Euthanasia: Does the elderly individual have the right to die?

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Euthanasia: Does the elderly individual have the right to die?

Durant, LeDonna Ree, M.A.
University of Nevada, Las Vegas, 1991
EUTHANASIA: DOES THE ELDERLY INDIVIDUAL HAVE THE RIGHT TO DIE?

by

LeDonna R. Durant

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Ethics and Policy Studies

Ethics and Policy Studies
University of Nevada, Las Vegas
May, 1991
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ABSTRACT

This Ethics and Policy Studies project explores the broad and controversial topic of euthanasia, particularly the right of the individual to decide when to die and to die with dignity. I intend to concentrate on the elderly individual, because this group is the segment of the population that is most afflicted by irreversible, long-term illnesses.

Does the elderly individual have the right to die? Should the elderly be forced to die because of the expense of health care in the United States? What about the quality of life of the individual if the individual is forced to live and can not employ euthanasia? These questions, as well as some of the related legal, moral, and economic concerns will be addressed in this project.

Chapter One is a basic introduction to the topic of euthanasia. Chapter Two focuses on the Hippocratic writings. The role of the church and the idea of death will be explored in Chapter Three. In Chapter Four, various views and policies regarding euthanasia will be examined, and Chapter Five takes a look at some medical, economic, and legal concerns of euthanasia today. Various cases in the right to die controversy will be examined in Chapter Six.
Chapter Seven reviews three prominent organizations in the right to die movement; the Living Will and state statutes will be reviewed in Chapter Eight. Next, the individual's rights as a patient will be investigated in Chapter Nine. Chapter Ten takes a look at the question, "Is euthanasia a right or a wrong?" Health care and the problems of aging will be touched upon in Chapter Eleven. Chapter Twelve is the conclusion of this project, presenting several policy recommendations concerning legal and ethical aspects of the right to die and euthanasia debates.
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I conclude by dedicating this thesis to my brother, Leo, and to the memory of my Dad and Mom, Donald R. Durant and Rexine J. Durant. They taught me that an education is important, not only for academic purposes, but even more so for the sake of benefitting from, and for the sake of others.
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CHAPTER 1: INTRODUCTION TO EUTHANASIA

Euthanasia is an extensive and controversial subject that is engulfed by various social, legal, moral, and economic concerns. There are numerous opinions and arguments either for or against the concept of euthanasia. In addition to the arguments, there is a multitude of terms involved when one takes up this subject, such as: active and passive euthanasia, voluntary and involuntary euthanasia, mercy killing, suicide, murder, right to die, etc.

Funk and Wagnalls' Dictionary defines euthanasia as

"painless, peaceful death. The deliberate putting to death painlessly of a person suffering from an incurable disease also called mercy killing. [Greek eu-easy - thanathos - death]" (219).

Taber's Cyclopedic Medical Dictionary defines euthanasia as

"...1. Dying easily, quietly, and painlessly. 2. The act of willfully ending life in individuals with an incurable disease" (580).

These may seem to be clear cut definitions, but society as a whole does not have a clear moral agreement or public policy for the restriction or the implementation of euthanasia. The religious, medical, and legal communities do not agree on the subject, and it is usually the affected individuals who suffer while the debate continues around them. It usually is not an easy,
painless, or peaceful death for the individual or for the family and doctors involved.

The controversy surrounding euthanasia is not new, and it remains controversial because it involves the termination of another human life or the end of one's own life. The developments in medical technology have increased our concern in regard to the question of euthanasia. Medical technology can almost prolong life indefinitely. Thus, professionals, philosophers, theologians, individuals, and other groups are being forced to reconsider the various concerns surrounding euthanasia and various possible policies for the implementation or restriction of euthanasia.

As humans, we instinctively wish to continue living. Euthanasia ends life. It ends the process of nature from which life begins. Since we are self-determining individuals, we must decide if euthanasia is an option for us in the face of a medical crisis which renders us incompetent, places us in extreme pain or agony, or from which there is no hope of a recovery. The pros and cons must be weighed, as well as the motives. Once the decision is made, the end result is death. It is a moral decision; but who makes it?

When the individual has the right to choose euthanasia or not, this allows the individual to continue his or her own self-determination and gives him or her a
choice. It allows the individual to extend his or her self-determination to the question of "when to die?" One may decide not to use or employ euthanasia, but at least this is an option. If the practice of euthanasia is judged to be socially, legally, or morally wrong, the individual has no voice in the future of his or her own life.

The laws surrounding euthanasia must be clarified. The right of euthanasia and the option of its practice must be available to the individual. We, as a society, must protect this right and the rights of the individual. We can not or ought not deny the individual the right to practice or not to practice euthanasia.

Euthanasia is a weighty topic that is relevant to all age groups, and especially for those who have a fatal or long-term disease. The elderly population is especially plagued by the inadequate guidelines regarding euthanasia. They are the segment of the population that is afflicted by long-term illness and diseases of old age such as Alzheimer's. There is a need for a uniform set of guidelines that will protect these individuals from being forced to either accept euthanasia as a measure to help lower the cost of health care or be forced not to be allowed a dignified death by being kept alive in spite of their wish to die. Therefore, I intend to concentrate on
the elderly individual in my recommendations with special attention to the "right to die" and related issues.

In addressing this subject and dilemma, I believe that it is beneficial to take a look at some of the past philosophies and traditions regarding death and the practice of euthanasia in the Western world. Maybe this can help us to understand our modern dilemma.

The Hippocratic writings will be looked at in Chapter Two. Euthanasia and the role of the church will be touched upon in Chapter Three. Various views and policies regarding euthanasia will be discussed in Chapter Four, and Chapter Five deals with some medical, economic, and legal concerns of euthanasia today. There are many cases in the right to die issue, but I have chosen the ones that I feel are the most important. These cases will be examined in Chapter Six. Chapter Seven reviews the three major organizations involved in the right to die movement, and Chapter Eight examines Living Wills, the durable power of attorney, and the various state statutes in the United States concerning the practice of euthanasia. Chapter Nine investigates what we mean by 'rights' and, in particular, the individual's rights as a patient. In Chapter Ten, I take a look at an essay by J. Gay-Williams and ask the question, "Is euthanasia a wrong or a right?" Chapter Eleven deals with health care and some of the problems
and dilemmas of aging. Chapter Twelve is the conclusion of the thesis, and it is here that I will make my policy recommendations for the elderly individual regarding euthanasia.
CHAPTER 2: EUTHANASIA IN THE ANCIENT WORLD

In the Ancient World, death was simple. Unlike today's attitudes, it was something that people prepared for without a great sense of fear. People did not fear death but rather accepted death. Death was symbolic and well thought out, and a person wanted to prepare for death. He or she would make himself of herself ready by observing various customs and giving oral speeches and let death come without resistance. The dying person was the focus of attention, was surrounded by friends and relatives, and usually died in his or her own bed. It was also a time when people were not concerned with where they were to be buried. People were buried in mass graves, and the bones were sometimes used as decorations in the churchyards. Eventually, the "cemeteries" were places for the living too. People would gather here for such activities as gambling, dancing, and marketing. This later changes, and cemeteries become a place of reverence and pilgrimage. Death during this time was as Ariès states a "tamed death" (Ariès).

In Greek literature, euthanasia was described as "...an easy and happy death, an ideal and coveted end to a full and pleasant life" (Wilson 18). Roman literature also presented death in this same manner. The Stoics described death as being noble. Death was considered to
be honorable, and no one questioned "...the means by which death occurred" (Wilson 18).

Beginning in the Fifth Century, B.C., the Hippocratic writings were developed to help or to instruct medical students and those who practiced medicine. The collection is made up of approximately seventy works by various authors and is the remains of a library.

"Many books in the Hippocratic Collection are not strictly 'books' at all; they consist of separate pieces written continuously without any bond of union" (Jones 4:xiii).

For over 2,400 years, these works have been studied. Modern medicine of the 19th Century stopped these writings from being used to the extent that they once had been, but many scholars continued to use them for their historical perspective, and they are receiving new attention due to current bioethics problems. Let us reconsider them with attention to euthanasia.

The writings speak of various epidemics, diseases, ailments, and their treatments along with the role of the physician. The best known of these writings is "The Hippocratic Oath":

"I swear by Appolo Physician, by Asclepius, by Health, by Panacea and by all the gods and goddesses, making them my witness, that I will carry out, according to my ability and judgment, this oath and this indenture....I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I
administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art....I will enter [patient's homes] to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me..." (Jones 1: 299-300).

This 'oath' is the foundation for medical ethics, since it contains

"...moral rules of practice, [and] makes [physicians] also promise to act in a certain manner toward co-practitioners" (Jones 1:291).

There was no medical etiquette in ancient times, since an etiquette

"...implies pains and penalties for the offender, and there was no General Medical Council to act as judge or executioner. It has been thought that the Oath implies existence of a medical guild. This is most doubtful, and even if true, the guild had no power to prevent a sinning doctor from practising [sic]; it could merely exercise care in the selection of its members to be educated. The Greek physician obeyed the laws of etiquette not through fear of punishment, but for love of his craft. The better sort of Greek was always an artist first and a man afterwards" (Jones 2:xxxiii).

Greek physicians were to help the sick and not to practice quackery, which was common during the
Hippocratic period. There were no tests for the physician to take before he set up practice. Some doctors were affected by superstition. "Rhetoric enabled a quack to palm himself off as a trained physician" (Jones 2:xxxix). The Greek physician was a practitioner yet a scientist. His curiosity and quest for answers propelled him. In regard to the patient, the Greek doctor was to persuade his patient.

"A Greek was always argumentative - even when ill - and a Greek doctor was bound to persuade his patient to undergo proper treatment" (Jones 2:xi).

In my search for some hint to the use of euthanasia, I found that death was talked about briefly in the four volumes of Hippocrates. For example, it was spoken about in regard to the description of a patient's progress and daily records. The Greek physician was bound to work toward a cure and to heal the patient. In "The Art" of the Hippocratic collection, one finds this definition of medicine:

"I will define what I conceive medicine to be. In general terms it is to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless..." (Reiser, Dyck, Curran 6).

This seems to say that if a patient is "overmastered" by the disease, the physician refuses treatment. Thus, here, not euthanasia but simply 'letting die' seems to
prevail. However, while the patient is dying, the physician could lessen the patient's suffering if he knows how.

It goes on to counsel the physician in cases that are too strong for medicine to cure. A physician must not expect that medicine can cure all ills. If the ill can be cured, then the physician is to do all that nature and his art of medicine allows him to do. If the illness is beyond cure, it is senseless for one to expect the physician to cure something that nature cannot cure.

"For in cases where we may have the mastery through the means afforded by a natural constitution or by an art, there we may be craftsmen, but nowhere else" (Reiser, Dyck, Curran 6).

Death was not feared by the individual or by the people who surrounded the dying patient in the Ancient World. The physician was to help the patient toward a cure by persuading the patient to undergo the proper form of treatment. However, if the patient could not be cured by the art of medicine or by nature, then the physician was to do all in his power to help alleviate the suffering of the individual. The patient was allowed "to die", and nature was allowed to take its course.
CHAPTER 3: EUTHANASIA AND THE ROLE OF THE CHURCH

In Third Century A.D., Neoplatonism developed and suicide was not approved of for any reason. They believed that man needed to stay where God assigned him. If one committed suicide, the life of one's soul would be adversely affected after death. Judaism also influenced the Roman society. Early Christians believed that one should not take the life of another or one's own life. They adhered to the commandment of "Thou shalt not kill." These two movements helped to destroy the belief in suicide.

"Under the influence of Christianity, the value of life, which for the Greeks and Romans was determined by the quality of life, was reinterpreted to mean that life itself was valuable regardless of the circumstances. As a result of the dominance of the church, Stoicism was undermined. Suicide was denounced as diabolically inspired, and in ecclesiastical law, those who committed suicide were denied Christian burial" (Wilson 23).

The church placed such a stigma on the act of suicide that legislation, as well as personal beliefs were greatly influenced and shaped. Many people who committed suicide were buried in unmarked graves or isolated places in Greek culture, because of a fear brought on by religious and superstitious notions. It was not because of legal punishments. As Christianity developed during the Middle Ages,
people who committed suicide were not allowed a Christian burial.

Emotions and fears about ghosts also helped to shape the laws against suicide. Religious, legal, and social elements created an environment during the Middle Ages where suicide was rare. In the Thirteenth Century, Thomas Aquinas believed that suicide was sinful, because it was a direct violation of the Commandment, "Thou shalt not kill." Aquinas believed that it was the most dangerous of sins, because one had no time to repent. He also stated that it was a law against nature, that it was unlawful because every man belongs to the community, and that it was a sin against God because He gave one the gift of life. The Christian afterlife came into play here also. What you do in this life matters.

Even though the Roman Catholic Church's authority was challenged during the Reformation, these values and beliefs about suicide were carried forth by the Reformers. The practice was opposed theologically and legally.

During the Reformation, there was evidence of euthanasia in Jewish literature. One account was of a practice that was prohibited by law in the Tur by Jacob ben Asher. The practice was to remove the
"...pillow from beneath a dying person...[thus enabling] the patient to die quickly" (Wilson 25). This continued into the 17th Century. It was not just a practice or superstition limited to the Jewish community. Another account was more magical in nature. To bring about an easy death, synagogue keys were placed "...under the pillow of the dying" (Wilson 25).

Euthanasia may have been performed in England, Wales, Scotland, and Ireland. Folktales and legends refer to euthanasia. For example in Brittany, there was an expression

"such as, 'We will need to take the holy hammer to finish him', and in ceremonies in which this was ritually enacted as late as the 19th Century. These suggest that death was once inflicted by means of a holy hammer, which was made of stone and usually kept in an old chapel in each district. When it was needed or requested, it was secured and 'operated' by the oldest person in the village in order to crush the head of the dying while all of the inhabitants prayed" (Wilson 25).

Wilson believed that the actual use of such a device for euthanasia had been relinquished to "rituals and incantations by the 17th Century" (Wilson 26).

Keeping these views in mind, let us take a look at the notion of death again. During the Eleventh and Twelfth Centuries, death became more intensely personal and the dying individual was more concerned with one's own self and one's own soul. The individual knew that
when it was his or her time to die, that one must ask for atonement from God. Then, one would rest until they awoke in Paradise. This later changed to the Second Coming during the Twelfth Century.

The individual was concerned about one’s own soul and the forces of good and evil. It was his or her responsibility to be good and perform good deeds, so that he or she would be saved and not be damned when the Resurrection took place. These forces of good and evil, figures of Christ as a judge, and the appearance of celestial beings started to appear in the paintings and literature of the Twelfth through Fifteenth Centuries. Death became an individual's performance. Dying was an art, "...the artes moriendi ..." (Ariès 34). Family and friends still attended the dying patient, but emotions set in and the death bed was a scene of crying and weeping by those who surrounded the patient. This continued for years, but today it has been reversed with people not wanting to show any emotion whatsoever.

Death continued to be emotional, and death was combined or associated with love. Death became more erotic and was seen as a break or release from life. An example of this can be seen in the play, Romeo and Juliet. The art and literature of the Fifteenth Century through the Eighteenth Century reflect this view.
People still died in their bed chambers with their loved ones around them praying for their souls. Death was considered natural and a blessing from God, so that the dying patient would be free from pain or suffering. Suicide or assisting in a suicide was still considered to be a religious and a medical taboo. Doctors could still try to ease the pain and suffering of the patient, but they were not to tamper with life.

With the emergence of new medical knowledge, the notion of death started to change. Some people had the ability to demand medical assistance to prolong one's own life, because they had the money to do so. They could afford to have a private physician come to their homes. People started to look at death as postponable, and as doctors and medicine improve, death takes on a new look. It is now a medical look; one of medical jargon with medical names and illnesses.

Christianity also influenced the hospice movement. Hospices had been around since the ancient Romans. They were places for people who needed care such as pilgrims, travelers, and the homeless. The Christians changed the nature of the hospice by not only tending to the sick in the way of medical care, but now they believed that the people also needed a dual care - that of body and of soul. It was almost a missionary goal to open the hospices to old people, so that they could convert them
to Christianity. The Catholic Church told their bishops to build their own hospices next to their churches, and the basic theme was to save souls. The church ran these hospices and they would hire doctors to cure the patients or to help them, but the nuns or "nurses" were concerned with the individuals' souls.

Approximately, around the Fifteenth Century, wealthy people joined with the church and established hospitals. Kings and queens financed the hospitals for the poor until the Sixteenth Century. The money was given to administrators who were to run the hospitals, but they abused their power and did not pass the money on. The wealthy were turned off by the embezzlement and by all the problems of the hospitals. They would have their private physicians come to their own homes. Hospitals were warehouses for the poor and very poorly run with poor hygiene. Thus, comes governmental involvement. The government takes over the hospitals and rules and regulations follow. This change brought on a change in philosophy. The hospices of the church had a monastic goal to help the individual self, as well as to cure the individual's body. The body and soul were treated as one. The new philosophy was that of caring for only the body. The philosophy was that of welfare and the self was cut in half. Gradually, the hospices were cleaned up, and the modern hospitals appeared in the Nineteenth
Century. Still, the emphasis on care was lost, and the emphasis on cure prevailed.
Endnotes/Chapter 3

CHAPTER 4: EUTHANASIA IN THE MODERN WORLD

John Gregory, a professor at a medical school in Edinburgh, wrote about ethics in 1770. His writings were popular and were promoted after the Revolutionary War by Benjamin Franklin. His writings were similar to Percival's in regard to the obligations that the physician was under to his patient. Yet, Gregory suggested some regulations for the relations between medical professionals. He also stated that,

"It is a physician's duty to do everything in his power that is not criminal, to save the life of his patient, and to search for remedies from every source..." (Reiser, Dyck, Curran 57).

He believed that the physician, the surgeon, and the apothecary should work together for the benefit of the patient and to consider the patient's welfare before their own welfare. Private interests such as money and pride should be avoided as one's prevailing motive in the case of a patient, so that the patient did not suffer from the care giver's own personal interests. The good of humanity and of the patient was not to be compromised for economic reasons.

In 1791, Thomas Percival, British doctor,

"... was asked by the medical staff of the Manchester Infirmary 'to draw up a scheme of professional conduct relative to hospitals and other medical charities'" (Reiser, Dyck, Curran 52).
This was after a dispute among the staff which led to resignations in 1789. Percival worked with both sides of the dispute, since he had very close friends on each side. He came up with a code that consisted of four sections: professional conduct in regard to hospitals and other medical charities, professional conduct in general and private practice, the physician's conduct towards apothecaries, and one that listed the professional duties of the physician and some reference to cases that require familiarity with the law. Jeffrey L. Berlant takes a look at Percival's section on private and general practice in his own article, "Medical Ethics and Monopolization" (Reiser, Dyck, Curran 52-64).

This section of Percival's code was a basis for the American Medical Association's Code of Ethics a half century later. Percival prescribes some general rules of moral conduct that include: humanity, secrecy, attention, delicacy, and confidences. The physician's own "quality of mind" was also discussed. He was to have temperance so that he could think clearly, and he was to retire when senility set in.

"Others have to do more specifically with handling the patient: reasonable numbers of visits to the sick, not abandoning doomed patients, admonitions to patients suffering from the wages of sin, observance of the Sabbath for both themselves and the patient except in emergencies, and abstention from
gloomy prognostications to maintain hope and comfort in the sick except when the patient must make his own death arrangements" (52).

Percival believed that, overall, the physician should exemplify the moral virtues of justice, responsibility, integrity, respect, and courage, and be of good moral character. He also believed

"... in the fundamental goodness of human nature and on this basis [he rejected] the need for sanctions [against the physician]. To assert the need for professional criticism and regulation would impugn the good character of physicians" (56).

The ethics of this view show that he believed that if the physician was shown ideals and use of reason, he would not need to have a set of punishments for violations. He wanted to create a code of moral advice that "... an ideally moral man could follow" (56).

Percival's ethics were conservative in nature and aimed at the elite. He felt that the medical profession was the only authority needed for medical matters, and he felt that they were bound to protect the public. Gregory felt that the public should assume more

"... responsibility for its own medical welfare than Percival would allow, and that the medical practitioner compromised some of the goals of the profession. Put another way, Percival tended to identify the practitioner with the profession, while Gregory restricted practitioners to one limited sphere within the profession" (58).
Both men were instrumental in providing more of a basis for modern medical ethics.

Percival's code of ethics circulated beyond England. It spread to other countries, especially English-speaking ones. In 1847, the American Medical Association (AMA) embraced a code of ethics based upon Percival's medical ethics. However, many of his suggestions were changed, and the AMA changed the code several times in the years that followed. Most of the changes dealt solely with the physician's services, exploitation of services, and costs, or economic concerns.

The AMA's 1957 "Principles of Medical Ethics" had ten sections. Section one is the one from which I wish to quote:

"The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion" (Reiser, Dyck, Curran, 39).

Special emphasis should be placed on the ethical implications of "full respect for the dignity of man". This emphasis has been lost by the medical profession today. The medical profession includes doctors, nurses, and administrators. It does not on the whole treat an individual with dignity. Usually, the terminally ill patient feels isolation and the self is stripped of its individual identity. Depersonalization is a big factor;
you are just one of many patients. The longer one is confined, the more isolation one feels. Physicians and other medical professionals need to minimize such feelings by attending to the patient's psychological needs, as well as the patient's physical needs. The idea here is to respect the individual's desires or values of independence, privacy, self-respect, happiness, freedom from the illness or disability, and control over one's life (Scully). Many times the terminally ill patient is treated as an undesirable or outcast. They are isolated in special wards of the hospitals, are heavily sedated so that their death may be brought about quicker or so that they are "easy patients" for everyone to deal with including the family members. We need to return to such an ideal of "full respect for the dignity of man" and put it to practice. Allowing a person to choose euthanasia rather than a prolonged and painful death is one meaning of respect for the "dignity of man".

The Western physicians of the Nineteenth Century generally rejected any suggestion to shorten inevitable suffering or dying patients' lives, so that they would not suffer. Napoleon asked his physician to give his mortally ill soldiers a fatal drug. The physician refused on the grounds that his duty was to cure, not to kill. The euthanasia debate heated up around the start of the 1870's. The medical profession along with the
public were moved by essays written by S.D. Williams and Lionel Lollemache.

"S.D. Williams proposed that when patients stricken with a hopeless and agonizing sickness requested that their lives be ended, the physicians should have the legal right to assist them. Lionel Tollemache followed shortly with an essay supporting this viewpoint and focusing, like Williams, on the excessive burden, suffering, and anxiety borne by unhealable patients" (Reiser, Dyck, Curran 488).

Both of these men were laymen, and even though no laws or codes of ethics changed, their essays stirred people to think about the euthanasia concept of a painless death.

With the medical advances of the Twentieth Century, physicians had many procedures available that would keep a patient alive who otherwise would have died quickly if he or she were allowed to let the natural forces rule. In 1904, Judge Simeon Baldwin expressed reservations about the benefits of medical progress or advances.

"The family asks the doctor if there is no hope, and he responds with some sharp stimulant; some hypodermic injection; some transfusion or infusion to fill out for a few hours the bloodless veins...the sufferer wakes to pain and gasps back to a few more days or weeks of life. Were they worth having? Do they bring life or a parody of life? Has nature - that is, the divine order of things - been helped or thwarted; but not for long. The suffering, or at best lethargic existence, has been successfully protracted, but the body will soon falter and fail in the unwanted functions forced upon parts of it made for other uses, and death come, to the relief of the dying and living, alike" (Reiser, Dyck, Curran 488).
No moral codes had been revised or developed to help the physician who now had the "technical ability to prolong lives... For example, prior to the 1960's, a mortally ill patient who stopped breathing was pronounced dead. But modern respirators gave physicians the ability to treat the condition" (Reiser, Dyck, Curran 489).

Most physicians chose to sustain the patient's life. Modern science had achieved great advances, yet many human beings were destined to suffer painful and lingering forms of death. The advances sustained life that would not have been lengthened previously if nature had been allowed to run its course. These advances and discoveries also lengthened the life expectancy rate. The elderly and terminally ill patients were increasing segments of the population. This brought about concern for the public's economic welfare, since these two groups would need to be cared for. All these changes raised or drew new attention to the issue of euthanasia as an option for controlling or dealing with the dilemma.

Two general definitions emerged as to what euthanasia entailed and what defined it. One definition concerned the incurable patient who was not yet close to death, and the other one applied to helping those who were close to dying. The latter was the more popular definition, since it meant helping the dying patient to exit this world with as little suffering as possible.
Four policies evolved that were based upon these two meanings of euthanasia.

1) The first policy advocated that the physician do nothing that would quicken death. The physician was to make the terminally ill patient as comfortable as possible and to make the remaining time as painless as possible. The patient usually received powerful pain killers when they were requested, food and beverage that pleased him, and the environment was bright and cheerful. Psychologically, the patient was prompted to dwell upon his past and the accomplishments that he had made. Religion was introduced when the patient needed hope of salvation. The physician could only relieve the suffering and comfort his patient. Death could not be hastened; dying could only be made "...gentle and easy" (Reiser, Dyck, Curran 489). This is similar to the hospice concept today where the goal is for the person to die with a sense of dignity. The patient is the main concern, and the environment is like that of a home. The whole individual is treated, and the patient is allowed autonomy by being allowed to take his or her own medication, having possessions around them, and having guest rooms for family and friends to stay in. There are trained professionals that are there to listen and to talk with the patients.
2) The second policy was supported by those who felt that the quality of life was more important with the length of life. The physician usually prescribed pharmacological or surgical measures to deal with the terminally ill patient's pain and suffering. Even though these actions may shorten life in some cases, they were justified because they were trying to prevent pain and were not aimed at ending life. The aim of this policy was to

"...use powerful remedies to reduce suffering, as opposed to the previous policy of comprehensive concern for the physical, psychological, and spiritual needs of the dying or incurable patient" (Reiser, Dyck, Curran 490).

This approach was advocated by the U.S. Academy of Moral and Political Sciences in 1949. The resolution advocated that physicians use therapeutic actions, even those that might cause death, as long as they did not intentionally solicit the death of the patient with their use.

3) The third policy for euthanasia was endorsed by the 1884 Boston Medical and Surgical Journal in an editorial.

"We suspect few physicians have escaped the suggestion in a hopeless case of protracted suffering to adopt the policy of laisser-aller, to stand aside passively and give over any further attempt to prolong life which has become a torment to its owner... Shall not a man give up the fight, take off the spur of the stimulant, and let exhausted nature sink to rest?... Perhaps logically it is difficult to justify a passive more than active attempt to
euthanasia; but certainly it is much less abhorrent to our feelings... May there not come a time when it is a duty in the interest of the survivors to stop a fight which is only prolonging a useless and hopeless struggle?" (Reiser, Dyck, Curran 490).

The physician was not to give strong remedies that were aimed at a cure and was to stop using any active therapy. Critics of this policy said that the doctor was abandoning the patient. This of course would be against Percival's Code of Ethics, since he believed that the physician should be there for the terminally ill patient and his family. It also went against the American Medical Association's position in the 1847 Code of Ethics. Patients should not be abandoned. I agree that patients should not be abandoned, but this policy could be effective without abandonment. A good physician would not totally abandon his patient. If a physician uses techniques that prolong the suffering of the patient, then that is a type of abandonment to me. The patient should be free from pain and suffering.

4) The fourth policy stated that the physician

"...had the moral right to purposely terminate a patient's life when he suffered from an incurable and agonizing disease, and wanted to die" (Reiser, Dyck, Curran 490).

People who defended this type of euthanasia felt that it was irreverent to allow a patient to function bodily when the consciousness had eroded away.
"Would it not be more respectful treatment of the loved ones, a more dignified ending of a worthy life, if respiration were allowed to cease when all higher functions have irrevocably departed?" (Reiser, Dyck, Curran 490).

The result of impending death and the suffering prompted physicians to give morphine to the patients; large doses were given until the patient finally expired. It was believed by those doctors that it was better to think of the patient rather than about the ethical or legal aspects of such an act.

During the Twentieth Century, people who advocated this type of euthanasia suggested that legislation be drawn, so that doctors could be liberated from sustaining the life of a patient who wished for a quick and painless death. One bill was introduced into the Iowa legislature by Dr. R.H. Gregory and another was introduced to the Ohio legislature by Miss Anne Hall. Both bills were aimed at establishing legal sanctions

"...to the participation of physicians in euthanasia. Gregory claimed that many doctors defied the law and commonly practiced euthanasia on their suffering and incurable patients. The British Medical Journal labeled Gregory 'a liar of the basest kind', and Anne Hall was criticized in a similar manner by physicians" (Reiser, Dyck, Curran 490).

Both bills were rejected; however, these proposed bills caused alarm. In reaction to this, a New York state legislator introduced a bill
"... that anyone suffering such euthanasia, verbally or through written document, be guilty of a felony" (Reiser, Dyck, Curran 490).

The bill was not accepted.

In the 1930's, the euthanasia debate was of major concern in England. Dr. Killick Millard stirred the legislative debate when he proposed legalization supporting euthanasia. Patients who were suffering from an irreparable and painful disease had a right to die without pain or without legal ramifications. Existing laws made it a felony to take one's own life even if one was incurably ill. This allowed the doctor, nurse, friend, or relative that helped to employ euthanasia to be prosecuted for a charge of manslaughter or even murder. Such a felony also damaged the family name.

In response to this, an organization was formed in England to promote legalization of euthanasia and to educate the public in regard to euthanasia. The organization was the Voluntary Euthanasia Legalization Society. It was supported by a number of top physicians and laymen who had joined the society. Millard's proposal was redrafted and sent to the Parliament on November 4, 1936. The bill stated that

"... the candidate for euthanasia must be over twenty-one, suffering from a disorder involving severe pain, and incurable. To initiate action required a formal written application, certified by two witnesses, which was sent to a referee who reviewed the request and interviewed the candidate. Permission granted,
someone other than the patient's doctor carried out the euthanasia" (Reiser, Dyck, Curran 491).

During the discussion of this bill, physicians pointed to the cases where drugs failed to provide relief for the suffering patient; the effectiveness of therapy did nothing to help the suffering of the patient and in some cases where morphine was continually administered, the patient's character suffered. They also argued that an open and legally sanctioned procedure for euthanasia would be much more beneficial. With legal sanctions for its use, the act and participation in such an act, would make the doctor's participation socially acceptable and end possible criminal ramifications for those who participated. The current choice for a physician was to risk a prison sentence if he tried to help alleviate his patient's suffering. Legalization would allow the physician to be free from bearing total responsibility for a painless death. The doctor would be joined by legal, religious, and other agents of society ... not only would patient and doctor benefit from such legislation, but so would relatives of the patient by escaping the financial and emotional strain of a prolonged illness" (Reiser, Dyck, Curran 491).

However, after hearing this discussion, the House of Lords rejected the euthanasia proposal, and on December 1, 1936, a second reading of the Voluntary Euthanasia Bill was declined by a vote of thirty-five to fourteen.
The deliberate ending of a life was of great concern to many people. The defeat of the bills regarding euthanasia showed that there was a great opposition from society, as well as from the medical circle to the fourth policy on euthanasia. The Hippocratic Oath's passage that states that physicians were forbidden to give 'deadly medicine to anyone, even if asked, nor[to] suggest such a counsel' was declared to be a basic principle on which the physician should rest his decisions. One doctor even stated, "If a life is worth living at all, it is certainly worth living to the very end..." (Reiser, Dyck, Curran 491). Others compared the doctor who performed euthanasia to that of an executioner and suggested that patients would not trust the physicians that played such a role. Some doctors were afraid that they would not be seen as the "guardians of life" anymore. Treatment of non-fatal illness was also seen as an obstacle if euthanasia were legalized. If euthanasia were medically and legally acceptable, how could a doctor convince a patient whose illness was non-fatal to endure the suffering and to be strong until the crisis passed? Also, if the physician did not fully utilize the personal and the scientific resources at his disposal, it implied that he had failed. Some doctors feared that mercy killing might stop the development of new drugs that could relieve the pain and suffering of
the afflicted. It might also stop the development of future medical technology or future therapeutic discoveries. A cure might be found the next day or in the few months that followed. There was also the possibility of an incorrect diagnosis and prognosis; the patient's life could be ended prematurely.

Other adversaries of the euthanasia proposals cited studies and observations of patients who were incurable. They pointed to evidence that the patients rarely expressed a wish to die, and that they summoned courage to face the idea of pain and death. Some patients could benefit by extending their lives, so that they could say good-bye to people, prepare for the disposal of their earthly goods, or to soothe their guilty conscience.

The Bible was quoted by some opponents too.

"Man must endure the pain of death as the penalty for sin: 'Providence ordains the day of our death ... to hasten that day is an act or rebellion against the Divine Will'" (Reiser, Dyck, Curran 492).

Some doctors believed that social approval of euthanasia might cause havoc in a civilization that was held together by the rule of "Thou Shalt Not Kill". Homicide was considered to be a natural part of man's instinct and once let go, it might be hard to control. It was feared that even if mercy killing were humanely applied, that medicine and society might be demoralized. Doctors might employ euthanasia under the pretense of mercy killing
only to reap financial rewards for such an action from greedy relatives of the patient. The physician might also use euthanasia to rid families, hospitals, society, and themselves of caring for patients who would not recover.

Euthanasia might also become a social solution by ridding society of unproductive or burdensome patients. Such euthanasia would help the public to use the tax money for medical care to serve the more valuable members of society. For example, a proposal was written in 1944 by a San Francisco doctor that advocated the use of euthanasia on the incurable mentally ill patient.

"... Most of these unfit are of no apparent use in the world. They require care and many are without hope of betterment. Not only are they a great burden upon society, but supported and protected, they are fast increasing their dead weight by reproducing their kind" (Reiser, Dyck, Curran 493).

This type of proposal became social policy in Nazi Germany. In the early 1930's before the Nazi takeover, the physicians debated the use of euthanasia against those who were mentally ill. After Hitler came into power, in 1939 all state institutions submitted lists of patients to a central bureau. These were names of patients who were ill and unable to work for five years previously. This central bureau

"... selected patients for euthanasia. An organization devoted to determining appropriate
children for euthanasia also existed, having the title, Realms Committee for Scientific Approach to Severe Illness Due to Heredity and Constitution. The hundreds of people killed through these organizations included mentally ill, epileptics, the aged sick, and sufferers from neurological diseases such as infantile paralysis and brain tumors" (Reiser, Dyck, Curran 493).

The previous uses of euthanasia as a solution are unacceptable. Euthanasia for the purposes of ridding society of "unproductive or burdensome patients" or those that are deemed by others to be undesirable is not an option. Euthanasia should not be used for these purposes or for those of controlling the cost of health care, dealing with the scarcity of resources, population control, or any other problems of society. Euthanasia is to be an individual's own decision and option. Not one forced upon the individual by a society.

Reiser felt the literature from the medical journals of the Nineteenth and mid-Twentieth centuries that he examined was quite sparse in dealing with the dying patient. The problems of the dying patient were usually ignored by educators and practitioners, and this

"... subject was examined in medical schools [of the latter part of the Nineteenth Century]; the young physician had to learn for himself what to do and what not to do [with the dying patient], in the most solemn and delicate position in which he can be placed" (Reiser, Dyck, Curran 493).
This discussion of what to do about the dying patient prevailed until the mid-1960's. Then the advanced technology of medical machines sparked the concern for the dying patient's treatment once again. Moral concerns grew, because machines were keeping the dying patient alive and usually the machines could not change the grim prognosis anyway.

Moral decisions had to be made that would satisfy both the patient and the doctor. These needed to allow for the autonomy of the patient when one sought medical services. The decisions were complicated by the fact that people were being kept alive by respirators, kidney machines, and other modern devices. Public and medical debates continued as they continue still today.

Arthur J. Dyck undertook to integrate physician and patient concerns in an essay in 1973 about euthanasia. Dyck believed that,

"The arguments for euthanasia focus upon two humane and significant concerns: compassion for those who are painfully and terminally ill; and concern for the human dignity associated with the freedom of choice. Compassion and freedom are values that sustain and enhance the common good" (Reiser, Dyck, Curran 530).

He stated that the argument for compassion occurs when people say that it is inhumane to keep dying patients alive when they are suffering from great pain, have lost bodily functions, and have lost the will or capability to communicate. Those who emphasize compassion search for
freedom for the patient; he or she should be able to choose when he or she will die, and "... should not be subjected to medical treatment to which that patient does not consent." (530)

Dyck explained how advocates of euthanasia morally justify the distinction between a painless death and killing. The advocates state that the terminally ill patient will die regardless of medicines' interventions; therefore, they believe that it is the suffering that should be ended and that legal sanctions should allow the patient to die with less rather than more suffering. Even though the patient is committing an act of suicide and the physician is helping such an act, these actions are morally justified. They are morally justified, because the dying patient's suffering was useless and is ended. The focus here is "... on the consequences of acts, not on their intent" (530).

Dyck referred to the Stoics and the Epicureans when he states,

"The ethic that defends suicide as a matter of individual conscience and as an expression of human dignity is a very old ethic ...[They] considered the choice of one's own death as the ultimate expression of human freedom and as an essential component of dignity that attaches to rational personhood. This willingness to take one's life is an aspect of Stoic courage. A true Stoic could not be manipulated by those who threatened death" (531).
Dyck then remarked that this ethic of euthanasia would make one assume that those who oppose the idea of voluntary euthanasia, "lack compassion for the dying and the courage to affirm human freedom" (531). Since they oppose the painless and deliberate process of death, they seem incompassionate. At first, the term euthanasia meant that the death was painless and happy. There was...

"... no reference to whether such a death was induced ... a second meaning of the word has [now] come to prevail: euthanasia now generally means 'an act or method of causing death painlessly so as to end suffering' (Webster's New World Dictionary, 1962)" (531).

Dyck invented a new term to include a happy death which he called

"... benemortasia. The familiar derivatives for this new term are bene(good) and mors(death). The meaning of 'bene' in 'benemortasia' is deliberately unspecified so that it does not necessarily imply that a death must be painless and/or induced in order to be good. What constitutes a good or happy death is a disputable matter of moral policy" (531).

In the policy or ethic of benemortasia, Dyck argued for four beliefs or values. The following points are what I consider to be the most important:

"1. That an individual person's life is not solely at the disposal of that person; every human life is part of the human community that bestows and protects the lives of its members; the possibility of community itself depends upon constraints against taking life; 2. That the dignity that attaches to personhood by reason of the freedom to make moral choices includes the freedom of dying people to refuse noncurative, life-prolonging interventions when one is dying, but does not extend to taking
one's life or causing death for someone who is dying; 3. That every life has some worth; there is no such thing as a life not worth living; ... human beings require constraints upon their decisions regarding those who are dying. No human being or human community can presume to know who deserves to live or to die ... religion and the Jewish Christian expressions of it are not obstacles to modern medicine and a better life; rather they help foster humanity's ceaseless quest to preserve and enhance human life on this earth" (535).

Dyck's policy for benemortasia argues for four beliefs or values. I agree that an individual's life is not solely at the disposal of that person or for that matter, at the sole disposal of another person. We have laws against murder, suicide, and social policies or practices that aim to rid society or the community of individuals who are no longer productive, desirable, or who have become a burden because of cost, time, or for other various reasons. Each individual is a part of the human community. The community's survival does depend on certain constraints against the taking of a life. That is why it is very important to have safeguards against the improper use of euthanasia. But as a member of society, each individual does have a right to have the freedom to make his or her own moral decision whether to live or die as long as it does not cause harm to others.

Dyck says that dignity is the freedom of dying people to refuse treatment or procedures, yet he does not extend this so that a person can take one's own life or
assist someone with taking his or her own life. He limits the term freedom and uses it only in the respect that the dying individual or patient can refuse treatment. After the patient has refused this treatment, what then? What if the pain and suffering are so great that the individual is left with agony and no other choice but to end the pain and suffering? Is it compassionate and humane to allow the patient to be alone in a quest for an answer? No, it is not. It also does not allow for the freedom of the individual; the freedom to be free of the terminal illness or the disease. The patient should be free to either administer a peaceful and painless drug to oneself or allow a doctor to administer the drug so that his or her suffering can come to a quick and desired end. This allows the person dignity.

Dyck's third value is that all human life has some worth. Of course, all human life has some worth, but he does not discuss the quality of that life. The quality of life is up to the dying individual. Only that person can decide whether he or she wants to live or to die. If the patient's quality of life is left up to others, the individual suffers both physically and psychologically. He is right in saying that "... no human being or human community can presume to know who deserves to live or to die..." It is only the individual that can make that
decision after weighing all the alternatives and after examining his or her own values. His term benemortasia leaves much to be desired as far as compassionate help for the dying individual is concerned in alleviating the suffering of that individual.
CHAPTER 5: CONCEPTUAL ISSUES

All of us, and especially the medical profession are faced with important consequences in regard to the medical practice of active or passive euthanasia.

A distinction must be made between active and passive euthanasia.

" 'Active euthanasia', as the term is used, means taking some positive action designed to kill the patient; for example, giving him a lethal injection of potassium chloride. 'Passive euthanasia', on the other hand, means simply refraining from doing anything to keep the patient alive. In passive euthanasia we withhold medication or other life-sustaining therapy, or we refuse to perform surgery, etc., and let the patient die 'naturally' of whatever ills already affect him" (Rachels 162-163).

Some people see no legal or moral distinction between the two forms of euthanasia, yet others do.

The physician faces moral, as well as legal consequences. Doctors are to protect and to save lives. They are not to exterminate lives. It has become more acceptable for doctors to employ passive euthanasia. Since a doctor is not allowed to give a patient a lethal injection such as in the case of active euthanasia, his other choice is to withhold treatment and let the patient die sooner than he would have if treatment were continued. The latter gives the doctor an avenue to accomplish the
compromise of not killing the patient and not prolonging the patient's agony or pain.

The American Medical Association in 1973 made a policy statement to address this concern.

"The intentional termination of the life of one human being by another - mercy killing, is contrary to that for which the medical profession stands and is contrary to the policy of the AMA. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family" (Rachels 163).

The AMA's statement is cautious in wording and in what it affirms. It still is no absolute guideline for the physician, but it does bridge the gap between not employing active euthanasia at all as a medical practice, yet foreseeing cases when passive euthanasia can be employed or when passive euthanasia may be advisable. It in no way releases the physician from legal ramifications in exercising a "procedure" to terminate a patient's life. Even though most criminal prosecutions for euthanasia deal with active or mercy killing, the physician still faces possible legal proceedings in employing passive euthanasia. Here we must also look at the hospital's liability too, since the hospital and other staff members may also be included in civil or
criminal proceedings resulting from the termination of a patient's life.

In some instances, doctors refuse to terminate a person's life even though the person has made a legal, living will or professed a belief in the use of no heroic measures to sustain his or her life. The doctor may feel that various social, moral, or legal concerns override the patient's wishes. More often than not, the case is that the doctor will respect the patient's express wishes to terminate the life process. This line of argument requires some reflection.

Lives that could have never been saved or prolonged in the past, now can be kept "alive" by machines and feeding procedures. The dilemmas that the doctors face have increased in the past few decades, because of the advances in modern technology. Some patients can be kept "alive" indefinitely. Their lives can be sustained with the use of these medical advances, but these advances also complicate the legal issues involved.

The legal concerns of the doctors, the hospital, the state, the courts, the family, and the patient are sometimes headed for a common result or in totally opposite directions. Whatever the direction or the end result, the patient usually suffers, and the right of the individual is often over-looked. It is the individual patient that counts foremost! The patient must be
allowed to exercise his or her right to terminate life, and the doctor must be able to comply with the patient's wishes without criminal proceedings. The physician should help the patient die painlessly. It is the patient's decision. Of course, I am assuming that the legalities involved will be outlined to a specific degree and that euthanasia remains an individual decision and not a form of extermination which is used to rid society of the patients it wishes to get rid of for economic reasons or for prejudiced concerns.

The economic concern is not a new one. Some people have proposed new guidelines regarding the termination of terminally ill individuals, patients that will never recover or regain consciousness, and elderly patients who may outlive their estimated years. The proposals stem from the high costs of medical treatment. Health planners are trying to develop policies to deal with the terminally ill and the nonterminal elderly, as well as government officials and citizens. The cost of medical care has reached a sum of a $1.25 billion a day in the United States. Approximately, 20 to 30 percent of health care costs involve the terminally ill. (Veatch 34).

Should a patient's life be terminated, because the expensive care is only bordering on being useful and may be useless? Only if the patient decides to exercise his or her right to employ euthanasia.
There must be safeguards, so that the decision of euthanasia is not forced upon the patient! Again, this requires more legislation and protection of individual rights. Whether one is looking at the nation's high cost of health care or the individual family's financial burden from a loved one's prolonged hospitalization, the patient's wishes to be kept alive or not to be kept alive are of paramount concern. Let us not opt for the "common economic good" if it is against the individual patient's right to self-determination. Instead, let us strengthen the legal rights of the patient, so that he or she will not become a mere pawn in a game of economic concerns dealing with the high cost of health care. Whether one is poor, terminally ill, competent or incompetent, or elderly should not matter. What matters is the individual's beliefs and wishes in continuing life or ending life. Euthanasia is a personal decision, and everyone should have the right to make such a decision without imposed restrictive guidelines that aren't moral or ethical.

So far in this thesis, I have tried to trace the philosophical and theological views of euthanasia from the Ancient World up until the 20th Century. With the advent of medical knowledge and
technology, there came a push for legalizing the use of active euthanasia. There is still controversy surrounding this issue and a push for legislation. There are many cases that have involved euthanasia, as well as, efforts to legalize the practice of euthanasia.

Some cases involved the petitioning of legislatures allowing a physician to use active measures to bring about a patient's death and end the suffering. This was regarded as mercy killing. Other cases of this nature involved individuals who aided in their spouses suicide or "murdered" the victim of an incurable and painful affliction. Whatever the case, today we still have the same events taking place. We still have conflicting views and arguments. There is still not an answer. Some of the people who have aided in someone's death have been prosecuted, yet others have been acquitted.
CHAPTER 6: CASES IN THE RIGHT TO DIE ISSUE

Now, I will take a look at a couple of cases dealing with the right to die. The first case deals with Karen Ann Quinlan. This case rocked the nation back in 1975 and is perhaps the best known of the right to die cases in recent years.

Karen Quinlan was 21 years old when she took ill on April 15, 1975. Her friends summoned a rescue squad after Karen had trouble breathing. They also tried to give her artificial respiration until the ambulance arrived. She was transported to a hospital in Newton, New Jersey, and was in an 

"unresponsive state and showed evidence of brain damage" *(In The Matter of Karen Quinlan 5)*.

Tests were performed, and she was transferred to a hospital in Denville, New Jersey. None of her physicians was able to determine what caused her first respiratory problems. She remained in a vegetative state and was totally unconscious; her doctors inserted a respirator tube, so that she could breathe properly. It was stated that her condition was hopeless and her coma was irreversible.

The Quinlan family believed that Karen would not recover, so after seeking religious and medical guidance, the family requested that the respirator be discontinued. Karen had made it known that she did not want to live in
a vegetative state. Family and friends testified to this.

Dr. Morse said that he would carry out the wishes of the family after a meeting in July or August. The Quinlans were asked to sign a release in reference to the doctor and the hospital. They did this, but a few days later, Dr. Morse said that he would not carry out the order due to legal concerns. He felt that the courts must come up with some criteria. He felt that there was not a medical precedent that favored the use of euthanasia in this case (In The Matter of Karen Quinlan).

The case captured national attention after Karen's father petitioned the Superior Court, so that he could be appointed her legal guardian. His purpose was to have his daughter removed from the respirator which sustained her life. After refusal by the lower court to grant Mr. Quinlan's petition, the request was later granted by the New Jersey Supreme Court, and Karen was removed from the life support system.

The New Jersey Attorney General and the prosecutor for Morris County did not appeal the New Jersey Supreme Court's decision. Therefore, the Supreme Court did not have to deal with the Quinlan case. The New Jersey Supreme Court's view of the case is significant, because of the court's concentration

"... on the possibility of Karen Quinlan's' ... return to cognitive and sapient life..."
(In The Matter of Karen Quinlan vii).
There are many ethical, social, and legal implications from this first national case for a right to die. Society's acceptance was based on feelings of compassion, sympathy, and goodwill. Society's unacceptance was based upon various moral, legal, and religious concerns such as is it right to play God, is it murder, etc?

The New Jersey Supreme Court considered Karen's mental capacities and believed that people in her condition would rather die than to be maintained by the use of a respirator. This conclusion was drawn from the medical opinions and testimony, plus common sense on the part of the Judges.

In this case, it was decided that Karen's right to privacy would allow her to refuse the treatment she was getting to sustain her life. The court felt that this right

"...should not be discarded solely on the basis that her condition prevents her conscious exercise of choice" (In The Matter of Karen Quinlan xiv).

The court decided that this right could be preserved by extending the ownership of such to the guardian and the family.

This idea of consent raises some ethical questions and legal questions about the boundaries of the right to privacy, but the decision in this case did help to provide the medical field with some protection from
regarding euthanasia of this type as homicide. Rather, it was regarded as death from natural causes, since she would not survive without the use of a respirator.

There are many other instances where individuals are equally brain damaged. They may also have irreversible symptoms as Karen did. What guidelines do the courts use? Should the guidelines be the same for an infant born with massive brain damage? There is no clear answer, but that the right to privacy of the individual must be considered. If the individual can not make the decision, this right should be given to the appointed guardian or the next of kin. Fifteen years after the Karen Quinlan controversy, another case brought national attention to the right to die issue. This was the case of Nancy Cruzan.

Nancy Cruzan was in an automobile accident in 1983. She had been in a coma and had not moved or done anything since that awful accident. She had food and water tubes in her stomach, and these tubes could have maintained her like this for possibly 30 years or more. (*N.Y. Times*, Jan. 14, 1990) She was in a vegetative state, and her family wanted to let her die. She was lying in a Missouri hospital awaiting the decision from the U.S. Supreme Court after the Missouri State Supreme Court decided against the plea from Nancy's family to end their
daughter's life. The Court held in a 4 to 3 vote that the feeding tube could not be removed.

"The Court held that the state right to promote life, however hideous, was virtually absolute. It also doubted the parents' claim that Nancy, when healthy, had expressed a clear preference, in such a circumstance, for death" (N.Y. Times, Dec. 3, 1989).

This was the first time that the U.S. Supreme Court had agreed to wrestle with the right to die issue. The Court had

"...avoided this unpleasant issue that weighs relentlessly on Americans' minds [and in July of 1990] it finally joined the debate and in doing so accelerated a movement toward a changing American view of death" (Gest 23).

Many people awaited the verdict from the U.S. Supreme Court. There were an estimated 10,000 other patients like Nancy Cruzan. These families were in the same boat as the Cruzans. Besides the individuals and families involved, other people from various professions and interest groups were concerned. Most of the families felt that it was a private matter, and that it should not be a battleground for the right to life groups (Gibbs). People on both sides of the issue wanted some guidelines.

The U.S. Supreme Court weighed the arguments from both sides. The State believed that they could constitutionally require a patient to receive food and water against his or her will. The Cruzans' lawyer, William H. Colby, argued that the Constitution requires a
state to defer to a family's judgment when the patient's wishes are not clear regarding life-sustaining treatment. Colby cited the 14th Amendment as a guarantee of liberty. He stated that it

"protects that person's right to be free from state intrusion" (Greenhouse B26).

The constitutional right to privacy was not referred to by the lawyers or the Justices. Greenhouse felt that either they believed that it was not implicated or that a decision based on broad constitutional grounds was not needed.

On June 25, 1990, the Rehnquist Court reached a narrow decision by one vote. The Court said that

"...Missouri could use the lack of 'clear and convincing evidence' of Nancy Cruzan's wishes to block removal of a feeding tube that has kept the 32 year old woman alive in a vegetative state for seven years. But in handing legislative leeway to states, the Court recognized for the first time a 'constitutionally protected liberty interest in refusing unwanted medical treatment', a finding that could lead toward euthanasia for millions with ailments from Alzheimer's to dementia" (Gest 22).

The Court found that people who clearly make their wishes known do have a "liberty interest" in being free of unwanted medical treatment or care. This applies to individuals who can currently express their wishes or those who have clearly expressed their wishes before they were rendered incompetent. So one must be competent at the time one expresses those wishes for treatment or non-
treatment. The Court did not define what the "clear and convincing evidence" could be. Does it mean a clear verbal or written statement? Does it mean a more formal written statement such as a Living Will or the appointment of a proxy in case of incompetency? The Court left the decision up to the individual states.

The Court's decision did little to help alleviate the family of Nancy Cruzan's dilemma. They had been granted permission to remove the feeding tube back in 1988 by a state trial court. Four months later, the Missouri State Supreme Court reversed the lower court's ruling. Now, the U.S. Supreme Court had upheld the state's right to demand "clear and convincing evidence" in the matter, and this returned the case to the Missouri courts.

On November 1, 1990, Judge Teel of Missouri, the same judge who had granted the Cruzan's pleas in 1988, heard new evidence in the Cruzan case. The Cruzan's lawyer produced three witnesses who testified that Nancy had said

"...that she would not want to live 'like a vegetable.'" Teel reaffirmed his decision" (Smolowe 64).

Now, the Missouri Rehabilitation Center in Mt. Vernon, Missouri, was free to remove the feeding tube that had kept Nancy Cruzan alive since 1983. The Cruzans, Joe and Mike, instructed the
hospital to remove the tube, and Nancy Cruzan lived twelve more days and finally died peacefully.

Missouri's Attorney General also asked the lawmakers to pass a bill that would resolve cases like those of Nancy Cruzan. Such a bill had been drafted and had been introduced to the legislature in 1989, but it had failed in the State Senate. The following is a list of conditions in that proposal for discontinuation or removal of life support systems:

"1) A person must be in a persistent vegetative or permanent unconscious state for at least 3 months. 2) Three doctors must testify independently to the patient's condition. 3) The patient must never have expressed a desire to be kept alive no matter what. 4) All members of the immediate family must agree to the withdrawal of treatment" (N.Y. Times, Jan. 14, 1990).

Hopefully, the bill will stand a better chance because of the Supreme Court's ruling.

There are many other cases that involve the right to die or euthanasia. In San Diego, Anna Hirth's daughter asked for the removal of her mother's feeding tube. The nursing staff and doctor refused to remove the tube from the 92 year old woman. Superior Court Judge Milton Milkes handed down the decision that the tube could be removed, but that the doctor who had objected did not have to
remove it himself. From this, San Diego County came up with some guidelines.

"Doctors may end treatment if 'the decision has been made by the patient, the family, or someone taking the place of the patient'" (Fritsch 34).

The guidelines also state that the physician does not have to do anything he finds ethically wrong. The patient can then be transferred to another physician who will take the steps necessary to end the patient's life. Patients who are minors can only "refuse" treatment if the parent or guardian consents to it. Patients who are comatose have the same rights as those patients who are competent. If they have not drawn a Living Will or written directives before becoming incompetent, the decision can be made by a relative or a court appointed surrogate. The Los Angeles County Medical Association and the Los Angeles County Bar Association developed guidelines in 1985 that endorsed similar rights for the patient and the doctor. The procedures, however, were not very specific (Fritsch). These procedures are not legally binding.

A case which is unique for the fact that the patient was not in a vegetative state or terminally ill was that of Claire Convoy. Claire was

"...severely demented...[and] at age 79 entered a nursing home in 1979. Four years later, she was unable to move from a semifetal position and was diagnosed to be in a state of
progressive senile dementia. In addition, she suffered from heart disease, hypertension, diabetes, a gangrenous leg, eye problems, and an inability to control her bowels, speak, or swallow. When her nephew requested that her feeding tube be removed, the nursing home refused, the case went to court. Before final arguments in the case were heard, Claire Convoy died, her nasogastric tube still in place" (Scully 289).

The New Jersey Supreme Court ruled that artificial feeding and other medical treatment would be removed if three conditions were met. First, the patient should have clearly made it evident that he or she did not want life supporting treatment. This could be that of a Living Will directive. If there was no such directive, then the

"...life sustaining treatment could be withdrawn or withheld if either of two 'best interests' tests (a 'limited objective' or a 'pure objective' test) is met satisfactorily" (Scully 289).

The second test, the limited objective test, requires that the guardian

"...attempt to deduce what the patient would have decided for himself based on trustworthy evidence, whereas, in the 'pure' objective test, the guardian would attempt to make the decision without resorting to what the patient would have wanted" (Scully 289).

The New Jersey Supreme Court made it clear that this three stage test was directed at facilities for extended care. There are thousands of hospitals and nursing homes that are a stage for such dilemmas. That is why the New
Jersey Supreme Court directed its decision toward such cases.

In another case, there is an 81 year old man identified as only L.W. In May of 1989, he suffered a series of strokes and heart attacks. This has left him in an irreversible comatose state. L.W. has lived in mental hospitals since 1951. His previous competence has been questionable. He has no immediate family or close friends to advise the courts whether he wanted the care of life-prolonging treatment. In June, a Wisconsin Circuit Court decided that Paul Lenz, the legal guardian of L.W., could decide whether to continue or cease the life support treatment. He, in turn, appealed to the Wisconsin Supreme Court for guidance. No further decision has been made in this case.

A case that represents an opposite situation from the previous cases is that of Helga Wanglie. Helga is an 87 year old retired school teacher. She has lain in a vegetative state in a Minnesota medical center. She has no future of ever recovering. The doctors who are attending Helga say

"...that they want to end life support for a patient whose prospects seem so hopeless. Cost is not an issue: the family's health insurance covers almost all expenses" (Tifft 67).

Oliver Wanglie, Helga's husband, refuses to permit them to terminate Helga's life support.
"'She told me that if anything happened to her, she didn't want anything to shorten her life.' says Wanglie, 86. 'I promised her I would respect that'" (Tifft 67).

The hospital administration has failed to convince Mr. Wanglie to transfer his wife to another medical facility. He has also been asked to file for an injunction that would force the center to continue their care of Helga. Therefore, Hennepin County Medical Center is planning to ask the State Court for permission to disconnect Mrs. Wanglie's life support systems. This is an unprecedented step.

"'We don't [sic] feel the physicians should be forced by the family to provide inappropriate medical care,' says Dr. Michael Belzer, Hennepin's medical director" (Tifft 67).

There are many cases that have resulted with the family taking matters into their own hands because of legal obstacles. In Chicago in 1989, Mr. Rudy Linares disconnected his 16 month old child's respirator. He had begged the doctors to unplug the unit, but the hospital officials refrained on the grounds that they were unsure about the legal concerns regarding patients who were not "brain dead". So Mr. Linares took it upon himself to end his child's life. He was charged with first degree murder (Johnson 26). He was later acquitted.

Roswell Gilbert was sentenced to life imprisonment for ending the life of his ailing wife. Mrs. Gilbert was 73 years old and suffered from Alzheimer's disease and a
painful form of osteoporosis. He fired two bullets into her brain to cease her pain and suffering. To him it was mercy killing, but to the prosecutor it was murder (Nordheimer). He was sentenced to life imprisonment, but he was later pardoned.

Janice Adkins was a 54 year old Portland school teacher who suffered from Alzheimer's disease. Janice had been active all of her life in several sports, and she loved to play the flute. As her disease progressed, her memory continued to fade. Her flute playing was impossible, and she feared

"...an excruciating future ....[and wanted] to maintain some dignity in death" (Gibbs 69).

Her family urged her to try the experimental treatments for the disease. When the therapy did not work and her memory continued to fade, Janice decided that she would commit suicide rather than to face a future that would not allow her to live the life that she treasured or that she wanted to live.

Even before her illness, Janice had joined the Hemlock Society which supports assisted suicide in the case of the terminally ill patient. In Oregon, however, assisted suicide was illegal. Her doctors would not recognize suicide as an option. Then, Janice read about Dr. Kevorkian.

Dr. Jack Kevorkian was a Detroit doctor who had
"...fought hard for a [terminally ill] patient's right to commit suicide and a doctor's right to help. [In the fall of 1989], he invented the easily replicable suicide machine using $45 worth of hardware and tried to advertise it in a local medical journal. When the editors refused, he peddled the story to the local newspapers and soon found himself on the 'Donahue' show ...[and] he became a standard-bearer for all those who fail to see a moral difference between unplugging a respirator and plugging in a poison machine" (Gibbs 69).

Janice contacted Dr. Kevorkian in October of 1989. He told her to seek medical treatment for the disease, since Alzheimer's can be stopped with medication in the early stages of the disease. Janice took the medication, but treatments still did not help. She continued to get worse, and she contacted Dr. Kevorkian again. Dr. Kevorkian called her Oregon doctor who said that there was nothing more that he could do to help her, so Dr. Kevorkian re-contacted Janice and agreed to help her relieve her suffering.

Before she arrived in Michigan, Dr. Kevorkian had been searching for a place to carry out the mercy killing.

"The hotels, vacant office buildings and funeral parlors he approached all turned him down. So he resurrected his 1968 Volkswagen, bought the cot and some clean sheets [and made his van ready for the procedure]" (Gibbs 69-70).

Janice Adkins flew to Detroit along with her husband, Ronald, and her three adult sons. Her husband
bought her a round trip ticket hoping that she would change her mind about the assisted suicide. The family met with Dr. Kevorkian, and he confirmed the Alzheimer's diagnosis. He also judged Janice to be lucid and competent.

On June 11, 1990, he drove her to a public campground near the lake. Dr. Kevorkian settled down beside the cot on which Janice was lying.

"He hooked her up to a heart monitor, slid an intravenous needle into her arm and started a harmless saline solution flowing through the tube. Then he sat back and watched the monitor as she pushed a big red button at the base of the machine. Immediately, the saline was replaced by a pain killer; one minute later came the poison potassium chloride. Within five minutes Janice Adkins... was dead of heart stoppage... As soon as the line on the heart monitor went flat, Kevorkian called the police" (Gibbs 69).

Before her death, Janice made a tape and wrote a statement as to why she had chosen to end her life. Her choice was to die with dignity. She did not want to have her family see her deteriorate or force them to care for her. She did not want to watch herself deteriorate and not be able to live the active, productive life that she valued. Dr. Kevorkian released the tape and the statement to the public after her death.

Janice's family was interviewed after her death. The family grieved their loss, yet they agreed that it was her choice to die with dignity. They knew that she
believed in living a full and active life. Her Alzheimer's disease would not allow her to do so. Her husband and her sons felt that she accomplished her goal of dying in a manner that gave her the dignity that she wanted.

Dr. Kevorkian was issued a temporary restraining order that barred him from assisting with other suicides. The Michigan prosecutors had to decide whether to prosecute him. A few years earlier, the Michigan Supreme Court had thrown out

"... a case against a man who gave a loaded gun to a friend who later shot himself. While suicide is not unlawful in many states, aiding and abetting suicide is" (McBride 70).

Dr. Kevorkian was not prosecuted. His only regret was that he wished the medical examiners would have arrived sooner, so that Janice's organs could have been used for transplant.

These cases are just a small fragment of the right to die cases that have occurred throughout the United States. The Supreme Court's decision in the Nancy Cruzan case does give the individual the right to be free of unwanted medical treatment or care if the person has clearly made his or her wishes known. But again, there are many questions left to be answered. Individual states will have to wrestle with these questions and
dilemmas—just as the individual patients, families, and doctors involved in the cases will have to do.
CHAPTER 7: ORGANIZATIONS FOR THE RIGHT TO DIE

There are three organizations involved in the right to die issue. The National Hemlock Society is a non-profit organization that supports the right to die with dignity.\(^1\) They publish a newsletter called the Hemlock Quarterly which reports on the events concerning dying and death. Their membership fees start at fifteen dollars and this includes the newsletter, a free copy of a Living Will, and the Durable Power of Attorney for Health Care. As a member, one can call or write and ask their legal department for help, yet the forms are quite self-explanatory. The organization also supplies the member with a Medical Emergency Card which you keep in your possession in case you should take suddenly ill. They also sell books on the subject of death and dying. The Hemlock Society endorses the option of

"lawful, voluntary aid-in-dying for terminally ill persons." The Society believes that there is a "... justifiable suicide - that is, rational and planned self-deliverance" (Humphrey 335).

The Hemlock Society's ethical parameters for this type of suicide are as follows:

"The person is a mature adult, the person has clearly made a considered decision, the self-deliverance has not been made at the first knowledge of the life-threatening illness, and reasonable medical help has been sought, the treating physician has been informed, and his or her response has been taken into account, the person has made a will disposing of his or
her worldly effects, the person has made plans to exit this life that do not involve others in criminal liability, and the person leaves a note saying exactly why he or she is committing suicide" (Humphrey 336).

The second major organization is the Concern for Dying. They are the originators of the Living Will. They also supply the members with the items mentioned above at an annual membership fee of ten dollars. The organization is non-profit and has been in existence for fifty-two years. Concern for Dying distributes documents and tries to protect the right for a natural and dignified death by educating the public and health-related professionals regarding the many aspects of refusing treatment.

The third organization is the Society For The Right to Die. The only distinction that I found between this and the Concern For Dying is that their membership fees differ. The Society For the Right to Die charges fifteen dollars for a membership fee. All the benefits are the same for both, as well as their address.

These organizations all provide the same benefit to the prospective member. They send a copy of the state's laws regarding the withholding or withdrawal of life-sustaining procedures and explain how to use all of the forms. The right to die issue has become much more controversial since the Supreme Court's decision in the Cruzan case in the summer of 1990. It suggests that your
personal wishes are entitled to protection under the Constitution, only so long as you clearly express your wishes in writing. One should have a Living Will.
Endnotes/Chapter 7

1 The National Hemlock Society, address, P. O. Box 11830, Eugene, OR 97440-3900, (503) 342-5748.

2 Concern For Dying, address, 250 West 57th Street, New York, NY 10107, (212) 246-6962.
CHAPTER 8: LIVING WILLS

The Living Will is a document that allows a person to make his or her wishes known regarding the use of life-sustaining procedures. It is a directive that is to be followed if one becomes unable to participate in the decisions regarding one's medical care. It states that the physician should withhold or withdraw treatment if it is only prolonging the person's dying. The Living Will states that one has the right to refuse treatment that one does not want, and one can also request the forms of treatment that one does want. One can list the specific treatments that one does not want to receive, such as: cardiac resuscitation, mechanical respiration, artificial feeding, etc. There is also a place for someone to be named as a proxy to carry out the patient's wishes, in case the patient is unable to communicate instructions listed on the Living Will Declaration. The Will is to be signed in the presence of two adult witnesses, and the witnesses will also sign the declaration. The original is to be kept at home with the personal papers of the writer, and signed copies are to be given to the doctors, family, and proxy of the writer. It is also advised to keep a wallet size document which states that you do have a Living Will and that it is among your personal papers. Some people register the Living Will with one of the
three organizations for the right to die mentioned previously.

In the event of incompetency, one may wish to prepare ahead of time for such restricted care by designating a person as one's agent through the use of the Durable Power of Attorney for health care. This allows another person to make medical treatment decisions on one's behalf if one should become incompetent. The documents for such a choice are very involved and must be taken very seriously, and must designate clearly the person to whom one entrusts this power to. Again, one can obtain this information through the Society for the Right to Die, so that it directly adheres to one's own state's statutes.

The Living Will and Durable Power of Attorney for health care are two procedures which have taken on importance as the right to die issue continues to emerge in today's society.

"In an attempt to protect the right of the individual to control his own body and his own life when there is no hope of recovery, and to avoid the 'euthanasia' controversy, many states have instituted living wills and durable power of attorney statutes" (Faller 9).

Louis Katner proposed the idea of the Living Will in the 1960's. The Concern For Dying Organization produced and distributed the Living Will in 1968. Enforcement or rather how to enforce the will was not dealt with until
several years later. California was the first state to act upon any legislation. In 1976, the state enacted a statute to recognize the Living Will as valid. Now, some thirty-nine states have statutes in connection with the Living Will, and all states grant the competent adult the authority to make a Living Will. Most states do not allow minors or mentally incompetent people to write a Living Will.

"Six states have provisions which allow minors or their guardians to make a living will declaration. Some states have set down tests to determine whether an incompetent person can refuse treatment through his representative, and a few states have special requirements if the person is in a skilled nursing home" (Faller 19).

Even though the legislative gains are regarded as a major step toward the right to die with dignity, the Living Will is limited. In many cases, the statutes add little to the legal rights of the patients beyond clarification of their desires. Living Wills are very limited in scope and not performative" (Faller 9).

The state statutes vary in their limitations and their similarities. The similar aspects of the Living Wills include the following:

"... (a) definition sections; (b) who may make a declaration; (c) the manner of execution of the document; (d) declarations stating that complying physicians will be provided with immunity from civil and criminal penalties; (e) declarations that the current wishes of the patient will supercede any previous declarations; (f) revocation procedures; and (g) declarations for the transfer of the
patient if the attending physician will not comply. Of critical importance are the following limitations: (a) in most states living wills can only be used to refuse extraordinary, life-prolonging care; and (b) they are only effective after a person is determined to be terminally ill" (Faller 10-11).

The definitions involved here with regard to the terms "life-prolonging" and "life-sustaining" are open to medical, ethical, and legal interpretation, and the different states differently interpret both terms and the execution of the specifics involved with the medical distinctions.

Of course, these statutes have been designed to leave some latitude, so that the writers of the Living Wills can specify which types of treatments they do not want employed. However, no one can foresee all the types of treatment which may be employed by the attending physicians. At times, the latitude and flexibility of the Living Wills do not provide for all possible medical measures that can be taken to prolong someone's life; therefore, the patient's wishes or desires are not met. They are kept alive against their previous directions because of not being able to anticipate all the various forms of treatment.

Terms such as artificial respiration, cardiac resuscitation, and artificial feeding are the universal language of the Living Will. These medical treatments
are used to prolong life and are specifically listed on the form, so that their use will be withheld. Other types of treatment such as surgery, kidney dialysis, transfusions, transplant surgery, and palliative chemotherapy are not viewed as drawing out the dying process and therefore, would not be encompassed under a living will despite the fact the quality of life they produce may not be desirable to the person(s) receiving them" (Faller 11).

The states vary with their views on these terms. Wisconsin recognizes the latter terms as processes which sustain life, and these treatments can be refused under the state's Living Will statute. By comparison, Tennessee adds more medical processes to it's statute such as,

"any other medical act designed for diagnosis, assessment, or treatment to sustain, restore, or supplant vital body function" (Faller 12).

It also lists examples of other medical care that is non-refusable under the state statute. This list includes:

"hygienic care, sedatives and painkillers, suction, nonartificial oral feeding, and hydration" (Faller 12).

Utah is the only state that allows a person to

"... refuse nutrition and hydration or antibiotics by explicit direction in their living will" (Faller 12).

The irreversible comatose patient may refuse treatment in New Mexico. Most of the states are similar in their view of what a terminal illness is, and define such as an illness that results in death. New Mexico is
the only state that allows the non-terminal comatose patient to refuse treatment. Idaho and California do not allow patients to

"... institute a Living Will until a terminal diagnosis has been made, and California further insists that the patient must have been notified at least 14 days earlier of the diagnosis before instituting a Living Will" (Faller 13).

Consequently, in these states, because a terminal diagnosis is essential, people who are accident or stroke victims are eliminated from benefiting from a Living Will. It is virtually impossible for them to institute such a declaration at the time of their affliction and still act in accordance with a statute like California's. In my opinion, this presents a problem that must be addressed in future legislation around the country.

In some states, the patient must be treated for a length of time even after he or she has declared a desire to refuse treatment. Life support for forty-eight hours is required in Colorado, and South Carolina requires six hours of treatment. In Connecticut, the next of kin or the legal guardian must be notified and must consent to the termination of life support procedures before the procedures can be ended. Such notification is required so that the durable power of attorney and family members may have the chance to challenge the legality of the Living Will. Connecticut also allows time to see if the
patient has the possibility of recovering from the crisis.

Nevada and Maryland accept the Living Will even if it is written in another state. These are the only two states which recognize the Living Will in this manner. Three states put a time limit on the validity of a Living Will, and most states automatically revoke the Living Will during pregnancy.

A person may revoke the Living Will at any time, but the states differ on the manner of revocation. Some states require that the revocation be oral and be witnessed, and others recognize nonverbal revocation. In Maryland, the patient must be notified of the terminal condition before oral nullifications are accepted. This, of course, poses problems for the patient who can not orally revoke his or her Living Will. Many states will not revoke the declaration until the patient or the patient's spokesperson communicates such a desire to the physician. Written or notarized nullification or both are required by some states. Yet, others allow revocation by simply destroying the document or damaging it. In Mississippi, the withdrawal of the Living Will must be

"...filed with the state bureau of vital statistics. In 15 states, revocation is authorized regardless of the physical or mental condition of the patient, and in the remaining
states revocations may occur at any time" (Faller 15).

Louisiana, Florida, Texas, and Virginia provide for the use of oral living will declarations. Louisiana and Texas allow for the declaration to be oral, written, or communicated by nonverbal means. The other states require that Living Wills

"..be executed willfully and voluntarily, written, signed, dated, and witnessed" (Faller 16).

Two witnesses are required in all of the states.

The Power of Attorney is recommended along with a Living Will declaration, so that a patient's wishes may be achieved in case of incompetence. It also would provide for the patient who is in the various states that do not recognize Living Wills until a terminal diagnosis has been made.

In regard to the physician's role in all of this, some states

"...exempt physicians who refuse to abide by the declaration from liability but provide for the transfer of the patient to another physician who will comply with the declaration. Some states also include a provision of a transfer from one institution to another if the former institution policies prohibit the removal of support system" (Faller 18).

Indiana and California do not find it necessary for the physician to accept the Living Will. This approach fails to guarantee the patient's wishes; it annuls the Living Will and its purpose.
I believe that the wishes of the patient should be recognized by institutions, physicians, and by family members. If the person has declared that he or she does not wish to be sustained by medical technology, then give them this freedom to be in control of his or her own destiny. The Living Will and the Durable Power of Attorney for Health Care must be recognized by all states (See Chapter 12, Recommendations).
1 I wish to thank Betty L. Faller, RN, BSN, for the following information regarding Living Wills and the Durable Power of Attorney. She wrote the paper, "Living Wills, Durable Power of Attorney for Health Care, and Euthanasia", for the Institute for Ethics and Policy Studies at the University of Nevada, Las Vegas. I greatly appreciate her assistance with the following information.
CHAPTER 9: YOUR RIGHTS AS A PATIENT

Before we take a look at a patient's rights, I feel that it is necessary to define the word "right". Black defines a right "as 'powers of free action'. He goes on to state that personal rights generally mean "...the right of personal security, comprising those of life, limb, body, health, reputation, and the right of personal liberty" (Black 1189-1190).

To further define the word "right", I have chosen to use a definition from The Encyclopedia of Philosophy. 

"...Human rights, in short are statements of basic needs or interests. They are politically significant as grounds of protest and justification for reforming policies. They differ from appeals to benevolence and charity in that they invoke ideals like justice and equality..." (198-199).

Now, let us take a look at one's rights as a patient. As a patient,

"You have a right to privacy and to control what is done to your body. You have a right to be treated with respect and not to be harmed. You have a right to information about your condition so you can make informed choices. You have a right to life and, many experts argue, a right to die as well" (Scully 60).

Scully believes that there are four elements that must be met so that the patient can give informed consent as to his or her condition. If the patient is incompetent, these elements apply to his or her legal guardian. The elements are:
"1) A patient competent to make health-related decisions; 2) Disclosure of relevant information by the physician, including risks, benefits, and alternatives; 3) Understanding of the disclosed information by the patient; 4) A choice freely made by the patient" (Scully 66).

As long as you are a competent adult who has been informed of all the risks, benefits, and alternatives, understand that information, and feel free to act in regard to your medical situation, then you can give informed consent. If any of the elements are missing, you or your legal proxy can not make an informed or free decision. If a doctor, nurse, or institution forces treatment on you without consent or the consent of your proxy, each is liable for criminal or civil action (Scully).

You have the right to determine what happens to your body. You are the one to decide what treatment you want to accept or what treatment you want to reject. You must determine what will bring you happiness, self-respect, independence, freedom, and other personal values that you treasure. Decisions must be made as to what is important to you and what kind of a life you wish to live.

Scully lists four ethical principles that can be a guide to protect yourself or the people that you love. These principles compliment the elements for informed consent. They are as follows:
"1) **Autonomy** is your right to determine what is done to you, to make decisions for yourself, to be told the truth and be sufficiently informed that you can make those decisions. 2) **Do no harm**...includes your right not to be injured or hurt in any way. 3) **Doing good for others**...obliges us to act in the best interests of others and to help them further their own welfare and well-being. 4) **Justice** in health care stems from the concept of fairness and the sharing of resources in an equitable way" (Scully 18).

The previous definitions, elements of consent, and ethical principles are important guidelines for your rights as a patient! You have the right or power to a feeling of personal security. Your needs or interests are basic human rights, and you can exercise these rights to protect what is important to your life. Many times, medical environments threaten a person's sense of autonomy and sense of security. These guidelines can foster a sense of security and create a less threatening environment for the patient, the patient's proxy, and/or the patient's family.

As a patient, you are part of the decision making process! If you are a competent adult or proxy, you have the right to accept or refuse any type of medical procedure or treatment. If you do not consent to a procedure or treatment plan, the medical facility or staff can not force treatment upon you. Many times doctors do not let you feel as if you have a choice in your decisions. You do. Do not be afraid to ask your
doctor questions. Get a second opinion. If your doctor does not cooperate in your search for a second opinion, then I would question his motives. It is your body and your life. You must decide what will protect your basic needs, interests, and desires. You are the one who has to decide what kind of a life you wish to live.

Let us take a look at the situation of a patient whom I shall call Gwen. Gwen is a 64 year old widow with two adult children. She had been very active up until three years ago when she suffered a major heart attack. She has been on light medication ever since and has been able to live a fairly normal, independent life. A few months ago, she suffered another heart attack, was hospitalized, treated, and later released. Her doctors prescribed more medication. The medication makes her feel dizzy, weak, and nauseous, but she has continued the treatment her doctor ordered even though it has altered her quality of life. Two weeks ago, Gwen suffered another heart attack.

Gwen has been in the hospital for two weeks. She is on oxygen most of the time and is on ten different medications to keep her heart functioning. Her doctors have given her several tests, and Gwen has asked for a second opinion. Both cardiologists agree that surgery is not an option. The prognosis is that she may live a matter of months or possibly a year or two. The doctors
tell her that they do not know how long she has to live and also recommend that she make plans to tidy up her estate and personal affairs. Gwen's only treatment is more medication, to take life easy, and to carry an oxygen tank around with her. At any time, she could suffer a heart attack or stroke. Gwen will need full time care.

Gwen is mentally competent to consider her moral options; she has been informed of her condition, and she understands all of the aspects. Now, she must make some decisions. She can continue to take the medication that is keeping her alive. She can discontinue the medication which will bring about her death almost immediately. She is free to choose to accept the treatment or to reject the treatment. She also knows that there is a possibility that she can suffer a stroke which could make her an invalid, comatose, or an incompetent.

Her family wants to do everything that they can to keep her alive. They tell her they will take care of her. Gwen knows that she will be a burden to them, yet she wants to live as long as she can. So Gwen decides to continue to take the medication and to live with her daughter.

Daily, Gwen feels weaker. She becomes less able to move about freely, has trouble eating because of the nausea, and is constantly tired and out of breath. She
sees that she can not take care of herself without someone's help. This makes her feel defeated by life. Gwen decides to discontinue the medication. She puts her financial and personal affairs in order and writes a Living Will. She chooses to end her own life by discontinuing the medication. She does not want to live a life that compromises her values of freedom, self-respect, independence, and happiness. She wants to take control over her own life and be free from the illness and disabilities. She believes in God and sees an after life as the ultimate freedom for herself. She wants to die with dignity.

Gwen's case is one that exemplifies the elements of consent and ethical guidelines. She has the right to choose what type of life she wishes to live or not to live. It is the individual that must make the decision and the individual has that right.
CHAPTER 10: EUTHANASIA: A WRONG OR A RIGHT?

In an essay entitled, "The Wrongfulness of Euthanasia", J. Gay-Williams believes that our society accepts the idea, as well as the practice of euthanasia. Society's acceptance is based on feelings of compassion, sympathy, and good will such as in the Karen Ann Quinlon story back in 1975.

The author feels that this type of situation produces feelings of compassion and a response that the person afflicted, as well as the family would be better off if he or she was dead. The author then comes to the conclusion that it must be all right to kill that person by taking steps to cease the life. The author can see the feelings of compassion, but does not agree that euthanasia is right. It is wrong from the standpoints of nature, self-interest, and from the view of its practical effects. She believes that these are critical points and proceeds to argue each of these individual standpoints and the factors involved in euthanasia.

Before I discuss these points, it is important to understand how the author defines euthanasia. The author states,

"An essential aspect of euthanasia is that it involves taking a human life, either [a] one's own or [b] that of another. Also, the person whose life is taken must be someone who is believed to be suffering from some disease or
injury from which recovery cannot reasonably be expected. Finally, the action must be deliberate and intentional [Intentional by whom? The patient or the caregiver?]" (Gay-Williams 156-159).

If a patient has no reasonable hope of living with the use of medical procedures, then his death does not constitute euthanasia. The death of the patient is only due to the injuries or disease that afflicts him. It is not because of his failure to receive treatment. This is also the case when there is failure to continue treatment on a patient who has little chance of benefiting from such treatment. It may be that this will spare the person pain, save him from personal indignity, and spare the family from further emotional and financial worries. His dying is unintended and therefore is not active euthanasia.

If a patient is given an injection of a drug to treat him and he dies as a result, this is not euthanasia or wrongful killing. The drug was believed to be a necessary procedure to treat a disease or to better the patient's condition.

If a patient is given an injection of the wrong type of drug by mistake, the intention here is not deliberate; it is wrongful killing. It is the result of an accident. Considering the author's opinions, let us know go on to the three categories of the author's arguments against euthanasia.
The first aspect of why active euthanasia is wrong is from the standpoint of nature. Human beings instinctively want to continue living, want to survive, and everyone by nature has this internal goal for survival. Our behavioral reflexes, responses, and daily actions show that we want to protect ourselves, and we exercise judgment and caution in doing so. Examples of this can be seen in our everyday actions. We drive carefully to avoid accidents, we stay our distance from hazardous materials or conditions, and we do not intentionally put our lives in danger.

The organization of the human body itself is so structured that it defends itself against foreign invaders. When the body is invaded by bacteria, it produces antibodies to fight these foreign organisms. Special cells clean up our bodies, so that the bacteria is eliminated. Our bodies also heal themselves when we cut ourselves. The process of healing starts immediately. Euthanasia defeats these processes of nature that strive for physical survival. Our bodies within themselves strive to survive.

Another factor in the nature argument is connected to that of religion. Some religious thinkers maintain that when man takes his life, he acts against God. God owns the body; man is only the trustee of his body. Thus, he goes against the Commandment which says that he
shall not take a life. This argument can only be accepted by people who have this religious conviction.
If a person does not believe in God or such teachings of holding life unconditionally sacred, this point then becomes invalid and is not considered euthanasia.

The author feels that reason alone shows us that euthanasia is against our nature, because of our behavioral responses and the organization of our bodies. Further, she states,

"...euthanasia does violence to our dignity. Our dignity comes from seeking our ends. When one of our goals is survival, and actions are taken to eliminate that goal, then our natural dignity suffers. Unlike animals, we are conscious through reason of our nature and our ends. Euthanasia involves acting as if this dual nature—inclination towards survival and awareness of this as an end—did not exist. Thus euthanasia denies our basic human character and requires that regard ourselves or others as something less than human" (158).

Reason sets man above other animals, and we should remember this when we discuss euthanasia.

The author's second argument against euthanasia is the self-interest standpoint. Death is something that is forever final, and it can not be reversed even in today's age of technology. J. Gay-Williams feels that euthanasia works against our own interests if we allow its practice on ourselves or others. Her reasons are as follows:

One might die needlessly in the face of a wrong diagnosis or prognosis. Our standards and achievements
in medicine are great, yet mistakes can be and have been made. A person may receive an incorrect diagnosis or prognosis. The person then believes that there is no hope of a recovery, because medicine has not found a cure. The person dies in vain, because euthanasia has been elected as the only answer. The error can not be corrected after the person is already dead.

Euthanasia also stops the hope for new techniques or experimental procedures which could pull a patient through a medical crisis. If such procedures are not allowed to be investigated, medicine may cease to further its knowledge. Euthanasia also leaves no space for miracles to happen, such as spontaneous remissions or sudden recoveries which do occur.

When a person knows that he or she can take life away at any moment or ask someone else to do it for him, the person may give in to euthanasia too readily or easily. Even though the patient has a strong will to live, pain, suffering, or emotions of despair can weaken this will to live. Many illnesses require that our bodies and our minds focus on becoming well. Euthanasia weakens our belief and the fight to become strong once again. It acts against our own best interests. We opt for the easy way out of the situation.

Along with these feelings of weakness and possible suffering, a person may also look at euthanasia in regard
to the people around him. He may have the impression
that he is too much of a problem for his family to deal
with. He may feel that the financial and emotional
burdens are too much for his loved ones to bear. Thus,
by ending his own life, he would make the family's life
easier and set it back on its normal path. The person
surrenders to these feelings. Euthanasia stops one from
surviving when a person might survive for a long time and
have a future.

The author's final argument is from the practical
effects standpoint. Euthanasia, as a practice or policy,
alters the end result or purpose of medical personnel.
They are to be totally committed to saving lives, not
ending them. The practice of euthanasia also may have a
corrupting effect, so that in severe cases, medical
personnel may not attempt to save a patient. This could
result in a carry over effect to patients who are less
seriously ill, and they would be dealt with in the same
manner, as those who were seriously ill. The author
states, "The result would be an overall decline in the
quality of medical care" (158). The practice would take
us into a corrupt and declining era of medical history.

There are many problems in considering euthanasia as
a policy. A person who is seriously ill may be allowed
to take his own life or may authorize others to take it
if he cannot function any longer for himself. Judgment
on the part of the patient, at the time, or the judgment of others comes into effect. In the latter case, judgment is based on the view of others and is not voluntary or personal according to the author. Someone else is acting for the patient. The author feels that this is only a beginning for practice by people who are not authorized to take someone's life. Such is an example of directed euthanasia, not voluntary euthanasia, and will lead to general practice and general abuse.

In conclusion, the author states,

"Embedded in a social policy, it would give society or its representatives the authority to eliminate all those who might be considered too 'ill' to function normally any longer. The dangers of euthanasia are too great to all to run the risk of approving it in any form" (158).

So the author states that euthanasia is naturally wrong, and personal and social dangers make it a very serious concept. She is against its approval in any personal or public form. She believes that the policy and the practice are beyond society's well-being and grasp, and that it all comes down to plain killing.

J. Gay-Williams explores the problems of euthanasia and challenges the reader to see that the practice of euthanasia and a social policy based on euthanasia are inherently wrong. The author brings some aspects of euthanasia to light, but many realms of this issue are not dealt with completely.
The author equates euthanasia with killing and leaves no room for a separation of the two acts, killing and ending one's life. In the author's mind, both are intentional and deliberate, but I feel that they are two separate issues. They both result in the death of a human being; however, there is a multitude of motives for practicing euthanasia, as well as in the killing of another person. I do not see euthanasia as killing or equate the two concepts.

Euthanasia is based on compassion, the beliefs, wishes, and the rights of the patient. The motives for killing another human being are those of the person performing the task. It has nothing to do with the "victim" or the "victim's" wishes. I do not equate murdering someone in cold blood for personal gain, with a person assisting a terminally ill patient in ceasing his life when the patient asked for such help. The patient has made his or her motives known, and the person assisting them in their endeavor is acting on behalf of the patient not on their own behalf.

Euthanasia, as a practice, should be morally and legally acceptable and be an option for the seriously ill patient. Patients suffering from terminal cancer, progressive multiple sclerosis, brain damage, AIDS, and other death-resulting diseases or injuries should have a
legal and moral option, such as euthanasia, available to them.

Many people make a decision to discontinue their own life, whether it be suicide or euthanasia. Suicide is when the individual takes the actual measures to end their life; they have no assistance by someone else, and death results. Both end in death, but the motives and the procedures are different.

Let me rather speak about the patient who has previously made the decision to discontinue life in view of a medical crisis. The person involved has previously made a conscious, competent, and unchangeable decision to terminate their own life. This may be done through verbal statements to family and friends or through a written legal document, such as in the form of a Living Will.

A Living Will allows a person to make a legal statement about their wishes in regard to their own life. The person's wishes are expressed and recorded in hopes that their life will be terminated rather than maintained in face of a future medical crisis. In my mind, this is just as legal and moral as with a regular will that expresses a person's wishes and provides guidance for the estate or other family matters. Both wills demonstrate the wishes of the individual and are very personal in
nature. Both should be regarded as rational and legal; they should be implemented as directed.

There are many legal problems in regard to a Living Will or verbal statements made in reference to voluntary euthanasia. The individual rights of the patient are complicated by the fact that the actual process of euthanasia has many dimensions. The physician has taken an oath to save life and not to intentionally terminate a human life.

The physician is faced with a moral and legal dilemma. Civil and criminal action may be taken by family members against the physician, hospital administration, or staff after the patient's death. This concern about the legal actions involved in the practice of euthanasia defeats the original purpose of the Living Will. The Living Will is proof of the patient's desires, and this fear of legal repercussions often places the patient on the sidelines. The concern dominates, and the original intent of the person's wishes is lost among the legal background. Here the matter is taken from the hands of the individual to the judgment of the court or possibly a hospital's ethics committee. Again, the original intent is delayed or may be possibly denied. The individual's rights are second.

In the situation where the patient is rendered incompetent by disease or illness and has not left a
Living Will, there is still another set of additional problems. Even though the patient may have verbally expressed his wish for euthanasia, there is no legal document. The family member must petition the court for legal guardianship, so that the wishes of the patient for euthanasia may be obtained. If the request is granted, there are still obstacles against the end result of euthanasia. The person who is petitioning the court must convince the court and the others involved that the patient does not wish to be kept alive by the life-prolonging treatment. This in itself can be a very frustrating and long process. The patient's dignity and the family's emotional and financial burdens are not the number one priority. The patient's right to cease a life that holds no value for them any longer, is not exercised promptly or never may be granted at all! The last instance places the patient in a manipulative state of not being allowed to control their own destiny, and makes him more of a financial and emotional burden to the family. What kind of a life is this for both the patient and the family? It delays the grieving process for the family and friends of the patient, and the situation is emotionally hard on the loved ones. The loved ones ache from the sight of their relative or friend being sustained in a life of medical efforts and practice. They feel torn by the sight of the patient and feelings
of guilt and frustration soar. They know that the patient would be horrified by the events surrounding them if the patient were cognitively conscious. What an awful situation for everyone concerned. Especially, since the patient's wish and option of euthanasia is being denied, and the right of the patient to die is being ignored.

Sometimes, this is too much for a friend or family member to cope with, and they may take measures into their own hands. They may make the decision to employ euthanasia without legal consent. The result is another moral, and possible, legal dilemma.

Whatever the situation, there are no moral or legal "cut and dry" solutions, and the patient's wishes are pushed aside. To keep a hopelessly ill patient alive against his wishes, takes away the individual right and dignity of that person. This is not part of our natural instinct or our own reasoning. Whether the patient is cognitive or not, the rights of the individual suffer!

Is this a human goal? A person who has elected euthanasia does not want to continue living a life of pain or that of incompetence. This is not "life" and is not their goal. To sustain this person's life by equipment or medicine, violates the patient's rights and dismisses them as less than human. I disagree with the author that euthanasia takes away one's dignity.
Preventing euthanasia, takes away one's dignity and the right of the individual to determine their own future.

I agree that the organization of our bodies and our behavioral responses, reflexes, and drives make the continuation of life a natural goal. But when the body itself is attacked by an irreversible and hopeless disease or injury, this argument against euthanasia no longer applies. The body is driven toward destruction in this case. Is it better to interfere with the natural body process, or does one let the body take its own course of action? It is much more humane to ease the suffering of the individual. It is the right of the seriously ill to elect their own alternative, whether continued treatment or euthanasia. This is also true in the case where the body alone sustains life, but the person is not competent. As long as the patient has made it clear that he does not want to continue in a life along such a depressing and hopeless path, euthanasia should be granted and employed.

The author refers to religion briefly in connection with the wrongness of euthanasia. I agree with the author that this argument can only be used with people who believe that God is the possessor of their bodies. The individual must contemplate the issue of religion and make his own judgment.
Gay-Williams sees euthanasia as wrong from other aspects besides that of nature. The author states that death is final and irreversible, and euthanasia works against our own interests. First, she points out that a diagnosis or prognosis may be incorrect, and the person may elect euthanasia when this is not the case. The person would die needlessly. I agree that there are many errors in medical tests, procedures, and reports, but this is also the case in the use of such treatments, too. A rational and competent human being would get a second opinion, at least. After considering all the data and the choices available to him, the individual would make a conscious decision. That may be to elect euthanasia or not to elect euthanasia. I feel that Gay-Williams looks at euthanasia as a "day-later" process and not a conscious and rational decision on the part of the patient. This makes the human race out to be very unintelligent and not capable of using reason.

Next, the author argues against euthanasia on the basis that techniques or new experimental procedures will not be tried, because the patient chose euthanasia instead of the medical treatments. Euthanasia does not stop this option for new medical techniques or procedures. The individual may choose to try this avenue of hope, but he must also have the right not to elect this route. Thus, the possibility of euthanasia does not
destroy all chances of future breakthroughs in medicine. I feel that the option of euthanasia guarantees the patient's inherent right not to be a pawn in some experimental procedure. It is not acceptable to experiment on a human being who does not wish to continue living a life of pain or incompetence. The body is not an experimental playground. The author's argument is thin. The patient is aware of the choices available and the possibility of remission or miracle at the outset. If the person elects euthanasia, it is his right to do so.

She argues that if a person knows that they can take their own life at any time, one might give up too easily. She points to the fact that people can be weakened by pain, suffering, and feelings of hopelessness. But anyone, whether ill or not, can take his own life at any time! A person may choose to commit suicide because of feelings of hopelessness or despair. Euthanasia is not the only way to take a life or the cause of people giving up too easily. It is only an option for the seriously ill patient and is not a requirement! The same issues are true in regard to the author's remark about the emotional and financial burdens placed on the family of a seriously ill patient. The patient may elect to end his life, so that he may ease the family's troubles. A person who is perfectly healthy may choose to end his
life, so that the family does not have to be harnessed with the person's financial obligations or personal emotional problems. A person makes a choice to give up on life for a variety of reasons, such as not being self-sufficient, feelings of uselessness, poverty, drug or chemical abuse, etc. Euthanasia is not a cause. It is only an option.

Gay-Williams deals with the practical effects of why euthanasia is wrong at the end of her essay. She thinks that euthanasia, in practice or policy, may have a corrupt effect on medicine and individuals. Medical personnel may not try hard enough to save a patient and may administer euthanasia without authorization. This can be true without the policy or the practice of euthanasia! Doctors may not try to keep a person alive, or they may feel that the patient is better off dead and take the measures to carry out the death of the patient. This problem is not exclusive to the practice or the policy of euthanasia. If euthanasia is not a "practice" or a "policy", this corruption and abuse is still possible. Just because there is no formal policy of euthanasia, does not mean that people will not administer death.

The author points to the aspect of euthanasia as a policy. Here she argues that this would give society a license to eliminate people who are considered seriously
ill. I see this as a great plot for a science-fiction book or movie; people who are too ill will be eliminated in mass numbers, such as during WWII in the Nazi death camps! I am not saying that this idea is impossible; I feel that it is improbable. There are always extreme possibilities with any social policy. In a world without euthanasia, one can find the same possibilities for abuse. I think that a social policy forbidding euthanasia is a greater fear for mankind. The horrors would be endless, and freedom of choice would cease to exist along with one's individual rights.
CHAPTER 11: HEALTH CARE AND AGING

In 1989, medical costs in the United States accounted for more than 10 percent of the gross national product and reached a total cost of $600 billion.

"About 50 million Americans have inadequate medical insurance, and as many as 37 million have none at all" (Toufexis 50).

Medical care is limited to those who can afford to pay, those who receive benefits through their places of employment, and those people who qualify for Medicare or welfare programs. The majority of Americans recognize the need for these costs to be restrained, yet some believe that everyone has the right to full medical care even if it is costly.

The health care system in the United States needs a major overhaul.

"...its health care delivery is among the most expensive, least efficient and least equitable in the developed world" (Toufexis 50).

We have the best equipped hospitals and many doctors throughout the country. Great technological advances have been accomplished. These procedures and machines allow people to live productive lives that are meaningful, yet others are being kept alive by machines with no possible hope for recovery and no hope for a normal productive life. Our health care system is also geared toward the "cure" rather than "prevention". The
major portion of money is spent on treatments and procedures rather than on research or programs to prevent various illnesses or diseases.

As a society, we must make some choices as to how we are going to deal with these soaring medical costs. Some solutions have been raised by various groups of our society. The idea of a national system of health care has been favored as one solution to the problem. Many doctors have rejected this idea, because they fear less profits and do not want to see the government involved in the business of health care or in their profession. In May of 1990, the second largest medical society in the US, the American College of Physicians, called for a major,

"...comprehensive health care reform that would include some form of national financing" (Toufexis 50).

This announcement is in direct conflict with the largest medical society in the US, the American Medical Association. The AMA has been in opposition to such a comprehensive change. They advocate that employers should be forced to provide health insurance for their employees and that Medicaid should be expanded to cover the poor. The ACP feels that these solutions might be helpful in the short run, but that they do not address the real problem or flaws in the system.
The ACP's paper lists several concerns and sights these as the biggest problems. First, many Americans have inadequate care. Second, the bureaucracies that pay for the care are

"...complex, confusing, costly, wasteful and intrusive..." (Toufexis 50).

Third, administrative overhead is wasteful and accounts for

"...22% of medical expenses, and enormous malpractice awards that force doctors to buy expensive insurance and pass the cost on to patients" (Toufexis 50).

The ACP did not suggest specific answers to these concerns. The ACP's Vice President, Dr. John Ball, explains

"One of the reasons we do not [sic] have solutions today is that we have not [sic] got societal agreement on what kind of health system we need, want and can afford" (Toufexis 50).

The broad guidelines of the report by the ACP does, however, use the health care system of Canada as a model with each citizen being issued a health card which is to be presented at the time he or she receives care. The doctors receive their money from the government. Thus, the government has control over hospital budgets and the fees of the doctors.

The AMA agrees that the US health care system needs improvement, but the AMA believes that the system works.
Secretary Dr. Louis Sullivan of Health and Human Services states that the ACP's proposal is

"Thoughtful and thoroughgoing, but that a simple national system will not meet the needs of such a diverse group of people" (Toufexis 50).

Both the groups, the AMA and the ACP, agree that the system needs improvement, but they do not agree on the kind and extent of such improvement.

Limiting organ transplant operations is another solution that has been raised in regard to rising medical costs. Supporters believe that organ transplants should be limited to those who would successfully benefit from them. These operations are already limited to the extent that the demand is much higher than the supply. Yet, if they were further limited by the age and the health of the patient and by the reason for such an operation, medical costs could be lowered. For example, let us say that the patient is elderly, in poor general health, has smoked cigarettes for most of his or her lifetime, and is in need of a heart transplant. These factors should be weighed. If there is another person who is young, in poor health only because of the heart's cognital inadequacies, and has great success of living a long and normal life, this person would present more of a monetary risk worth taking than the first patient. It is hard to make decisions like this, but this way more health care
could be "purchased" for the same cost for more people. The procedures which use extraordinary means again cost more than if we would deal with "prevention" rather than "cure" by medical procedures.

This brings us to another area that would help to eliminate some of the rising medical costs in the US. More money needs to be spent on research that could reduce or eliminate various diseases or illnesses. Also, more programs need to be instituted to provide education and treatment for prevention of diseases or illnesses. For example, if more prenatal care was given to poor mothers, the rising costs of treating premature and struggling babies would decrease dramatically. All the medical costs of treating these babies could be used in prevention rather than in costly treatments or extraordinary measures. In most cases the cutbacks in programs are in the prevention stage of medicine or medical programs rather than in the extraordinary measures or procedures area which costs much more in the long run.

Another area that needs to be looked at is the ever growing elderly segment of our population that requires long-term medical care. The costs of long-term hospitalization and use of life prolonging equipment could be used for another, younger segment of the population.
These are some suggestions concerning the rising cost of health care in the United States. Again, there are no simple answers. The elderly segment of the population does require a greater portion of the health care, but the burden should not be placed solely on the elderly. All age groups need to be looked at, and prevention rather than the cure is of a foremost concern.

Long-term medical care's monetary factor does create problems for some elderly patients and for some families. If the patient does not have health insurance or insurance that does not cover all the costs, the financial burden creates problems for the family. Bankruptcy and family discord or possible destruction of the family unit may result. What is the quality of life for the patient and for the family? This is a question that they will have to investigate and deal with.

The average human life expectancy at birth has almost doubled since the mid-19th Century from 40 years to 75 years. Some people live past 100, and there have been reports that some individuals have reached 115 years of age.

"Even if science could eliminate heart disease and cancer—which account for nearly 50% of all the deaths in the U.S.—it is unlikely that the average life expectancy at birth would increase much beyond 85" (Elmer-DeWitt 86).

"Of the industrialized nations, the U.S. ranks 17th in life expectancy..." (Toufexis 50).
In a recent report in Science magazine, three experts, a demographer, a gerontologist, and a biostatistician reported that an increase in the human life-span is unlikely unless there is an unexpected breakthrough in science. Despite medical advances, the human life-span has its limits. The human body seems to contain a

"...built-in biological limit programmed into the cells of the human body. In laboratory experiments, human cells divide only about 50 times before they begin to fall apart like old jalopies. This planned obsolescence on nature's part makes a certain amount of evolutionary sense. Survival of the fittest, after all, rewards only those who reproduce, not necessarily those who reach old age. Once procreation is over, human bodies may as well be disposable goods, biologically speaking" (Elmer-DeWitt 86).

Researchers are trying to unlock the secrets of the human cells to find out why and how they wear out. They are also trying to find the genes that are responsible for the diseases that affect old age such as Alzheimer's, osteoporosis, and arthritis. If this can be accomplished, one's life expectancy may be increased. At the same time, those extra years would be worth living if the quality of life could be greatly improved by finding the cause of degenerative diseases. Despite medical advances, degenerative diseases of old age continue to plague the elderly. Researchers do not know if or when these will take place.
The question that I pose is this: Why increase life expectancy for the elderly if the quality of life can not be worth living?

The elderly must be allowed to make their own decisions as to how they wish to live and exist and what they consider to be their quality of life. If a terminally ill patient wishes to be kept alive, this is his or her right. If the patient does not want to be kept alive, the patient should be allowed to die painlessly and peacefully.
CHAPTER 12: CONCLUSION AND RECOMMENDATIONS

The preceding discussion on euthanasia is far from complete. Just as in the past, there is no general consensus about euthanasia though new laws are being passed by agreement. I have looked at some views on the subject from ancient times up until the 20th Century. I have also looked at some present day concerns in regard to euthanasia. I limited myself to some of the medical, legal, economic, and moral implications. There is so much to say when one speaks of ending the process of nature. Euthanasia ends life. Death becomes real; we have a hard time facing death, even today.

Around the country and around the world, people are trying to wrestle with this difficult and emotional issue. It is highly publicized. Almost, every day I come across something on euthanasia either in print or from the television media. Even though euthanasia is being discussed more by theologians, philosophers, and professionals, little has changed in regard to the legalization of active euthanasia. The Netherlands has legalized a form of euthanasia, but it will be a long time before we can look at the outcome. It is relatively new there. But American juries acquit elderly people who help a suffering and dying spouse to die with dignity....
I find it hard to see that it is morally or ethically acceptable to kill someone in time of war, yet morally wrong not to ease the pain and suffering of a terminally ill patient by a lethal injection if he or she desires such. I believe that a terminally ill patient should be allowed to die if that is what she or he wishes and believes in. One should have a right to decide for oneself, and then if you decide to employ euthanasia, the means should be there legally. To keep a hopelessly ill patient alive against his or her wishes takes away the individual right and dignity of that person. To sustain the person's life by equipment or medicine, violates the patient's rights and dismisses them as less than human. In preventing euthanasia, one's dignity suffers as well as the individual's right to a choice that lets he or she determine his or her own future. Otherwise, we are left in a position to be manipulated by others. Whatever one's conviction is in regard to euthanasia, one must consider a basic thread of our society...the freedom of choice and individual rights for the pursuit of happiness. If we do not protect this idea of freedom or the individual right to self-determine our future, we all will suffer the consequences of such a grave and foolish error. Euthanasia is neither right nor wrong; it is an individual option. One has the "right" to decide for himself or herself.
Some guidelines have been drawn up by doctors and legal organizations, but some are specific, others are not, and many times the family or patient must still rely upon the courts. The reliance upon the courts would not have to be so great if legislation were adopted to guarantee the individual the right to termination of life. It is an emotional issue; one which is not easily answered.

Right to life groups want to see that people are maintained with artificial feeding. They have been lobbying state legislatures in hopes of getting limits on the withholding of liquids and nutrients. Oklahoma enacted a strict law on the continued feeding of incompetent patients in 1988. This was a gain for the group. (Otter)

Others believe that euthanasia works against our own interests if we allow its practice on ourselves or others. One might die needlessly in the face of a wrong diagnosis. Our standards and achievements in medicine are great, yet mistakes can be and have been made. A person may receive an incorrect diagnosis or prognosis. The person may believe that there is no hope of recovery, because medicine has not found a cure. If euthanasia is elected, the person may die in vain.

Others believe that euthanasia stops the hope for new techniques or experimental procedures which could
pull a patient through a medical crisis. If such procedures are not allowed to be investigated, medicine may cease to further its knowledge. The practice of euthanasia leaves no room for miracles to happen, such as spontaneous remissions or sudden recoveries which do occur.

Some argue that euthanasia is an easy way out for the patient or the family. I disagree. Nothing about euthanasia is easy! It is a complicated, emotional issue. What we need are guidelines that protect the individual's right to opt for euthanasia or not to opt for euthanasia. This right must be further guaranteed by legal statutes that help doctors and hospitals carry out the express wishes of the patient or the family involved in euthanasia. Again, to keep a hopelessly ill patient alive against his or her wishes, takes away the individual right and dignity of that person. To sustain the person's life by equipment or medicine, violates the patient's rights and dismisses them as less than human. In preventing euthanasia, one's dignity suffers as well as the individual's right to a choice that lets he or she determine his or her own future. Otherwise, we are left in a position to be manipulated by others. Whatever one's conviction is in regard to euthanasia, one must consider a basic thread of our society...the freedom of choice and individual rights for the pursuit of happiness. If we do
not protect this idea of freedom or the individual right to self-determine our future, we all will suffer the consequences of such a grave and foolish error. Euthanasia is neither right nor wrong; it is an individual option. One has the "right" to decide for himself or herself. Let us make sure that the legal precedents reveal a humane view of this broad issue.

This study concludes with several recommendations designed to protect the elderly individual or patient from being forced to accept euthanasia or from being forced to not be allowed a dignified death. The recommendations are as follows:

1. Society must not implement any social policies or programs that force the elderly individual or any other individual to participate in any form of euthanasia;

2. The American people must familiarize themselves with the state statues and must become actively involved in advocating legislative changes in the current euthanasia or right to die statutes. These statutes need to protect the individual's freedom of choice and recognize the directives of the individual's Living Will and/or the Durable Power of Attorney. In Nevada, two bills have been introduced. Senate Bill 442 would allow a family member of a terminally ill or comatose patient to make the decision whether to continue or discontinue life support measures even if there was no Living Will in existence or if the patient had not granted the power of attorney. It would also give strength to the Nevada Living Will law by forcing physicians to comply with the terms of the Living Will or to transfer the patient to another physician who would abide by the wishes of the family or patient. Assembly Bill 594 would presume that a terminally ill patient who was unable to make decisions would
want continued life support treatment unless there was a Living Will or Power of Attorney (McKinnon);

3. The American judicial system must recognize the changes in the state statutes and protect the rights of the patient;

4. Living Wills and the Durable Power of Attorney written in another state should be recognized in all states. There should be no time limit for the Living Will and the Durable Power of Attorney. The U.S. Congress must make a federal statute to cover this recommendation;

5. Medical professionals must recognize the patient's freedom of choice and not force unwanted medical care upon the patient. Medical professionals' ethics ought to defer to the patient's decision in a case that is a "close call";

6. Medical professionals should be allowed to practice active and/or passive euthanasia without fear of criminal prosecution if such is the wish of the patient. They must be free to carry out the express wishes or directives of the patient. They should do all that they can to make the patient comfortable and without pain or suffering until death results. In December of 1990, the Nevada Supreme Court ruled that quadriplegic Kenneth Bergstedt's right to die outweighed society's right to keep him alive. Before the ruling was handed down, Kenneth's father Robert Bergstedt, took matters into his own hands. He gave his son sedatives to ease the pain and suffering, and then he loosened the respirator that Kenneth was connected to; Kenneth died peacefully. Robert Bergstedt died a week later due to cancer before the Court's ruling was handed down (German, Vogel). This reflects a new attitude for such measures to be sanctioned by the Courts;

7. The patient's right to euthanasia should not be limited to terminal illness, but it should also include any form of medical technology that keeps the patient alive against the patient's better judgment;
8. Individuals who wish to die with dignity and feel that they have a right to die should write a Living Will and assign the Durable Power of Attorney to someone whom they trust. They should also make their physicians, family, and friends aware of such a document and carry on their person a wallet size card to this effect. Individuals should keep a copy of the Living Will and the Durable Power of Attorney for themselves, give one to their proxy, and file one with their physician. It is important that this should be done before the need for such measures arise;

9. Individuals must exercise their rights as patients. After they have sought medical help or guidance in the face of a terminal illness or a physical handicap that they can not tolerate, they should actively seek help to end their life if they so desire without involving others in criminal liability; they should also leave a message as to why they decided to terminate their lives;

10. Patients should write a will to dispose of their personal effects and goods in addition to the Living Will; and finally,

11. We must recognize the right of the individual to decide when to die, and protect this right legally and morally.
Endnotes/Chapter 12

1 The Nevada Senate passed Senate Bill 442 on May 9, 1991; the bill went to the Assembly for consideration (Dornan).

2 On May 10, 1991, a Detroit jury acquitted 73 year old Bertram Harper. He had been charged with second-degree murder for assisting in the suicide of his 69 year old wife, Virginia, who had terminal cancer. They had flown to Michigan, because they believed that assisted suicide was legal in that state. Virginia had failed several times in her attempt to kill herself by putting a bag around her head. Bertram secured the bag with rubber bands after she fell asleep, and he called the police after she died (Angel).
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