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EUTHANASIA: ORCHESTRATING “THE LAST SYLLABLE OF . . . TIME”

Stephen A. Newman*

INTRODUCTION

Taboos and unwritten social rules surrounding death, suicide and euthanasia have strangled candid discussion of these related topics for many years. Euthanasia—acting to produce a merciful death—has been a matter for whispered conversation among doctors, occasionally practiced but only recently publicly raised as a matter for “proper” debate.

The grip of silence has been dramatically broken by various events, most notably:

- the publication in a 1988 issue of the Journal of the American Medical Association of an article by an anonymous doctor recounting his administration of a lethal dose of morphine to a woman dying of ovarian cancer, entitled It's Over, Debbie
- a statement published in the New England Journal of Medicine in 1989 by ten doctors associated with the nation’s leading hospitals and medical schools declaring their belief that “it is not immoral for a physician to assist in the rational suicide of a terminally ill person”
- the publication in 1991 in the New England Journal of Medicine of

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The title of this article is partly borrowed from William Shakespeare:

Tomorrow, and tomorrow, and tomorrow
Creeps in this petty pace from day to day
To the last syllable of recorded time

Macbeth, Act V, scene v.

1. Lawrence K. Altman, Use of Suicide Device Sets in Motion Debate On A Disturbing Issue, N.Y. TIMES, June 12, 1990, at C3.
a detailed account by Dr. Timothy Quill of his decision to help a patient suffering from leukemia to commit suicide

- the widely publicized death of Janet Adkins, a woman suffering from Alzheimer's disease who used a suicide machine devised by Dr. Jack Kervorkian, a retired pathologist, to end her life
- the publication of a suicide manual called Final Exit by a small publishing house that remarkably zoomed to the top of a major national best seller list

All of these events provoked wide commentary in public and professional arenas, in marked contrast to the near silence that prevailed previously.

The significance of the articles in the New England Journal of Medicine and the Journal of the American Medical Association can hardly be overestimated. As gatekeepers and arbiters of materials deemed fit for widespread, serious discussion by the nation's physicians, the two leading journals of the medical profession signaled that open discussion of euthanasia is now acceptable. In the Quill article the author described and took responsibility for an act of assisted suicide. The fact that the account was signed rather than anonymous added further to the respectability of the discussion.

Voluntary euthanasia, commonly performed at the request of an individual suffering from catastrophic disease, is a version of suicide done with the assistance of others. Responses to suicide historically have been harsh, with penalties ranging from refusal of traditional burial and confiscation of property to exposure of the corpse to scavenging animals and criminal punishment for unsuccessful suicide attempters.

Even in modern times, suicide is often denied, disguised as an accident,
unreported in obituaries, and kept "within the family." Part of the reticence about euthanasia can be traced to the social opprobrium that attaches to suicide.

The new openness in thought—no doubt motivated by a dread of medical technology that draws life out to harrowing extremes—has led to a serious movement to legalize euthanasia. An initiative to do so was on the November, 1991 ballot in the State of Washington. Significant efforts have also been made in other states, and public opinion polls show surprisingly strong support for such proposals.

Major opposition to legal euthanasia comes from physicians and right to life groups. The debate promises to intensify in the years ahead as proponents draw strength from the successes of the right to die movement and opponents try to stem the public's enthusiasm for euthanasia.

Since particular instances have the powerful effect of galvanizing debate on public issues in America, it is worth taking special note of three of the above-listed events that involved individuals whose deaths were hastened by physicians. I will discuss these events first.

Next I will consider the key questions generally raised in the controversy over the legalization of euthanasia. To date, the answers offered too often consist of poorly supported predictions about the future consequences of a limited euthanasia policy. Little consideration is given to other, sometimes more plausible outcomes.

It is important for all participants in the controversy to keep in mind the uncertainty that marks any position taken on the best course for future social policy. Medical, legal and social science expertise stops short of predicting the future. Calculated risks are an unavoidable part of every public policy decision—including the decision to maintain the status quo.

"It's Over Debbie"

Few articles in the staid Journal of the American Medical Associ-

13. See Parachini, supra note 11.
ation (JAMA) have stirred such visceral responses as the brief essay entitled “It’s Over, Debbie.” In this essay, an unnamed young resident on call at a large private hospital receives a late night phone call summoning him to the bedside of a twenty-year-old woman named Debbie. From a scan of the patient’s medical chart and a hurried conversation with the nurse, he learns that Debbie is dying of ovarian cancer. She has recurrent vomiting and her weight is down to eighty pounds. Entering the room, he sees a hollow-eyed, emaciated woman, looking much older than twenty. She is breathing heavily, starved for air. An older woman is holding her hand. The resident recounts that Debbie had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words... were, “Let’s get this over with.”

The resident prepares to administer a dose of morphine, thinking it “will give her rest” and also expecting it will “do the job.” He tells the two women that he will “give Debbie something that would let her rest and to say goodbye.” The essay continues:

Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the now sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved.

It’s over, Debbie.

Letters to JAMA from physicians generally condemned the doctor’s behavior, often angrily, and added their view that JAMA was wrong to publish it. The editor of the Journal took to his own pages to defend the decision to publish and to describe the unusually strong and conflicting reactions the article sparked among doctors and members of the public. He noted:

15. Id.
16. Id.
Most of the early letters were from physicians and tallied about 4:1 against the action the physician described and 3:1 against THE JOURNAL for publishing the essay. Reactions from the public and media were delayed but were extraordinary in volume and duration.

... While our early mail was heavily in opposition, our recent letters have run strongly in favor of the act described by the physician and of THE JOURNAL'S courage in publishing about euthanasia. If physicians' letters are any indication, mainstream physician involvement in active euthanasia is unlikely in the near future.18

The troubling aspects of Debbie's case are clear. The resident did not know the patient, having knowledge of her only from the chart and from a quick conversation with a nurse in the hallway. He acted on the patient's ambiguous statement, "Let's get this over with." He did not consult with the older woman in the room with Debbie; he did not even ask who she was. He did not consult with the attending physician, who presumably knew the patient, family, and case best and had primary responsibility for it.

All of this is true. But there are other truths here as well. The resident was faced with a patient in great distress. Her suffering was quite apparent. Her doctors had already made the decision to limit medical attention to supportive care only; she was to be allowed to die. The tragedy's end was already written. It had only to be acted out by the patient.

Allowing nature to run its course was supposedly the humane thing to do so as not to prolong dying when the case was hopeless. Nevertheless, her dying was prolonged. How humane was it to let her suffer for days, without the relief of sleep, brutalized by her disease, with (presumably) her mother holding her hand? How many hospital caregivers had walked by this tableau of suffering and thought "the sooner the end comes, the better?" How many had simply decided not to think about it at all?

Debbie had been treated with chemotherapy. If treatment had worked only to slow the inexorable progress of the disease, then doctors had only contributed to drawing out her death. Doing nothing while the torment continued seems more like letting her suffer than letting her die.

Debbie could not have been given relief without a clear danger to her life. Even a modest dose of narcotic painkiller was enough to cause

her death. If the young woman and her family wanted relief at any cost, they should have had access to it.

Unfortunately, this resident made little effort to ascertain their wishes. By relying instead on his own intuitions about their thoughts, he took too much of the decision away from both patient and family member.

The resident’s failure to consult other doctors is more understandable. It is possible that this resident could anticipate the reaction of doctors in his hospital to any suggestion of euthanasia. The ability to block out others’ suffering, a broad streak of self-righteousness, and an overweening fear of even the most improbable legal involvement are, unfortunately, some of the less-than-noble ingredients in the modern medical psyche. These traits can easily discourage the kind of doctor-to-doctor consultations that raise sensitive moral and ethical issues in decision making at the end of life.

“Diane” and Dr. Quill

Dr. Timothy Quill’s sensitive and moving account of his aid to a woman desiring suicide is a landmark in the euthanasia debate. His patient, identified as “Diane,” refused a stressful course of therapy designed to combat her leukemia. The proposed treatment—which included chemotherapy and bone marrow transplants, with all the painful side effects and consequences—would not guarantee her survival. The mortality rate with treatment was in fact quite high. Some long term cures did result, however, about 25 percent of the time. The outcome without treatment was almost certain death.

Despite the possibility of a cure, Diane refused treatment. Quill made sure she understood the options and the odds. He assured her of his best effort to minimize her pain if she chose treatment, and as a former hospice director he took this aspect of care very seriously. She was nevertheless “convinced she would die during the period of treatment and would suffer unspeakably in the process (from hospitalization, from lack of control over her body, from the side effects of chemotherapy, and from pain and anguish).” Diane discussed the matter extensively with her husband and college-age son. She talked to a psy-

20. See Quill, Death and Dignity, supra note 4.
21. Id.
chologist. She consulted with Dr. Quill, who came to agree that she had made the right decision in refusing treatment.

Diane soon confronted her doctor with another decision. She wanted to die when she no longer felt she could maintain a dignified existence. Quill assured her of his belief in comfort care, in controlling pain and lessening suffering as much as possible. But Diane "had known of people lingering in what was called relative comfort, and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible." Quill sympathized, but initially felt he could not promise her his assistance. Yet, Dr. Quill recounted,

In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left until she found a safe way to ensure her death. I feared the effects of a violent death on her family, the consequences of an ineffective suicide that would leave her lingering in precisely the state she dreaded so much, and the possibility that a family member would be forced to assist her, with all the legal and personal repercussions that would follow.

After satisfying himself that she was rational and unwavering in her decision, Quill suggested to Diane that she contact the Hemlock Society, a group that supplies information on suicide. A week later, when she requested sleeping pills, he had another conversation with her to discuss her plans:

In our discussion it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted.

Diane lived several more months. Toward the end, she experienced weakness, bone pain, and fever. She faced a future that "held what she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation." She told Quill the time had come. Two

22. Id.
23. Id.
24. Id.
25. Id.
days later, after saying her goodbyes to friends and family at her home, she used the pills to end her life.

Dr. Quill reported the cause of death as leukemia. He did not mention suicide, wishing to avoid the involvement of police, an ambulance crew, the medical examiner’s office, a criminal prosecutor—the people society authorizes to invade the privacy and lives of those who have suffered enough. But Dr. Quill’s publication of his story and the vast coverage it received in newspapers and the media led a county prosecutor to present the case to a grand jury. The grand jury refused to issue an indictment.26

Unlike many physician-authored accounts, in this one the patient, not the doctor, is the principal character. Quill had a role to play in Diane’s life, but the drama that unfolded clearly was not his story but her story. Quill accepted his diminished role without peevishness or loss of self-esteem.

Quill’s experience demonstrates that once the doctor gives up the effort to control the patient’s life, he is freer to participate in it on a deeper level. Quill manifested his respect for Diane by attempting to understand her and her stance toward the life and death questions she faced. When Diane determined that she would rather end her life than have her disease destroy it, Quill had to make a crucial decision about his own role. He could have refused to discuss her suicide, discouraged it as a matter of principle, cited the state law that makes assisting in suicide a crime, or participated with what politicians call “deniability” by prescribing the sleeping pills but speaking about them only as an insomnia remedy.

Dr. Quill chose none of the above. He talked with Diane directly about her suicide choice and offered his help in forestalling physical pain. He kept the door open to other alternatives and struggled to comprehend her overwhelming final decision.

He decided he would support her to the fullest extent. It is impossible to read Quill’s thoughtful and heartfelt account without feeling a deep sense of his humanity and commitment to the care and not the control of his patient.

26. Lawrence K. Altman, Jury Declines to Indict a Doctor Who Said He Aided in a Suicide, N.Y. Times, July 27, 1991, at Al. Since the proceedings of the grand jury are secret, the basis of its decision is not known. However, Dr. Quill did testify for several hours, and undoubtedly the grand jury was fully informed of what he did and why.
On June 4, 1990, Dr. Jack Kervorkian helped Janet Adkins, a fifty-four-year-old woman with Alzheimer’s disease, commit suicide. He did so by means of a home-made suicide machine. It was described by a Michigan judge as consisting

of a frame holding three chemical solutions that fed into a common intravenous line, which was controlled by a switch and a timer. . . Mrs. Adkins herself activated the switch that actually turned on the machine; however, he shook the bottles containing the chemical solutions to ensure that the flow was correct.\(^{27}\)

Kervorkian had never used the machine before. He was a retired pathologist, intent on starting what he termed a

unique medical practice: to assist the rational suicide of patients who are suffering from imminently terminal illness, severely crippling or painful disease or deformity or trauma, and who, on their own, have decided that the quality of life for them has degenerated to intolerable levels. Candidates for the service must be alert and mentally competent, and their underlying condition must be physical (not psychiatric).\(^{28}\)

Kervorkian met once with Mrs. Adkins and her husband, videotaping the session. She appeared, in the words of the judge, “coherent, responsive to verbal communication, and without significant, clinically obvious physical or mental impairment; it was reported that she played tennis within days of her induced death.”\(^{29}\) Her doctor testified that she might have survived for seven to ten more years. Upon autopsy, it appeared that the disease had in fact reached an advanced stage in her brain.

Kervorkian faced two court proceedings; in one he was charged with murder and in the other he fought against an injunction to restrain him from further use of his suicide device. The murder charge was dismissed.\(^{30}\) In the civil case, Judge Alice L. Gilbert ordered Kervorkian not to use the machine or in any other way to aid a patient to commit suicide.\(^{31}\)

Judge Gilbert accused Kervorkian of self-promotion and sharply

28. Id. at 110 (Letter from Kevorkian to Michigan Dept. of Licensing and Regulation).
29. Id. at 113.
30. Schmidt, supra note 5.
criticized his conduct as a physician. Rather than carefully assessing the condition of his patient, she stated, he hastily agreed to take on Mrs. Adkins as a subject for testing his experimental device. He did not know Mrs. Adkins well; he did not confirm her diagnosis; he did not explain the options she had and the possibility for new discoveries about Alzheimer's on the scientific horizon. He lacked the training and experience necessary to evaluate an Alzheimer's patient. Judge Gilbert found that "it was, in fact, the patient . . . who dictated the treatment modality, and Dr. Kervorkian simply obliged."\(^8\) His patient was "neither imminently terminally ill nor suffering pain,"\(^3\) although the judge felt "it is probable that she did have sufficient mental impairment to preclude the capacity to make the decision she made."\(^4\)

A very different light is shed on the matter in an account published by Myriam Coppens, who served as the Adkins' family therapist for the last year of Janet Adkins' life. Ms. Coppens wrote:

I can . . . assure you that Mrs. Adkins had a longstanding, voluntary, well-considered philosophy of life that included her wanting the option of a physician's aid in dying in case of terminal illness or a disease such as Alzheimer's. Mrs. Adkins read about Dr. Kevorkian in a magazine in October 1989 and spoke to him at that time. . . . At the request of her family and with Dr. Kevorkian's encouragement, she sought experimental treatment for Alzheimer's disease in Seattle from December 1989 through March 1990. It failed to help her. It was then that Mrs. Adkins began to work with Dr. Kervorkian. He obtained two medical opinions and her medical records from two physicians who had seen her and had confirmed her condition. He informed her that she needed to be rational at the time of the assisted suicide. The decision she made was well thought out. She was, each time I had contact with her, through numerous telephone conversations, consistent and competent regarding the plans she was making. I saw her two final times with two of her sons and her husband . . . and I could only respect what she, a competent woman, had decided with the incredibly courageous support of her whole family. Like her minister, I stood by her and those close to her. There was never any doubt in her mind. She was a strong-willed person. Having Alzheimer's disease, she wanted to die before her mind escaped her and made her, in her eyes, a nonperson. She wanted death with dignity, and she found it. By giving her the choice she wanted, Dr. Kervorkian permitted her in turn to enjoy life fully while she still could. That she died in a van in a parking lot was of no importance to her. It was the choice that counted.\(^5\)

32. Id. at 119.
33. Id.
34. Id.
35. Myriam Coppens Letter, 324 NEW ENG. J. MED. 1434, 1435 (May 16, 1991). In the letter, Ms. Coppens discloses that in March, 1989, she took a position as coordinator of the Hemlock Society in Oregon. She first met Janet Adkins in July, 1989, through that organization. The Hemlock Society is a prominent advocacy organization for euthanasia.
The two accounts are not entirely irreconcilable. Judge Gilbert criticized Dr. Kervorkian for failing to act as a physician, and she correctly concluded that he did not perform all the usual functions of a physician. It seems safe to say that if you haven't made the decision to die, you shouldn't see Dr. Kervorkian. What Kervorkian really did was to invent a suicide device and make it available to those he deemed qualified to decide to use it. This sort of entrepreneurship is in the tradition of the free market. But the profession of medicine and the mores and morals of the marketplace do not mesh well. An unregulated free market in suicide machines is obviously poor public policy.

But the machine, like barbiturates, is in some important way not the real problem. Looking at the incident from Janet Adkins’ perspective, as the Coppens account does, the problem becomes: When can people decide to take their lives because of severe illness, and what sort of assistance can others provide them? If it is permissible to assist Ms. Adkins to die, a machine that works to provide a quick and painless death at the behest of the user is not a bad thing.

When Janet Adkins sought out Dr. Kervorkian for assistance in committing suicide, she sought a release from the future course of her Alzheimer’s disease. Was this a rational, permissible thing to do? A reader replied to a New York Times editorial which criticized Dr. Kevorkian:

Alzheimer’s is an incurable, relentless destruction of the functioning mind. . . . [F]or the victim, these [so-called “good” years] are the nightmare years, the time when each loss of competence is noted and the next one dreaded. Frustration, fear and anger chase one another in the continuous downward spiral.

By the time intelligent conversation has given way to singsong gibberish and limbs have forgotten their function, the opportunity to opt out is long since past. It is only at the onset of the disease that the victim still retains some control over her fate.

. . . . [S]ome may wish to exit before their competence is gone and their image in the memories of others is diminished. . . . I would consider it a blessing if Dr. Kervorkian is around if and when I need him.36

Marcia Angell, executive editor of the New England Journal of Medicine, considers both the Alzheimer’s victim and her family:

People like Janet Adkins, newly diagnosed with Alzheimer’s disease, can expect their brains to be destroyed slowly over many years. Early on, they may be frustrated by their confusion and loss of memory. Eventually, however, the frustration is gone, as is every other indication of higher brain function. At the time of

diagnosis, if not later, they realize that the entire burden of the disease will at some point be carried on by their families.

Most of us know someone who took on the back-breaking and soul-destroying job of caring at home for a spouse or parent with Alzheimer's disease. This means round-the-clock attendance, including diapering, feeding and bathing. When the patient is put in an institution (where the care is often indifferent at best), the family must "spend down" to qualify for Medicaid.7

From these perspectives, Janet Adkins' case can be viewed another way. The choice of death with dignity that she desired was available to her only through the aid of a maverick physician offering his personal suicide invention. What she found was a death with less than complete dignity—in the back of a van, in a parking lot far from home—but a death nevertheless that was better to her than the life and "natural" death that awaited her. She maintained control over her life's end, avoided the dreaded mental, social and familial effects of Alzheimer's, and achieved a closure to her life that met with her needs for meaning and self-respect. She had informed herself about her condition, discussed her options with her family, met with a therapist, and consulted a minister. There seems to be little evidence for Judge Gilbert's uncertain opinion that she was not competent to make the decision she made. If her death had taken place in more dignified surroundings, her competence might never have come into question. It appears to have been a decision consistent with her character and values, and one which rational people in her circumstances might make.

Key Questions in the Euthanasia Debate

Individual cases alone, of course, cannot resolve broad policy issues. The deaths of Debbie, Diane and Janet Adkins, however, provide help in thinking about the public policy questions that surround the lifting of the prohibition against euthanasia. I turn now to the key questions in the current debate that need to be addressed directly.

1. Is actively bringing on death immoral?

In our prevalent religions, in our public morality, and in our law, there is a strong moral injunction against taking a life. Justification for active euthanasia must overcome this basic injunction.

A consensus has emerged on the "passive" means of facilitating death. "Letting die" by withholding or withdrawing a respirator, sur-
gery and other treatments is now legally and medically acceptable. These treatments may be foregone in extreme circumstances when their effect is to prolong life that is too burdensome to bear. The cause of death, it is said, is not the withdrawal of life support, but the underlying disease that made such support necessary.

This reasoning has been applied to the withdrawal of artificial nutrition and hydration. In one case, the Supreme Court of Illinois decided that if nutrition and hydration were discontinued for a man in a persistent vegetative state, the cause of death would not be starvation but the underlying disease. This was so, the court held, even if the man could have remained alive but unconscious for years if given the nutritional support.

Another accepted means of bringing on death is through the "double effect" phenomenon. Doctors cause death by administering painkilling drugs which can and do suppress respiration. Because pain relief is the motive and death is not intended, even though death may reasonably be expected, this form of death-inducing behavior is deemed permissible.

We have decided in these instances of "letting die" that existence in certain circumstances is unendurable, that death is preferred to life, and thus we will stop preventing death. But with the "double effect," we actually bring on death, with more or less certainty depending on the dosages and condition of the patient. If dosages of narcotic drugs are sufficiently high and the patient's respiration is poor, death is a virtual certainty. Similarly, with the withdrawal of feeding and hydration, we guarantee that death will come, eliminating the uncertainty that attends some "let die" methods.

Thus it is not so evident that there is much of a moral difference between removing a feeding tube, providing a dose of narcotics for pain knowing it is likely to be fatal, and ending life by so-called "active"

40. Id.
42. See id.; see also Lundberg, supra note 18.
means. All of these actions in fact bring on death. They are done knowing death to be the outcome. These actions are taken with the view that death is not only inevitable but, under the circumstances, desirable.

It is sometimes claimed that the "passive" techniques are morally acceptable because they allow for a natural death, while "active" techniques independently cause death. But in the modern medical setting, these terms and distinctions are ephemeral. The concept of natural death in the hospital has lost its meaning. "If you want to have a natural death," says Dr. Alan Stone, "you have to stay out of the doctor's hands."

If you make it alive to the hospital, medical technology derailss nature and alters the course, experience and timing of death. Medical techniques extend the process of dying to unprecedented and unnatural limits. People can live for decades with most of their brains destroyed, with bodily systems near total breakdown, in states of irreversible unconsciousness. Given its power to manipulate and prolong death, modern medicine cannot avoid responsibility for the fates of patients after physicians treat them, keep them alive, find no cure and then give up hope. A decision for nonintervention at this point does not restore the status quo ante. As Kenneth Vaux has written:

Logically and emotionally, we cannot intervene at one phase and then be inactive at another, more painful phase. We cannot modify nature and then plead that nature must be allowed to run its unhindered course.

Even if we view nonintervention as deferring to nature, the question of moral responsibility is not resolved. Nonintervention presents its own moral problems. For if we decide to stand by and allow nature to run its course, there is no guarantee that its course will run smoothly or well. Some "natural" deaths are peaceful and quiet; others are quite awful. By withdrawing and "letting die," we are leaving people to a kind of peaceful death lottery, where winners are carried off easily and


45. Considering this point, Justice Antonin Scalia once remarked upon "the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it." Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990) (Scalia, J., concurring).

46. Kenneth Vaux, Debbie's Dying: Mercy Killing and the Good Death, 259 JAMA 2140, 2141 (1988); see also Albert W. Alschuler, Reflection, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 105, 109 (Ron Hamel, ed., The Park Ridge Center, 1991) ("After blessing us with reason and the power to choose, God may have given us responsibility for other awesome decisions as well—choices that we would rather leave to God but cannot.")
quickly and losers linger and suffer long, drawn out deaths-by-degrees. Stopping medical intervention—leaving things to nature—brings catastrophes as well as relief. It is precisely this perilous game of chance with nature that we try to avoid with our science and technology. For many, perhaps most of us, a peaceful death, with some measure of dignity and control, is a desired goal. Its achievement can sometimes be best assured through active assistance rather than leaving all to chance. We strive to affect our fate when we live; why give up when we contemplate death?

2. Will legalized euthanasia have untoward consequences that society ought to avoid by means of a blanket prohibition?

A common refrain in arguments against euthanasia is fear of the "slippery slope." Opponents of legalization sometimes argue that even if euthanasia is justified in certain circumstances, its legal acceptance will lead to unjustified applications. For example, will we eventually be tempted to eliminate people—the elderly, the unproductive, the mentally disabled—who are deemed burdensome or undesirable by society at large? This type of argument often invokes the specter of Nazi Germany and its murderous pursuit of population groups deemed socially unfit. The claim is that a public policy of murder inexorably follows from an initial, limited step, namely the adoption of a carefully defined euthanasia policy.

The Nazi experience, however, does not support a slippery slope argument. "Euthanasia" when used by the Nazis was a term that masked a carefully organized and politically approved plan to condemn the handicapped, the mentally ill, and designated others to death. The use of the term euthanasia by the Nazis was a misnomer, as this description of the program makes clear:

National Socialist euthanasia or "mercy death" was a program of killing persons with unworthy lives. These persons were not moribund, and their families, with the rarest exceptions, wanted them to live. It was not a "good death," as the word denotes, but a systematic program of killing without any mercy whatsoever. The program was conceived before the Second World War, but high officials deemed it best to start after the outbreak of war, assuming the public would accept it more readily as a measure to conserve scarce resources rather than to waste them on "unworthy" chronically sick, unproductive, and undesirable persons... The program referred to in the National Socialist bureaucracy as T4 was not based on any law, but was initiated by a secret order, traceable to Hitler.

and his chief physician, Karl Brandt. ... The T4 program ... was well organized. Mental hospitals were required to report all chronic schizophrenics, manic-depressives, mental defectives, epileptics, and, later, debilitated old persons. A separate division, the "Public Service Transport Division for the Sick," took care of the collection and transport of such patients to institutions where they were put to death. ... Relatives received false death certificates and even letters of condolence. ... It is estimated that [after two years of this program] ninety thousand persons went to their deaths.48

Robert Jay Lifton, in his book *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, demonstrates that the so-called euthanasia program bore no resemblance to mercy killing. Death orders were issued without consent, without compassion, with murderous intent, and in furtherance of a specific political agenda.49 The medical personnel who condemned patients to death worked only from questionnaires filled out by officials at various medical institutions around the country. Based upon the barest information about diagnosis, ability to work, and ethnic or religious identification, and without medical histories or personal knowledge of the cases, the Reich's specially chosen physicians determined who should be killed. Representatives close to Hitler monitored the program, and Hitler himself expressed "intense interest" in it.50 The infamous SS directly participated in its implementation. In Lifton's words;

SS personnel manned the buses [transporting the victims], frequently wearing white uniforms or white coats in order to appear to be doctors, nurses, or medical attendants. There were reports of "men with white coats and SS boots," the combination that epitomized much of the "euthanasia" project in general.51

In his study, Lifton consistently puts the word euthanasia in quotation marks to emphasize that this was a program not of euthanasia, but of mass murder.

Lifton observes that although doctors administered the effort, its driving force was the extremist ideology of Nazism.52 The Nazi "biomedical vision" insisted on Aryan superiority, demanded racial "purification," espoused virulent anti-semitism, and rejected individual rights in favor of the Nazi-defined collective social and racial health of

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50. *Id.* at 50, 63-79.
51. *Id.* at 70.
52. *Id.* at 22-44.
the people. Universities, the legal system, and the medical profession reinforced this vision with research institutes, special courts, and medical societies that promoted notions like "racial hygiene," eugenic sterilization, and the elimination of "life unworthy of life."^{53}

If there is a slippery slope argument to be made out of the Nazi experience, it cannot be based upon a progression from euthanasia to murder. In fact, what preceded the Nazi killing program was not euthanasia but compulsory sterilization.^{54} Animated by the same Nazi racial ideology, the sterilization program called upon the medical profession to administer an effort to limit reproduction by disfavored groups.

Yet even the claim that state-sponsored involuntary sterilization inexorably leads to medical murder is unavailing. The United States experienced its own eugenics movement early in the twentieth century.^{55} State laws authorizing involuntary sterilization of those deemed mentally deficient received constitutional approval in the United States Supreme Court. Mr. Justice Holmes provided a ringing endorsement of the practice in *Buck v. Bell*,^{56} declaring that: "It is better for all the world, if . . . society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough."^{57} Nevertheless, enthusiasm in the U.S. for involuntary sterilization did not last.^{58} Instead of leading down a slippery slope to even worse practices, forced eugenic sterilization itself faded away.

A distinguished presidential commission studying ethical problems in medicine pointed out a central problem of slippery slope arguments:

For such an argument to be persuasive . . . much more is needed than merely pointing out that allowing one kind of action (itself justified) could conceivably increase the tendency to allow another action (unjustified). Rather, it must be shown that pressures to allow the unjustified action will become so strong once the initial step is taken that the further steps are likely to occur. Since such evidence is commonly quite limited, slippery slope arguments are themselves subject to abuse in social and legal policy debate.^{59}

53. *Id.* at 16, 17, 21.
54. *Id.* at 22-44.
55. *Id.* at 24.
56. 274 U.S. 200 (1927).
57. *Id.* at 207.
59. President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 29 (March 1983). For an additional refutation of the Nazi slippery slope (or "wedge") argument, see
The Nazi sterilization program occurred in circumstances that created pressures for the most extreme excesses. A ruthless totalitarian leadership, espousing an ideology of racial and ethnic hate, took control over key societal institutions and deliberately led a significant part of the medical profession toward a program of medically supervised murder. Ideology and terror enabled the political leadership to exert maximum pressure for its extermination plan. Resistance was dangerous. Secrecy and deception reduced outside pressures to stop the carnage. Finally, a network of institutions which had themselves undergone Nazification reinforced and supported the extermination effort.

No parallel to all this exists in the United States. History is not a linear progression of inevitable steps, but a complex texture of political, social, economic, institutional and cultural forces and events. Upon close examination, it must be concluded that the gruesome Nazi experience does not support the contention that legal euthanasia in this country poses a danger of degeneration into unrestricted killing.

3. Will euthanasia adversely affect the doctor-patient relationship, or the level of public trust in physicians and the health care system?

Some writers contend that legalization will reduce the public's trust in doctors and in the health care system. Michael Levy warns of the erosion of "trust that the health care delivery system will do everything possible to relieve suffering prior to terminating life." Dr. Alan Stone claims that

[it is destructive to the public good to make people worry that when they go to a hospital the doctor is thinking about whether to allow them to live or die. When I go to the emergency room I want to know that the doctor is going to do everything to keep me alive. I do not want to go to somebody who has had a course on ethics and is thinking that maybe I would prefer to die.]

These speculations fail on several counts. The erosion of trust in medical professionals and their institutions is already well underway. Reasons for this include doctors' poor communications skills, unwillingness to spend time with individual patients, and overreliance on tech-


60. LIFTON, supra note 49, at 22-79.


62. Stone, supra note 44, at 642.
Hospitals and nursing homes are notorious for their exorbitant charges and inattention to patients' needs.\(^{64}\)

It is possible that permitting euthanasia will have no effect on the existing level of trust—that the other factors at work influencing and corroding the doctor-patient relationship are more important than any change in the legal rules on what is allowed and not allowed. If the editor of JAMA is correct that mainstream physicians will not practice euthanasia,\(^{65}\) there may be no perceptible effects on the everyday practice of medicine. Doctors who display the traditional virtues—warmth, compassion, skill and attentiveness—will win their patients' trust. Doctors who are too busy, too machine oriented, or too emotionally frozen, will not.

Refusal to give aid in dying, however, may actually add to the level of distrust. The public seems to fear the dying process now because it believes doctors' efforts will prolong, not relieve, suffering. Physicians Christine Cassel and Diane Meier offer this analysis of the popular view of current medical practice:

The public appears to be losing faith in doctors, at least partly because of our paternalistic and sometimes cruel insistence on life at any cost.

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The medical profession in the United States has reflected our society's unwillingness to accept death as part of life and to face it with some humility. Perhaps the public is now ahead of the medical profession in this regard, as patients increasingly seek the assistance of physicians in their time of need, when dying with dignity becomes more important than prolonging life. The rigid view that physicians should never assist in suicide denies the complexity of the personal meanings life can have in favor of a single-minded devotion to its maximal duration. \ldots

The refusal of physicians to deal with their patients at the level of the personal meaning of life and death is a reflection of how sterile and technological our profession has become.\(^{66}\)

The alternative of euthanasia may well make things better between doctors and patients. Euthanasia requests might foster a deeper dimension to some doctor-patient relationships. Making euthanasia legal moves it into the arena for open discussion and consideration. Since

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64. See Norman Cousins, The Healing Heart: Antidotes to Panic and Helplessness (1983) (author avoids hospitalization as hindrance to health); for a chilling story of nursing home care and expense, see Conolly, infra note 104, at 505-506.
65. Physicians would have a choice under current euthanasia legalization proposals, which make participation optional, not mandatory.
no law is likely to force an unwilling doctor to practice euthanasia, a
process of conversation, explanation and negotiation may ensue be-
tween doctors and patients requesting help in ending life. As Professor
Anne Davis has said: "Dying is one of life's most profound experiences.
To share this . . . with another who is willing to understand and ac-
knowledge this type of suffering, and to act on it, surely must create
one of the most trusted bonds that can be possible."67

In any event, it is clear that trust cannot survive in the present
context surrounding dying. How can the public place much faith in a
process that involves, in the words of Dr. Robert Wood, "long, drawn
out months to years of increasingly complicated illness that can require
an array of specialists, confusing choices, false hopes, loss of control
and dignity, misery and pain"?68 Add to this enormous costs and the
propensity of certain doctors to block out others’ suffering, to avoid
contact with the dying, and to neglect available measures for pain re-
lied, and the picture of an ailing doctor-patient relationship becomes
complete.

Dr. Stone's concern that emergency room doctors will assume he
wants to die is unfounded. A physician who knows nothing of the pa-
tient and treats an emergency is always expected to do all he can to
address the immediate crisis. No euthanasia proposal would change
this.

4. Will euthanasia be freely chosen or subtly coerced?

Some predict that euthanasia, if available, might be chosen under
subtle pressure. This pressure might come from families or doctors
wanting to induce someone to request euthanasia, or it might be an
internal reaction on the part of the patient to a cold and uncaring envi-
ronment. As Professor Stephen Sapp puts it,

. . . Thus the truly voluntary nature of active euthanasia among the elderly seems
hard to guarantee. The possibility of ending their lives sooner, with moral and
legal sanction, may well lead to a form of subtle coercion, with the implication
that the responsible course to pursue is to utilize this option.69

Davis).
68. Id. at 12.
69. Stephen Sapp, Reflection, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE
Another commentator suggests that the dying will “come to feel that it is not just their right, it is their duty to linger no longer, to just hurry up and get out of the way.”

This prediction may fall by reality’s wayside, because it underestimates people’s desire to live and overstates their susceptibility to suggestion that they just kill themselves. Moreover, our present experience offers no evidence to suggest that family members subtly coerce decisions for withdrawal of respirators and other life supports, or that doctors do so casually or meanly or in a way contrary to ethics or good medical practice.

There is another problem with the subtle coercion argument. To say that severely ill people soberly considering their overall life circumstances, which often does include societal indifference to their plight, are “coerced” is stretching the meaning of coercion. In truth, all decisions are made against a backdrop of societal regard or the lack of it, and we must not sacrifice others’ decision making power because collectively we treat them worse than we should.

If there is true coercion exerted on an individual by family members or doctors, of course it would destroy the voluntariness of the euthanasia decision. Certainly, coercion that leads to unwanted euthanasia could be criminally punished and presumably deterred.

5. If euthanasia is legalized, what social messages will be communicated?

A sociological objection often comes into discussion of euthanasia, to the effect that legalization will send out bad messages to society, for example, that we don’t care about the dying or that we are not upholding the value of the sanctity of life. I am skeptical about this on several grounds.

Interpreting the “messages” communicated by any social practice is a speculative undertaking too easily influenced by one’s moral or political position on the practice. Who is to say what message emanates from the acceptance of euthanasia? Some might say it is a message of disrespect for life. Others may say it is a message of respect for autonomy, choice and freedom from the fear of a cruel and tormenting end.

Even more important, the argument tends to turn people into symbols serving a cause bearing a “good message” for us all. The cause

may in fact be deserving, or it may represent a moral crusade to impose certain ideologies on others. Either way, turning people in need into symbolic messengers and sacrificing their personal welfare for the sake of sending a better message is a troubling and in this instance unwarranted thing to do.

It is grossly unfair to make the sick and dying bear the burden of preserving society's devotion to the sanctity of life. If society is failing in that regard—and its wanton violence, inadequate provision of basic nutrition and health care, high rates of child abuse and infant mortality, and childhood poverty of millions indicate that it is—making the desperately ill endure cruel suffering is not the answer.

Some writers worry about the effects of euthanasia legalization on the community. Daniel Callahan writes that it would "create the wrong kind of relationship between people, the creation of a community that sanctions private killings between its members." This, he asserts, would be a "momentous . . . social change, one that would be fundamental and far-reaching in its implications for human relationships."

It is hard to rely on such a dire prediction. It assumes too much: that a whole community will be dramatically and adversely affected by a change in a single medical practice. This argument implicitly diminishes the importance of all other social forces in our culture that affect human relationships. The killings that do affect our societal relations and quality of life, I suggest, are not the occasional ones motivated by mercy and compassion. They are the ones perpetrated every day by a large class of people with virtually no ties to the social and moral community that should encompass us all. In truth, the legal status of euthanasia will probably have no effect on the very troubled state of human relations we experience today.

6. Will euthanasia have a negative impact on doctors? Is it outside the medical role?

Not all doctors regard euthanasia as inherently outside the medical role. Even if a majority do, this does not preclude a change in the

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73. Id.
74. The State, L.A. TIMES, May 8, 1988, at Pt. 1, 2 (poll of San Francisco physicians indicating that most support voluntary euthanasia for the terminally ill); Thomas Lace, The Physician Can Play a Positive Role in Euthanasia, 262 JAMA 3075 (Dec. 1, 1989).
role definition. The medical profession, though initially conservative and resistant to change, has made adjustments in its thinking in the past.

Not so many years ago, doctors opposed passive techniques of "letting die." In the landmark case of In re Quinlan,75 Karen Quinlan's doctors fought her father in court to keep her respirator attached, despite the fact that she was permanently unconscious. The New Jersey Supreme Court permitted withdrawal of the respirator, galvanizing the national right to die movement. Citizens and courts pushed the medical profession throughout the country to change its attitude.76 Now withholding and withdrawing treatment is deemed medically ethical77 and is widely practiced.

So are other forms of euthanasia, although doctors avoid the label. The administration of narcotics to kill pain, in dosages that sometimes suppress breathing and kill the patient, is also an accepted practice.78 The withdrawal of nutrition and hydration has garnered increasing support, most memorably in the case of Nancy Cruzan, a young woman in a state of irreversible, permanent unconsciousness.

Ms. Cruzan's doctor at first opposed withdrawal of tube feeding. In court, her parents sought an order permitting cessation of artificial feeding and hydration. The state of Missouri asserted its right to require a showing of clear and convincing evidence that Ms. Cruzan would have desired withdrawal of these treatments. After the United States Supreme Court upheld Missouri's position,79 a new hearing was held in the Missouri courts and her doctor agreed that withdrawal was the right thing to do.80 The Missouri court permitted withdrawal and Ms. Cruzan died soon thereafter.

Courts in several other states have ruled this form of euthanasia acceptable, despite the unique feature of such withdrawals: they cause death, regardless of the underlying condition.81 When we withdraw a

76. See Sprung, supra note 47.
77. See id. at 18.
78. See Meier & Cassel, supra note 41.
80. See Andrew H. Malcolm, Judge Allows Feeding-Tube Removal, N.Y. TIMES, Dec. 15, 1990, at 10 ("Asked by Miss Cruzan's court-appointed guardian, if it was in her best interests to continue like this, the doctor, who had originally opposed stopping her nutrition, paused. 'No, sir,' he said. 'I think it would be personally a living hell.").
respirator, there is some chance the individual will breathe on his own; when we withdraw nutrition, there is no chance of self-feeding. The line between “letting die” and terminating life has already been blurred, without noticeable effects on the moral character and role definitions of doctors.

Euthanasia proposals like that considered in Washington State would allow but not require doctors to participate in actively aiding desperately ill persons to die. Doctors who reject euthanasia would therefore not need to revise their own professional and personal role definitions.

Will approval of euthanasia by physicians render doctors insensitive to the dying or disorient them in their primary role as healers? In the present health care system, doctor behavior toward the dying is already insensitive. A common problem aired in the literature centers on doctor neglect and abandonment of dying patients. Perhaps the present system fosters this by allowing an inordinate amount of suffering to continue for months, leading many caregivers to simply block it out. By avoiding the hopeless patient and the family, the doctor learns to live with the brutality of prolonged suffering by disregarding it.

What medicine seems to lack today is a mature acknowledgement of human finitude, failed efforts, and the limits of human endurance. No one wants doctors who give up too soon, but the greater fear today is of overly enthusiastic physicians. Euthanasia requests will disorient such headstrong doctors, but they need to be disoriented, and reoriented toward the realities of life and their profession. Doctors who appreciate the difficulties of living with extreme burdens, whether physical or psychic, already understand the need to subordinate the healing role. When healing becomes impossible, other things begin to matter more than continued existence. These doctors won’t be disoriented by the legalization of euthanasia; they need only to consider expanding the range of conduct that best serves their incurable patients’ interests.

7. What of the possibility of mistake and abuse?

Many writers raise questions about the possibilities of mistaken diagnosis and prognosis which may lead to misguided choices for early death. In addition to mistake, there is the possibility of abuse by some

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practitioners, whose lack of skill, whose callousness, or whose deliberate wrongful conduct may result in unwarranted terminations of life.

These are serious concerns. A public policy decision to legalize currently unauthorized versions of aid in dying must consider the effects of scale. It is possible to have euthanasia occur on a small scale, quietly, with the participation of doctors who are sensitive to the sufferings of their patients and willing to exceed formal boundaries to do what they believe is right in the particular circumstances. Dr. Quill provides perhaps the most prominent example of a doctor who knew his patient well, discussed options with her, did all he could to alleviate her suffering, and helped her even when she finally chose to end her life.

Although things often work acceptably on a small scale they may not work out so well on a large scale. When not just the Dr. Quills, but the entire medical profession is potentially involved, including its worst elements—the poorly trained, the barely competent, the insensitive, the arrogant, the lazy, the tired, the harried, and the lesser skilled at medicine and human relations—there is the danger that practitioners will fail to do what they can to avoid euthanasia where euthanasia is inappropriate.

While this properly causes concern, legalization may not work so as to produce more mistakes or abuse than nonlegalization. First, we may be headed for a time when euthanasia will be practiced more and more, whether or not the medical profession participates. The interest in suicide as an option is on the rise, and may be expected to increase as the baby boom generation enters old age. If the medical profession ignores the demand for easy death, people will resort to self-help, which undoubtedly will carry its own incidence of abuse and mistake.

Second, as the story of "Debbie" shows, euthanasia as practiced clandestinely today presents its own set of concerns. Making the practice illegal discourages discussion. One must be very sure of others' reactions before confiding in them. The useful deliberation that comes from sharing ideas and perspectives is thereby lost. If we restrict euthanasia to the realm of covert action, we thereby run added risks of mistake and abuse.

Third, we may not see euthanasia practiced on a truly wide scale

83. See Altman, supra note 6.
84. See Lundburg, supra note 18 who writes "Such discussions should not be confined to whispers in doctors' dressing rooms and hallways and such actions covered up easily because the autopsy has become a vanishingly rare procedure in many hospitals, hospices, and nursing homes and because hospital death investigations have become increasingly inconsistent."
following legalization. If the reaction of most physicians is to shun the practice, we will still have only a limited number of participants and the scale will remain small. Polls of physicians indicate that even supporters of euthanasia in principle may not personally want to engage in its practice.86

Fourth, we may again look to the experience concerning permissible versions of euthanasia. We have already undertaken the risk of mistake and abuse in making decisions to withdraw nutrition, artificial respiration, and other life sustaining techniques, and by administering potentially lethal doses of painkilling drugs. We do not hear of abuse of the power to exercise these death-inducing actions; one would expect evidence of abuse to have surfaced by now.

Fifth, the risk of abuse may not be so great, because of the deterrent effect of homicide laws. If killing is lawful if done according to an established euthanasia procedure, but criminal if it is not, ordinary doctors are likely to pay close attention to proper procedure and not treat the matter casually. In fact, the threat of criminal prosecution may be so strong that it discourages not merely potential abusers but also prudent physicians, who may refuse to perform the permitted procedure.

Finally, the existence of risk need not preclude legalization. In making policy, risks of all sorts are weighed; some are deemed worth taking. Consider social policies that favor auto travel, gun possession, and building bridges and skyscrapers. Consider those that tolerate safety hazards in the workplace and environmental hazards of known and unknown dimension. In many such policy areas, we accept even deaths of healthy people as a consequence of policy choices. Many of these accepted deaths are accidental, like the 50,000 deaths annually occurring on our highways. They are predictable statistically, however, and the choices we make are as lethal to the victims as intentional deaths.86 In medical practice, there is no absolute certainty. We must and do permit people to take risks, even with their lives. Given the power of modern medicine to postpone death without enhancing life, a policy permitting people to avoid a prolonged and dreadful dying experience is worth some risk.

8. **What interests of the individual does euthanasia serve?**

   a. **Philosophical and spiritual self-assertion**

   For the severely, irreversibly ill, a rational choice for euthanasia promotes control over the end of life. At stake, observes Sheldon Kurtz, is a "matter of vital, exclusive importance: the timing, manner and circumstance of one's death."\(^{87}\) The choice has practical, philosophical and spiritual ingredients.

   Opponents of euthanasia often emphasize the spiritual nature of their views, rooting their opposition in the idea that life is a gift of God. The cliche about "playing God" when making life and death decisions is meant to restrain decisions favoring death. But it is wrong to leave the spiritual ground to euthanasia opponents. Decisions about death are inherently philosophical and, for believers in God, religious. Believers who contemplate euthanasia must necessarily resolve for themselves spiritual questions as to life's meaning and the proper realms of God and man.

   In so doing, Americans do not always follow their religious leaders. Almost all religions reject "active" euthanasia, although they often accept the withdrawal of life-sustaining treatment in hopeless cases.\(^{88}\) Yet many Americans who support euthanasia come from religious backgrounds. A 1991 Roper poll conducted in the states of California, Oregon and Washington\(^{89}\) showed strong support for aid in dying among both Protestants and Catholics.\(^{90}\) This included approval of doctor-provided lethal drug prescriptions to terminally ill people who request them, and the use of powers of attorney to enable family members or friends to make decisions about administration of lethal drugs for individuals who have lost mental capacity.\(^{91}\)

   In 1987, pollster Louis Harris reached this conclusion about the views of religious Americans: "There is no major segment of the public that does not support euthanasia by wide margins. This includes

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89. These states have been the stages for political efforts to legalize euthanasia.


91. *Id.*
Catholics and members of the Moral Majority whose evangelical preacher leaders vigorously oppose legalizing euthanasia.\textsuperscript{92}

One's appreciation of life may lead to an acceptance of its end in circumstances that promote ideals of love, kindness and human connection. Dr. Timothy Quill, in his account of his patient Diane, noted that once she had a supply of drugs available to end her life, she was relieved of the fear of a painful and dependent death. She was then able to make "deep, personal connections with her family and close friends."\textsuperscript{93} The last months of life were very intense and important for Diane. Her son stayed home from college, and they were able to be with one another and say much that had not been said earlier. Her husband did his work at home so that he and Diane could spend more time together. She spent time with her closest friends. I had her come into the hospital for a conference with our residents, at which she illustrated in a most profound and personal way the importance of informed decision making, the right to refuse treatment, and the extraordinarily personal effects of illness and interaction with the medical system.\textsuperscript{94}

Diane's manner of living and control over dying profoundly affected Quill himself. He wrote:

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. She taught me about life, death, and honesty and about taking charge and facing tragedy squarely when it strikes. She taught me that I can take small risks for people that I really know and care about.\textsuperscript{95}

Quill eventually turned that small risk of detection of his own role into a much larger risk by publicly describing his deliberate stretching of legal and professional rules.

If our lives are to have a transcendent meaning, as religious traditions would insist, one's transcendence is perhaps most truly realized in the capacity to inspire profoundly the lives of others. Diane, through the events that preceded and included her self-chosen time and means of death, did just that.

b. \textit{Avoidance of suffering by patients and families}

Disease and its treatment rob the individual of a great deal. Some

\begin{itemize}
\item \textsuperscript{92} See \textit{Harris}, \textit{supra} note 12, at 157.
\item \textsuperscript{93} See \textit{Quill}, \textit{supra} note 4, at 693.
\item \textsuperscript{94} \textit{Id.}
\item \textsuperscript{95} \textit{Id.} at 694.
\end{itemize}
conditions cause a host of extreme physical effects: bones so brittle they easily break, severely impaired breathing, constant exhaustion, emaciation, paralysis, blindness, recurrent nausea and vomiting, persistent fever and inability to eat or sleep. Physical problems often come in multiples, with increasing bodily degradation and pain. Mental deterioration adds a different cluster of problems, from loss of memory and ability to perform everyday tasks to the inability to communicate with or even recognize others. Treatments for serious diseases often have their own toxic side effects, intensifying physical and mental suffering.

The magnitude of psychological suffering that accompanies dire medical conditions is easily underestimated. The varied sources of psychic pain that grip the victim of catastrophic illness include losses of privacy, lifestyle and established routines; the destruction of one's sense of security and sense of normalcy; the painful awareness of one's former physical powers and present incapacities; the dreaded anticipation of future mental and physical deterioration; the loss of control over one's life and life plans; the unwanted dependence on machines and doctors; the loss of home and of social roles in the outside world brought about by hospitalization; and the loss of hope, of optimism about the future, and of pleasure in life. For some there is the pain of knowing that one is destined, in Samuel Gorovitz's words, "to witness and endure a final stage not as an effective agent, but merely a deteriorating object." \[96\]

Socially, disease can precipitate a kind of social death in which there is loss of contact with other people. Isolation of the incurably ill, even in busy hospitals, is common. \[97\] The desire for distance from the dying, doctors' priorities in caring for those with a reasonable chance for recovery, the monetary reward system, time pressures, and other personal and institutional factors all contribute to what one physician has called "a miserable job of caring for the dying" performed by the medical system. \[98\]

Patients and families also suffer the stress of mounting emotional and financial burdens. The wish to avoid depletion of family resources may motivate some to seek a quicker rather than slower death. Few

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97. See Newman, supra note 82.
98. Ronald E. Cranford, Reflection in Active Euthanasia, Religion and the Public Debate, supra note 69, at 80.
mothers and fathers would want to leave behind an impoverished family. Many would also not want to feel responsible for ruining the quality of life of a family member who would have to serve as a caretaker during an arduous, chronic fatal illness.

Finally, people have an interest in how they will be remembered. The manner of one’s death may overshadow other facets of one’s life, to the point of haunting loved ones who witness an intolerable death. Justice Stevens, dissenting in *Cruzan*, suggested that this interest was of supreme importance:

Nancy Cruzan’s interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family, and to others. How she dies will affect how that life is remembered. The trial court’s order authorizing Nancy’s parents to cease their daughter’s treatment would have permitted the family that cares for Nancy to bring to a close her tragedy and her death. Missouri’s objection to that order subordinates Nancy’s body, her family, and the lasting significance of her life to the State’s own interests. The decision we review thereby interferes with constitutional interests of the highest order."

c. *Avoiding ineffective, family-assisted or premature suicide attempts*

Some people interested in suicide as a better end to life than chronic, incurable, debilitating illness are going to pursue their interest whether euthanasia is legal or not. Unfortunately, some will attempt suicide and make things worse for themselves. As George Colt observed in his work *The Enigma of Suicide*,

Despite popular belief to the contrary, suicide is not easy—particularly if one is old, infirm, or terminally ill. Under current laws those without access to lethal drugs are often driven by desperation to more secretive, violent, and lonely deaths. One terminally ill cancer patient, immobilized in a Stryker frame and partially paralyzed, doused his chest with lighter fluid and set himself afire. Even worse, without knowledge of proper dosages and methods, suicide attempts are often bungled, leaving the victim worse off than before. Many intended suicides by gunshot leave the person alive but brain-damaged; drug overdoses that are not fatal may have the same effect.100

100. *COLT, supra* note 8.
Betty Rollin, author of a book called *Last Wish* about the suicide of her mother has written:

Among the saddest [of letters from readers] are from people—or the close relatives of people—who have tried to die, failed and suffered even more. Many of these people sought help—from physicians or family—but were denied it because although suicide is legal, assisted suicide is not.101

Some individuals too weak to commit suicide unaided will seek help from spouses. The burden on such spouses, even those who believe in the benevolence of the death, will be great. Dr. Diane Meier has commented: "[F]orcing husbands and wives to take the role of participating in an assisted suicide for their loved one because they can't get help from their doctor is a terrible and punishing thing to do to a family."102

A total ban on assisted deaths might have another unintended, detrimental effect. Persons with diseases like Alzheimer's are now tempted to try suicide at an early stage of their disease when they are still mentally and physically fit. If they knew euthanasia were available later, perhaps through an advance directive or health care proxy, these individuals might choose to live longer, through a later stage of the illness. Commentators made much of the fact that Janet Adkins, although suffering from Alzheimer's, was active and fit at the time she sought out Dr. Kervorkian's suicide machine.103 It is possible she chose this early death because of the lack of a choice later, when she degenerated into mental incompetency.

9. *Would better efforts at pain control provide a substitute for euthanasia?*

In an article promoting pain control as an alternative to euthanasia, Dr. Matthew Conolly writes: "All too often physicians fail their patients, either through ignorance of the drugs available, or through neglect of the other forms of treatment available."104 He rejects one common reason for providing inadequate relief from pain, saying that

101. Altman, supra note 6.
the "fear of drug addiction in terminally ill patients would be laughable if it had not caused so many patients to endure needless pain."\textsuperscript{108} What the terminally ill patient needs, he continues, is a "very active ongoing and hopefully scientific endeavor on his behalf to control pain."\textsuperscript{106} Other physicians have also noted the "sadly deficient" efforts at pain relief provided by many doctors.\textsuperscript{107}

Dr. Conolly describes effective pain control as depending upon special skills, including in-depth knowledge of a wide range of drugs, detailed understanding of the disparate sources of physical pain, and good diagnostic assessment.\textsuperscript{108} Physicians must also be prepared to spend time carefully following a sometimes changing diagnostic picture and monitoring patient reactions to different pain control techniques. If all this is done, Conolly states, there will be no need for euthanasia, for "the terminally ill, when properly cared for, simply do not ask for euthanasia."\textsuperscript{109}

There can be no argument with the notion that doctors must do better at relieving controllable pain. A number of leading physicians, finding that pain management "seems to be an unfamiliar area to many physicians," have sensibly recommended that "educational material be distributed to [doctors] . . . from a noncommercial source."\textsuperscript{110} Other proposals include changing medical school and residency training to include care for the dying, and making hospice care an integral part of the nation's health care system.\textsuperscript{111}

Suggesting that pain management be improved is one thing; positioning it as an alternative to legalized euthanasia, however, is quite another. Given the special skill needed and the apparent widespread lack not only of that skill but of the attitudes that support learning and using them, how realistic is it to expect that pain relief will be adequately provided in all the cases in which it is needed? Over three decades ago, Professor Yale Kamisar noted similar complaints from lead-

\begin{itemize}
\item 105. \textit{Id.} at 501.
\item 106. \textit{Id.} at 504.
\item 107. \textit{Wanzer, supra} note 3, at 847.
\item 108. \textit{Conolly, supra} note 104, at 501. Pain sources include pressure on nerves, involvement of bones, infections, abscess formation, and side effects of surgery, radiotherapy or other treatment.
\item 109. \textit{See Conolly, supra} note 104, at 504.
\item 110. \textit{Wanzer, supra} note 3, at 847.
\item 111. \textit{Laurie Jones, Hospices Next Step: Into Medical Mainstream, AM. MED. NEWS, Jan. 7, 1991.}
\end{itemize}
ing professionals about the neglect of pain control. Overcoming this persistent, intractable problem will require supplanting well entrenched physician behavior that seems highly resistant to change. Social policy must be based upon reality, and the reality seems to be that the problem of physical pain for patients will not go away. Pain will be a major factor for many patients in dire medical circumstances. If pain management reforms someday permeate the medical schools and health care institutions of this country, that is fine. But it won’t happen overnight, it may not happen at all, and hoping for it forms a poor basis for social policy argument.

Even if pain control were to become the health care system’s top priority, the contention that this will end the need to consider euthanasia is ill-founded. Some people will reject the invitation to choose drugs that induce mental stupor in order to avoid pain. For the incurably ill, losing alertness, control and even consciousness may not be acceptable as a way to prolong existence. Further, it is not universally held that pain control techniques guarantee against all physical pain. Dr. Quill’s description of the course of treatment that his patient Diane could have chosen involved much toxicity and pain, with death the most likely outcome. He reveals that “the last four patients with acute leukemia at our hospital had died very painful deaths in the hospital during various stages of treatment.” Quill himself was a former hospice director, but he could not relieve the reality of pain for many patients.

Perhaps most important, the pain management alternative to euthanasia considers only one form of pain, physical pain. It ignores the deeper sources of psychological pain that contribute to suffering. Anguish is not readily susceptible to drug treatment, even if pain is. As Anne Davis has said:

There are times when the existential experience of dying becomes an affront to the patient’s meaning of his or her own life. Even when the patient is dying in an environment of care and compassion, there is a deep suffering, having nothing to do with physical pain, that cannot be reached or helped by another person. This sort of suffering does not build character, and wanting it ended is not a sign of cowardice.

112. Kamisar, supra note 7, at 1009.
113. In one article, twelve doctors state that the “proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness” Wanzer, supra note 3, at 847.
114. Quill, supra note 4, at 692.
115. Should Physicians Perform Euthanasia?, supra note 61, at 15 (response of Anne
Perhaps the very availability of euthanasia will be a spur to physicians to improve their knowledge of pain control. If euthanasia is not seen by doctors as a desirable outcome, being prepared to offer an alternative of effective pain control will seem more worthwhile. People for whom physical pain is the prime factor may indeed withdraw assisted suicide requests if offered the prospect of effective pain relief.

10. Can improved support services provide an alternative to euthanasia?

Those opposed to euthanasia sometimes say that if the sick in our society were given decent supportive care and services to help them deal with their illnesses and their related needs, there would be no need to consider euthanasia. Before legalizing euthanasia, shouldn’t we explore this option first?

This past summer the New York Times carried a news story about therapists ministering to the dying. It portrayed the work of one therapist sensitively working with a man dying of AIDS, helping him to deal with the many issues he confronts: how and what to say to his eleven-year-old son; how to come to terms with his loss of job and of many of the ordinary activities of his life; how to choose among treatment options and deal with the cycles of hope and fear that occur; what financial arrangements to make; how to “budget his limited energy” most productively, and finally, how to get ready “to die in a state of peacefulness.” It is apparent that this therapist cares about his client, and he is rendering a great and much needed service.

It is also apparent that most Americans will never receive such help. It is too expensive, putting it out of the reach of most, and government is not likely to pay for it. Social services, whether for the ill, the abused child, the battered woman, the pregnant addict, the mentally ill, the victim of crime, or the many others who could benefit from social supports, do not merit high priority in contemporary society. Reallocating limited resources is difficult enough even when it would be

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116. See, e.g., Prof. Michael E. Mahler Letter, L.A. TIMES, June 16, 1990, Pt. B, at 6 (“The participants in active euthanasia are avoiding the difficult problems of making the quality of life better for a patient with a bad disease [Alzheimer’s]. They are taking the convenient way out for themselves, masquerading their needs as mercy for the patient.”).

cost effective to do so. It is beyond imagination to expect the provision of expensive services for the seriously ill to be forthcoming. In this circumstance, social policy decisions should not be influenced by the theoretical existence of preferred but costly alternatives. Just as we do not rely upon medical miracles to defeat the demand for withdrawal of treatment from the very ill, so we should not rely upon social miracles in making policy choices about euthanasia.

Even if support were forthcoming, the desire for merciful death would not necessarily cease. A supported, mentally sound person with AIDS might well opt for suicide and seek assistance as a way to defeat the cruelty of the disease. The notion that support services would displace the desire of some to die fails to take account of the rationality of the choice of death over the multiple cruelties of existence. Those with supportive families may have even more reason to choose death. An early death may be less arduous for oneself and for loved ones than an extended period of illness marked by progressive degradation of the body and extensive caretaking burdens borne by family members. While the demand for euthanasia may be lessened by high quality human support services, these services alone will not substitute for a sound policy allowing merciful death.  

11. How can we devise standards for the proper use of euthanasia?

The search for standards for the employment of euthanasia and assisted suicide will be difficult. The law can only do so much to define the appropriate circumstances. Inevitable ambiguities of terminology and variations from person to person in medical condition, degree of confidence in diagnosis and prognosis, and degree of suffering complicate the rulemaking task.

In the Netherlands, euthanasia is practiced within an ambiguous legal framework. Despite the penal code’s explicit prohibition against euthanasia, a series of judicial opinions beginning in 1973 created an exception for justified euthanasia responsibly carried out. As described

119. Examples of reported cases in which better support services might have provided an option to the patients preferable to euthanasia include McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990) and State v. McAfee, 385 S.E.2d 651 (Ga. 1989). After Mr. McAfee won the right to have his ventilator disconnected, he chose to live instead when adequate social services were made available. Lawrence Applebome, An Angry Man Fights to Die, Then Tests Life, N.Y. TIMES, Feb. 7, 1990, at A1 (late ed.).
by M.A.M. de Wachter in 1989, the conditions imposed on the practice are:

(1) voluntariness: a persistent, conscious and free request by the patient; (2) a hopeless situation: a state of the disease or illness that both physician and patient consider to be beyond recovery; and (3) consultation of a colleague: confirmation of the decision-making process whereby physician and patient agree on the appropriateness of the euthanasia request.\textsuperscript{120}

Despite the open consideration given the issue since 1973, de Wachter reports that “many serious questions remain. No comprehensive ethical or legal framework has been constructed. . . .”\textsuperscript{121} Hospitals have developed their own procedures, and physicians who object to the practice are not required to engage in it.

Restricting the practice to competent patients, as the Dutch do, has certain advantages. Guidelines can be constructed using traditional medical and legal notions. The request from the competent patient, for example, clearly should be voluntary and informed. The Dutch notion of persistent and consistent request over some reasonable time period seems a sensible way to ensure that the request is not the transient product of depression, of impulse, or of a judgment distorted by “pain, strain or narcotics.”\textsuperscript{122} There are some who argue that we must never trust the judgment of those in the grip of catastrophic illness,\textsuperscript{123} but this wholesale dismissal of sufferers’ rationality is too sweeping and constitutes a gross denial of free will.

Requiring informed consent would certainly mean at least that individuals be aware of their medical conditions and prognoses, be advised of any medical uncertainty, and know the nature of pain relief available. Since the euthanasia request would seek an unusual kind of cooperation, this might be an opportunity to make the consent process more meaningful by requiring discussion of the decision, a burden not ordinarily placed upon patients. Rules might mandate disclosure of the euthanasia request to family members, to ensure that they are aware of it and able to take part in discussing the matter with the patient and

\textsuperscript{120} M.A.M. de Wachter, \textit{Active Euthanasia in the Netherlands}, 262 JAMA 3316 (1989).
\textsuperscript{121} \textit{Id.} at 3319. A recent news article reports on an important study describing how euthanasia is actually working in practice in the Netherlands. Most euthanasia, it states, is performed by doctors in the patient’s home. Marlise Simons, \textit{Dutch Survey Casts New Light on Patients Who Choose to Die}, N.Y. TiMas, Sept. 11, 1991, at C12.
\textsuperscript{122} Kamisar, \textit{supra} note 7, at 977.
\textsuperscript{123} Richard M. Glass, \textit{AIDS and Suicide}, 259 JAMA 1369 (1988); Kamisar, \textit{supra} note 7.
physician if they wish. Freeing the physician of the obligation to provide assistance in dying, in addition to showing respect for physicians’ moral sensibilities, might also encourage some patients to discuss the issue. Through discussion, they may persuade physicians not opposed in principle to assisted suicide that theirs is a rational and deliberately considered request.

A requirement of consultation with a second physician, usually directed to confirmation of medical condition and prognosis, might also contribute to the discussion that seems essential to a proper response to a request for euthanasia. In some circumstances, discouragement of suicide might be appropriate. As Marzuk and colleagues observe, “Although the illness is terminal, efforts at suicide prevention are appropriate to allow patients to rationally evaluate alternatives to treatment, to integrate their lives in terms of financial and other planning, and to allow resolution of personal relationships with family and friends.”

Confining aid in dying only to competent persons, however, has serious drawbacks. We allow advance directives in the form of living wills and health care proxies to empower people to forego life sustaining efforts, precisely because people fear the undue suffering of life prolongation when they are no longer competent. It would seem unjustified and unresponsive to public concerns to fail to include a provision in any euthanasia bill for the prior directive and the designated proxy decision maker. In addition, those with diseases like Alzheimer’s, knowing they will lose mental competency in the future, may choose suicide before incompetency sets in unless they have the ability to control their fate through the device of advance instructions.

The never competent, for example, infants and those adults who have never been mentally competent, pose special problems in any discussion of euthanasia. There is no way to draw upon such a person’s own beliefs and values or prior statements to conduct decision making on their behalf. If euthanasia is to have any application, it would be to relieve unbearable suffering, according to some objective standard that would be recognizable by any reasonable person. The law could address such cases in terms of strict standards and burdens of proof: a requirement of clear and convincing evidence of the medical condition, of the futility of treatment, and the high degree of unavoidable pain.

Euthanasia for infants, if permitted, would likely be rare. Parents

124. Peter Mazuk et al., Increased Risk of Suicide in Persons with AIDS, 259 JAMA 1333 (1988).
of infants might be overcome with guilt if they consented to euthanasia, but a few parents might see the option as a merciful shortening of an otherwise doomed existence. If the alternative is literally watching the infant wither and die slowly and fitfully, euthanasia may understandably appear to be the lesser evil.\textsuperscript{125}

Another possible restriction is to limit euthanasia to the terminally ill whose death is imminent. If death is to come soon no matter what, we may find little reason to require someone to endure suffering for the length of time the dying process takes. A question exists as to whether someone like Dr. Quill's patient—who rejected a difficult leukemia treatment regimen that held out some hope for recovery—would be considered terminally ill. If the rejection of treatment is not a part of some irrational suicide plan, and the disease is terminal if not treated, it would seem proper to categorize the refuser as terminally ill.

But it does little to further the goals of legalized euthanasia to limit its use to the terminal patient near death. As Ronald Cranford points out, if a person is not close to death, but could possibly live for months or years with great suffering, then the case for active euthanasia becomes stronger. Physical conditions such as intractable respiratory distress, diarrhea, itching, and vomiting are much more important criteria for justifying active euthanasia than just one form of suffering, physical pain.\textsuperscript{126}

Limiting euthanasia to those near death would exclude all Alzheimer's victims except for those in the final stage of that disease. Limiting it to competent persons would disqualify those in the final stage. Someone like Janet Adkins would be legally compelled to endure the full brunt of Alzheimer's disease.

Some writers suggest a distinction between assisted suicide and active euthanasia.\textsuperscript{127} The former involves assistance like providing prescription drugs; the latter involves administering the lethal agent, by injection or other means. The distinction may not be well grounded, however. Where, for instance, does it leave the cancer patient who clings to life until it is clear only suffering lies ahead, but then is too physically debilitated to ingest the prescribed drugs? A patient like Debbie fits this description. Would she be disqualified, assuming that

\textsuperscript{125} Rachels, \textit{supra} note 7, at 78-79.
\textsuperscript{126} Cranford, \textit{supra} note 98, at 81.
\textsuperscript{127} Wanzer, \textit{supra} note 3, at 848.
she actually requested euthanasia, because she could not participate sufficiently in the process?

Perhaps some of these problems could be limited by adopting a suggestion of Steven Wolhandler that the least active method possible be used.\(^{128}\) The more the individual participates, the clearer it is that he has voluntarily chosen death. Such a rule also spares those rendering assistance the heavier psychological burdens they may feel if the final act is theirs.

Much more discussion and debate must precede precise formulation of formal standards and procedures. Difficulties of definition and phrasing are not insuperable, however, if the desire for euthanasia is perceived as just.

**CONCLUSION**

Doctor-assisted suicide, a suicide machine, a best-selling book on how to kill yourself—all have unleashed a candid debate about euthanasia. Public reaction has revealed a willingness to accept the idea that suicide can be a rational response to devastating illness, and that doctors should be allowed to aid persons who wish to end their lives.

This reaction has encouraged political efforts to legalize euthanasia. Many questions are raised by this suggested change in public policy—some moral, some philosophical, some religious and some pragmatic. Many writers have offered a bleak picture of the likely consequences of a euthanasia policy. There are good reasons, however, to believe that the calculated risks involved are manageable and that the medical profession can adjust to a role it has played occasionally and clandestinely in the past. The publication of Dr. Timothy Quill’s detailed account of an assisted suicide may show the medical profession that aiding in a planned death can serve a patient’s interests, and can be done with humility and courage.

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