

## Chapter Five: Blurring the Line: The New Euthanasia

This chapter is about the changing meaning of euthanasia, how and why the word has been changing, and whether that change is helpful. Since included within that change of meaning are some forms of suicide, this chapter overlaps the previous one. The cases discussed in this chapter include people who end their own lives with the aid of someone else. The discussion also includes people who are put to death without their consent. And finally, there are cases where people are allowed to die either because a treatment was originally withheld or because it is subsequently terminated. The term euthanasia has spread out so as to cover all of these disparate situations but unfortunately that has produced inconsistency and confusion in the term's usage.

A positive meaning for euthanasia has been a somewhat surprising development in recent decades. The term's etymology is positive, that is, it means a happy or good death. But the word was coined as a euphemism for a practice that was widely and severely condemned. As happens with many social movements, a small group of believers doggedly insisted in the face of widespread disapproval that euthanasia - mercy killing - should not only be allowed but should be seen as an important good. In recent years, the movement seems to have achieved considerable success.

One extension of the term euthanasia has been to include physician-assisted suicide. The logic here is understandable; a happy or good death might include the patient asking for an end to life. Thus, it is said that euthanasia can be voluntary as well as involuntary. Voluntary euthanasia certainly draws more support and approval than does involuntary euthanasia. Euthanasia as a term has managed to gain a more positive meaning by the introduction of this distinction. Voluntary euthanasia is intended to be less harsh in meaning than the connotations usually associated with the term suicide.

A more questionable move in euthanasia becoming a positive term has been its extension to cases of allowing a person to die. The practice of allowing death to occur has a long history of being morally acceptable. Euthanasia automatically acquired a more positive meaning by this wider inclusion.

One can argue that there is nothing illogical in this more comprehensive meaning of a good death. Nevertheless, one should be suspicious of this move which has more to do with political acceptance than logical consistency. Discussion henceforth was not to be about the contrast between allowing

someone to die and killing someone; it was about two kinds of euthanasia.

Whether or not the intention was to mislead, these two kinds were inaccurately named *Active* and *Passive*, terms that obscure the heart of the issue. Once the language of two kinds of euthanasia was in place, there was a claim that no significant difference exists between killing and letting die. The latter, *Passive* euthanasia, in fact involves activity. The result is that *Euthanasia* and *Active* euthanasia can then be used interchangeably. The implication is that *Passive* euthanasia should disappear. *Euthanasia* thus was rehabilitated by the creation of *Passive* euthanasia, which began disappearing immediately after its birth.<sup>i</sup>

I do not think this change was the result of a plot or a conspiracy. Language is not so easily controllable and probably no one had charted the course of this change. The shift in *Euthanasia* happened among a public that may have been open to persuasion. But a change of language can either help to clarify points of debate or it can cloud an issue that is in need of further inquiry. How we use the term euthanasia is in some ways a minor question but it is tied up with important changes that need debate.

Until recent decades, the meaning of *Euthanasia* was clear. The *Oxford English Dictionary* gives a summary of its meaning as *The action of inducing a gentle and easy death. Used especially with reference to a proposal that the law should sanction the putting painlessly to death of those suffering from incurable and extremely painful disease.*<sup>ii</sup> Up to the middle of the twentieth century, both friend and foe would have concurred on that meaning of euthanasia. The attitude of the medical profession was succinctly stated in 1973 by the American Medical Association: *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.*<sup>iii</sup> This brief document then allows that there can be a cessation of *Extraordinary means* to keep a patient alive.

One of the first and most famous mercy-killing trials was held in Manchester, New Hampshire in 1950. The entire city had been shocked at the announcement that Dr. Herman Sanders, a highly respected physician, had been indicted on a charge of first degree murder. He had four times injected 10 cc. of air into the vein of a dying patient. According to Sanders, the patient had asked him to do so. He duly noted on the patient's chart what he had done. The trial attracted national and international attention. The jury acquitted Sanders, apparently on the basis that there was no proof that his actions were the cause of death. Juries

in subsequent mercy-killing cases have also refused to convict a physician of murder.

### Physician-Assisted Suicide

The phrase *physician-assisted suicide* brings up issues of the law and ethics. There is a question about the right to be assisted in the committing of suicide, a right that implies a duty for someone else. There are also questions about whether a physician is the person who should assist, whether all physicians should be required to assist, and in what ways a physician should assist.

By referring to *physician-assisted suicide*, one avoids the simple, blunt question: Is it all right to kill oneself? By bringing in the physician, a kind of approval is given or implied. The current assumption about physicians' role in assisted suicide demonstrates that we remain in the grip of the norm that first took hold in the mid-nineteenth century, when physicians displaced clergy as the principal and even exclusive custodian of death and dying.

By including the physician, we seem merely to be discussing various medical treatments. But the question of suicide raises the issue of the physician's proper professional role. There are some cases where people are physically incapable of ending their own lives, but there are many others in which a person is fully capable of the act. If the principle on which suicide is judged acceptable is the patient's autonomy, then always referring to the physician's assistance fails to be forthright about what is being discussed.

Many physicians would object to being required to help kill the patient. The two roles of healer and killer are not easily combined. If not the physician, then who would do the assisting? It is difficult to imagine a new professional specialty of suicide assistant. Jack Kevorkian has not had volunteers to follow him in his self-designated role. In some cases, a close friend might be able to assist. One famous case involved the television reporter, Betty Rollin, who recounted in detail how she helped her mother to die.<sup>v</sup> Rollin prepared the lethal dose of the drug and then left before her mother took it. Although there were legal grounds for Rollin's arrest, the state's attorney general refused to indict her.

Rollin had made a distinction between helping her mother to secure the means of death and actually administering the drug. Some people might find the distinction trivial but, especially for physicians, it could be crucially important. If a friend or a physician administers the lethal drug there is always a question about the patient's consent. Even people who thought that Kevorkian was raising the right issue disagreed with his *suicide machine*. He claimed that he was only

helping to die those who had asked for his help. But most of his clients were aged; many of them were depressed.

There are degrees of coercion by powerful people, even when they do not intend to coerce. The physician - part father, part guru, part scientist - always has to be careful about dominating the patient who is frightened, in pain and feeling helpless. The person's mood may change from day to day, hour to hour. When a person says "I just want to die," he or she may really mean it or the person may be going through a bad patch. People can change their minds about most things and they can act differently in the future. The obvious exception is if they ask someone to end their life and the decision is carried through.

There is a need for strict safeguards that protect the patient's consent if physician-assisted suicide is acceptable. The assistance that the physician provides should probably be limited to information, which might include a prescription, but not include the physician administering the means of death.

The extremes in carrying out physician-assisted suicide are illustrated in two cases, one reported in the *Journal of the American Medical Association*, the other in *The New England Journal of Medicine*. The first article was a mere seven paragraphs long but it caused a firestorm of criticism directed at the journal's editor and became the subject of dispute with prosecutors in Chicago. The essay entitled "I could not give her health, but I could give her rest," was published anonymously. It is so extreme that one might suspect it is fiction done for the express purpose of stirring up controversy.<sup>vi</sup>

The article's brevity is inherent to its intended result. A gynecology resident is awakened in the middle of the night and directed to a unit unfamiliar to him. "Bumping sleepily against walls and corners...I grabbed the chart from the nurse's station on my way to the patient's room, and the nurse gave me some hurried details." What he found was a twenty-year old girl, Debbie, who was dying with ovarian cancer. "The room seemed filled with the patient's desperate effort to survive....It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, 'Let's get this over with.'" The intern concludes that "the patient was tired and needed rest...I could give her rest." He does so by injecting her with 20 cc. of morphine sulphate. Within four minutes her breathing stopped.

One detail after another violates the standards that most advocates of physician-assisted suicide would maintain. The description seemed designed to

mock any standards. A half-awake intern in unfamiliar surroundings hears a young woman speak five ambiguous words. He tells a nurse to prepare a lethal injection and immediately kills the patient. It is difficult to believe that an intern would so cavalierly risk his career, not to mention arrest, even if he was totally convinced of the value of physician-assisted suicide.

The contrasting case of a patient named Diane was recounted by Dr. Timothy Quill.<sup>vii</sup> He had worked with the patient for three and a half years when she was diagnosed with leukemia. Although intervention with this disease had a twenty-five percent success rate, the patient had no desire to undergo the chemotherapy and bone marrow transplant. All she wanted to do was go home and be with her family. She had no further questions about treatment and in fact had decided that she wanted none. Quill talked to her several times and at length to be certain she understood what she was doing. We arranged for home hospice care...left the door open for her to change her mind, and tried to anticipate how to keep her comfortable in the time she had left.

The patient, Diane, went a step further. When the time came, she wanted to take her life in the least painful way possible. The physician told her where to get information and he prescribed the barbiturates in the amount necessary for suicide. Several months later she said her final goodbyes to her husband and son and asked to be left alone. After an hour they found her dead. Quill told the medical examiner she had died of acute leukemia which, he later said, was the truth but not the whole story.

Timothy Quill clearly believes that Diane's suicide is a model case that would persuade almost anyone that a physician should sometimes offer careful and indirect help to the commission of suicide. His empathy, care and candor have been widely admired as he has continued to champion the cause of physician-assisted suicide. The patient, Diane, also exemplified carefulness and courage.

There are two sentences in the essay, however, that raise a concern. Quill writes that It was extremely important to Diane to maintain control of herself and her own dignity during the time remaining to her. As the description of her indicates, Dignity was equated with control. Quill assumes the same meaning in saying A was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death. Although one should not belittle the value put on being in control, it is too bad that Dignity was thought to depend solely on retaining control. The vast majority of the world will never die with the rational control that is put forward in the article as the only way to die a dignified death. In many cultures and in many homes, hospices, and

communities of this culture, people are treated with dignity despite their lack of rational control.

This concern that suicide may be looked upon as a necessary protection of dignified dying is at issue in the Dutch experiment. The Netherlands has been engaged for several decades in the world's most extensive experiment of assisted suicide. The guidelines, which were given final approval in 2002, stipulate that the patient must face a future of unbearable and interminable suffering, and he or she must make a voluntary, well-considered request to die. The physician, along with the patient, must be convinced that there is no other solution, and must consult with another physician. Finally, life must be ended in a medically appropriate way.

These regulations seem reasonable and well-designed to protect the patient's interests. However, the legalizing of suicide seems to create an atmosphere that is lax in the observance of the guidelines. For example, two government studies in 1990 and 1995 found that more than half of Dutch physicians felt that it was appropriate to suggest euthanasia to patients. Since voluntary may not be so clear cut as is often assumed, it is not surprising that the studies found many nonvoluntary cases, or cases where there was no explicit consent.<sup>viii</sup> Consultation with another physician is often perfunctory. What is more surprising is that a study reported in 2000 found that seven percent of assisted suicide cases had complications associated with the methods used to achieve a speedy death.<sup>ix</sup> In many of these cases, the physician administered the lethal medication after the patient's failed attempt at suicide.

Supporters of physician-assisted suicide will say that these problems with the application of the law can and will be solved. The more important question, however, is whether Dutch (as well as U.S.) physicians are adequately trained for and properly sensitive to managing pain and relieving suffering. Suicide can become a routine way to deal with intense suffering. Some of the problem lies in the medical school's preparation of physicians to provide palliative care. Another aspect of the problem is an overly restrictive policy on narcotic drugs for the dying. A survey of 1400 physicians and nurses in five major U.S. hospitals found that eighty-one percent of respondents agreed that the most common form of narcotic abuse in caring for dying patients is under treatment of pain.<sup>x</sup>

It is somewhat paradoxical that the demand for physician-assisted suicide has arisen just when great progress has been made in the control of pain. Although suicide is being urged in the name of patient autonomy, the physician and the health care system still set the options within which choice is made. The only

choice offered to many people may be between inadequate care and suicide. One might ask, says Carol Tauer, whether a medical system that is the subject of so many complaints and so much wariness is a system that ought to be entrusted with additional power, the power to kill.<sup>x</sup>

### Allowing to Die

What historically has been distinguished from killing - by one's own hand or another - is a tradition of allowing death to occur. The argument now is that there is no bright line that separates killing and allowing to die. Before we overturn a long tradition here, the distinction deserves careful consideration. It is important to attend to the precise formulation of the distinction.

Before the advent of modern medicine the discussion of allowing to die used the language of ordinary and extraordinary means. A physician or a patient was required to use all ordinary means to sustain life. In recent times, it has become misleading to employ this distinction. The distinction implies that some things are simple and ordinary; other things are complex and extraordinary. Focusing on the things used in the treatment misses the point. The main issue is what kind of treatment makes sense in relation to the patient's overall situation.<sup>xii</sup>

The Vatican Declaration on Euthanasia proposed a distinction between proportionate and disproportionate means.<sup>xiii</sup> This recognition is significant because the Catholic church had much to do with shaping the language of ordinary and extraordinary. The test should be the burden laid upon the patient. If the treatment simply prolongs a person's dying of a painful disease, there is no proportional benefit for the dying patient. Thus, an IV line to provide nutrition and hydration cannot be called either an ordinary or an extraordinary means in today's medical practice. While a feeding tube makes eminent sense for someone recovering from surgery, the same instrument makes no sense for someone who has suffered irreversible damage to the neocortex and has no prospect for regaining consciousness.<sup>xiv</sup>

Pope Pius XII was prescient in addressing this question in 1957. Hardly a liberal reformer, Pius XII was simply applying a centuries-old tradition. It is unnatural to prevent death in instances where there is no hope of recovery. When nature is calling for death, there is no question that one can remove the life-support system.<sup>xv</sup> The Pope did not merely say that disconnecting life support was allowed; he called the indefinite continuance of such instruments unnatural. People often refer to not using artificial means to extend life. But most of medicine and much else in human life is artifice that protects and

extends life. The artificiality of the means is not the problem; the unnaturalness is, that is, the artifice used goes directly counter to the organism's preparing to die. Pius XII referred to extraordinary or heroic means but he pointed to the burden on the patient and the survivors. The whole situation, including economic concerns, have to be included in judging whether the application of means is proportionate.

In the United States the courts have been arbiters of the ethics as well as the judges of the law in the care of the dying. The first benchmark case for the removal of a respirator was that of Karen Ann Quinlan. On one side, Lawrence Casey, a Catholic bishop in New Jersey, testified that extraordinary means to keep her alive were unnecessary. But the court-appointed guardian argued that *One human being, by conduct or lack of conduct, is going to cause the death of another human being.*<sup>vi</sup> And the lawyer for the physicians said it was *Alike turning on the gas chamber.*<sup>vi</sup>

After the court allowed the respirator to be removed from Karen Ann Quinlan, courts assumed a line between a respirator and a feeding tube, although ethically there seems little difference. The operative principle in both situations is that the patient is allowed to die. There may be a strong emotional difference if removal of a respirator leads to death in a few minutes, while death occurs after several days when a feeding tube is removed.

People who oppose removing a feeding tube usually argue that such a procedure is starving the patient to death. That is no more accurate than describing the removal of a respirator as smothering someone to death. One of the signs of impending death is an inability to eat; the organism is preparing to shut down. A feeding tube is not eating and removal of a feeding tube when the patient is prepared for dying is not starvation.<sup>xvii</sup> Hospices generally recognize the difference and do not introduce the invasive technology of a feeding tube; that is, the patient is allowed to die. In hospitals, respirators and feeding tubes are routinely attached to the dying. Here also there is an emotional difference between not starting a life-support system and discontinuing it. But not to turn off a machine can be as much a decision as turning it on.<sup>xviii</sup>

In the case of Nancy Cruzan, the parents asked for the removal of the feeding tube after she had been in a coma for three years. It took them four more years of court battles before the tube was removed; she expired twelve days later.<sup>xix</sup> Her tombstone reads: departed, Jan. 11, 1983; at peace, Dec. 26, 1990.

Courts look for evidence of what the patient's own wishes would be. These

days, some people have living wills which state a person's wishes if he or she is unable to make known those wishes. Despite all the talk about living wills, only a small minority of people actually have one. Even when people have living wills, hospitals and physicians often disregard them, sometimes because the living will is too vague.<sup>xx</sup> A living will that simply says I do not wish to be kept alive artificially is not precise enough these days.

When the patient is a child or a young person, the parents are usually in the best position to decide but often they are forced into long legal battles with the hospital, the physician, and outside advocacy groups. When the parents of Jamie Butcher, who had been in a coma for seventeen years, tried to remove the feeding tube, they were opposed by an advocacy group for disabled people, Nursing Home Action. Concern for protecting the rights of disabled people is certainly legitimate but the attempt to intervene in the Butcher case made no sense. The parents had done everything possible until they finally decided that Jamie should not be in a coma for a longer time than for the seventeen years he had lived before the accident. The court-appointed referee, James Finley, ruled that the advocacy group had no standing in the case: We have caring parents who have taken care of their son his whole life. There wasn't any dispute that they are loving, caring, decision makers.<sup>xxi</sup>

People do occasionally recover from long comas so that precipitous action here should be avoided. But today's technology does make it possible to determine if there is any glimmer of activity in the cerebral cortex. That determination shows whether the patient can ever regain consciousness and participate in a human community. How long one should wait before disconnecting life-support machinery cannot be made into a rule. But surely at some point - after eight years, seventeen years, x years - it makes no sense to continue keeping the body functioning.

In the case of Paul Brophy, the wife, mother, children and parish priest joined in appealing for the discontinuance of life support. What we have here, said the Catholic priest, is an intervention that is not working. Only the chief physician disagreed. His lawyer said that starving a person to death is not a death with dignity. The physician said that the patient was in good health except for being in a coma. I am not in the business of killing people, the physician said. When asked how long he was prepared to keep the patient alive, he referred to a case that went on for more than twenty years.<sup>xxii</sup>

This physician and protesters in several of these famous cases presumably believe that they are defending the right of individuals not to be killed.

Unfortunately, however, their actions have the opposite effect. By equating the removal of the machinery with the act of killing, they have joined the advocates of euthanasia in their claim that there is no ethical difference between killing and letting die. That judgment can be especially cruel on parents who have had to face this decision. Stephen Carter's opinion on the Cruzan case is both explicit and outrageous: "The thing that is precious in the human, the thing that makes life worth protecting, does not vanish because higher brain function is lost. Consequently, the starvation that occurs when feeding and hydration cease - not the underlying injury that caused the coma - is the cause of the end of that precious human substance. And it is the family, the unit to which the state has delegated the decision, that has made the choice to cease the feeding and, thus, to destroy that precious substance."<sup>xiii</sup>

In such statements, thousands of parents of children, and thousands of children of aged parents, are accused of being state-delegated executioners. In the Cruzan case and in thousands of similar cases, the family members neither wished to kill the patient nor were they the cause of death. They simply recognized that after years of sorrow and care the disease or injury made recovery impossible. They removed the machinery that was delaying the completion of the dying process. Up to a few decades ago in the United States, the cause of death would be evident, as it still is in much of the world. The temporary intervention of machinery does not change the cause of death.

In these situations "Acceptance," the term made famous by Kubler-Ross, is helpful to recall. Acceptance is an attitude one comes to after a long struggle of denial and resistance. Human freedom exists on two levels: a fundamental attitude of yes or no, and a range of options to choose from. Even when the options narrow down to a single possibility, one still has the freedom to say yes or no. When dying is imminent, life that now includes one's death is all that is available for choice. Acceptance is a yes to dying, not the desire to kill or to end one's own or another's life, but a recognition that a life has been completed.

Daniel Callahan uses the helpful analogy of a man shoveling snow from his driveway during a storm. If the snow is light, he might be able to keep up with it and keep the driveway clear. As the snow becomes heavier there will come a point when the shoveler recognizes that his efforts are futile and that the driveway will be clogged with snow no matter how hard he works. When he stops shoveling it is not because he wants his driveway covered with snow but because he accepts the fact that the snow storm is in control. The cause of the driveway being covered with snow is the snow storm, not the cessation of shoveling. In this case, the storm eventually ceases and shoveling can begin again. With

some diseases and injuries, the storm never ends; acceptance of death is final.

It is obviously better when the dying patient can express this acceptance, if not verbally then by a prior written directive. The person who refuses a medical treatment does not desire to die but instead accepts the fact that resistance to dying no longer makes sense. The person's judgment may be distorted; physician, counselor or family member may need to try persuading the patient that the treatment would be worthwhile in the particular situation. In Kubler-Ross's distinction, the patient may simply be giving up (Resignation) rather than having reached acceptance.

Sometimes the decision has to be made by someone acting as a proxy for the dying patient. A family member or close friend will usually be the one who can decide what is best for the patient's interests. However, there can be conflict of interest when, for example, the heirs to a sizeable estate are involved.

Many hospitals now have an ethics committee or a committee of the person to protect the rights of the patient. The courts or the hospital administration are not in the best position to decide when acceptance of death is appropriate. No one is an infallible judge. But if someone has to decide when death is to be accepted, one hopes for a loved one on the scene, who can decide to accept that death should be allowed to happen.

## Killing

In recent years the line has been crossed that separated allowing to die from killing. More accurately, the argument has been that there is no line, that what had been called allowing to die amounts to the same thing as killing. Change in the meaning of Euthanasia has facilitated the shift for advocates of assisted suicide who can now argue that the question is solely and simply about various means of achieving a good death.

Central to such an argument has been the claim that Active and Passive are the two kinds of euthanasia so that the issue turns on whether a positive act is performed. Ronald Dworkin, commenting on a recent court decision, writes that Although the distinction between acts and omissions is often valid...that distinction does not seem important in this context. He could then conclude that Removing life-support systems already in place, which the *Cruzan* case said states must allow, is as positive an act as an injection.<sup>xiv</sup> He is correct that allowing a patient to die involves positive acts, but the kind of act performed, its meaning and intention, is crucial.

When intention is acknowledged as important, there may still be a claim that intention is blurred or cannot be determined. That position is taken especially in cases where large doses of potentially lethal drugs are given to a patient. Is the intent to relieve pain? Is the intention to bring on death? Does it make any difference? Many people are tempted to go with the third question and answer no. And yet both legal and moral traditions have always considered intention to be one of the major factors in determining the legality or morality of particular actions.

It must be admitted that there are times when it is unclear to an outsider and even to the actor what his or her intention is. A son removes the respirator from his father who is dying. If the intention is to allow his father to breathe his last and complete a peaceful death, that is one kind of action. If the son's intention is to get hold of his inheritance, that is a different kind of action. The external action is the same, but the moral value differs.

If one provides a pain killer that might hasten death by some days in the distant future, the intention to relieve pain seems obvious. If one administers the same drug and death follows in a few minutes (or hours? or days?), can one still claim that the intention is pain relief? The traditional language was *double effect*, a rule for intending a good effect while acknowledging an unintended bad effect. (The military's euphemistic phrase, *collateral damage*, is now well known). The new medical technology, especially pain-killing drugs, has complicated the issue. I do not think one can entirely abandon the principle of double effect because it applies to practically all human actions. We are seldom in control of all the effects of our actions.

In most circumstances, the difference between allowing to die and killing is clear. The fact that there are cases where the difference blurs and genuine debate is possible does not eliminate the difference between an intention to kill and an intention that is not to kill. Night and day are different, although it may not be clear exactly when one passes into the other. Analogously, thirty miles per hour and sixty miles per hour are different even though the difference between twenty-nine and thirty-one miles per hour may be difficult to determine.<sup>xxv</sup>

To those who say there is no clear line between letting die and killing, Robert Burt responds: "From my perspective, however, it is precisely the tenuousness of the logical distinction that recommends its preservation as a way of giving expression to the inherently limited force of rationality." He goes on to ask "how the format for decision making can be structured so that this ambivalence, this tension, can be most effectively and visibly preserved. On this score, terminal

sedation has clear advantages over physician-assisted suicide.<sup>xxvi</sup>

The decisions in two United States circuit courts approving physician-assisted suicide opened a new level of discussion about euthanasia.<sup>xxvii</sup> The U.S. Supreme Court overturned both decisions by a vote of nine to zero. The unanimity of the Supreme Court is somewhat misleading because several opinions indicated an openness to challenge the traditional distinction.<sup>xxviii</sup>

The Ninth Circuit Court in the state of Washington ruled that a prohibition of suicide violated the fourteenth amendment's equal protection clause that requires All persons similarly situated...be treated alike.<sup>@</sup> Judge Stephen Reinhardt said that the prohibition of suicide @places an undue burden on the exercise of that constitutionally protected liberty interest.<sup>@</sup>

As to whether disadvantaged persons might be pressured into suicide, the court said that was Audicrous on its face.<sup>@</sup> This dismissal of a serious issue was shocking. It did not occur to Reinhardt that helplessness might undermine voluntariness, that an individual's wish for continued life could be clouded by a disability that undermined accustomed self-confidence, even though the diagnostic label of mental incompetence might not clearly apply.<sup>@xxix</sup>

Judge Robert Beezer in his dissent took a more balanced view. He said that the change in health care has forced us to step back and reexamine the historic assumption that all human lives are equally and intrinsically valuable. Viewed most charitably, this reexamination may be interpreted as our struggle with the question of whether we as a society are willing to excuse the terminally ill for deciding that their lives are no longer worth living. Viewed less charitably, the reexamination may be interpreted as a rationalization for house-cleaning, and burden-shifting - a way to get rid of those whose lives we deem worthless. Whether the charitable or uncharitable characterization ultimately prevails is a question that must be resolved by the people through deliberative decision making.<sup>@</sup>

The Second Circuit Court of Appeals in New York State made a similar ruling shortly afterward. It said that those on life-support systems are being treated differently than those who are not, in that the former may hasten death@but the latter may not hasten death through physician-assisted suicide. The premise here is that refusing life saving treatment is nothing more nor less than assisted suicide.<sup>@</sup> Chief Justice William Rehnquist, in the Supreme Court's ruling, reaffirmed the difference between allowing to die and killing: A distinction recognized and endorsed in the medical profession and in our legal traditions is both important and logical; it is certainly rational.<sup>@xxx</sup> The Supreme Court saw no

unfair discrimination. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted, life saving medical treatment; *no one* is permitted to assist a suicide.

The Second Circuit Court used inflammatory language in describing the allowance of death. *The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration.* The Court also used two spurious arguments in referring to *Active/passive* and *Natural*. It claimed that *The writing of a prescription to hasten death...involves a far less active role for the physician in bringing about death than through asphyxiation, starvation and/or dehydration.* I noted earlier that it may be desirable to restrict the physician's role but the issue is muddled by contrasting the act of writing a prescription and the act of disconnecting a respirator. Both are actions but they differ in meaning and intention. Removing a respirator is a condition for death to occur; writing a prescription for lethal drugs is a contributing cause of death.

Even more muddled was the Court's contention that by the discontinuance of life-support system *A patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease.* As I commented in chapter one, no human action is merely natural. The moral issue is whether the natural is being shaped for good and human purposes or whether the natural is being violated with a violent intrusion into the cycle of life and death. The introduction of life-support systems and their discontinuance are deeply personal acts that affect the rhythms of human nature. One might well make the case that some *Astening* of death is sometimes compatible with the natural process leading to a human death but only in cases where as the Court said *death is imminent and inevitable.* When intervention stops and death immediately ensues, the death is indeed the result of the disease. The intervention has merely stopped an intervention.

In a 1999 case before the Supreme Court, Justice Anthony Kennedy contrasted *Active intervention* and *Nature taking its course.* The phrasing could have been better. Lawrence Tribe rejected Kennedy's opinion; but Tribe's statement that *none of these patients is in a state of nature* introduces worse phrasing. Talking about a *state of nature* is a distraction from the important question about the limits of the control of natural processes.

The blurring of the line between allowing to die and killing can be looked at from opposite directions. Looked at from the side of allowing death, the act of letting die can be said to be not *essentially different* from killing. However,

blurring the line can also be a move from the opposite direction so as to make killing seem a form of letting die. Of course, some forms of killing are obviously different from letting die. It is the forms of killing that do not violently intrude on nature that are deemed acceptable. Thus, what is natural and what is not natural remain an issue. And that is why the court could claim that one is only hastening death. If the result were the only thing important, without regard to what is natural, why would one merely hasten death instead of bringing it about immediately and certainly? Why would a quick acting bullet to the back of the head not be preferable to hastening death through drugs?<sup>xxx1</sup>

The question is a serious one. When the state executes prisoners it looks for means that appear to be medical procedures. The guillotine or the firing squad are too revealing of what the state is doing, arrogating to itself the power to kill human beings. If the state is licencing physicians or other specialists to kill, the language for this permission ought to be clearer than hastening death.

An American Hospital Association study found that seventy percent of deaths in the United States included a negotiated settlement regarding technology.<sup>xxxii</sup> In the majority of cases there is a clear difference between killing and allowing to die. The joint effort should be directed at comforting the patient physically and spiritually. No doubt there are cases when the effort to reduce pain has an immediate connection to the ending of the life. Physicians should be given some leeway of interpretation lest they generally under medicate those who are in pain. But extreme cases do not make good law.

A legal approval of physician-assisted suicide and euthanasia creates a new context of medical treatment. Then the unclear line shifts to voluntary and involuntary which many Dutch physicians seem to cross. The result is that euthanasia solves the problem of a runaway technological medicine with a final resort to technique. It opposes the horror of a purely technical death by using techniques to eliminate the victim.<sup>xxxiii</sup>

I would subscribe to the two guidelines that Robert Burt offers:

1. Intentional, unambiguous infliction of death in any context should be rigorously avoided and socially disapproved.
2. Where death cannot be avoided, ambivalence about its moral status is unavoidable and should be self-consciously honored through design of practical techniques for highlighting, even amplifying its presence.

In our attempt to master death through rational means we are in danger of creating new horrors. The attention of the country ought to be on improving

health care rather than finding a quick and technically efficient solution. We now have medicines and technology that can do wonders in curing many diseases. But dying is part of what physicians, researchers and the rest of us must still accept and we will always feel some ambiguity when our decisions concern our own or another person's dying.

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- i. William May, *The Physician & Covenant* (Philadelphia: Westminster Press, 1993), 16, accepts the language of active and passive euthanasia but then argues that the moral justification in each case depends upon the motive and intent of the agent and the wishes of the patient rather than on the act defined as an omission or a commission. I think James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine*, 292(1975) is logically on stronger ground in dismissing any significant difference between active and passive euthanasia. If motive and intent are crucial, then one should not accept Rachels's language in the first place.
  - ii. *Oxford English Dictionary*, 904.
  - iii. "The Physician and the Dying Patient," in James Rachels, *The End of Life: Euthanasia and Morality* (New York: Oxford University Press, 1986), 88.
  - iv. Robert Burt, *Death is That Man Taking Names*, 181.
  - v. Betty Rollin, *Last Wish* (New York: Simon and Schuster, 1985).
  - vi. Anonymous, "I Could Not Give Her Health But I Could Give Her Rest," *Journal of the American Medical Association*, 1988.
  - vii. Timothy Quill, "A Case of Individualized Decision Making," *New England Journal of Medicine*, 324:691-94 (March 7, 1991); see also *Dying Dignified*
  - viii. Herbert Hendin, *Seduced by Death* (New York: W.W. Norton, 1998), 26-27; Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia," *Issues in Law and Medicine* 7(No. 3, 1991), 339-44.
  - ix. Joanna Groenewoud and others, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," *New England Journal of Medicine*, 342(No. 8: 2000), 551-56.
  - x. *American Journal of Public Health*, in *The New York Times*, Jan. 14, 1993.
  - xi. Carol Tauer, "Philosophical Debate and Public Policy on Physician-Assisted Suicide," in *Must We Suffer Our Way to Death*, ed. Ronald Hamel and Edwin DuBose (Dallas: Southern Methodist University Press, 1996), 60.

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- xii. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatments: A Report on the Ethical, Medical and Legal Issues in Treatment*, (Washington: U. S. Government Printing Office, 1983).
- xiii. Sacred Congregation for the Doctrine of the Faith, *Vatican Declaration on Euthanasia*, 5(May, 1980).
- xiv. William May, *The Physician's Covenant* (Philadelphia: Westminster, 1993), 76.
- xv. Pope Pius XII, *The Prolongation of Life*, *The Pope Speaks*, 4(No. 4: Spring, 1958), 395-96.
- xvi. Peter Singer, *Rethinking Life and Death* (New York: St. Martin's Press, 1994), 70
- xvii. Daniel Callahan, *The Troubled Dream of Life* (New York: Simon and Schuster, 1993), 81
- xviii. Solomon and others, *American Journal of Public Health*, 83(1993), 14,17.
- xix. Cathy Siebold, *The Hospice Movement* (New York: Twayne Publishers, 1992), 48.
- xx. Mildred Solomon and others, *Decisions Near the End of Life: Professional Views of Life-Sustaining Treatments*, *American Journal of Public Health*, 83(1993): 83 % of physicians agreed that all competent patients have the right to refuse life-support, even if that refusal may lead to death. However, the wishes of patients often go unrecognized, as reported by Sean Morrison, *Journal of American Medical Association*, 274(August 9, 1995), 478-82.
- xxi. *New York Times*, Oct. 18, 1994.
- xxii. Interviews on the ABC television program, Dec. 5, 1985.
- xxiii. Stephen Carter, *The Culture of Disbelief* (New York: Basic Books, 1993), 242-243.
- xxiv. Ronald Dworkin, *New York Review of Books*, Aug. 8, 1996, 47.
- xxv. Jonathan Glover, *Causing Death and Saving Lives* (New York: Viking, 1990), 166.
- xxvi. Robert Burt, *Death is That Man Taking Names*, 163, 167.
- xxvii. *Washington v. Glucksberg*, 1997, 117 S. Ct 2258; *Vacco v. Quill*, 1997, 117, S. Ct 2258.
- xxviii. Ronald Dworkin, *What the Court Really Said*, *New York Review of Books*
- xxix. Robert Burt, *Death is That Man Taking Names*, 116.
- xxx. *New York Times*, June 27, 1997, A18.
- xxxi. Thomas Lynch, *The Undertaking* (New York: W.W. Norton, 1997), 170-71 asks this

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question with graphic language: A@Why not pearl-handled, silver-bulleted, hair-triggered, .22 caliber Smith & Wessons? Pressed under the right earlobe, the entrance wound is tiny, the severance of the spinal cord is immediate and humane, and the exit wound, if indeed there is any, leaves no mess at all.@

xxxii. *New York Times*, Dec. 9, 1990.

xxxiii. William May, in *Must We Suffer Our Way to Death*, 105.