

Death with Dignity

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Introduction

Public support for Euthanasia or physician-assisted-death has grown considerably over the last fifty years. In the early 1950s only around thirty-five percent of Americans supported Euthanasia, but since then support has grown dramatically and as of last year, nearly 75% of Americans believe that doctors should be allowed by law to end a patient's life if they or their family request it (Gallup, 2017). Despite apparent widespread popular support, only a handful of U.S. jurisdictions have such laws. In this paper we will provide an overview of euthanasia laws, followed by a survey of their justification and a survey of the opposing view. The implications and assumptions of each side will be teased out and explicated, and in conclusion a deeper level of analysis and public discourse will be argued for.

Definitions

The word euthanasia may not be as straightforward as its common and colloquial usage suggests. Euthanasia in its strictest legal definition refers to the administration of lethal drugs by a doctor, and this is illegal in all U.S. states (Oregon Health Authority, 2018). Physician-assisted-death, on the other hand, refers to a patient who is given a prescription from a doctor for a euthanasian drug which is then administered by the patient him or herself. Despite this subtle distinction, the term "euthanasia" is often used by researchers and laity alike as a catch-all expression for any terminally ill person who is legally allowed to employ some medical means of ending their life, regardless of whether they personally administer it or not. In this paper, "euthanasia" will be used in its broader sense.

Another important distinction is that between active and passive euthanasia. *Passive* euthanasia refers simply to non-interference in the dying process. Passive euthanasia consists in "letting nature run its course" for those who are imminently near death, as opposed to attempting

to prolong life through treatment and intervention. Passive euthanasia is legally uncontroversial. As Srivastava (2014) writes, “Passive euthanasia is considered legal in all USA jurisdictions as it does not involve an act of killing someone rather one is letting someone die on [their] own, naturally” (p. 81). A do-not-resuscitate (DNR) order is essentially passive euthanasia in practice. Active euthanasia, on the other hand, consists in accelerating a patient’s death either through a treatment strategy that will bring the patient closer to death, or the administration of a lethal drug (p. 81). *Active* euthanasia will be the focal point of this research.

Overview of States with Active Euthanasian Laws

Oregon was the first state to legalize active euthanasia. In 1994 the Death with Dignity Act (DWDA) was proposed, and it was enacted in 1997 (Blanke, LeBlanc, Hersman, Ellis, & Meyskens, 2017). The DWDA leaves euthanasia up to individual patients and providers, and the law imposes four conditions on the patient in order for them to be considered eligible to receive a prescription for life-ending drugs. These conditions include: 1) the patient must be over the age of eighteen, 2) the patient must be a resident of the state of Oregon, 3) the patient must be regarded as mentally competent to *personally make and communicate* the decision, and 4) the patient must be diagnosed with a terminal illness with a prognosis of six months or less to live (OSR 127, 1994).

A few additional comments are warranted regarding the conditions under which a patient in the state of Oregon may participate in the DWDA. The Act clearly forbids the possibility of a patient’s family, friends, or other close relations making the decision on behalf of the patient. Not only must the patient be able to make the *decision* on their own, but they also must be able to *communicate* that decision to the attending physician. The role of the physician in Oregon’s DWDA act is comprehensive. In Oregon, it is the responsibility of each individual physician to

determine whether or not the DWDA criteria are sufficiently met. Oregon does not have a board or committee reviewing each case, but entrusts their physicians, knowing the medical details of each patient's case, to judge whether or not their prognosis is serious enough and if their judgment is sound enough to participate in the Act. Oregon residents who elect to participate in the act may withdraw previous intent to participate at any time prior to actually administering the prescription.

As the first state to implement any sort of legislation allowing and controlling active euthanasia, Oregon's Death with Dignity Act became something of a template for other states to follow. In addition to Oregon, the states of California (AB-15, 2016), Colorado (Prop 106, 2016), Hawaii (HB 2739, 2018), Vermont (Act 39, 2013), Washington State (Initiative 1000, 2008), and Washington, D.C (B21-0038, 2016) all have very similar legislation. All of these states impose the same four conditions in order for a patient to be considered eligible for a life ending prescription. In the cases of both Washington State and Oregon, death with dignity legislation was decided by citizen ballot, with the other states deciding in the legislature.

California's "End of Life Option Act" became law in 2016 applies an additional burden of criteria on patients who wish to end their lives. What distinguishes California's Act from Oregon's (and the others discussed in this paper) is that California's Act specifies that in addition to being capable of making and communicating the decision, the patient must also be regarded as physically and mentally capable of self-administering the lethal drug (AB-15, Sec. 443, 2016). This makes California the only state whose statutes take additional control measures to ensure that the patient can, in fact, administer the drug they'll be prescribed.

Without exception, all of these states' legislation places strict controls on the physicians as well. Physicians must all be licensed according to their states, and must be the primary care

providers of their patients. Additionally, the laws regulating physician assisted death also specify reporting measures. These reports are typically delivered annually, although the names of the physicians prescribing life-ending drugs and patients requesting them are withheld.

Before concluding this overview of existing euthanasia laws, the curious case of Montana bears some mentioning. In *Baxter v. Montana* (2009), the Supreme Court of Montana ruled in a 5-4 decision that Montana's did not regard physician assisted death as illegal. However, it is legally unclear as to whether or not this ruling is tantamount to positively *allowing* euthanasia analogous to the ways it is allowed in Oregon and the other states. The Death with Dignity Center (2018) which tracks the current status of states' euthanasia statutes says that despite the ruling, Montana has no statutes that actually permit physician aided death (para 1). Since the *Baxter* decision, bills have been proposed every year in Montana to both adopt an "Oregon-styled bill" (positively *legalizing* euthanasia) and to make physician assisted suicide criminally prosecutable (para 2). With annual consistency, efforts to both legalize and criminalize it have failed, making Montana a state where euthanasia is legal *de facto*, but where the same controls and careful legislation governing it in other states are absent.

The Main Arguments

Death with Dignity: Pro

Those who have spearheaded or supported euthanasia allowing laws regard euthanasia as something of a moral good. The reasoning to support this conclusion can vary. Some argue that it is more a question of respecting human rights, while others argue that the comfort or mercy provided by euthanasia is itself a proper moral good.

To the view of euthanasia as an instrument of securing human rights, we can turn to Governor Edmund G. Brown. Governor Brown (2015) wrote to the California State Assembly

regarding California's proposed "End of Life Options" bill by saying that he carefully considered the arguments for and against the bill, but that

In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others. (p. 1)

Similarly, Dr. Peter Goodwin who was part of the committee in Oregon which spearheaded the DWDA in the 90's said in an interview with *Time* (2012) that "I think the patient should be in control of the [dying] process. The patient then can pick the time when family will be present and can say goodbye" (Cited in Lunscombe, para 7). In both cases, the justification for physician assisted death revolves around the rights of the patient. The idea isn't so much that it is *necessarily good* for a patient to select to end their life, but that the patient has a *right* to so select, and that *interfering* with the right would be wrong. When asked how this was any different from arguing that people have a right to kill themselves *carte blanche*, Goodwin replied by saying that physician assisted suicide is a very deliberative process and has controls in place to (at least theoretically) make the decision completely non-impulsive (para 2). So (the argument implies) it is not respecting the rights of people at all costs and under all circumstances, but only when it is the case that they are exercising their rights in a completely aware, considered, and deliberate way.

Another argument in favor of euthanasia's morality revolves more around the idea that it is a matter of virtue—mercy or compassion—to assist or at least allow a person who is terminally ill to end their life. To be sure, this argument can be combined with the former argument; there is no mutual exclusivity between the two. Dr. Anette Childs (2017), an advocate

for euthanasia reform in Nevada, argues that “fear is a horrible form of suffering. For those who fear a prolonged and/or suffering death, this type of legislation provides a potent medicine” (para 8). Similarly, the president of Compassion and Choices, Barbara Coombs Lee (1996) addressed the US House Subcommittee on the Constitution regarding the possibility of euthanasia reform:

The problem is that medical science has conquered the gentle and peaceful deaths and left the humiliating and agonizing to run their relentless downhill course. The suffering of these individuals is not trivial and it is not addressed by anything medical science has to offer... When we know that certain rare and desperate cases call for a compassionate response in the form of assisted death our democratic heritage demands that the law be consistent with that knowledge. (paras 4, 8).

In both cases, the argument is different from the rights-based perspective. The argument from compassion or mercy does not merely cede to a putative right possessed by a candidate for euthanasia, but goes slightly further and argues that the euthanasian act itself is of moral merit, not dissimilar in principle from providing any other form of pain-killing medication. And since the moment of death is of course one of much greater magnitude than some transient pain, there is an additional moral burden to treat with respect, dignity, and compassion those who are facing imminent death. This sometimes includes euthanasia.

Death with Dignity: Contra

One argument against euthanasia is that it is a social evil because it devalues life. Richard Doerflinger, a Public Policy Fellow at Notre Dame (2017), argued that euthanasia laws cyclically change social sentiments in a way that enforces the devaluation of life: “Most patients request the lethal drugs not due to pain (or even fear of future pain), but due to concerns like 'loss of dignity' and 'becoming a burden on others' – attitudes that these [pro-

euthanasia] laws encourage” (para 2). Doerflinger argues that the solution is to reassure dying patients that their condition does not make them less human or dignified, and to instead make use of hospice and palliative care. Similarly Wesley Smith (2011), a Fellow at the Discovery Institute’s Center on Human Exceptionalism argued prior to California’s end of life reforms that euthanasia is not a dignified choice but “the end of all choices... it is really the euthanasia of hope” (para 11). In both cases, we see how the argument essentially challenges the premise that euthanasia is *dignified*. The presumption at work in this (contra) argument is that life *as such* has a certain dignity which is present even in suffering, and that “real” compassion consists not in ending life but in encouraging those who have it, *especially* when they are suffering.

There are also moral arguments provided from a physician’s perspective. These differ slightly from the arguments just offered, and consist in arguing that including physician-assisted suicide under the umbrella of legitimate medical care fundamentally perverts the relationship between doctor and patient. The American Medical Association’s (2018) code of ethics reads in part: “physician assisted suicide is fundamentally incompatible with the physician’s role as healer” and that instead, physicians should “aggressively respond” to the needs of a dying patient with comfort care and pain control” (paras 4, 6). Courtney Campbell, Doctor of Ethics and Science at Oregon State (2007) asserted that “it is contrary to the vocation of medicine to intentionally hasten or cause death... taking human life should be a last resort, and until our society has given appropriate attention to pain control, hospice care, and advance directive, we will not have met the criteria of last resort with respect to legalized euthanasia” (para 1). It would seem that even policy makers who advocate for euthanasia agree to some extent with these objections, since all of the states where euthanasia is legal prohibit doctors from personally

administering lethal injections, establishing the role of the physician in the death process as prescriptive.

Whether pro or contra, this has not been an exhaustive catalog of possible arguments for or against euthanasia. Rather, it has been a selection of some of the more proliferate arguments for and against, as given by relevant authorities engaged in the public discourse. The question of euthanasia both from a philosophical and a policy perspective is highly complex, as the reticence of most U.S. jurisdictions to legalize it suggests.

Some Further Philosophical Considerations

Having considered what relevant authorities, policy makers, and influential voices have to say about the topic, there are some additional points of discussion to be extrapolated prior to conclusion. These focus around the more deeply embedded philosophical issues at play in the question of euthanasia.

As intimated in the survey of opinions regarding euthanasia, “Death with Dignity” is a rhetorical term. It implies that suffering is ignoble, a claim that is typically accepted without much of a challenge. Despite the proliferation of the expression, the nobility or ignobility of suffering is not a medical or practical question but a philosophical one. Would it be just to suppose that a soldier, grievously wounded but still committed to fighting, does so with less dignity than if he were to turn his gun on himself? Or to suppose that a parent who loses a child and bears the *mental* anguish of that loss for the rest of their life does so ignobly, and that the more *virtuous* decision would be to end their life? These are rhetorical questions in turn which should be asked in the public discourse over euthanasia, since the notion of “death with dignity” goes more or less unchallenged, at least explicitly. By what principle is the selection of death in the face of terminal, unending suffering *dignified*?

To be clear, this is not to say that the decision *isn't* dignified, only to say that the claim that it *is* should be argued and justified rather than assumed. The answer, presumably, would be that it is the *right* of the euthanasia candidate to *choose* which should be regarded with dignity, regardless of what that choice *is*. Answering this way avoids the thorniness of implying that someone who chooses to suffer is less virtuous. But if it were true that our exercise of autonomy *as such* are things of dignity, then the idea of euthanasia as dignified isn't quite as potent, since someone who selects to bear their suffering (rather than end it) must also, by definition, be making a dignified choice. At bottom the “dignity” of euthanasia becomes indistinguishable from the “dignity” of simply dying from the course of an illness or old age.

But more problematically, if our raw *ability* to choose is dignified in itself, then isn't every deliberate choice dignified in a real sense? But this leads to absurdities, for we would regard premeditated murder as dignified and vehicular manslaughter as undignified. Or suppose the drama is scaled back and more innocuous choices are considered—is the deliberate choice to eat Cheetos, bite one's finger nails, or watch Netflix really *dignified*? It would seem that for dignity to retain any force as a moral virtue, the *object* of one's choice must factor into the equation as much as, if not more than the mere fact that one is *making* a choice.

These questions are particularly difficult because if they have answers besides “all choices are dignified,” then they are going to be, at least to some extent, morally indicting. If euthanasia (or non-euthanasia) *aren't* dignified, then what are they? To be sure, a thing is not necessarily heinous or even wrong at all just because it isn't dignified. But as has been seen, proponents and opponents couch their arguments in strong, moral language. So the tone and tenor of the debate has already been set in a way that makes it difficult to get away with an “everyone's doing the right thing” type answer.

For states that criminalize euthanasia, the idea of “dignity” is found in the existence of a human life. In that view dignity is found “in” the human person regardless of the quality of their life. This is really a very old idea, tracing back in the Western Tradition to a sort of archetypically-Aristotelian idea of human beings having an *essence* or a *substance*, the existence of which is good in itself. The general notion is “that which *is*, is good.” Evil, in this view, is simply the absence of some good. Sickness is evil because it is the absence of health. Death is evil because it is the absence of life. And so on. That’s why hospice and palliative care make sense for this view: they attempt to restore something that is currently absent: comfort.

Admittedly, this view is in stark contrast with empirical phenomenology and more contemporary notions of goodness being intimately united to utilitarian notions of sensory happiness and pleasure, which are essentially the philosophical underpinnings at work for those states where euthanasia has become legal and controlled. From that perspective, it follows that the loss of sensory pleasure or happiness is tantamount to death itself, so why not skip ahead to “the real thing?” Unfortunately, these deep philosophical presumptions—on both sides— are not particularly well-articulated by those who have them.

Conclusion

So by way of conclusion, the real exhortation of this paper isn’t for more or fewer euthanasia laws, but for a better level of public discourse in discovering why we should or shouldn’t have them. It is good that both sides of the debate are prepared to argue not just the pragmatics but the moral-philosophical issues at play. Laws are not (and should not) be arbitrary. They should be a reflection and implementation of what is conducive to the flourishing of a society and the individuals within it. Undoubtedly, both states with and without euthanasia laws think that their policies are ordered toward that end. Nevertheless, the positions

are mutually exclusive. It cannot both be right and wrong to positively end the life of someone who is suffering. The continued tension between these two positions could very well see resolution if the public discourse on the matter dove deeper. The quality and nature of discourse should be more introspectively critical and question the deeper, unmentioned, and unproved assumptions at play in each argument. For the Pro-euthanasia states and apologists, this means proving (not just assuming) that euthanasia actually has some virtue or dignity. And for the anti-euthanasia states and apologists, this means laying out and proving (not just assuming) that the human person has inherent worth by virtue of its existence.

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