Euthanasia, The Gentle Death: A Legal and Ethical Prospectus on the Right to Die

Kirkland Alan Fulk
EUTHANASIA, THE GENTLE DEATH: A LEGAL AND ETHICAL PROSPECTUS ON THE RIGHT TO DIE

KIRKLAND ALAN FULK*

"Do not go gently into that good night"
- Dylan Thomas

INTRODUCTION

The issue rages in the newspapers and on television - Freedom of Choice versus Right to Life. The issue centers around whether an individual has the right to control her own body even to the point of death. And yet, there is a deeper and darker question that lurks in the background. A question that, until recently in this country, has been largely avoided or, more specifically, ignored by the media. Does one have the inherent right to decide the time and manner of his own death?

Given the proper set of circumstances, it might be easy to envision a situation where death is a reasonable alternative to life. A young woman, diagnosed with terminal cancer and no possible hope of survival, may choose to forgo treatment that would extend her life but would also result in unbearable side effects. A father may choose to discontinue life support for his son permanently brain damaged from oxygen

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1 Throughout this paper, this author uses the masculine pronoun in a gender neutral sense. It is simply the style of the author and no offense is intended.

deprivation. These are not the types of cases that are troubling to the normal individual. The more difficult question involves the situation where an individual actively seeks to end his life rather than wait for eventual death. This is the "gentle death" of euthanasia.

The staunch individualist in me rebels at the thought of someone, or some agency, dictating the course of my life or manner of my death. After all, who, other than myself, should have the right to decide the appropriate time for me to die? It is in attempting to answer this question that the true issue comes to light. Where should the line to be drawn between refusing treatment and actual suicide?

The ultimate question cannot go unanswered. This paper will explore the ethical and legal dilemmas that surround the issue of active euthanasia. In this respect, I will draw insight from the Netherlands where, even though not legally sanctioned, the individual is allowed to choose to end his life rather than face the eventualities of a lingering death or perpetual disability. At the same time, some of the myth that flows from this country with respect to the freedom to die will be dispelled. Viewpoints from the medical profession in the United States will also be examined, in addition to exploring the current state of the law in the United States with respect to assisted suicide and the current trends in various parts of the country toward amending the law to allow for it.

While many of the issues involved in the question of legalizing euthanasia could be, and perhaps should be, argued from a religious perspective, it is not within the scope of this paper to examine the religious beliefs and teachings of the various religious groups within this country. Additionally, this author does not feel qualified to adequately present the arguments that are posed by the religious community. Therefore, the debate from a religious point of view must be left to those infinitely more capable than myself.

I. THE NETHERLANDS - MYTH VERSUS REALITY

The classic myth that must first be dealt with is that euthanasia is legal in the Netherlands. This is not true. Rather it is still a criminal offense to perform euthanasia, yet, under certain circumstances there are no criminal prosecution.

Articles 293 and 294 of the Dutch Penal Code provide:

Art. 293: He who robs another of life at his express and serious wish, is punished with a prison sentence of at most twelve years or a fine of the fifth category [approximately 50,000 U.S. dollars].


Art. 294: He who deliberately incites another to suicide, assists him therein or provides him with the means, is punished, if the suicide follows, with a sentence of at most three years or a fine of the fourth category [approximately 12,500 U.S. dollars].

At the same time, the Dutch Medical Association, together with the Nurses Union, in its “Guidelines for Euthanasia” has defined euthanasia as “as action which aims at taking the life of another at the latter's express request. It concerns an action of which death is the purpose and the result.” Yet, using this definition, euthanasia, as is currently practiced by physicians in the Netherlands, is a direct violation of the Dutch Penal Code. How then are the laws and professional practices reconciled?

In 1973 in the Netherlands, the court, through its rulings, created an exception to the express language of the Dutch Penal Code. It was in this year that a physician was tried for the death of her mother. The physician’s mother was seventy-eight years old and partially paralyzed from a stroke. After having been admitted to a nursing home a few weeks earlier and having expressed the desire to die (according to the testimony of her daughter), her daughter, a physician, administered a lethal dose of morphine. After a trial and a subsequent conviction for violation of Articles 293 and 294, the doctor was sentenced to one week in jail and a suspended prison sentence. By its action, the District Court Leeuwarden in essence set the guidelines by which active euthanasia could be performed without fear of prosecution in the Netherlands. The patient must: 1) have an incurable condition due to accident or illness, 2) have unbearable physical or psychological suffering, 3) state the request to terminate life in writing, 4) have begun the dying phase and 5) request the aid of a physician in his termination.

Various Dutch courts have added additional criteria in the ensuing years, but these basic elements have remained essential to the District Attorney’s (Officier van Justitie’s) determination of whether to prosecute. Of the five criteria listed above, all Dutch courts have considered two to be absolutely essential in the prosecution decision, and both concern the patient. First, the patient must take the initiative in the request for termination of his life. It is not enough that the patient wishes to die or
simply agrees with termination. Additionally, the physician should not solicit the request for death. However, he may inform the patient of the options available. The ultimate decision must be an exercise of the free will of the patient, free from any pressure from the physician or family.

The second major criteria applied by the judges is the fact that the patients feel their condition is unbearable. This element, however, concerns more than just the patient's feelings. A more extensive medical check is necessary to determine whether there are reasonable alternatives available for treatment. In essence, it is the responsibility of the physician to treat the patient, which includes counseling to eliminate the fears and anxiety associated with treatment. Often, this type of counseling combined with treatment to control any associated pain can prevent the anxiety experienced by the patient and thereby moderate his desire to die. "Euthanasia... should not become an answer to failing care, fear, and loneliness."

Since 1984, all Dutch courts have applied a third requirement: that the physician consult with a colleague. This allows for the confirmation of diagnosis and prognosis, verification of the correct medical performance of euthanasia, and a double check to make sure that all the legal requirements are met.

The Dutch courts over the ensuing years have refined the guidelines to include the following seven elements:

1. The patient must repeatedly and explicitly express the desire to die.
2. The patient's decision must be well informed, free and enduring.
3. The patient must be suffering from severe physical or mental pain with no prospect of relief.
4. All other options for care must have been exhausted or refused by the patient.
5. Euthanasia must be carried out by a qualified physician.
6. The physician must consult at least one other physician.
7. The physician must inform the local coroner that euthanasia has occurred.

This is the current state of the law in the Netherlands. The decision whether to prosecute is made by the District Attorney on a case-by-case analysis based on the criteria listed above. Should the State decide to

10 M.A.M. de Wachter, Active Euthanasia in the Netherlands, 262 JAMA 3316, 3317 (1989).
11 Id.
12 J.K.M. Gevers, Legal Developments Concerning Active Euthanasia on Request in the Netherlands, 1 Bioetica 156, 162 (1987).
13 See de Wachter, Active Euthanasia, supra note 10, at 3317.
14 Id.
prosecute, a lower court composed of three judges hears the case. If the physician is convicted, two appeals are available to him: one to the Court of Appeals and the other to the Supreme Court.\textsuperscript{18}

A. Trends

To assume that the issue of euthanasia is settled in the Netherlands would be far from the truth. At two extreme ends of the spectrum of Dutch professional opinion are Dr. Pieter Admiraal and Dr. I. van der Sluis. Admiraal has been a firm advocate of the euthanasia movement since the early seventies. During a recent interview Dr. Admiraal expressed the opinion that when medicine could no longer rescue a patient, "[T]he only thing left a doctor could give was an open door to a threshold they [the patients] now wished to pass."\textsuperscript{16} Admiraal, who in the interview discussed performing hundreds of acts of euthanasia,\textsuperscript{17} explained the two fundamental reasons for his actions. First, he believes that when the pain of the patient can no longer be controlled or abated, the patient should have the freedom to choose death over a life of intense pain. Second, he believes that the loss of human dignity, a concept he relates to being totally incapacitated and unable to perform even the simplest task to care for one's self, would be sufficient reason to end someone's life.\textsuperscript{18} In his own words, "I would blame myself if I did not do it. I say you must blame the doctor who does not stop this suffering."\textsuperscript{19}

Admiraal appears to superimpose his own personal views about the "quality of life" on those of his patients. It may be that in his mind the concerns he expresses are the penultimate considerations. However, they must not be construed to be the ideas of every member of society.

Quite a different view is presented by Dr. van der Sluis. He states, "Euthanasia is not a right. It is the abolition of all rights."\textsuperscript{20} This remark was an attempt by Dr. van der Sluis to dispel the myth that all physicians in the Netherlands believe in the propriety of euthanasia. His concern is that, with the advent of this new permissive attitude, life is no longer an "incomparably precious and unique gift, but a disposable good, something you own . . . and [something] that you can throw away if it no longer suits you."\textsuperscript{21} The main thrust of his argument is that when life no longer has inherent value, physicians may be able to exercise too much discre-

\textsuperscript{18} Id.
\textsuperscript{17} Id.
\textsuperscript{18} Id.
\textsuperscript{19} Id.
\textsuperscript{21} Id. at 456.
tion in the practice of euthanasia. His fear is that euthanasia no longer remains voluntary, but rather that the physician imposes his own standards of life on the patient. This fear of involuntary euthanasia is very real in many of the elderly people in the Netherlands.  

A survey of patients in a Dutch nursing home revealed that 93% were opposed to euthanasia and that 95% were opposed to the legalization of euthanasia. It was reported in the same article, that the family members more frequently request termination of a patient’s life than does the patient himself. Additionally, family members often pressure the doctor to end the suffering and life of the patient.

The arguments presented by Dr. van der Sluis appear to reflect the concerns of many Dutch citizens. They fear that allowing euthanasia to exist in its current form detracts from the inherent value of human life. They fear that someone else’s concepts of “quality of life” will be arbitrarily imposed on them. They fear that their doctors will succumb to familial pressures in the determination to prescribe euthanasia. They fear for their lives.

Just as there is no consensus in the medical community in the Netherlands, there is no consensus in the Dutch Legislature. In the early part of 1989, two separate bills were to be proposed to Parliament. The first, the Kohnstramm Bill, advocated the legalization of euthanasia. The second, proposed by the coalition government, sought to keep euthanasia punishable. Neither issue was presented, however, because the coalition government fell in the spring of 1989.

B. Summary of Netherlands Law

Despite the common belief, euthanasia in the Netherlands is still against the law. The Dutch courts have carved out exceptions to prosecution provided that strict guidelines are followed. Doctors and hospitals, it seems, are left to their own devices to decide what procedures need to be in place to ensure that these guidelines are followed. However, just as opinions may vary as to the procedural difficulties of performing euthanasia, so too do the opinions as to whether euthanasia should be practiced at all. At very best, Dutch society has developed a tolerance for the concept of euthanasia.

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22 J.H. Segers, Elderly Persons on the Subject of Euthanasia, 3 Issues L. AND Med. 407 (1988). The sampling was relatively small and perhaps should be replicated on a larger scale to insure the percentage, however, given the size of the elderly population in the Netherlands, this author believes that it is representative of the whole.

23 Id. at 420, 421.

24 Id. at 424.

25 de Wachter, Active Euthanasia, supra note 10 at 3318.

26 Id.
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If one were looking for a model on which to base a standard for euthanasia, it would not be the Netherlands. The elderly fearing death at the insistence of their families, doctors imposing their views of the "quality of life" on their patients and the ultimate loss of the value and sanctity of a human life are not qualities that could be recommended to any society that considers itself civilized.

II. Euthanasia in the United States

A. History of Euthanasia in the United States

As surprising as it may seem, the move to legalize euthanasia in the United States is not a new issue. The earliest attempt to legalize voluntary active euthanasia occurred in the Ohio state legislature in 1906. The bill proposed that if an adult of sound mind was seriously injured or so seriously ill that recovery was impossible, the physician could ask the patient in front of three witnesses if he wanted to die. If the patient's response was affirmative, then three other physicians were to be consulted, and if they concurred that the plight of the patient was hopeless, they were to make the necessary arrangements to end the suffering of the patient.

This piece of legislation was presented to the Committee on Medical Jurisprudence where it was rejected by a clear majority, by a vote of 78 to 22.

For the next thirty-one years, there were no major attempts to legalize active voluntary euthanasia in the United States. Then, in 1937, a bill was sent to committee in the Nebraska legislature for review. However, this legislation was never acted upon.

The 1930s, however, saw more than just this piece of proposed legislation. The Euthanasia Society of America (ESA) was formed in 1938. This group, the first of its kind in the United States, had its focus in attempting to legalize euthanasia nationwide. Its credo was that "with adequate safeguards, the choice of immediate death rather than prolonged agony should be available to the dying." In 1939, the ESA attempted to gain enough support in New York to pass legislation similar to the failed Nebraska bill. Despite its efforts, the bill failed to reach the New York legislature.

With the advent of World War II, the movements in the United

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88 Id.
90 See generally Jerry B. Wilson, Death By Decision 32, 33 (1975).
91 Russell, supra note 27, at 72.
States to legalize active euthanasia were put on hold. The activities in the death camps of Nazi Germany caused the willingness of Americans to support any euthanasia movement to wane. However, as the war ended, many chose to forget the atrocities committed during the war in the spirit of racial purity and, in 1945, the ESA again began to muster support for its cause. In 1947, a proposal written by the ESA was presented to the New York legislature. This bill incorporated a new idea allowing one suffering from a painful and incurable disease to petition the court for euthanasia. Even though supported by 1,776 physicians and fifty-four clergymen, two years of lobbying could not get the bill before the legislature.

Failing in every attempt to place a bill to legalize active voluntary euthanasia before the legislatures, the ESA developed a different point of attack. During the 1950s and 1960s, the ESA abandoned its legislative efforts and instead attempted to spread its message by educating the public on the subject of euthanasia. In this respect, it was able to establish the Euthanasia Education Fund in 1967, which later prepared and distributed the Living Will, a document which provides that no artificial means will be used to maintain life in the event that the signer becomes unable to make such decisions due to injury or terminal illness.

Even after ESA abandoned its legislative attempts, three states have considered bills that would permit active euthanasia - Montana, Idaho and Oregon.

It appears the question of whether to allow active euthanasia will not disappear. This continuing controversy seems to result in lax enforcement of the laws that prohibit assisting suicide and even murder. Thus, the real characters in the drama of the debate, the patients, will remain unprotected.

B. The United States - A Medical Viewpoint

"It's Over, Debbie", an unsigned article submitted to the Journal of the American Medical Association (JAMA) early in 1988, created a storm whose fury has yet to cease. The article told the following story. Late one night, a resident at a private hospital received a call. It seemed that a patient, Debbie, was having trouble resting. The physician examined the patient's file on the way to the room and discovered that the patient was dying of ovarian cancer. Chemotherapy had given no relief and she was

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33 Id. at 87.
34 HUMPHREY & WICKETT, supra note 29.
35 Id.
37 Id. at 274.
suffering from chronic nausea from the alcohol drip given to her for sedation. As the doctor entered the room, the patient's only words were, "Let's get this over with." The doctor administered 20 mg of morphine to the young woman and within minutes, she was dead.\(^7\)

The physician in the article was a resident on call at the hospital. The only contact he had had with the patient, Debbie, was the information he gleaned from her chart while on his way to answer her call for "assistance". Were the events subsequent to Debbie's request the result of her informed choice or were they the result of the fatal misinterpretation by the doctor of her comment based on his prognosis of her disease and its painful ramifications? Debbie did not have the benefit of the seven safety valves provided in the Netherlands. The doctor made the decision for her and administered the lethal injection with no further counseling or questions, no express desire to die from Debbie, no thought of alternative treatment or even the courtesy of consulting Debbie's regular physician.

From a single ambiguous statement made by a woman who was not his regular patient, and based solely on the patient's chart, a physician in training decided that the woman would be better off dead and took it upon himself to give her the "rest" she had requested. The doctor took matters into his own hands to decide what was best for Debbie, and based on his view of her medical condition, ended her life. Is this the extent of the power that should be bestowed upon the doctors of this country? Should they be given the ultimate power of life or death? Should they be allowed to kill?

After the article was published, JAMA received numerous replies and responses. All told, the replies were about 4:1 against the action of the physician and 3:1 against JAMA for even printing the essay.\(^8\) JAMA, however, supported its position in publishing the article by maintaining that it was merely an attempt "to provoke responsible debate within the medical profession and by the public about euthanasia in the United States in 1988."\(^3\)

In 1986, The Council on Ethical and Judicial Affairs of the American Medical Association stated that a physician may not deliberately end life ethically; but may withhold life support and medications from a hopelessly terminal person.\(^4\) This is as true today as it was seven years ago.

\(^7\) "It's Over, Debbie," supra note 2, at 272.

\(^8\) George D. Lundberg, "It's Over, Debbie" and the Euthanasia Debate, 259 JAMA 2142 (1988).

\(^3\) Id.

Yet, there are those in the medical profession who believe that this is not enough. They argue that the right to die is personal and that the patient should be allowed to choose a dignified death.  

This is the position of Dr. Timothy Quill, who, more recently, wrote of a case remarkably similar to Debbie's. He admits that he is the physician who gave his patient the prescription for the barbiturates that ended her life. It is his view that the individual should be allowed to make the informed decision on whether or not to end his life. He wrote of Diane, the woman whom he helped commit suicide, "Diane taught me about the range of help I can provide if I know people well and if I allow them to say what they really want."  

The main difference between Diane's story and that of Debbie's is the relation between the patient and the physician. Unlike the doctor in Debbie's story, Dr. Quill was the regular physician of Diane and had attended her for years. He counseled her and her family on the eventualities of her disease. He had her consult with a psychologist. The decision to die was made by Diane, and not by a doctor, and appears to have been truly an informed decision. In short, Dr. Quill conformed to all the requisites maintained as safeguards to euthanasia by the Dutch.  

Dr. Quill is not alone in his support of active euthanasia. Timothy Lace makes the comment:

I believe, however, that physicians can play a positive role in the active euthanasia of mentally competent, terminally ill people who request assistance in ending their own lives. It is crucial that physicians who choose to help dying patients in this way should be free to do so without the fear of criminal prosecution.

In his article, Lace tries to reconcile the differences between the values expressed by many historical sources and realities of ancient medical practice and the Hippocratic Oath taken by physicians, which forbids the physician from giving a "deadly drug to anybody, not even if asked for it, nor will I make a suggestion to this effect". It is his view that the Oath is inconsistent with the ancient views and he therefore proposes that there is a classical foundation for the practice of active euthanasia. This seems to be based solely on the fact that many classical philosophers including Pliny and Porphory considered suicide an honorable alternative.

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42 Id. at 694.
44 Id. (quoting Hippocratic Oath).
45 Id.
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to hopeless illness."46

The main argument propounded by those of the medical profession who support the concept of active euthanasia is summed up in the final sentence of Lace's article wherein he says, "We must not let our personal need to cure take precedence over the right of patients to determine for themselves the course of their lives - it may be all the control they have left."47

Yet is this belief in self-determination enough to allow the physicians to actively participate in the deaths of the patients they have taken an oath to protect? More importantly, can the hopelessly ill patient separate his feelings from those of his physician in order to decide if suicide is an appropriate treatment? Is it not more likely that the patient will rely on the opinion of the physician that his life is no longer meaningful? As the disease progresses, the decision-making processes of the patient are often hindered by both disease and the drugs used to treat it. Is it possible to insure that the patient is truly competent to make a life or death decision? These are questions that the doctors who support the active euthanasia movement seem unable or unwilling to answer.48

Physicians opposing acceptance and adoption of the practice of active euthanasia in the United States have no problem answering the foregoing questions. They argue that, armed with all the tools and training that are currently available today within the realm of the field of medicine, physicians must not forget who they are and what they represent.

Despite the technological revolution, we physicians must continue to honor a tradition that has preserved for thousands of years: the necessity to preserve the best possible life for the longest possible time. When one backs away in any sense from the utter sanctity of maintaining human life, the slope becomes very slippery indeed.49

The physician must remain a healer. To allow a physician to participate in the taking of human life would serve only to destroy what is possibly the last bastion of inherent confidence left in the civilized world today. This loss of faith in the decisions of those we entrust with our health can do nothing but undermine the effectiveness of the physician to heal.50

One of the major arguments made in support of physician-assisted

47 Id.
48 See David Orentlicher, Physician Participation in Assisted Suicide, 262 JAMA 1844, 1845 (1989).
49 Lundberg, supra note 38, at 2143.
euthanasia in the United States is that it is the patient’s free choice to end his own life. However, this argument is fundamentally flawed by its disregard of the influence of the physician over the patient’s perceptions of the nature and possible effects of his illness. The influence exhibited by the physician only increases the angle of the “slippery slope”.

When life has no value and it is just as easy to help patients to die as it is to attempt to fight for their lives, where is the incentive for the physician to exert any effort beyond a cursory attempt to save a life? Medical care would take on a character closely akin to triage. The healthy and those with high degrees of probable successful treatment would receive the best care available. Those whose illnesses appear beyond the current limits of medical technology would be advised, if not actively encouraged, to consider the alternative of euthanasia. Those that the doctors are unable or unwilling to cure could easily be killed to justify the failure as “another hopeless case”.

It is the physician who paints the picture of things to come for the patient. Who among us would be able to resist the temptation to end our lives if presented with a future of nothing but intolerable pain, total dependence and loss of human dignity? “A prohibition against euthanasia provides protection against any conflicted feelings of the physician in response to the patient’s failure to recover or because of the patient’s difficult behaviour.”

Within the medical community of the United States (as in the Netherlands), there is no consensus concerning the question of allowing active euthanasia to be practiced. The arguments for euthanasia are the same that are found in the Netherlands. Similarly, the arguments against euthanasia are consistent with those expressed by Dutch opponents. Because the medical community has not reached an answer to satisfy all those concerned, the debate is continuing.

As physicians become more trained in the “hard” sciences, the trend is to lose sight of the healing objective. Science must be grounded in philosophy for physicians to continue to resist the appeal of being mere technicians and again becoming healers. The art practiced by physicians is not an absolute science but rather a talent for discerning a path through a universe of constantly changing variables. The physician who casts off the cloak of absolutism and accepts the challenge of the unknown to formulate decisions in a constantly changing environment is the true healer.

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81 Id.
C. The United States - Social Policy

In contemporary society, almost any policy question will be resolved with some consideration of cost and cost containment. What happens then when society views the cost of the patient’s care as disproportionately expensive? Human beings are then forced to justify their existence in terms of dollars. “In a society that is dominated by cost-containment, we must fear for the debilitated elderly, the mentally ill and mentally retarded, and the victims of AIDS, Alzheimer’s disease, and other devastating disorders.” These are the individuals who might soon be judged to be “unworthy of life”, since they are perceived as not being “productive” to society. Similar ideas formed the soil from which the euthanasia movement grew in Germany prior to and during the Nazi era. Pre-holocaust, it was the physicians who selected patients and carried out this practice. This trend, once begun, snow-balled until, by the time the Nazi Party had grown to full strength, anyone who was deemed to be inferior or incapable of benefitting society was put to death. This group included the mentally incompetent, criminals and even racial groups that were deemed inferior. The machinery already in place, it was easy for the Nazi Government to implement the policies that led to the death camps of the holocaust era. A relatively simple form was devised and sent to doctors whereby certain individuals could be admitted to “hospitals for treatment.”

This is an all too real historical example of the quick descent of the slippery slope. Once the door is opened and the barriers to euthanasia are removed, the inherent value of life is diminished until anyone is at risk of termination if he is no longer “productive”. It is easy to visualize this scenario taking place in the United States today.

Consider the AIDS patient. He has no hope of survival once the virus becomes activated — it is only a matter of time before he ultimately succumbs to disease and dies. During this time, his productivity, gauged in terms of earnings, decreases due to the effects of the illness, while at the same time the cost of medical treatment skyrocket. Since he cannot earn enough to pay for the required medication and medical assistance, society must bear the burden of his existence until the day he dies. Why not speed up the process and save money? After all, he is going to die anyway.

Similarly, the aged and physically impaired may consider their lives

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88 Id.
84 Id.
87 See Dyck & Reichel, supra note 52, at 1322.
valueless and at best view their existence as burdens, if not on society, then on their families and loved ones. "Will not some feel an obligation to have themselves 'eliminated' in order [to preserve] funds allocated for their [families] or, financial worries aside, in order to relieve their families of the emotional strain involved."88

The argument of those who attempt to reduce the value of human life to a balance sheet equation and then demand a balance of the debits and credits fails in one simple respect. Human life cannot be measured in terms of dollars and cents. In reality, a person's life is not his own.89 Each of us belongs to the community and the "highest goal [of that community] is to protect the lives of all of its members."90 The concern for human life and the realization of its inherent value are not just the dogmata of religious sects or the tenets of an ancient society, but rather are the base of our civilized community.91 "What Albert Schweitzer called a 'reverence for life' underlies all of our moral principles and values of civilised [sic] society, and is the basis of the professional ethic that has served humanity well over the past 2500 years."92

To say that we are each the "masters of our own destiny" and that the decisions made with respect to our living or dying affect no one but ourselves is completely without merit. As a community, each of us interacts with others in such a fashion that the decisions of one affect the rest of the community. This can best be explained in terms of the old movie "Its a Wonderful Life". The story line is simple. A man wishes that he had never been born and then has the opportunity to view the results of his nonexistence. He realizes that, with or without conscious effort, he touched and positively influenced the lives of the rest of the community.

It takes courage to live in our world today, and perhaps, in this generation, it takes even more courage to face death. "The deaths we most admire are those people who, knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet, with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can."93 As a part of the overall "social contract" that each of us ratifies by remaining a member of society, we owe a duty to that society to persevere. For it is through this

89 Id. at 990.
90 Id. at 990.
perseverance that others may gain the courage to succeed against what at the present may seem to be insurmountable odds. Each life touches another and when human life loses its inherent value, even in the sense of a critically ill patient, we all lose. We lose all that could have been gained from having come into contact with the individual. We lose the sense of self that is achieved by viewing ourselves through the eyes of another. In short, we lose a part of us which has set our human civilization apart from the animal kingdom. We lose ourselves.

The social structure of the United States is based upon the ethical perspectives brought to this country with the first colonists. The early settlers brought with them beliefs that unquestionably have transcended the ages and are still present in society today. Despite the tarnish of time, these beliefs are as strong today as they were three hundred years ago when they were first brought to this shore. The fear in many, like the "slippery slope" problem, is that when one allows even a slight erosion of the ethical beliefs that have been the strength and mainstay of this country, the results will be an ever-widening stream across which no dam can be erected.

In a recent article in The New England Journal of Medicine, Dr. Christine K. Cassel made the following observation: "Finally, in an era in which the discipline of medical ethics has become widely accepted in medical schools and hospitals, we need to teach moral reasoning." And yet in the same article she states that, "Patients seeking comfort in their dying should not be held hostage by our inability or unwillingness to be responsible for knowing right from wrong in each specific situation." Dr. Cassel stresses the need for increased attention to "moral reasoning" and yet, seemingly, would instill in physicians the belief that due to the nature of their training and education they should have some special insight as to right and wrong. No one, simply because of the nature of their chosen profession and education, can intrinsically determine right and wrong. In effect, what Dr. Cassel is proposing is exactly what was proposed in Nazi Germany — placing the decision of life and death in the hands of the physician. It is not the function of the doctors of our society to play God or to be the ethical barometers of our society. The physician's role is to heal and, where that fails, to give comfort and support to those for whom death is inevitable. Otherwise, don't we all place our lives in the hands of the doctor portrayed in "It's Over, Debbie"? A doctor, tired from the ardors of his routine, made the arbitrary decision to end a patient's life based on a single ambiguous comment made by an ill and medicated patient. Is this an "ethical" decision of the doctor or a way to ease

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"45 Id.
his own path? No longer would he have to face the reality that doctors
cannot heal everyone or, more than this, face the reality that perhaps
doctors are not the omnipotent beings that they often portray.

"So what was once a crime becomes a debate. And, if history holds
true, that debate will usher the once unmentionable into common prac-
tice." As far back as 1983, polls indicated that over 63 percent of Ameri-
cans approved "mercy killings". More recently, a 1988 poll revealed that
over 50 percent of attorneys favored legalizing euthanasia. We are, it
seems, our own worst enemy. In the debate over the issue of legalized
euthanasia, we tend to lose sight of the ultimate atrocity we would allow.
When we argue philosophically about the right of the individual to choose
to die, we disregard one of the basic beliefs upon which this country was
founded — that life, regardless of how it appears to anyone else, has in-
trinsic value and should not be taken lightly. We lose sight of the not too
distant history where similar arguments succeeded and countless millions
of people were put to death for the cause of racial purity and the overall
"good of society". We lose.

D. The Current State of Euthanasia in the United States

Criminal homicide is defined as the unlawful killing of a human be-
ing with malice aforethought. While the underlying terms may change
the essence of this definition is found in the criminal codes of all fifty
states. In order for one to be found guilty of criminal homicide, it must be
shown that there was a causal connection between his acts and the death
of a human being. That the death may have been otherwise imminent is
immaterial. "The crime lies in causing the death to occur earlier than
otherwise would have been the case." That the act of the accused is not
the sole cause of death is not a defense as long as the act contributed
substantially to the result. Technically then, one who assists another in
committing suicide could be convicted of criminal homicide.

This was precisely the result in the Michigan decision, People v. Rob-
erts. When Roberts' wife, who suffered from multiple sclerosis, failed in
her attempts to commit suicide, she solicited the help of her husband.
Roberts placed a poison mixture within her reach and with this help she
was at last able to end her suffering. The Michigan court, however,
viewed this "mercy killing" as murder and convicted Roberts of murder
in the first degree.
Euthanasia, The Gentle Death

The Roberts decision was not to be a lasting trend in Michigan. Between the Roberts decision in 1920 and People v. Campbell in 1983, there were but three cases in which a court in the United States convicted of criminal homicide those who assisted in suicide. The appellate court in Campbell reversed the trial court's decision where a verdict of guilty was returned against Campbell for murder when he provided a person a gun with which the victim shot himself. The appellate court stated that it was not sure that Roberts was still the law in Michigan and that after a survey of statutory law of other states, no legislature had explicitly made assisted-suicide murder and only one-third had passed special incitement statutes, with much more lenient punishment. The court concluded that a review of the common law disclosed that only three states had ever upheld convictions for murder and that incitement to commit suicide probably had never been a common law crime.

What had happened in the United States in the interim period between 1920 and 1982 to reach such opposite conclusions based upon the same laws? Approximately half of the states today have passed special statutes that make it a crime to assist a suicide. It should be noted that assisting a suicide in these states is a felony, although such acts do not carry the same penalty as homicide. Yet what is the difference? How can it be said that surreptitiously administering poison to someone is criminal homicide and, at the same time, maintain that purposely giving someone the same poison, knowing that the person is going to kill himself, is not? There is no logical answer except that we as a nation are one step closer to the brink of the "slippery slope".

California, in 1988, attempted to gain enough signatures to place a referendum on the ballot that would legalize euthanasia. This initiative,

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73 335 N.W.2d 27 (1983).
74 Id. at 29-31.
75 See Garbesi, supra note 68, at 95.
76 335 N.W.2d at 31.
77 See Id.
sponsored by both the Americans Against Human Suffering and the Hemlock Society failed, at least to most observers, because of organizational problems and not because of public sentiment. Public opinion polls in California indicated that approximately three-fifths of the public favored legalizing euthanasia under certain circumstances. The California initiative, while in some instances more stringent than its counterpart in the Netherlands, was also in many ways more liberal. It allowed euthanasia by advance directive. An adult, healthy or not, could grant a durable power of attorney to authorize euthanasia if he became terminally ill within seven years.

In an answer to the issues raised by the proponents of euthanasia in California (who had planned to raise the issue again in the 1990 elections), there was a response from the medical profession. Of all the many arguments that have been raised in favor of legalizing euthanasia, the supporters in California focused on two: the right to be relieved of unbearable suffering and the right of the patient to control his medical treatment, including the right to request and receive euthanasia.

To the first issue raised, the medical profession responded in agreement that the relief of pain and suffering is a crucial goal of medicine. The question then became whether the care of patients could be improved without resorting to the drastic measures of euthanasia. In the care and treatment of dying patients, it is not necessary that they suffer, as the proponents of euthanasia would lead one to believe. Through the appropriate use of analgesia, pain can be controlled to allow the patient to lead as normal a life as possible. However, despite this relatively simple procedure, physicians continue to underuse analgesia. What is required of physicians is not the ability to perform euthanasia without fear of prosecution, but rather better management of pain.

The second argument raised in favor of euthanasia in California, the right of the individual to choose, has also been answered. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated the answer far better than any single legal scholar could: "Policies prohibiting direct killing may also conflict with the important value of self-determination . . . . The Commission finds this limitation on self-determination to be an acceptable cost of securing the general protection of human life afforded by the prohibition of

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76 Id.
77 See The Humane & Dignified Death Act, CAL. CIV. CODE § 10.5 (1988). The proposed law in California required that the candidate be terminally ill, with a life expectancy of less than six months with or without medical treatment.
78 Christine K. Cassell, The Nature of Suffering and the Goals of Medicine, 322 NEW ENG. J. MED. 1226 (1982).
direct killing”.

It is interesting that throughout the campaign to gain enough signatures to place the Humane and Dignified Death Act on the ballot in California, the staunchest supporters of the new law refused to use the terms “euthanasia” or “suicide”. This was purportedly done in order to avoid the emotional and vague connotations. Isn’t it more likely that the Hemlock Society, founded to raise public consciousness of the issue of euthanasia, feared that, if the people really knew what it was they were voting for, the support they had gained would be lost?

A truly frightening aspect of the fight to get this piece of legislation on the ballot was the sources from which the movement obtained support. In 1987, the California State Bar Association voted to put the proposed law into its legislative program. The vote, 289 to 239, while a narrow victory, was nevertheless a victory for the proponents of the act. This “victory” in the eyes of many, this author included, unequivocally spelled the diminishing value of human life in this country. When those who are in a position to direct the course of our lives are supporting a proposition that is repugnant to the moral and ethical background of society, even though they are only slightly in the majority, we must fear for the fate of our society.

The defeat that the Hemlock society suffered in California was not to be an end to the group, nor can it be said that the opponents of the act gained a decisive victory. The Hemlock Society not only vowed to get the initiative on the ballot in 1990, but also to have the issue before the electorates in Florida, Oregon, and Washington.

A proposal similar to the California initiative was drafted in the later part of 1989 by students at the University of Iowa. The proposal was entitled a “Model Aid-In Dying Act”. Prepared as a class project, the act resembles the California initiative in that it would allow for the termination of life upon request in certain well-defined situations.

Like a cancer, the trend to legalize euthanasia is growing unfettered in this country. What was once a philosophical debate concerning the rights of the individual, because of the publicity given the issue, has found a rich environment in which to grow. No longer is the issue merely a debate, but rather a real problem that must be addressed and resolved. And yet, there are still those in this country who refuse to view the problem as a reality and would rather maintain the status quo. This is not an answer.

The prohibition against active euthanasia is the canvas on which is

**President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions 73 (1983).**

**Derek Humphry, Legislat ing for Active Voluntary Euthanasia, 48 The Humanist 10, 11 (1988).**
That prohibition has served as a dam. We have staked our territory on the very edge of life and worked to humanize it. But this is land we have claimed and tilled by restraining the waters. Remove that dam and a flood will surely overwhelm us. The courts and prosecutors will rush in. Our own ambivalence toward the dying will surge forward. Informality in decision-making, our commitment to care at the end of life, and the safety of the bedside will be swamped. It is not a matter of keeping the current landscape — the law and practice for the termination of treatment — intact and simply taking another step, as some would have it, in furtherance of established principles of liberty and self-determination. That landscape cannot remain untouched by such a change.

Let me make the case: that the progress made has depended in part on this dam, and that the consequences of removing it will be unfortunate.

There has always been the trust in the commitment of the physician that he would do no harm to the patient. In this respect it has been the wisdom of the courts that urged those involved in the termination decisions to steer clear of the courts. Those in control of the judicial system long ago realized that these bedside treatment decisions are not the province of the criminal law, and the states, for the most part, have conceded this issue.

One of the main concerns of the opponents to any type of legislation that would legalize euthanasia, even on a small scale, is that there is no possible way to draft adequate legislation that would provide the requisite safeguards. In order for the concept of self-determination of the time to die to be accepted, those who do not wish to participate must have allayed their fears that they will become the unwilling victims of runaway legislation. This was the concern of Lord Raglan who presented a bill on euthanasia to the House of Lords. He said of his own bill: "... the problem of drawing up a suitable declaration may well be insuperable: all the attempts that I've seen at drawing up a declaration had too many weaknesses for my liking, and had too many holes picked in them." This is simply a concept that can not be legislated into reality.

E. Trends in the United States

In the relatively short time since this project was begun, at least one

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state has put the question of euthanasia to the general public for a vote. The question of physician-assisted suicide was on the Washington State November 5, 1991 ballot as Initiative 119, the "death with dignity" measure. Even though Initiative 119 failed to gain popular support (the measure was defeated 56 - 44 percent), both sides of the struggle are claiming victory. Eileen Brown, leader of the "Vote No on Initiative 119" coalition saw the defeat as a clear indication that people are not ready for euthanasia. She was quoted as saying, "They [the people] want their physicians to care for them, not kill them."

Aligned with those who sought to defeat the initiative were the American Medical Association and the Washington State Medical Association. The AMA's opposition was derived from the ethical standard that physicians should not participate in patient suicide for any reason.

The faction that supported the initiative claim a "moral" victory. The executive director of Citizens for Initiative 119, Karen Cooper, said, "We have won by getting the issue in front of the public." This group predicted a rebirth of the euthanasia issue on both Oregon and California ballots in elections to come.

**CONCLUSION**

It seems an eternity ago that I began this task. In the search for answers, there have only been more questions. The individual spirit has been tempered with the realization that there are some things that should not be left to fleeting whim and transitory fear of the unknown.

Nowhere in the world today is there a country that provides an adequate model for active euthanasia guidelines. The system in the Netherlands, while providing what some would call adequate safeguards, has failed to gain the support of the people it is ultimately to serve. There is as much fear among the elderly today as there was among the Jews of the Holocaust era: that their lives are fast becoming a mere factor in some overall social equation. They fear that abuses in the system will allow for the safeguards to fail and they will be put to death on the insistence of others. Worse, they fear that the decision will be made entirely by the physician that they have entrusted with their care.

Even those in the medical profession in the Netherlands can come to no agreement as to whether active euthanasia should be allowed to be practiced. The decision is ultimately left to the individual physician to

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88 Id.
89 Id. at 23.
90 Id.
91 Id. at 1.
gauge his actions according to his own conscience.

This is not a model but rather an acceptance of the status quo. In essence, the legal system of the Netherlands says that it is illegal to actively assist in the taking of another's life, but we won't prosecute if you kill by the rules - rules which are left to the practitioners to formulate and police.

The movement to legalize euthanasia in the United States has raised no new arguments. The same debate continues to rage and no answers are forthcoming. The medical profession is split. The legislators are split. The people are split. However, unlike a simple contract negotiation, there can be no middle ground. A decision must be reached that will settle the issue.

It has been said that often the best decision is the decision not to make a decision. However, in this case, the status quo is not sufficient. The United States was founded on the underlying concept that the government would protect its people. We must act to protect our society from the abuses that are inherent in any type of program of legalized active euthanasia. We cannot afford to wait and try to correct the abuses as they become apparent. Lives are at stake and even one wrongful death is too many.

Do not go gently into that good night
Rage against the dying light
-Dylan Thomas
EXHIBIT A

Instructions

Diagnosis should be as precise as possible. In the case of traumatically-induced conditions, the nature of the trauma in question, e.g., war wounds or accidents at work, must be indicated.

Under the heading “exact description of employment” the work actually done by the patient in the institution is to be stated. If a patient’s work is described as “good” or “very good”, reasons must given why his release has not been considered. If patients on the higher categories of diet, etc., do no work, though they are physically capable of employment, that fact must be specifically noted.

The names of patients brought to the institution from evacuation areas are to be followed by the letter (V).

If the number of Forms I sent herewith does not suffice, the additional number required should be demanded.

Forms are also to be completed for patients arriving at the institution after the latest date for return, in which case all such forms are to be sent in together exactly one month after the date in question, every year.

Registration Form I  (To be typewritten)

Current No.

Name of the institution

At

Surname and Christian name of patient

At Birth

Date of Birth Place District

Last place of residence District

Unmarried, Married, widow, widower, divorced

Religion Race

Previous profession Nationality

Army service when? 1914-18 or from 1/9/39

War injury (even if no connection with mental disorder) Yes/No

How does war injury show itself and of what does it consist?

Address of next of kin

Regular visits and by whom (address)

Guardian or nurse (name, address)

Responsible for payment

Since when in institution

Whence and when handed over

Since when ill
If has been in other institutions, where and how long

Twin Yes/No __________ Blood relations of unsound mind __________

Diagnosis __________________________________________________________________________

Clinical description (previous history, course, condition: in any case ample data regarding mental conditions)

____________________________________________________________________________________

Very restless? Yes/No __________ Bedridden? Yes/No __________

Incurable physical illness? Yes/No (which) ____________________________________________________________________

Schizophrenia: Fresh attack __________ Final condition __________

   Good recovery _______________________________________________________________________

   Mental debility: Weak __________ Imbecile __________ Idiot __________

Epilepsy: Psychological alteration _______________________________________________________________________

   Average frequency of attacks _______________________________________________________________________

Therapeutics (insulin, cardiazol, malaria, permanent result

   Salvarsan, etc., when?) _______________________________________________________________________

   Yes/No _______________________________________________________________________

Admitted by reason of par. 51, par. 42b German Penal Code,

   etc., through _______________________________________________________________________

Crime __________________________________________________________________________

   Former punishable offenses _______________________________________________________________________

Manner of employment (detailed description of work) _______________________________________________________________________

____________________________________________________________________________________

Permanent/temporary employment, independent worker?

   Yes/No __________________________________________________________________________

Value of work (if possible compared with average performance

   of healthy person) _______________________________________________________________________

This space to be left blank

__________________________________ Place Date ____________________________