment is beneficial, and instead only causes harm or prolongs a painful death, the use of the method is unjustified. In such a circumstance, the appropriate use of the DNR is not optional, since failure to use it in

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[15] Vaux, Kenneth, "Debbie's Death–Mercy Killing and the Good Death" (1989), from Euthanasia the Moral Issues, Prometheus Books.

the appropriate circumstances goes against the physician's duty to provide for the patient's welfare.

With the acceptance of the DNR order as a starting point, we can ask if there are circumstances where the use of other methods to allow death to come are required of the physician. The duties of the physician as defined in the Hippocratic Oath and professional codes of ethics stipulate that the physician has a duty to do what is best for his or her patient and provide the medical means to help patients reach their treatment goals. If we can successfully argue that there are circumstances in which patients benefit from forms of euthanasia, then it follows that the physician is required to provide them, since he or she has a duty to respect the patient's interest. In the Netherlands, while the use of euthanasia remains broadly illegal, the law recognizes that there are specific circumstances that necessitate the use of euthanasia to give dying patients an escape from terrible suffering due to a mixture of physical and psychological pain. If the appropriate use of euthanasia can be likened to other appropriate medical treatments, then the physician can be argued to be required to provide them as a component of the treatments necessary to attain a complete standard of care. Like other treatments, if the physician is unwilling or unable to act, then the patient can be referred to the appropriate provider. As Timothy Quill suggests however, assisted suicide, and logically euthanasia, should only be carried out in the context of a meaningful doctor-patient relationship in which the patient is also undergoing treatment for the disease in addition to seeking a request for death. If it is not possible to have a long standing relationship, the choice should not be made until the physician has had the chance to familiarize him or herself with the patient's case over several meetings, so the new doctor is in a position to give advice, or in specific circumstances, assistance.

The Physician's responsibilities for assisted suicide

As presented in the previous chapter, Dr. Timothy Quill, and Jack Kevorkian have both supported physician assisted suicide in the face of terrible pain for a patient over a long course of degenerative disease. Quill has given guidelines to establish when PAS is a reasonable choice on the part of the patient, which was presented in the previous chapter. He requires that the patient be acting fully voluntarily with informed consent, and only considers PAS when all other treatment options have been exhausted. Once these requirements have been met, it can be argued that the patient should be allowed to choose assisted death. I have differentiated assisted suicide for medical reasons from the non-rational suicide pursued for other reasons in the previous chapter, and I concluded that rational, medical suicide is morally different from suicide for other reasons.

After the patient has been granted the right to choose PAS, it needs to be asked if it is ethically permissible for the physician to provide the patient with the means to a speedy death? If so, does he or she have any duties to comply with such requests from the fully voluntary patient when asked?

Earlier in this chapter I argued that in certain circumstances, after the patient has met specific requirements, the physician is allowed to give the patient a lethal dose to allow him or her to die a painless death. This is a hard topic and one I am not entirely comfortable thinking about, but I am more uneasy thinking about patients suffering a prolonged death for months, with their only experiences being one of horrific pain or constant sedation. It has also been argued that the use of physician assisted suicide is not substantially different from active euthanasia, if used in the correct circumstances. Just as with active euthanasia, there are certain requirements that must be met and the physician should not assist the patient in death in lieu of long-standing relationship. Ultimately, it can be argued that there are circumstances in which it is ethical for the physician to give the patient a prescription to allow him or her to end his or her suffering. The case of Dr. Quill and Diane demonstrates of how the physician can compassionately offer a method for the patient to die with dignity and allow her to be free of horrible pain.[16]

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[16] Quill, Death and Dignity., pg. 9-18.

I have stated that in many circumstances, when the patient is acting with full autonomy and all comfort care alternatives have been exhausted, then PAS is ethical. If the physician is allowed to provide an active method of euthanasia or withdraw extraordinary medical means as part of a care regimen that represents the patient's best interest, then he or she is allowed to aid the patient in seeking death by a rational medical suicide. In the previous chapter, I differentiated the patient who chooses a medical suicide versus the patient who chooses death for non-rational reasons or due to a physiological mental illness. If it is rational for the physician to participate in other methods of hastening death, then he or she can prescribe medication that leads to medical suicide. Some people have even argued that PAS is preferable to active euthanasia since the patient has more of a role in the action, so they encounter less of a risk for coercion. Obviously it is difficult to think about the physician participating in death, but the alternative, when the doctor ignores the patient's request for peace in the face of intolerable suffering, would be worse and would not be consistent with the compassion that a physician is supposed to show for his or her patient. Dr. Quill had some doubts about providing the barbiturates to Diane, but in the end felt that he was violating more of his responsibilities by letting her suffer needlessly in the face of horrible pain. He knew that he could give her peace, and to ignore this request would violate the relationship they had formed.

Additionally, as asked more broadly above, we can consider if their is a duty that exists for the physician to respond to requests from patients for assistance in suicide. Basically, if we can justify a duty to provide euthanasia, then we can accept a duty to give assistance in rational suicide. If doesn't do the patient much good to grant them a right to die and to then prohibit the physician, who is the most appropriate medical professional to engage in the process, from participating in the action. If the patient has the right to expect to not have a painful death prolonged, then the physician has the obligation to provide the means to a peaceful death through rational suicide.

The education of the physician regarding life and death issues

Another criticism of the role of doctors in euthanasia is that they lack appropriate medical training to carryout such a responsibility in the ending of patient's lives. One doctor said that he felt ill equipped to deal with these issues and to carryout requests for death. If it is decided that it is moral for the physician to comply with a request for death, what changes do there need to be in the education of medical students and residents to insure that they have the medical and emotional training to deal with such circumstances?

As stated in the section dealing with hospice care, there are limitations that some physicians exhibit when dealing with dying patients. They may be uncomfortable with dealing with these issues, so the majority of the care of the dying may fall to nurses and health care aids. To effectively treat the dying, the physician needs to have the training and counseling to be able to better deal with these issues. If doctor is not comfortable in his or her dealings with the issues of death, how can the patient be expected to be? Most medical schools have only minimal portions of their curricula devoted to issues of death and dying, and in most cases, what offerings there are usually elective and are often poorly attended. If the physician is to responsibly accept a role where they can compassionately comply with requests for death, they need a firm grasp of these philosophical, ethical and emotional issues. In order to prepare physicians to meet these responsibilities, there need to be changes in the training of new doctors to give them backgrounds so that they can comfortably discuss issues of death and dying and be prepared to fulfill such a role if needed. Obviously it is a tough subject, but if we recognize that various forms of euthanasia can be used to give patients control of their deaths and minimize suffering, then the physician needs to be trained to deal with such issues, or the training he or she receives cannot be considered to be complete.

If we deny the physician the role of the professional who is to attend to the patient's requests for death, and it subsequently falls to other lesser trained professionals, there may be the possibility for abuse. In the Netherlands, it has been reported that approximately 30% of all primary care doctors say they have responded to a request for death at some time in their careers. The law has correctly realized that there are instances where the physician's duty to alleviate suffering overrides the duty to prolong life. These legal codes also only grant exemption from the laws under specific circumstances to doctors.[17] If centers arose to provide death to terminal patients then the proper treatment issues may not be addressed and the patient might not be given all the options or be certified to be acting in a fully voluntary manner. If this type of medical treatment is to be allowed, it should take place in a medical setting, where all aspects of care can be attended to, not in a non- medical instance such as in a house or motel and be practiced by a non-physician. It is hard to think about the intervention of the physician who is supposed to seek life over death in most circumstances, in euthanasia and assisted suicide. There does exist the possibility for abuses, but also the opportunity for appropriate compassionate care. If we assert a right to die for the patent and the physician is prohibited from beneficent intervention, then the process may become considerably more unethical as the action of providing the means of a painless death falls outside the medical arena. The physician has the knowledge and the training to diagnose and treat terminal conditions, and to entrust the practice of euthanasia and assisted suicide to those of lesser training and knowledge could lead to many problems.

Conclusion

Using several arguments, the patient's right to choose not to prolong suffering can be defended. They have the right as autonomous beings and people deserving of respect to be granted the right to choose the timing of their passing. If this right is granted, then it can only transpire if the physician who participates in the administration of care is ethically able to offer aid-in-dying, whether through withdrawal of medical treatment, active euthanasia or assisted suicide. There have been several groups such as the AMA that have opposed the role of the physician as a provider of euthanasia and similar methods with the intent to hasten death. They

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[17] De Wachter, Maurice, "Euthanasia in the Netherlands." *the Hastings Center Report*, Briar Cliff NY, March-April, 1992, pg 25.

worry that the participation of the doctor in such a process would undermine the respect for life that the medical profession does and should have.

On the contrary, I believe it can be shown that a refusal to participate in the euthanasia decision is a failure of the physician to hold the patient's quality of life and right to have their personal dignity respected as an important factor in the foundation of compassionate medical care. A profession that only seeks to prolong life, regardless of quality is not as useful as one that seeks to prolong meaningful life and to allow patients to choose when to die when such lives are devoid of meaning or are only filled with continual pain. For the comatose patient or horribly malformed infant, the physician should only seek to prolong those lives that have a potential to either develop or return to a pain free, cognizant state.

If the medical profession refuses to take on the responsibilities of caring for patient who are facing a long course of pain or existence devoid of dignity or human interaction, it cannot call itself a profession that fully values the patient at the center of treatment decisions. With the continual advances in medicine, there exists the possibility to prolong many useful lives of patients who would have otherwise died, but there also exists the possibility for the needless prolongation of lives that are of an extremely poor quality. If the medical profession refuses to take on these issues and take responsibility for its interventions at one end of treatment but not at the other, then patients will feel that decisions are not fully theirs and the trust that they previously had in the medical profession to treat their suffering will be lost.

CONCLUSION:
A POLICY FOR EUTHANASIA AND ASSISTED SUICIDE

Euthanasia is a topic that has many important issues associated with it. The topic evokes a strong response from people since they may have experienced the death of a loved one who may or may not have died in a painless and timely fashion. The topic may also make them think about what they would choose if they were in such a circumstance, or what one would choose if forced to make a decision for a loved one. It is important for people to be educated about this issues. These ideas enable physicians and medical staff can provide the best possible care to their patients, and people who are directly involved in a case, whether they are a patient or concerned family member, are then able to have the most complete information to allow them to make the right choice.

This paper has explored many important topics to allow us to answer the questions of whether euthanasia is an ethical choice for patient to make and whether it is an acceptable action for a practitioner to carry out. In both situations, the answer seems to be yes. Many medical illnesses and injuries produce circumstances where the patient's quality of life may be severely diminished to the point where they suffer from constant pain, or have lost their identity due to progressive dementia or persistent vegetative state. In many of these circumstances, euthanasia is an ethical and appropriate choice since it allows the patient to take control of his or her life, be free of terrible suffering and retain a level of basic human dignity. This paper has argued extensively for the right of the autonomous patient to make choices on his or her behalf. This right to autonomy, which is grounded in Kantian theory and the principle of Respect for Persons gives the patient the right to make rational decisions about circumstances that effect his or her life. This right to autonomy is paramount to concerns such as economic factors or utilitarian judgments that do not place the patient at the center of treatment decisions.

For the physician, it can be argued that he or she is allowed to participate in the action of euthanasia and PAS since the procedure can be shown to be in the best interest for some patients. Several ethics codes and theories show that physicians have a special duty to their patients to provide for their best interest. If euthanasia or PAS is in the best interest of a cancer patient or permanently comatose patient, then the physician is duty bound to provide for that interest. Additionally, physicians have a general duty to alleviate pain and suffering. Often this duty is thought to conflict with the duty to prolong life, but in the case of cancer patient who is terminal in a few months who suffers from great pain, the duty to treat the pain is the more important of the two duties.

Another major reason that euthanasia has become such an important issue is because of the advancement of medical technologies. Before the advent of new treatment methods, may patients died considerably earlier, so there were fewer philosophical problems. Today, elderly patients survive to experience heart failure or progressive dementia, newborns who would have died in the delivery room are placed on respirators and all the newest technologies are invoked, only to leave them with brain damage or underdeveloped organs that threaten their lives.

Many important questions have been explored here, such as how much pain a cancer patient should have to endure before he or she can be allowed to receive active euthanasia, whether some forms of euthanasia are justified for infants who are born with significant developmental and physical anomalies, and what are the correct treatments for late-stage Alzheimer's patients. I have offered several principles to attempt to answer these tough questions.

The first idea that we can apply is the notion of informed consent and voluntary decision making. This idea seeks to determine if patients are able to make fully autonomous choices regarding their care. If they are, then their rights should be respected and the appropriate steps should be taken to follow their desires to ensure that they die in the manner that they wish, not in a way that they are dehumanized and made to suffer a loss of respect and dignity. Several factors need to be considered. The first is their ability to understand their treatment options and to be able to give fully informed, voluntary consent. If it is determined that they cannot make a fully informed choice, whether because of a lack of understanding of medical terminology, anxiety about their illness or possible mental illness or physiological depression, then we need to help them gain the ability to make a fully informed choice. They can receive treatment for depressive conditions, can get additional counseling or the doctor can be encouraged to explain the nature of the disease to the patient more completely and in simpler language so he or she can make a fully informed choice.

If there are larger factors compromising informed consent, such as severe mental illness, profound retardation or dementia, young age, or a temporary or permanently unconscious state, then we may need to develop principles to allow loved ones to choose the best option for the patient. The first is the notion of prior autonomy. If a living will exists or references to a series of conversations that help to establish how the patient wanted to be treated in the event of incompetence to decide, then these directives should be respected. There is debate as to whether wills and conversations can serve as full consent, but failing first-person consent, they are the most reliable tool to gauge the patient's prior wishes. Secondly, if no advance directive exists, we can attempt to decide using substituted judgment, knowing what we knew about this person and who they were, what they would want. Lastly, failing all other methods, for a patient with no family or history of decision making, we can attempt to determine a general best interest for the patient in this specific situation. We must try not only to determine what this particular patient would want, but what any patient in a similar situation would want, and what is best for them. What is in the best interest of a newborn who will spend his or her whole life in a hospital bed unable to breathe without mechanical respirators, or for an eighty year old in congestive heart failure who has suffered several cardiac arrests, only to be brought back to suffer another arrest?

If the patient is able to make an informed choice, then we can ask if it is ethical for them to choose to die. Also, are there differences between methods that they can utilize to die a dignified death? If the patient is not able choose are their choices we are not allowed to make? What level of neurological or biological function is necessary for a patient's life to be valuable?

Conclusion: A policy for Euthanasia and Assisted Suicide

Another important issue that is discussed extensively in the euthanasia debate is the distinction between active and passive euthanasia. This debate centers on the question of whether there is a relevant moral difference between taking a direct action to end a patient's life through a method like an injection versus the withdrawal of medical treatment such as a respirator or feeding tube. There are many people who contend that there is a relevant difference and often state that active methods are worse since the patient dies as a result of the physician's actions, whereas in passive euthanasia, nature takes it's course. In this paper, I have rejected this distinction on the grounds that both actions are conscious decisions on the part of the doctor and both actions result in the death of the patient. If we decide that active euthanasia is wrong, then passive euthanasia is equally wrong, since both actions intend the death of the patient. If one is acceptable, then they both are. In most cases, both types are from a beneficent motive, so they are morally acceptable.

The debate over active and passive impacts the patient's choice, since if we maintained the distinction, then there would be people who might deny the patient the right to voluntarily choose active euthanasia. In the case of the patient who suffers from severe pain, active euthanasia is clearly preferable, since death comes sooner rather then later. If we have chosen euthanasia, it makes sense to choose the method that gives the patient the greatest amount of comfort.

A policy for euthanasia

Throughout the paper, many abstract philosophical ideas have been explored including the major theories of Kantianism, Utilitarianism and a theological approach to the debate. Additionally, many personal and professional views regarding the rights of patients and the obligations of physicians have been stated, plus a variety of medical examples have been presented. With this theoretical foundation, can we establish a policy to allow patients to choose the way they die and to give families and physicians ways to decide for patients who cannot choose for themselves? Such a policy would need strict guidelines to determine the types of patients who would be candidates to choose euthanasia in one form or another and to avoid the euthanasia of those for whom euthanasia may not be in the best interest, or whose prognosis for death is not certain. Many people who object to euthanasia and physician assisted suicide do so because of a fear of a slippery slope that would extend a policy of a right to die to those who have not voluntarily chosen it or are at risk to be chosen, such as the poor, the old, unwanted newborns and adults with mild to moderate mental deficits and physical handicaps. An all inclusive policy would need clear guidelines to avoid such a slide and would need to guarantee that a patient had either acted with fully informed voluntary consent, or though a long analysis, a choice of euthanasia had been determined to be in their best interest.

One method that such a policy could use to insure at least representative consent to protect those who might become incompetent to decide, whether through injury, aging or disease would be to incorporate the use of advanced directives into common use. Such a policy would require doctors to encourage their patients to execute a living will as a regular part of a plan of preventive medicine. If the living will was made a part of the regular medical chart, then it would be clearer as to the patient's wishes regarding resuscitation, invasive surgery, extraordinary medical treatment and other concerns if they were to become incapacitated. If such a policy was instigated, then maybe ordeals like the *Cruzan* and *Quinlan* cases could be avoided. If the majority of patients had living wills, then there might not be as many concerns when it came time to decide for patients. A copy could be given to the physician, lawyer, and children of an elderly patient, or family or spouse of other patients. Then, in the event of a questionable situation, there would be more information available.

If euthanasia was to become an accepted medical practice in a majority of states, there would need to be changes in the training of physicians and other medical staff. Many of these changes have begun at several medical schools where, more emphasis is given to medical ethics and the issues of death and dying, but for a widespread success in better dealing with these issues, all physicians would need a basic level of competence in such issues. They would need to be well versed in the foundations and theories of medical ethical decision-making that would allow them to discuss issues, guide policy and encourage patients to make plans to determine the type of treatment regimen they desire. Additionally, there would need to be continuing education at the professional level to allow health care providers to keep up with current developments. Required seminars could be implemented into the medical system that would be run by public health agencies and academic medical centers. Such a requirement could even be integrated into licensing protocols to be included in continuing education requirements for the recertification for the M.D., R.N., etc.

Another area of concern in developing policy to include carefully selected cases where euthanasia could be chosen as an alternative to an undignified death due to pain or suffering is the question of mental competence to decide. Many people worry that if euthanasia was allowed in the United States, there would be large numbers of patients with clinical depression seeking death by way of euthanasia or assisted suicide. These depressive disorders often accompany terminal illnesses, so it would be necessary to evaluate patients who have requested euthanasia to determine the impact of a possible depressive condition on their decision to seek euthanasia. Patients who are depressed are not acting with full autonomy, so it is wrong to allow them to choose death, since it does not respect their right to make a fully autonomous choice. They would need to be treated for the physiological depression, and only then could they clearly choose their own path.

A final barrier to a policy that would allow patients the right to choose euthanasia would be the question of what conditions justify euthanasia. There is a large debate over how severe or dehumanizing a condition needs to be to justify euthanasia. A loose list could be complied to give physicians a rough idea of what conditions they would likely encounter and give them an ideal of the moral and professional standards. Another slippery slope argument is that if we allow euthanasia to be used widely, that the conditions for which it is used will expand. In the Netherlands, provisions in the law only cover specific conditions and types of suffering. They also require the demonstration of mental competence, and the informed nature of the choice. For the United States, regulations would only allow euthanasia for certain conditions. To be included in the list would be conditions that entail substantial pain, such as cancer and AIDS, an extremely low quality of life as demonstrated by a lack of human contact and a dependence on machines or complete paralysis such as in ALS. Patients who are permanently comatose or have entered a persistent vegetative state could be included, since they have no quality of life and have no ability to ever return to a wakeful, cognizant state. There could also be provisions to include termination of care for newborn infants with no prospect for a decent quality of life as determined by severe mental deficits, extreme prematurity below the 24th week, or severe neurological disorders.

For newborns, there would need to be strict laws to guard against abuses such as occurred in the Baby Doe case, when the parents sought to discontinue the life of their son because of his mental handicaps due to Down's syndrome. I have included some serious mental deficits in the category of acceptable conditions, but Down's in no way qualifies, since with adequate care and early therapy and education, the majority of people with Down's Syndrome can lead happy, at least moderately productive lives where they can often hold simple jobs or participate in special educational programs. The same safeguards would need to be in place to prevent similar abuses and coercion in nursing homes for the elderly population.

This policy outline may seem to be pretty extensive, and one might think that a policy to allow euthanasia would have too many regulations to prevent abuses. Even with the extensive regulations required, the good that such a policy could bring would outweigh the bad, since it would allow many terminally ill patients to take control of their lives and would allow comatose patients and severely handicapped newborns to die with dignity instead of living a life devoid of human contact. In the Netherlands, there are similar levels of regulation, and the practice as a whole remains illegal, except for certain provisions in the law when a high level of consent or a clear best interest has been demonstrated. In the United States, with the complex government and health care systems, such a policy would not be easy to implement, and would meet with stern opposition on many fronts, but if Oregon and the nearly passed attempts in California, Idaho and Washington are any indication, this topic has gathered a lot of interest over the past few years and will only continue to increase in importance as the population ages. This issue is too important not to consider. It is probably better done at the state level, since it allows different states to tailor specific regulations with in a defined basic structure to meet the needs of it's citizens.

Euthanasia and physician assisted suicide are difficult topics to think about and carry many moral and religious concerns. There are many objections to work though when discussing it, but in the end, we can determine that it is an ethical practice in several carefully chosen circumstances and can be used to alleviate suffering and preserve the dignity of many patient groups who are dependent on medical technology that saved their lives, but left them with no quality of existence. The right to die and the right to refuse life-sustaining technologies are fundamental rights, since if we have the right to determine how we live our lives, we should have the choice of how we die. Euthanasia, when used properly can give people choices and allow them to pursue the type of death they desire, the good death.

BIBLIOGRAPHY

Admiraal, Peter,
"Justifiable Active Euthanasia in the Netherlands," Appears in Euthanasia: the Moral Issues (1989), Buffalo, NY. Prometheus books, Robert Baird and Stuart E. Rosenbaum, editors.

American College of Physicians,
Ethical Statements Regarding the Conduct of Physicians (1989) Amer. Coll. Physicians, Philadelphia, PA.

Anonymous,
"It's Over Debbie," Appears in Euthanasia: the Moral Issues, Reprinted from *the Journal of the American Medical Association* 259, no. 2, January 1988.

Baird, Robert M and Start E. Rosenbaum, ed.
Euthanasia: the Moral Issues (1989) Buffalo, N.Y. : Prometheus Books.

Battin, Margaret Pabst,
The Least Worst Death : Essays in Bioethics on the End of Life (1994) New York : Oxford University Press.

Beauchamp, Tom L. and LeRoy Walters,
Contemporary Issues in Bioethics, (1989) Belmont, Calif. : Wadsworth Pub.

Brock, Dan,
"Voluntary Active Euthanasia," (1992) *The Hastings Center Report* , Briarcliff Manor, NY, Vol. 22, Number 2, March-April 1992.

Carson, Robert,
"Washington's I-119", (1992) *The Hastings Center Report*, Briarcliff Manor, NY, Vol. 22, Number 2, March-April 1992.

Childress, James F. and Tom L. Beauchamp,
Principles of Biomedical Ethics, 3rd edition, (1989) New York, Oxford, Oxford University Press.

Childress, James F. and Tom L. Beauchamp,
Principles of Biomedical Ethics , 2nd edition,(1983) New York, Oxford, Oxford University Press.

Chochinov, Harvey M, *et al*,
"Desire for Death in the Terminally Ill," *The American Journal of Psychiatry*, Vol. 152, No. 8, August 1995.

De Wachter, Maurice,
"Euthanasia in the Netherlands." *The Hastings Center Report*, Briar Cliff NY, March-April, 1992.

Dubler, Nancy N. and David Nimmons,
Ethics on Call. Taking Charge of Life-and-Death Choices in Today's Heath Care System (1993), Vintage Books.

Froehock, Fred M,
Special Care. Medical Decisions at the Beginning of Life, (1986) Chicago, University of Chicago Press.

Gaylin, Willard, Leon Kass, Edmund D. Pellegrino and Mark Siegler,
"Doctors Must not Kill," appears in Euthanasia the Moral Issues, Prometheus Books, reprinted from the *Journal of the American Medical Association*, 259, no.14 April 8th, 1988.

Hamel, Ron,
Choosing Death. Active Euthanasia, Religion and the Public Debate (1991) Philadelphia, Trinity Press International.

Harris, C.E,
"The Ethics of Respect for Persons" Appears in Introduction to Ethical Theory (1991) Kenneth Rogerson, editor, Fort Worth Tx, Holt, Rhinehart and Winston.

Hippocrates,
"Selections from the Hippocratic corpus, the Oath," W.H.S. Jones Trans., pg. 5. Ethics in Medicine, (1977) Reiser, Stanley Joel, Arthur J. Dyck, and William J. Curran, Editors, Cambridge, MA, MIT Press.

Hoefler, James M, with Brian E. Kamoie,
Deathright: Culture, Medicine, Politics, and the Right to Die (1994) Boulder, Colo. Westview Press.

Judicial and Ethics Council of the American Medical Asssociation,
Proposed 1995-95 Resolutions, (1995) The AMA, Chicago, IL.

Kass, Leon,
"Is there a right to die?" *The Hastings Center Report*, Vol. 23, no. 1, January-February, 1993, Briarcliff, NY.

Klaus, Marshall H, and Averoy A. Fanaroff,
Care of the High Risk Neonate (1993), Philadelphia, PA.
WB Saunders and Co, Publishers.

Koop, C. Everett,
"The Case of Karen Quinlan", Appears in Euthanasia: the Moral Issues (1989)
Baird, Robert M and Stuart E. Rosenbaum, ed, Buffalo, N.Y.
Prometheus Books.

Kuhse, Helga,
The Sanctity-of-Life Doctrine in Medicine: a Critique (1987)
Oxford : Clarendon Press ; New York : Oxford University Press.

Kuhse, Helga and Peter Singer,
Should the Baby Live? The Problem of Handicapped Infants (1985),
New York, Oxford: Oxford University Press.

Lyon, Jeff,
Playing God in the Nursery (1985) New York, W.W. Norton and Co.

Macklin Ruth,
Mortal Choices. Ethical Dilemmas in Modern Medicine. (1988)
Boston, Houghton Mifflin.

Mile High Down's Syndrome Association,
"What is Down's Syndrome?" The Mile High Down's Syndrome Association,
(1995) Denver Colorado.

Missouri Vs Cruzan,
Appears in Euthanasia: the Moral Issues (1989) Baird, Robert M and Stuart E.
Rosenbaum, editors. Buffalo, N.Y. Prometheus Books.

Moore, Francis D,
A Miracle and a Privilege: Recounting a Half Century of Surgical
Advance, (1995) Washington, D.C, Joseph Henry Press.

Moreno, Jonathan D,
"Ethical and Legal Issues in the Care of the Impaired Newborn,"
Ethical and Legal Issues in Perinatology, vol.14, no. 2 June 1987.

Moskop, John C. and Rita L Saldanha,
"The Baby Doe Rule, Still a Threat," appears in Contemporary Issues in
Bioethics, (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters,
editors, Belmont, Calif. : Wadsworth Pub. Co.

Paris, John J, and Anne B. Fletcher,
"Withholding nutrition and fluids in the hopelessly ill patient," *Ethical and Legal Issues in Perinatology*, vol.14, no. 2 June 1987.

Quill, Timothy,
Death and Dignity. Making Choices and Taking Charge, (1994) New York. London, W.W. Norton and Co.

Rachels, James,
The End of Life. Euthanasia and Morality (1986) Oxford, New York, Oxford University Press

Ramsey, Paul.
Ethics at the Edges of Life: Medical and Legal Intersections New Haven : Yale University Press, 1978.

Reiser, Stanley Joel, Arthur J. Dyck, and William J. Curran, Editors,
Ethics in Medicine (1977),Cambridge, MA, MIT Press.

Rogerson, Kenneth,
Introduction to Ethical Theory (1991) Fort Worth Tx, Holt, Rhinehart and Winston Publishers Inc.

Satz Vs Perlmutter
Appears in Contemporary Issues in Bioethics, (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters, editors, Belmont, Calif. : Wadsworth Pub.Co.

Shannon, Thomas A,
Bioethics (1976), New York, Paulist Press.

Robert and Peggy Stinson,
"On the Death of a Baby," Appears in Contemporary Issues in Bioethics, (1989) 3rd ed, Tom L. Beauchamp, and LeRoy Walters, editors, Belmont, CA, Wadsworth Pub. Co.

Shilts, Randy,
And the Band Played On. Politics, People and the AIDS Epidemic, (1987) New York, St. Martin's Press.

Wicker, Christine,
"Sentenced to Life," Euthanasia: the Moral Issues (1989). Appears in Baird, Robert and Stuart E. Rosenbaum editors, Buffalo, NY. Prometheus books.