Exigence

Volume 1 | Issue 1 Article 3

2017

Death with Dignity

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Euthanasia, or physician-assisted suicide, is a controversial issue and one which has become increasingly prominent in the media and subject to public debate, both in the U.S. and the UK, in recent years. This is in large part due to publicity surrounding cases in which individuals, such as Brittany Maynard in the United States and Craig Ewert in the UK, have sought to end their lives due to suffering from a terminal illness, in addition to the increase in suicide tourism to Switzerland. Although this increased media coverage is due to different country-specific issues, there is a shared common denominator – the question of whether the scope of legal euthanasia should be expanded, or, indeed, curtailed. There are ethical arguments on both sides of the debate, in addition to logical reasons for and against expanding the scope of euthanasia in the United States and abroad. The issue regarding expansion is not only a geographic one, but also involves the ethical and legal dilemmas involved in increasing the availability of euthanasia to different classes of people, such as children and the mentally ill.

The topic of euthanasia has been, and will continue to be, one which is a subject of heated debate, on which there are many views at all points on the spectrum. As Ezekiel J. Emanuel, an American bioethicist, stated: "Physician-assisted suicide and euthanasia have been profound ethical issues confronting doctors since the birth of Western medicine, more than 2,000 years ago" (qtd in Haerens 14). Although a discussion of the history of euthanasia is outside the scope of this paper, one early example of discussion of the subject was an editorial in the medical journal *The Lancet* in 1899, relating to the use of morphine and chloroform for pain relief in a patient with ovarian cancer. Emanuel's opinion was as follows: "We consider that a practitioner…perfectly justified in putting such treatment to an extreme degree, if that is the only way of affording freedom from acute suffering…[and] even should death result, the medical man has done the best he can for his patient" (qtd in Pappas 2).

The etymological origin of the word "euthanasia" means "good death" (Somerville 25). However, although the word is often used in the general sense to mean just this, it has been ascribed with the technical meaning of active conduct by a doctor in the death process, rather than the physician's role being limited to the provision of lethal drugs. The Oregon.gov website clearly differentiates between the two, stating that that the state's Death with Dignity Act "allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose." In contrast, it states that "Euthanasia is a different procedure for hastening death" in which "a doctor injects a patient with a legal dosage of medication." In the context of this paper, the distinction would only be relevant when discussing euthanasia in the Netherlands, Belgium, and Luxembourg, countries which permit this, as true euthanasia is not legal in the United States. Therefore, the generic term "euthanasia," which is commonly used to describe both true euthanasia and physician-assisted suicide will be used in this paper. To complicate the matter further, a distinction is commonly drawn between "active" and "passive" euthanasia; the former relates to a doctor giving a lethal injection, as above, whereas the latter refers to "denying (or even removing) life-supporting treatment" (Huxtable 5).

Additionally, there are the self-explanatory terms "voluntary" and "involuntary" euthanasia (the latter is outside the scope of this paper), and "non-voluntary" euthanasia where the person lacks capacity to consent, such as children or those in a persistent vegetative state. Finally, the term "death with dignity" is also used when discussing euthanasia, but, as Huxtable says, this can be a "slippery notion" which has been used as a "rallying cry" by those on both sides of the euthanasia debate; he states that "for those opposed to the practice, dignity reflects the sanctity of human life; for those in favor, dignity involves respecting autonomous choices

[including a choice to die]" (Huxtable 128). However, as the term "euthanasia" is frequently used in the media and books on the subject in the general sense, it will be used likewise in this paper when discussing any form of physician-assisted death.

In addition to Oregon, as referred to above, some other states have legalized euthanasia in the context of physicians prescribing legal doses of medication to terminally ill patients; these are Washington, Vermont, and, most recently, following the much-publicized case of Maynard, California. Countries in Europe which have legalized euthanasia include Switzerland, Belgium, Luxembourg and the Netherlands, the latter three allowing true euthanasia, with active participation by a physician.

Opponents of euthanasia commonly put forward several arguments as to why euthanasia should not be legalized, or why its scope should not be extended to other states, countries, or circumstances. One reason cited is the religious argument; for example, several religions see euthanasia as a form of murder and morally unacceptable. At best, some see voluntary euthanasia as a form of suicide, which goes against the teaching of many religions (Nordqvist, 2015). Glanville Williams, the Cambridge legal scholar, presented the idea in his book, *The Sanctity of Life and the Criminal Law*, that opposition to reforms such as the decriminalizing of euthanasia, contraception and abortion was "exclusively religious and particularly Roman Catholic." Furthermore, Williams asserted that "euthanasia can be condemned only according to religious opinion" (qtd in Jones). Other concerns focus on the idea of a "slippery slope;" according to Jones, such arguments have been important in the euthanasia debate for at least half a century. These arguments are based on the premise that legalization of euthanasia could lead to unintended consequences, such as the death of vulnerable people, including those who are unable to consent. As Somerville states, "While proponents usually intend euthanasia to be

limited to competent patients, the possibility remains for a slippery slope to the involuntary euthanasia of incompetent patients" (146).

A related concern is that the slippery slope could lead to euthanasia of vulnerable populations such as "the elderly and minorities, who might be subject to economic pressure" (Pappas 98). Economic issues are not the only concern; there is also the concern that guilt could drive patients to take their own lives in jurisdictions where voluntary euthanasia is permitted. Nordqvist states that there is a risk that patients may feel they are a burden on resources and are psychologically pressured into consenting to euthanasia. They may feel that the burden – financially, emotionally, mentally – on family members is overwhelming.

Religious objections to euthanasia aside, the main concern of those against euthanasia is that its scope will extend further than originally intended, from true voluntary euthanasia to euthanasia of vulnerable members of society. The Catholic pro-life education organization American Life League quotes an opinion put forward by Germain Grisez and Joseph M. Boyle in their book *Life and Death with Liberty and Justice*: "If voluntary active euthanasia is legalized without regulation, those who do not wish to be killed are likely to become its unwilling victims; this would deny them the protection they presently enjoy of the law of homicide." It is evident that many people will have strong views against euthanasia due to their religion, and believe that it can never be justified for religious reasons. Most people would probably agree that others are not only entitled to such beliefs, but such strongly-held opinions are unlikely to be influenced by any logical arguments in favor of euthanasia.

Concerns about legalizing euthanasia or expanding its availability with regard to a slippery slope are certainly valid concerns, as the vulnerable members of society need to be protected from an enforced death, either by their own hand in the context of passive euthanasia,

or due to physician intervention, that is, active euthanasia. Therefore, the question arises as to whether legal euthanasia can indeed be effectively regulated. I agree that every effort must be made to protect people from potential abuse of euthanasia provisions, and to ensure that such provisions do not lead to unintended, dangerous consequences. But is there any evidence that such a slippery slope is in fact a real possibility or indeed occurring in jurisdictions where euthanasia is legal? Do the benefits of euthanasia outweigh the risks incumbent in legalizing the process of assisting people to take their own lives? What is the cost in terms of human suffering to deny them access to a reliable euthanasia process in which trauma to them, their family and friends is minimized? As Jones asks, "does evidence [from Belgium and Luxembourg] bear out the presence of a slippery slope, or, on the contrary, does it demonstrate that euthanasia or physician-assisted suicide can be regulated effectively without adverse effects on the vulnerable, on those who cannot consent…?"

It is evident from the passage of legislation with regard to the legalization of euthanasia, cases publicized by the media, published data, and the existence of advocacy groups that there is a demand for euthanasia by the terminally ill. Indeed, pro-euthanasia societies have been in existence since the last century, on both sides of the Atlantic. The Voluntary Euthanasia Legalization Society of England was founded in 1935, and the Euthanasia Society of America was formed in 1948 (Pappas 16). Currently, those such people who are not fortunate enough to live in a state or country where euthanasia is legal are forced to travel in order to avail themselves of a reliable method of ending their lives. This was the case with Maynard, who, after being diagnosed with Glioblastoma, a terminal brain cancer, moved from California to Oregon to take advantage of the latter's euthanasia provisions rather than undergo the debilitating and traumatic symptoms she would experience if the disease ran its course. Having

made this decision, Maynard became a spokesperson for Compassion & Choices, a pro-euthanasia advocacy group.

In Europe, a 2014 study revealed that within four years, from 2008 to 2012, the number of suicide tourists going to Switzerland had doubled, with a total of 611 non-Swiss residents travelling there for the purpose of euthanasia. There are six right-to-die organizations in Switzerland, four of which allow individuals from other countries to use their services (Gauthier, et al.). The main organization, which has become a household name in the UK, is Dignitas, founded in 1998 with the motto: "To live with dignity - to die with dignity." English newspapers frequently publish stories about people who have travelled to Switzerland, usually to Dignitas, to end their lives. Such clinics provide a controlled environment for people suffering from terminal conditions to self-administer a lethal dose of medication, with the minimum possible amount of distress to themselves and their families. A moving 2010 documentary, *The Suicide Tourist*, followed 59-year old Ewert from his home in the UK to Dignitas, accompanied by his wife. When talking about his decision to end his life due to suffering from Lou Gehrig's disease (also known as Motor Neurone disease), Ewert said: "At this point I've got two choices…I've got death, and I've got suffering and death. You know, this makes a whole lot of sense to me."

In my opinion, this is infinitely preferable to people having to suffer the natural consequences of their illness, often suffering for years with debilitating diseases, before dying a potentially painful and lingering death. Many such people would not consider suicide by more violent or unreliable means for several reasons, including the effect on relatives and friends, or may not be physically able to carry it out. Indeed, in a recent case reported in the UK publication, the *Daily Mail*, Jackie Baker, who suffered from Motor Neurone disease, was not

physically capable of holding the lethal dose of liquid medication, instead clicking a button with her toe to self-administer the drug (Oliver).

Other people may, in desperation, commit suicide by more unpleasant means, as in the case of Tony Mitchell from the UK. Mitchell, who became a campaigner for assisted dying, suffered from cancer and multiple sclerosis and had planned to travel to Dignitas to die on his own terms. However, he had a heart attack before he could make the trip and was no longer able to travel alone. Rather than risk his family being prosecuted for assisting suicide should they help him to travel, he took the option of starving himself to death (Evans). Surely it is morally and ethically correct to allow people to take their lives in a controlled painless manner when this is their clearly stated wish, even if this does mean increasing the number of jurisdictions where euthanasia is legal – responsible pet owners would not allow an animal to suffer, so why should humans? As Linda Kelsey says in an article in the UK magazine, *Woman*, "I wish my mum could die like my beloved dog."

I have witnessed firsthand the devastating effects of cancer on friends, which has led me to support the legalization of euthanasia in all states and the expansion of legal euthanasia to the UK. I saw a friend a few days before she died and listened as she described her excruciating pain. Another close friend of mine moved to Washington after receiving a diagnosis of terminal Pancreatic cancer because of the state's euthanasia provisions under the Death with Dignity Act. I respected his right to choose the time and manner of his passing, but ironically he left too late to take the medication and died a lingering death in a hospice as he was no longer able to make the critical decision for himself. I have also been told by my elderly father in the UK that he would go to Dignitas should the occasion arise – only today he mentioned "going to Zurich," a

euphemism for Dignitas, as is "going to Switzerland." I, too, would choose euthanasia if I were to be diagnosed with a terminal illness or one which leads to an unbearable quality of life.

I can respect the religious arguments against euthanasia; however, religious debate on the topic could be the subject of an entire paper. One step towards common ground may be for subscribers to the opinion cited by Ewert – that "Suicide is wrong. God has forbidden it" – would be for them to read his words on the subject: "But you know what? This ventilator is playing God. If I had lived without access to technology, chances are I would be dead now" (*The Suicide Tourist*). In a similar vein, Dr. Herbert Cohen said with regard to the Dutch euthanasia law: "If we can keep people alive but give them a life that is no life, we must be consistent and give them the choice to end it" (qtd in McDougall 184).

Religious objections aside, I agree that adequate safeguards should be in place to protect the vulnerable members of society against being pressured into euthanasia due to economic reasons, or the burden of guilt, for example. However, the question arises as to whether this is in fact the case. In a 2007 journal article studying the impact of legal physician-assisted dying in Oregon and the Netherlands on patients in vulnerable groups, Battin et al. found: "no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups." Furthermore, there was "no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying."

In the Netherlands, a 2015 study of end-of-life- decisions for children under one year of age found that, in comparison with similar studies in prior years, the frequency of using drugs to deliberately hasten death decreased in 2010. The authors concluded that one reason for the reduction related to the introduction of routine ultrasound examination around 20 weeks of

gestation; another explanation was the introduction of legal criteria and a review process for deliberately ending the life of a newborn (ten Cate, et al.). If the latter did indeed have a significant effect on the findings, it is evidence that such legislation and procedures are effective in the avoidance of a slippery slope. Furthermore, adequate safeguards, such as those already in force where euthanasia is legal, should also be implemented if euthanasia provisions are expanded to other jurisdictions. As John Harris says, "Slopes are only slippery if they catch us unawares and we have strayed onto them inadequately equipped" (qtd in Jones).

A middle ground may be for us to agree that people should not have to suffer a lingering, painful death from an illness which is going to kill them in a relatively short period of time. If we can further agree that a legal, highly-regulated and controlled means of ending their suffering in a peaceful manner (such as we do for our family pets) should be available for those people who are competent and wish to end their lives at their discretion, no matter where they live, we have a basis for reconciliation of the viewpoints. This viewpoint is certainly the current trend as, following the publicity generated by Maynard's case, her advocacy on behalf of Compassion & Choices, and public opinion, death-with-dignity legislation was introduced in half of all US states this year, and California's End of Life Option Act was passed (*The Brittany Maynard Fund*). At present, euthanasia in the United States and in the other European countries mentioned in this paper is sufficiently well regulated to ensure adequate safeguards, and its application should not therefore be curtailed – indeed, current provisions in these countries should be expanded by appropriate legislation to ensure uniform availability of euthanasia. As Maynard said, "My dream is that every terminally ill American has access to the choice to die on their own terms with dignity. Please take an active role to make this a reality" (*The Brittany Maynard Fund*).

Finally, as all opinions should be heard (and to finish on a lighthearted note):

Works Cited

"Arguments Against Euthanasia." *American Life League.* American Life League, n.d. Web. 12 Nov. 2015. <http://www.all.org/learn/euthanasia/arguments-against-euthanasia/>.

Battin, MP, et al. "Legal Physician-Assisted Dying In Oregon And The Netherlands: Evidence Concerning The Impact On Patients In 'Vulnerable' Groups." *Journal of Medical Ethics* 33.10 (2007): 591-597. Print.

The Brittany Maynard Fund. Compassion & Choices, 2015. Web. 13 Nov. 2015. <http://thebrittanyfund.org/>.

Dignitas. Dignitas, n.d. Web. 17 Oct. 2015. <http://www.dignitas.ch/>.

Evans, Sophie Jane. "Cancer Sufferer, 68, Who Became Assisted Dying Campaigner Starved Himself To Death When He Became Too Ill To Go To Dignitas." *Daily Mail.* Daily Mail, 17 Sept. 2015. Web. 22 Nov. 2015. <http://www.dailymail.co.uk/news/article-3238917/Cancer-sufferer-68-assisted-dying-campaigner-starved-death-ill-Dignitas.html>.

Gauthier, Saskia, et al. "Suicide Tourism: a pilot study on the Swiss Phenomenon." *Journal of Medical Ethics* 41.8 (2015): 611-17. Print.

Haerens, Margaret, ed. *Euthanasia.* Farmington Hills: Greenhaven Press, 2015. Print. Opposing Viewpoints.

Huxtable, Richard. *Euthanasia.* N.p.: McGraw Hill, 2013. Print. All That Matters.

Jones, David Albert. "Is There a Logical Slippery Slope from Voluntary to Nonvoluntary Euthanasia?" Kennedy Institute of Ethics Journal 21.4 (2011): 379-404. Project MUSE. Web. 9 Nov. 2015. <https://muse.jhu.edu/>.

Kelsey, Linda. "I Wish My Mum Could Die Like My Beloved Dog." *Woman* 14 Sept. 2015: 36-37. Print.

McDougall, Jennifer Fecio, Martha Gorman, and Carolyn Roberts. *Euthanasia: A Reference Handbook.* Rev. ed. Santa Barbara: ABC-CLIO, 2008. Print. Contemporary World Issues.

Nordqvist, Christian. "Euthanasia and Assisted Suicide." *Medical News Today*. MediLexicon, Intl., 30 Oct. 2015. Web. 12 Dec. 2015. <http://www.medicalnewstoday.com/articles/182951.php>.

Oliver, Amy. "A Final Selfie and a Harrowing Goodbye: The Moving Diary Entries of the Daughters who threw a Hen Party to pay for their Mother to Take Her Own life at a Suicide Clinic." *Daily Mail.* N.p., 21 Nov. 2015. Web. 22 Nov. 2015. <http://www.dailymail.co.uk/news/article-3328759/A-final-selfie-harrowing-goodbye-moving-diary-entries-daughters-threw-hen-party-pay-mother-life-suicide-clinic.html>.

Oregon State. Oregon Health Authority. Public Health Division. "Death with Dignity Act." *Oregon Health Authority.* N.p., n.d. Web. 13 Oct. 2015. <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx>.

Pappas, Demetra. *The Euthanasia/Assisted-Suicide Debate.* Santa Barbara: ABC-CLIO, 2012. Print. Historical Guides to Controversial Issues in America.

Somerville, Margaret. *Death Talk.* 2nd ed. N.p.: McGill-Queen's, 2014. Print.

The Suicide Tourist. PBS Frontline, 2010. Video.

ten Cate, Katja, et al. "End-of-Life Decisions for Children Under 1 Year of Age in the Netherlands: Decreased Frequency of Administration of Drugs to Deliberately Hasten Death." *Journal of Medical Ethics* 41.10 (2015): 795-98. Print.