# *Chapter 10* Allowing Someone to Die, Mercy Death, and Mercy Killing

## LEARNING OBJECTIVES

- • Define and differentiate between the following terms: ***euthanasia***, ***allowing someone to die***, ***mercy death***, ***mercy killing***, ***ordinary*** and ***extraordinary*** **means for keeping people alive,** ***persistent vegetative state (PVS)***, and ***brain death***.
- • Explain why allowing someone to die has become an issue in the light of advanced medical technology, and discuss a dying person's **right to refuse treatment, "living wills," natural death declarations**, and **durable powers of attorney for health care.**
- • Evaluate the moral aspects of allowing someone to die, mercy death, **physician-assisted suicide**, and mercy killing in light of the hospice approach to care for the dying.
- • Evaluate the question, "Is allowing someone to die morally justified?"
- • Evaluate the question, "Is mercy death morally justified?"
- • Evaluate the question, "Is mercy killing morally justified?"

A central question in ethics concerns how one is to live a good life—how to live well. Leading such a life seems to entail that one close out or end life well. Are human beings entitled to a "good death"? Do people have a right to die? The question of euthanasia and related issues take us into the territory of some of the most difficult cases concerning the application of human rights. In practice, these issues also take us to some of the most difficult and heart-wrenching ethical decisions human beings must make.

## DEFINITION OF TERMS

The word ***euthanasia*** comes from Greek and originally meant **"a good death."** However, it has also been interpreted, especially in the twentieth century, to mean **"mercy killing,"** legally a form of murder in most countries of the world. Dr. Richard Lamerton, former director of St. Joseph's Hospice Home Care Service in London, has stated that in using the term *euthanasia* to stand for both mercy killing and allowing someone to die, we seriously blur a very necessary and important distinction between an act of murder and what is merely good medical practice (allowing people to die of natural causes, without using any extraordinary or heroic measures to keep them alive).

Dr. Lamerton states further that even though *euthanasia* once meant "a good death," it no longer has that meaning but rather means mercy killing or murder.[1] Therefore, because of this confusion and the ambiguity of the meaning of *euthanasia,* this chapter will not use this term but will substitute three other phrases: "allowing someone to die," "mercy death," and "mercy killing." Each of these phrases has a different meaning, and they must be clearly defined and distinguished before one can deal with the important moral issues surrounding them.

### Allowing Someone to Die

The phrase **"allowing someone to die"** implies an essential recognition that there is some point in any terminal illness when further curative treatment has no purpose and that a patient in this situation should be allowed to die a natural death in comfort, peace, and dignity. In no way does this involve an active termination of someone's life. Rather, it involves a refusal to start curative treatment when no cure is possible and the willingness to halt curative treatment when it can no longer help a dying patient.

What it means, in short, is allowing a terminally ill patient to die his or her own natural death without interference or intrusion from medical science and technology. It does not mean that there is nothing that can be done for the patient or that the patient should be abandoned to die in pain and misery. It does mean, however, that medical science will not initiate heroic efforts to save a dying patient and that it will stop any such efforts that have already been started when it becomes clear that they cannot serve any useful purpose for the patient and his or her family.

## Mercy Death (Including Physician-Assisted Suicide)

The phrase **"mercy death"** means taking a direct action to terminate a patient's life because the patient has requested it; in short, mercy death is really an assisted suicide. Chronically or terminally ill patients often are unable to commit suicide and therefore ask someone (often a physician) to "put them out of their misery." These patients not only give their permission to end their lives but also, in most cases, request or even demand that their lives be terminated.

## Mercy Killing

The phrase **"mercy killing"** refers to someone's taking a direct action to terminate a patient's life without the patient's permission. The decision to take such an action is often made on the assumption that the patient's life is no longer "meaningful" or that if the patient were able to say so, he or she would express a desire to die. The important distinction between mercy killing and mercy death is that mercy killing is involuntary, or does not involve the patient's permission or request, whereas mercy death is voluntary and done with the permission of the patient and usually at his or her request.

# CURRENT LEGAL STATUS OF MERCY DEATH AND MERCY KILLING

At present, 39 states specifically prohibit mercy death (or assisted suicide), and almost all of the remainder, and most countries of the world, make it illegal under general homicide statutes. Mercy killing is presently outlawed in all of the U.S. states, with the exception of Montana, Oregon, Vermont, and Washington, and most of the countries of the world. However, two legal actions by two U.S. courts of appeal, one in New York and the other in the state of Washington, have muddied the legal questions surrounding assisted suicide, and this has led to further appeals and upcoming decisions by the U.S. Supreme Court.

In April 1996, the U.S. Circuit Court of Appeals in Manhattan ruled that New York's manslaughter statute could not be used to prosecute doctors who prescribe lethal drugs to terminally ill patients who ask for them and then use them to commit suicide. The judges wrote, "What interest can the state possibly have in requiring the prolongation of a life that is all but ended? . . . And what business is it of the state . . . to interfere with a mentally competent patient's right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life?"[2]

On March 6, 1996, in San Francisco, California, the Ninth Circuit Court of Appeals "declared physician assisted suicide to be a fundamental constitutional right protected by the 14th Amendment's guarantee of 'liberty.' " "The decision how and when to die is one of the most intimate and personal choices a person may make in a lifetime, a choice central to personal dignity and autonomy."[3] Of course, legality is not our main concern in dealing with these problems; we are concerned with whether any of these three options is moral and, if so, under what conditions. Therefore, we will now discuss each of these options in more depth, examining the arguments for and against each of them and exploring the full implications of each. Before doing this, however, it is important that we define one more phrase.

## Brain Death

The advanced medical technology and sophisticated procedures available in the twenty-first century have created new moral dilemmas, one of which involves irreversible brain damage, popularly known as **brain death**. Before medical technology became so sophisticated, when patients' hearts or lungs failed, soon their brains also failed, and when their brains failed, heart or lung failure soon followed. In our time, however, we have discovered ways (e.g., by using respirators and heart machines) to bypass the brain, thus avoiding heart or lung failure.

If a patient is brought in with a head injury from a motorcycle accident, for example, the emergency crew may get the person's heart and lungs restarted and manage to stabilize these two organ systems. Later, doctors may discover that the head injury was so serious that the patient's brain has been *irreversibly* damaged; in other words, the brain is permanently dead, not just temporarily injured or even partly injured. Without brain activity, the patient is reduced to a body with a beating heart and breathing lungs. After a number of such instances had occurred, the medical community began to recognize the possibility that a person could be pronounced dead in a medical sense if his brain were irreversibly damaged—even if the patient's body could be considered to be alive in all other respects.

In 1968 an ***ad hoc*** committee was formed at Harvard Medical School to decide upon criteria for determining brain death. The *ad hoc* committee's final report cited four criteria: (1) unreceptivity and unresponsiveness, (2) no spontaneous movements or breathing, (3) no reflexes, and (4) a flat **electroencephalogram (EEG)**.[4] What this means, then, is that people can be declared medically dead even though their hearts and lungs are still functioning. Many people have confused the problem of brain death with allowing someone to die and mercy killing; they maintain that if a doctor or nurse disconnects the respirator or heart machine or feeding tube that is aiding a patient who has suffered brain death, then this person is guilty of allowing the patient to die or of mercy killing. This, however, is not the case; if patients are declared dead in an official medical sense, then any equipment can be disconnected and any procedure can be stopped without there being any implication of wrongdoing. After all, how can a patient who is already medically dead be allowed to die or undergo mercy killing?

The confusion that arises in such cases comes chiefly from our distaste for disconnecting patients with breathing lungs and beating hearts from machines that would keep these organs functioning. Suffice it to say that brain death has nothing to do with allowing someone to die, mercy death, or mercy killing. Some states (California, for example) have even included brain death in their legal definition of death. There is still a problem, however, in dealing with people who have not suffered brain death but who are severely brain damaged. Some injuries do not kill the brain; rather, they leave it so badly damaged that when and if patients awake from a coma, their lives are likely to be radically altered. Furthermore, such patients may remain in a coma for an indefinite period yet not meet the criteria cited earlier for brain death. The issues of allowing someone to die and mercy killing may definitely arise in relation to this last type of case, but they should not be considered as being in any way related to a clear-cut case of total brain death.

## Persistent Vegetative State or Irreversible Coma

Brain death should be carefully distinguished from **persistent vegetative state (PVS)**. PVS results from damage to the cerebral cortex, or neocortex, which controls the cognitive functions. For this reason, it might be called **cortical** or **cerebral death**. The body, however, is not dead because the functions of the brain stem continue in whole or in part. In PVS there may still be, and usually is, spontaneous breathing and heartbeat. Persons in this state often are awake, but they are not aware of what is going on around them. There is no conscious interaction with the environment and no awareness of self or the environment. A person in this state lacks and will permanently lack even that minimal level of functioning that makes life human. They are, in short, incapable of any human interaction. The very famous cases of Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo are examples of PVS, as you will see later.

# ALLOWING SOMEONE TO DIE

As we have already defined it, "allowing someone to die" means allowing a terminally ill patient to die a natural death without any interference on the part of medical science. The problems surrounding this issue, along with

those surrounding mercy death and mercy killing, have arisen much more frequently in the twentieth and twenty-first centuries than at any other period. The reason for this, as we have already mentioned, is that advancing medical technology has made it possible for more people to live longer than ever before. As recently as a few years ago, when the heart or lungs failed, a person was sure to die within a short period of time. Nowadays, however, a person can be kept alive almost indefinitely by respirators, heart machines, feeding tubes, pacemakers, miracle drugs, organ transplants, kidney dialysis machines, and so on.

With these advances, which certainly are a blessing for many, we also have incurred problems as to the quality of the lives we are extending. For example, people with kidney failure, who would have died prior to 1960, now can be saved. Many of them adjust beautifully to their situations, but others feel that if the only way they can remain alive is to be hooked up to a kidney machine for the rest of their lives, they would rather be dead.

Medical science is also working very hard on a cure for cancer, frequently a long, drawn-out disease that causes patients to slowly deteriorate and eventually lose their sense of dignity. It is ironic that as these patients' lives are extended by means of advanced medical technology, so too are their pain, suffering, and misery—sometimes in the hope that a cure will be found and sometimes simply because the doctors don't want to give up on any of their patients.

Similarly, because most people live longer than ever before, they sometimes become senile and infirm. We tend to relegate such people to hospitals or nursing homes, where, in many instances, they live out a tiresome, dreary, and despairing existence, often in pain and suffering. Therefore, literally thousands upon thousands of people, of various ages and in various stages of dying, face what many would describe as lives of low quality. If we add to this the extremely well-documented fact that people of the Western world, and especially those living in the United States, generally do not have the ability to face aging or death well, we have a serious problem that we must try to solve in the most ethical way possible.

Very few of us want to see other human beings suffer or live lives from which they are begging to be released. For this reason, it seems to many people that what we need to do is to accept as moral, and then legalize, some methods of allowing patients to die, mercy death, or mercy killing, preferably in some painless form to be administered by doctors, or by patients with the help of doctors, so that "miserable, meaningless" lives can be ended with dignity.

It is difficult to question the validity of the motives behind the desire to end the misery and pain of others. Furthermore, we can justify these motives within the five basic principles. Because we revere life and yet *accept death;* because we can bring happiness and eliminate pain, both for patients and their families, creating harmony where there was disharmony, and ending lives lacking excellence, whereas enhancing other lives with excellence; because we can be just and fair, not only to patients and their families but also to the rest of society on whom sick and dying patients often are a burden; and because we can grant individual freedom to terminally ill patients to die and be allowed to die, as well as the freedom to decide how and when to die, it seems obvious to many that allowing someone to die, mercy death, and mercy killing can be morally justified.

Let us now examine the arguments for and against allowing someone to die.

## Arguments Against Allowing Someone to Die

It is a common assumption that human life always is to be protected and preserved, regardless of its quality, by every means we have at our disposal. This assumption has given rise to a number of arguments against allowing someone to die.

## ABANDONMENT OF PATIENTS.

Some people argue that not using or discontinuing any means that might keep dying people alive even a little longer is tantamount to refusing them proper medical care. They feel that if health care professionals (doctors,

nurses, etc.) refuse to apply curative treatments, they are abandoning patients and their families to suffering and misery.

It certainly is true that health care professionals could conceivably abandon patients for whom "nothing more can be done." This probably has happened in the past, and indeed, it may be happening in some cases today. However, there is no reason why this need occur. Abandonment arises from an overemphasis on that aspect of medicine involving curing and healing patients and a lack of emphasis on the aspect involving comforting and caring for them, which is every bit as important. As we shall see a little later, the hospice approach to care for the dying makes this distinction clear and completely eliminates the abandonment problem.

# THE POSSIBILITY OF FINDING CURES.

Another argument frequently offered is that if we are too quick to let people die, we may be denying them the opportunity to be cured of their illness. New cures for disease are constantly being discovered, and there are also so-called "miracle cures," that is, cures that occur in seeming defiance of all medical knowledge. Therefore, it is argued, if we continue every effort to keep dying patients alive, a miracle cure may occur, or a scientific cure (new drug or surgical procedure) may be discovered that will lengthen patients' lives or even cure them completely.

Not all doctors are willing to accept the existence of miracle cures, however, and many of them also argue that the time to be concerned with cures is when the disease is first diagnosed, not when the patient has been completely debilitated by it. They would argue, for example, that the time to perform radical surgery, radiation therapy, and chemotherapy on cancer patients is not when the cancer has completely ***metastasized*** (spread) throughout the patients' bodies but when such treatment can do some good, either in slowing cancer growth or in stopping it completely. Using "aggressive medicine" to treat completely metastasized cancer patients, they would argue, is closer to torturing patients than to healing them.

# THE IMPOSSIBILITY OF OPTING FOR DEATH.

Many doctors, as well as others not in the medical profession, argue that by virtue of the nature of medicine, we can never opt for death; we must always choose life. After all, the reason medicine exists is to save lives, not end them, and the minute we start to make those choices that lead to death rather than life the very basis for medicine is nullified. This results not only in the discouragement of doctors but also in an elimination of patients' trust in doctors, often a necessary adjunct to the healing process.

One of the arguments brought against this view is that there is a great deal of difference between "choosing" death and "accepting" death when it is inevitable. A second argument is that many dying patients do not agree that "everything must be done" to save them, and they strongly object to doctors overriding their decisions about their own bodies and lives. The doctors, of course, argue that they know best and that they must be the ones to make all the decisions about a patient's treatment. The patients, however, feel that they ought to have the right to refuse treatment as well as to accept it.

# INTERFERENCE WITH GOD'S DIVINE PLAN.

The final argument against allowing someone to die states that only God can create and take away life, and that mere human beings should not be permitted to allow people to die, much less take their lives in an active way. According to this argument, we must use all of our abilities and every method at our command to save, protect, preserve, and extend human life until the Creator has decided that it is time for a terminally ill patient to die.

In this situation, however, it becomes a two-edged sword; that is, the concept of God's divine plan can be used to argue for or against allowing someone to die. The argument against such an action has already been stated. The argument for allowing someone to die begins with the assumption that God meant for all humans to die and that

the development of medicine has interfered to a great extent with God's original plan. That is, God did not mean for human beings to live forever, and when medicine prolongs life it interferes with His plan.

The problem with both sides of the argument, of course, is that it is not at all clear what God's specific plan *is* in relation to allowing someone to die. Furthermore, deciding when to start or stop medical treatment is not a decision made by God. Rather, people—doctors or patients—make these decisions. People who believe in God can certainly say that God has given them a choice with regard to this issue, but they cannot abdicate their responsibility by saying that God is doing the deciding.

## Arguments for Allowing Someone to Die

Most arguments for allowing someone to die are based upon the principle of individual freedom—specifically, upon the rights of individual dying patients to make decisions about their own bodies and lives.

# INDIVIDUAL RIGHTS OVER BODIES AND LIVES.

In much the same way as it applied to the arguments for suicide, the idea that people have the right to decide about their own lives or deaths applies to allowing someone to die, and also—as we shall see later—to requesting mercy death. This right also includes the right of rational patients to refuse treatment when they so desire.

There is, of course, a difference between taking a direct action to end one's own life and merely allowing a disease, deemed to be a part of the natural process, to follow its course without interference. And the process of allowing someone to die does not involve suicide or killing of any kind. In "A Patient's Bill of Rights," which was drawn up by the American Hospital Association, patients are accorded, among other rights, "the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences" of their actions.[5]

No one has absolute rights over his or her own life and death. This belief is reflected in the phrase "to the extent permitted by law" in the Patient's Bill of Rights—a phrase that obviously limits people's rights over their own bodies and lives. The general view, however, is that mentally competent people (and mental incompetence is very difficult to prove legally) should have the right to refuse treatment in most cases. This point of view is most strongly held when the treatment is as bad if not worse than the disease—which often is the case. For example, many treatments for cancer result in constant nausea, loss of hair, destruction of healthy as well as diseased tissue, and disfigurement. The individual rights argument offers patients the option of simply letting the disease follow its course rather than being subjected to the sometimes horrible effects of the various treatments offered to them.

# SHORTENING OF THE PERIOD OF SUFFERING.

Another argument for allowing someone to die is that it shortens the time during which a dying patient must endure suffering, pain, and misery. Often our highly advanced medical technology is used to prolong the death—rather than the life—of patients so that they can "enjoy" a few more hours, days, weeks, or months of pain. For example, if a cancer patient has about eight hours left to live and goes into kidney failure, then prolonging his or her dying by starting dialysis would be considered to be an extension of pain and suffering but not of meaningful life. It is much more humane, according to this argument, to alleviate the person's misery by allowing him or her to die of uremic poisoning.

The main criticism of this argument attacks its very basis. Yes, critics may say, allowing someone to die will shorten a patient's suffering, but it will also shorten his or her life, and shortening a person's life is immoral. Furthermore, if the policy of allowing people to die were to become general practice, it might be applied to those whose pain could be controlled and who therefore might have led relatively happy, significant lives.

# THE RIGHT TO DIE WITH DIGNITY.

Another argument for allowing someone to die is that people have the right to die with dignity rather than waste away and suffer until there is little left of their original character. This argument is especially forceful in relation to long-term debilitating and degenerative diseases, such as cancer. The idea at the basis of this argument is that if nothing is done in the way of extensive medical treatment, then patients will die without enduring the indignities of being operated on, fed intravenously, or hooked up to machines. The argument states further that "dignity" is also achieved when patients are given choices concerning the kind of living and dying they will do.

The main criticism of this argument is that the phrase "death with dignity" can mask everything from medical abandonment to mercy death and mercy killing and, furthermore, that no dignity will be lost as the result of a heroic attempt to save people's lives or to keep them alive as long as we possibly can.

## Ordinary and Extraordinary Means

There is an important distinction to be made when one is dealing with the problem of allowing someone to die, and it has to do with exactly what means doctors are justified in using to keep people alive. In a speech to anesthesiologists in 1957, Pope Pius XII described two types of means that may be applied in medicine to keep people alive, calling them **"ordinary means"** and **"extraordinary means."** What he said, essentially, was that doctors are justified in using extraordinary means up to a point to keep people from dying, but that they are not obligated to use such means indefinitely. In hopeless cases, doctors are obligated only to use ordinary means, and they are given the option either to not start or to discontinue extraordinary means. The distinction inherent in these two phrases sounds promising, but unfortunately the terms often are quite difficult to define clearly. Let us examine more closely what Pius XII said and then see if we can make some clear distinctions ourselves.

## EXTRAORDINARY, OR HEROIC, MEANS.

The pope defined *extraordinary means* as those that "according to circumstances of persons, places, times, and cultures . . . involve a grave burden for oneself or another."[6] This is, of course, a rather vague definition, and because persons, places, times, and cultures vary a great deal, it is not easy to come up with a stock list of extraordinary means. The situation described earlier in this chapter of the completely metastasized cancer patient who went into kidney failure is a clear example of this. To apply dialysis in this case would be to employ extraordinary means to save this person's life; on the other hand, to merely try to control pain and keep the patient comfortable would be to use ordinary means of treatment.

If a patient is in a coma as a result of a drug overdose, then perhaps using dialysis to purify his or her blood of the toxic substances would be more justified than it would be in the cancer case; nonetheless, one still might question whether kidney dialysis is not always to some extent extraordinary treatment. Still, there certainly is a difference between keeping a patient comfortable and well cared for and doing radical surgery or giving radiation therapy.

## ORDINARY MEANS.

The phrase "ordinary means" is almost as hard to define as "extraordinary means," again because of the wide variation in people, places, times, and cultures. We could make the distinction that once a patient's disease has been diagnosed as terminal, then continuing with chemical and radiation therapy or doing radical surgery would be extraordinary means, whereas controlling pain and other symptoms would be ordinary. This example may offer a fairly clear distinction, but there are other cases that are far more problematic.

For example, when kidney dialysis machines were in scarce supply and when individual patients had to pay the expenses (about $30,000 per year at that time), the use of these machines would have been considered *extraordinary* even though they were necessary to keep people with kidney failure alive. Now, however, when there seem to be enough machines to dialyze all kidney failure patients and when about 85 percent of the cost is paid by the government, perhaps dialysis can be considered to be ordinary means. It is interesting, however, that this treatment has placed heavy enough financial, physical, and emotional burdens on a few kidney failure

patients and their families that they really did seem to consider it *extraordinary* means to the extent that they discontinued it.

At any rate, whenever there is discussion as to the problems inherent in allowing someone to die, the distinction between these two types of means usually comes into play. Generally speaking, when we are considering allowing someone to die, we are talking about not starting, or about discontinuing, extraordinary means (e.g., respirators, heart machines, radical surgery, and organ transplants). However, we also may be considering the not starting or discontinuing of ordinary means. For example, feeding patients is often considered to be ordinary means in most circumstances, but doctors can switch from high-nutrient feedings to minimal or no nutrient feedings that will not effectively prolong patients' lives.

There was a case several years ago concerning a man in his eighties who told his family he didn't want to live any longer. From that moment on he refused to eat anything, and he begged his two grandsons not to let anyone force-feed him in any way. They honored his request, and he was allowed to die the death he had chosen.

Similarly, a woman in the advanced stages of metastasized cancer had a large growth blocking the tube that passes food to the stomach. The doctor and her family did not use any extraordinary means, such as surgery, to remove the growth, nor did they try to force-feed her in any way. They merely kept her comfortable; letting her taste homemade food even though she couldn't swallow it and letting her suck on ice chips to quench her thirst. Literally, they were allowing her to die of starvation. As these two cases illustrate, there are times when even the refusal to use ordinary means may also be involved in allowing someone to die.

# APPROPRIATE OR INAPPROPRIATE CARE.

Perhaps, given the confusion that abounds in reference to the terms *ordinary* and *extraordinary,* more suitable terms would be ***appropriate*** and ***inappropriate*** care. Although initially these terms may seem as vague as the others, they allow doctors, nurses, patients, families, and other caregivers to decide on how to treat a patient based upon what is *appropriate* to the particular patient. Rather than trying to decide what would constitute ordinary or extraordinary means, caregivers and patients could then base their decisions on what seemed to suit the particular situation of the patient.

Under this criterion, all means of care would have to be decided upon by the patient, family, doctors, and nurses as to whether or not it would be appropriate for a particular patient in a particular situation. This means that *all* forms of care are subject to the determination of being appropriate for a particular patient so that even food and hydration could be considered inappropriate at certain times as long as the patient was still comfortable and pain-free. The guiding force here would primarily be the clearly stated desires of the patient or the person he or she has designated to act on their behalf.

# Patient Self-Determination Act

In 1990, the U.S. Congress passed the **Patient Self-Determination Act (PSDA)** as a part of the **Omnibus Reconciliation Act (OBRA, 1990).** The PSDA requires that health care providers inform patients of their rights to make health care decisions and to execute advance directives. It also requires health care providers to educate their staff and community regarding these rights. The following are some of these rights:

- **1.** The right of patients to considerate and respectful care.
- **2.** The right of patients, in collaboration with their physicians, to make decisions involving their health care, including the following:
    - (a) The right of patients to accept medical care or refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
    - (b) The right of patients to formulate advance directives and appoint a surrogate to make health care decisions on their behalf to the extent permitted by law.

- **3.** The right of patients to acquire the information necessary to enable them to make treatment decisions that reflect their wishes.

In connection with item 2b, even though advance directives had existed long before, until the effective date of the PSDA (December 1991), there was no requirement that patients be informed that they could execute an advance directive. This directive would eliminate the confusion surrounding PVS patients, especially when family and caregivers are trying to decide on appropriate treatment.

Three extremely famous cases concerning patients in a PVS have focused the attention of millions of people in the United States on the importance of executing advance directives. They are the cases of Karen Ann Quinlan of New Jersey, Nancy Cruzan of Missouri, and Terri Schiavo of Florida. Interestingly, despite these real-life events, people are not executing advance directives to the extent they should be, probably because they don't want to deal with their deaths and dying.

# KAREN ANN QUINLAN.

Karen Ann Quinlan was 20 years old when she stopped breathing long enough for a part of her brain to be destroyed; she then lapsed into a PVS. She was put on a respirator, but her parents wanted her to be in a natural state without any artificial means of life support; therefore, they petitioned the hospital and doctors to remove the respirator, which they refused to do. After a lengthy court trial that eventually went to the New Jersey State Supreme Court, Quinlan was taken off the respirator and allowed to exist with just simple bed and body care and food and water.

She continued in this PVS for another ten years, finally succumbing to pneumonia while residing in a skilled nursing facility. It should be made clear that at no time was Karen ever brain dead. She would sit up, thrash about in her bed, react to sound, light, and touch, but at no time was she conscious or aware of her surroundings or the people in them.

# NANCY CRUZAN.

Another woman, Nancy Cruzan, 25, lay in a PVS for seven years following a serious automobile accident. She was fed through an abdominal tube, and her parents asked that the tube be removed and that Nancy be allowed to die her own natural death. This case was litigated up to the Missouri State Supreme Court and finally to the U.S. Supreme Court. Because Nancy had not executed any sort of advance directive, the U.S. Supreme Court ruled that "clear and convincing evidence" that Nancy desired to refuse treatment was lacking, and therefore that it could not and would not rule that her parents had the right to act as her proxies in such a decision.

When her case was returned to Missouri, after hearing further testimony from several of her friends and acquaintances that Nancy had made clear that she did not want to continue in such a state, a Superior Court judge ruled that this additional testimony provided "clear and convincing evidence" of her desire to refuse treatment and ruled that the feeding tube could be removed. It was, and she died several weeks later.

Incidentally, to indicate the great strain and sorrow caused by dealing with the allowing to die of a loved one, on August 17, 1996, her father, Lester "Joe" Cruzan, at age 62, committed suicide by hanging himself in his carport. He had fought depression all his life, and Nancy's accident, her coma, her lack of recovery, and the strain of fighting for seven years to get the law to allow her to die finally took their toll. According to family and close friends, he did not commit suicide because he felt guilty about fighting for Nancy's right to die, nor did his suicide note indicate this in any way.[7]

# TERRI SCHIAVO.

Probably the most notorious PVS patient of extensive media hype was Terri Schiavo because Michael Schiavo, her husband, wanted her feeding tube removed, whereas her parents, Mary and Bob Schindler, wanted the feeding tube left in. The Schindlers claimed that Terri smiled and looked at them with love in her eyes. However, a distinguished neurologist, Ronald Cranford, examined her with the following results: The CAT scan showed a massive atrophy of the brain. What Terri Schiavo manifested was a classic vegetative state. It looked as if she was looking at you, but really she was not. It looked as if she was grinning at you, but really she was not. The key test is whether someone can track movement, which Terri did not. An examiniation of Terri's video tape showed that she was really not looking at her mother. She was really not tracking. Despite this information, many people still argued that her brain was alive. After spending many years trying to improve her condition, Michael stated that he wanted her feeding tube removed. The Schindlers said she was alive despite Dr. Cranford's expert opinion and that they wanted the feeding tube left in. There then followed the strangest series of events involving various arms of government. First, the governor of Florida, Jeb Bush, the president's brother, asked the Florida legislature to give him the power to keep Terri alive, which they did. The courts still insisted that her feeding tube be removed. Then Republicans in Washington passed similar legislation, and President Bush flew to Washington, D.C., to sign such a bill into law. Never before had politics played such a part in what was a personal matter, and many decried such interference. Despite the interference, the feeding tube was removed per her husband's request. Why do you think the confusion existed between Dr. Cranford's expert opinion and how Terri appeared to nonmedical people? To what extent do you feel government should interfere in such issues? Why is PVS so difficult to deal with compared to brain death? What's the difference between the two?[8] The Quinlan and Cruzan cases, and others like them, have fostered a sense of urgency concerning the rights of people to determine their own treatments and deaths and have led to the creation of the previously mentioned PSDA and to encouraging people to execute advance directives.

# Advance Directives

Because being allowed to die seems to have become a significant moral issue of our time, and because this issue involves individual freedom and patients' rights over their own bodies, treatments, and lives, certain documents or directives have been created to allow people to inform others of the kind of treatment they wish to receive if and when they become seriously ill. Through such documents, people hope to ensure that they will receive the kind of treatment they want even if they become too ill later on to communicate effectively to others how they wish to be treated. Further, by means of such documents these people hope to relieve their families, doctors, nurses, and hospitals of the burdens (economic, emotional, moral) of making decisions that would allow them, as patients, to die their own natural deaths with peace and dignity. There have been various documents or directives: the Living Will and Health Care Proxy, the Natural Death Act Declaration, and, probably the most well known, the **Durable Power of Attorney for Health Care (DPAHC)**. Advance Directives for each state can be easily located with a simple Internet search.

Regardless of how one feels about such documents, they are evidence of a growing concern on the part of human beings about the encroachment of medicine and medical technology on their freedom, lives, and dignity. These documents also provide further evidence that people wish to have a strong voice in determining the nature of the medical treatment they receive and to exert their own control over their own living and dying. Finally, it is important to note that none of these documents in any way authorizes either mercy death or mercy killing; they pertain only to allowing someone to die.

# The Hospice Approach to Care for the Dying

Before we begin to discuss mercy death and mercy killing, it is important that we look closely at a different approach to care for the dying than that generally practiced in this country: This is called the hospice approach to care for the dying. The word ***hospice*** formerly meant a refuge for wayfaring strangers. Now, however, it refers to a place where tired, sick, and dying people can be cared for and comforted. The modern hospice does not deal with acute cases or with emergency medical care; rather, it seeks to help terminally ill patients live as comfortably

and meaningfully as they can until they die. The hospice approach involves seven different aspects of patient care. A close examination of these will help to clarify how hospices differ from hospitals and other medical facilities.

# COMFORTING AND CARING FOR PATIENTS.

First of all, the hospice approach emphasizes **comforting and caring** for patients rather than **curing and healing** them. As mentioned earlier, there comes a time in every terminal illness when the possibility of curing patients of their diseases no longer exists. At this point, medical care should not be discontinued, nor should patients and their families be abandoned; rather, the medical care should shift from curing and healing to comforting and caring for the patients. The emphasis here is on *appropriate* medical treatment, which involves pain and symptom control and assistance at all levels to patients and their families until the patients die; it also means continued assistance, when needed, to the patients' families after they have died.

# A TEAM APPROACH.

Recognizing that human beings have dimensions beyond the physical, which is the basic focus of medicine, the hospice approach utilizes a team concept in its care for the dying. The team includes patients, their family and friends, other patients, doctors, nurses, clergy, social workers, physical and occupational therapists, psychologists or psychiatrists, and volunteers. Because sickness, dying, and death involve all dimensions of people, their mental, emotional, social, and religious needs must be met along with the physical needs. The assumption is that dying patients and their families must have total care to get through what often is a difficult time.

# PAIN AND SYMPTOM CONTROL.

The hospice approach recognizes that there is a difference between *acute pain* and *chronic pain.* **Acute pain** is that which will eventually disappear—for example, the pain one feels after surgery. **Chronic pain**, on the other hand, is pain that not only will remain but also is likely to get worse. Obviously, a completely different approach to controlling pain must be used when dealing with the chronic type. Second, the hospice approach recognizes that pain, especially chronic pain, is a complex phenomenon that involves the mental or emotional, the social or sociological, and the spiritual or religious aspects of patients as well as the physical. This is another reason why the hospice approach utilizes a team; there is a basic recognition that social pain can be helped by social workers, mental and emotional pain can be alleviated by psychologists or psychiatrists, and spiritual pain can be eased by clergy.

Once chronic pain has been seen for what it is, a *preventive* rather than a *reactive* approach to pain control should be used. For example, once a terminal cancer patient begins to suffer pain, the method of pain control should not be to wait until the moment the pain returns, thus *reacting* to the pain symptoms; rather, the patient's pain should be prevented from occurring. Pain medication should be given to patients orally wherever possible so as not to further aggravate already existing pain with hypodermic needles, and the method of pain control must be examined daily to ensure that it fits each patient's individual needs. A more detailed description of the hospice approach to pain control may be found in Sandol Stoddard's (1927– ), *The Hospice Movement: A Better Way of Caring for the Dying.*[9]

# OUTPATIENT AND HOME CARE.

Because dying patients do not as a rule need extraordinary medical care, they often can be treated at home. Whenever possible, the hospice approach encourages dying patients to remain at home, offering both patients and their families total care and support from the entire team whenever it is needed. This brings greater *comfort* to the patients by allowing them to stay in familiar surroundings with their families and their own favorite belongings around them. The key to this type of care, of course, is that complete support and care must be made available by the team. One of the reasons more people have not chosen to die at home, especially in our country, is that there

has not been support available to patients and their families, and families aren't always able to cope alone with all of the problems that surround the dying of a loved one. If the support is there, however, then the home often is the place where patients receive the best care and are the most comfortable.

## HUMANIZED INPATIENT CARE.

When home care coupled with outpatient care is not feasible—and many times it is not—humanized, homelike, comfortable inpatient facilities should be available. Patients should be placed in care units or wings so that they can relate to others in similar situations. The rooms should be warmly decorated and should have large floor-to-ceiling curtained windows and at least partial carpeting. Patients should be allowed to have their own familiar belongings around them (easy chairs, plants—even pets, where feasible), and visiting hours should be liberal, with no restrictions on age so that children can visit their parents and grandparents. Food and drink of the patients' choice (including alcoholic beverages if desired) ought to be available. And, finally, patients should be kept pain- and symptom-free and be given loving care, but they should be spared the intrusion of extraordinary or inappropriate medical technology, such as intravenous lines, respirators, and so on.

## FREEDOM FROM FINANCIAL WORRY.

All hospice care, in- or outpatient, should be performed on a nonprofit basis. Where available, existing medical insurance, private or government, should pay for as much as possible, but no hospice patient should be refused treatment because of lack of finances. Nor should patients be dunned for money. Many hospices will tell patients and their families how much their care costs and ask them if they can contribute anything toward their care, but usually they are asked only once and never refused treatment because they have no money. Hospices derive their financial support mainly from fund-raising activities, grants, and donations or memorial gifts. Also, it has been proved that keeping dying patients at home on an outpatient basis or even in hospice facilities is far less expensive than keeping them in convalescent homes or acute care hospitals. This is not the main reason that one should consider the hospice approach, however; rather, what is impressive is the humane and compassionate care it provides for dying patients and their families.

## BEREAVEMENT COUNSELING AND ASSISTANCE.

Helping dying patients and their families to adjust to the fact of death before, during, and after its occurrence is an important part of the hospice approach. This is yet another reason that the team approach is used—so that social workers, clergy, trained volunteers, and other nonmedical members of the team can aid medical personnel in caring for the entire family unit. Too often in our society the patient is cared for and the family is forgotten. When the patient dies, however, the grieving family remains, and often its members experience tremendous difficulty when dealing with the death of their loved one. If the family *and* the patient can be treated as a unit during the dying period, then much of the difficulty that might occur after the patient dies can be averted—that is, family members can go through at least some of their mourning while the patient is still with them.

## SOME CONCLUDING COMMENTS.

The hospice approach allows patients to die their own natural deaths in peace and dignity and with the full support of their families, friends, the medical community, and society in general. Because two of the main reasons for mercy death and mercy killing are to put people out of their pain, suffering, misery and to end lives that allegedly have no meaning, the hospice approach obviates the need for such measures in most instances. If patients can die in peace and dignity, free from pain and suffering, they will have no need to commit suicide, assisted or otherwise, or have their *lives of despair* terminated for them. The reasons for mercy death and mercy killing have not been completely eliminated, but a humane alternative does exist in many of those cases that might call for such drastic measures.

# Cases for Study and Discussion

The following cases should be studied together because they have a number of elements in common. Some discussion questions related to the two cases are presented after the second case description.

### CASE 1 Down Syndrome Child with Intestinal Blockage

A 38-year-old nurse gave birth to a baby girl who had both Down syndrome (a disease that involves mental retardation) and an intestinal blockage. This type of birth often occurs in women over age 35. The nurse and her husband agreed that the child's existence would be poor in quality because of her mental retardation, and, knowing that she would die if the intestinal blockage weren't removed, they refused to sign a permit for surgery to remove the blockage and told the doctors to do nothing to save their daughter. The doctors and the hospital agreed that the parents had the right to make this decision, so the child was left in the nursery to die. After 11 days, she died of starvation.

### CASE 2 Down Syndrome Child with Heart Defect

Another woman, age 42, was rushed to the hospital to have her baby, but the little girl was born in the car on the way to the hospital. The child was born with Down syndrome, intestinal blockage, and a hole in her heart that made it very difficult for her to breathe. The woman and her husband already had three children and had not planned for this one. Because of these problems, they also had both financial and marital difficulties. They refused to sign the permission form the doctors needed to remove the intestinal blockage, saying that even if the little girl survived this surgery, she still would have to have heart surgery later on. Furthermore, they said that if she managed to survive the heart surgery, she would still be severely mentally retarded. The doctors disagreed with the parents, and after obtaining a court injunction allowing them to operate, they removed the blockage. The parents did not even name their daughter, and they refused to take her home until the pressure put upon their other children by their peers forced them to do so. A year later the little girl was still alive, but because of her heart defect she often had to gasp for breath. The parents were so unhappy with the situation that the mother even contemplated smothering the infant with a pillow, but she could not bring herself to do it. The family's financial situation was deteriorating, and the mother was concerned because the longer they kept the baby, the more everyone in the family was becoming attached to her and the harder it would be for them all if the baby were to die. The parents blamed the doctors and the judge who handed down the injunction for creating this nearly unbearable situation.

***Some questions for study and discussion***

- **1.** Both of these cases are quite similar except that the second baby has an additional serious defect, the hole in her heart. Should this make a difference?
- **2.** Which set of medical personnel do you feel did the *right thing?* Explain your answer, giving specific reasons.
- **3.** How would you resolve the conflicts among the following rights involved in these two cases?
    - (a) The right of the babies, regardless of their problems, to medical care that could save their lives.
    - (b) The right of parents to decide whether their defective or deformed babies should be allowed to live when, in the past, they would not have lived because our medical technology was less advanced.
    - (c) The doctors' and hospitals' right to save lives when they know they can.
    - (d) The conflicting rights of society to (1) protect its members (in this case, the babies) and allow them to live and (2) not be burdened with defective and deformed children when the omission of extraordinary care would allow the children to die of natural causes.
- **4.** In the first case, how do you feel about the fact that the baby was left for 11 days to die of starvation? Do you feel she should have been immediately and painlessly killed instead, or do you feel she should have been operated on regardless of the parents' wishes?
- **5.** If parents do not wish to take the responsibility of raising children who have defects and deformities, do you feel society as a whole has an obligation to give such parents extensive financial and social aid in raising the children or to assume the responsibility for raising such children itself?

- **6.** If society or the parents have to institutionalize such children in places where bare maintenance is all the children receive, do you think it would be better to allow the children to die, as in the first case?
- **7.** To what extent do you think that not performing what is a relatively simple and safe surgery on a deformed or defective child amounts to unfair discrimination against handicapped children?

### CASE 3 A Man Who Beat His 11-Year-Old Stepdaughter Wants Say in Keeping Her on Life Support

A man accused of beating his 11-year-old stepdaughter to the point where she is in a PVS asked judges on the case to allow him to have a say in continuing or discontinuing life support. She is currently on a respirator and a stomach feeding tube. The judges were sceptical about his request. If the judges have the respirator and the feeding tube removed, one interesting consequence is that if the girl dies, then the stepfather could be tried for murder. If you were a judge on this case, how would you rule? Are there any circumstances where you might rule in the man's favor? What would they be?[10]

# MERCY DEATH

The phrase **"mercy death,"** as stated earlier, means a *direct* action taken to terminate someone's life at his or her request—it amounts to an assisted suicide. Patients, often because they are in pain or because they just do not want to live longer, ask to have their lives ended immediately, usually by some painless means. The motives for such a request vary. Often such patients do not feel they will have the courage to commit suicide and want someone to help them, whereas at other times patients are not able to end their own lives because they either are paralyzed or are too weak to do it themselves. In any case, however, these patients want to be mercifully put to death, not just allowed to die.

In a New York U.S. Circuit Court of Appeals ruling the court did not find that suicide was a constitutional right but found that New York failed to honor the constitutional guarantee of equal protection under the law. According to the court's ruling, patients on life-support equipment are allowed to hasten their deaths by instructing doctors to turn equipment off, but patients wanting lethal medication are denied it; therefore, the court ruled that any distinction as to the way in which a person chooses to end his own life constitutes irrational and unjustifiably unequal treatment under the law. This decision raises serious questions about the distinction between allowing to die and mercy death.[11]

## Arguments Against Mercy Death

Many of the same arguments used against suicide are applicable to mercy death, at least to some extent, but the issues surrounding mercy death are further complicated by the fact that someone else has to do the killing. Let us examine the arguments used against suicide as they apply to mercy death.

# THE IRRATIONALITY OF MERCY DEATH.

This argument may have less force here than when it is applied to suicide as people are more likely to accept as rational a decision to die when the person making the decision is to die soon anyway and/or when his or her life at the time of the decision is full of pain, suffering, and misery. Furthermore, even when people who request mercy death are not in imminent danger of dying, their lives may now be so radically altered that they would rather not live anymore (e.g., a physically active person who will be permanently paralyzed from the neck down because of a serious accident). Despite these mitigating factors, however, the argument against mercy death goes on to say that people who are suffering and in pain are in such a state of fear and depression that they simply cannot make rational decisions. If these people will patiently wait to see what therapy and medical science can do for them, the argument continues, perhaps they will adjust to their situation and change their minds about dying.

The criticism of this argument is that many requests for mercy death have come from people who have tried for some time to live with their tragic situation and have still decided that death is preferable to a limited life. Also, it

is difficult to argue that because a person is suffering, he or she cannot make a rational decision in favor of death.

## THE RELIGIOUS ARGUMENT.

The religious argument applies to mercy death in much the same way as it does to suicide. Indeed, it gains force in this case from the fact that a second person must do the killing, which, in religious terms, is even worse than suicide. The religious argument maintains that killing is killing, regardless of the motive, and states that no one has the right to take innocent people's lives, even at their request.

This argument is further supported by many of our laws. It is true that most states and countries have repealed those laws designating suicide as illegal, but many of them still have laws against helping others to commit suicide. People who do this can, in fact, be charged as accessories to murder. Mercy death does fit our earlier definition of "murder" except that the phrase "especially with malice aforethought" does not apply. Furthermore, it differs from murder in that it is not done against the will of the "victim."

In addition to the criticisms already presented in rebuttal to the religious argument against suicide, there is another criticism we can consider: It is precisely the difference in motive that makes mercy death morally acceptable, especially because the person to be put to death agrees to his or her own death and requests it. Most killings are committed from motives of greed, revenge, anger, hate, or viciousness; mercy death, on the other hand, is done out of love and mercy for a person who is suffering.

## THE DOMINO ARGUMENT.

Both the domino argument and the criticisms of it apply here in much the same way as they do to suicide, war, and capital punishment. Those who argue against mercy death, however, believe that the domino effect that results from permitting mercy death can be much more pernicious than in those other cases. It is obvious, they say, that if mercy death, which is performed at a person's request, is authorized or given moral sanction, the next step will be mercy killing; that is, decisions for death will be made by others for those unable to request death for themselves. Once the door is opened for the one, they say, it is open for the other. It is also possible, however, to legally allow mercy deaths and not mercy killings, just as it is legally possible to permit the allowing of someone to die without condoning either mercy death or mercy killing.

## THE JUSTICE ARGUMENT.

Here again, many of the same arguments that apply to suicide apply also to mercy death. There are some additional problems, however. For example, is it just for people to ask others to kill them? Doesn't this place a terrific burden of guilt and depression on the person who has to perform the act? And what about the feelings of guilt and loss on the part of the family members? Won't they always wonder whether something more should have been done, perhaps on their part, to help the person live? There is no doubt that mercy death places a greater burden on others than suicide does.

## THE POSSIBILITY OF FINDING CURES.

The arguments here are much like those presented in the discussion of allowing someone to die, and they are best characterized by the cliché, "Where there's life, there's hope." The counterarguments also are the same, with the additional criticism that many patients who request mercy death either feel they have no chance of being cured or find the wait for a cure too painful to bear.

## THE HOSPICE ALTERNATIVE.

In his article “Euthanasia,” Dr. Richard Lamerton has said, “If anyone really wants euthanasia, he must have pretty poor doctors and nurses.”[12] He might just as easily have said that the patient must be receiving pretty poor medical care from the entire society. According to the hospice argument, because we already know that the hospice approach will work, we should exert our efforts in that direction rather than in trying to discover how we can morally and legally justify mercy death or mercy killing. Under the five principles, the hospice approach reveres, preserves, and protects human life; it promotes goodness by giving pleasure and avoiding pain, by creating harmony, by making lives as excellent as they can be, and by allowing and encouraging creativity at whatever level is possible; it provides for honesty and truth telling by dealing with the patients where and as they are and relating to them as real and whole human beings, not merely as diseased bodies; and it gives patients and their families the freedom to enjoy life and each other for whatever time is left, while at the same time allowing them the freedom of a truly dignified death, not by killing but by compassionate treatment.

It seems obvious, then, that if all of these things can be done to alleviate pain and misery and meaninglessness in people’s lives, and if the hospice approach can be made the rule rather than the exception, then the need for mercy death or mercy killing should be decreased a great deal, if not eliminated entirely.

The criticism of this argument is that there may be some patients who do not want any further treatment of any kind, in a hospice or elsewhere, and who choose death rather than a limited life. Furthermore, there are those to whom the hospice approach doesn’t really apply—for example, paraplegics, quadriplegics, victims of paralysis, and other patients who suffer from extremely debilitating chronic, but not necessarily terminal, diseases. In the opinion of such patients, the alternative of mercy death is still viable.

## Arguments for Mercy Death

## INDIVIDUAL FREEDOM AND RIGHTS.

The main argument for individual freedom and rights, as in the suicide issue, is the argument that people ought to have the right to decide when their lives should end. If they choose not to live any longer and request to die, we should oblige them, recognizing that they have made a free, rational choice. All we are doing is carrying out their decisions in a spirit of love, compassion, and mercy.

The difference between mercy death and suicide, however, is that in the case of mercy death we are asked to end their lives for them, and this can certainly be seen as an infringement upon our rights and freedom. A doctor expressed this point of view on a television documentary called *Right to Die.* The doctor said, “You have the right to choose death for yourself, but you do not have the right to involve *me* in your choice.”

## HUMAN RIGHTS VERSUS ANIMAL RIGHTS.

Another argument states that just as we are generally willing to put animals out of their misery when they suffer, so we should accord our fellow humans, who certainly are of higher worth to us, the same consideration. Furthermore, because they have asked us for death, we should have no compunction about ending their lives mercifully.

The main criticism of this argument is that the rights of human beings to live or die are not in any way the same as those of animals. Western religions, of course, maintain that human beings have immortal souls, but even nonreligious humanists talk about the “human spirit,” or personality, stating that it should be accorded a greater respect than the mere physical self.

A counterargument to this is, “Yes, humans and animals are different, but above all this should mean that humans have free will and therefore should be able to decide for themselves whether or not they should end their own lives with or without assistance.”

## Changes in Attitudes Toward Mercy Death

Several events reflect a change in attitude toward mercy death.

# ACTIVE ADVOCATES FOR MERCY DEATH.

As has been stated earlier, presently mercy death is illegal in many of the 50 states and in most countries of the world, but there is strong advocacy not only for allowing people to die their own natural deaths but also for allowing people to be assisted by doctors in committing suicide when they no longer feel that their lives are worth living (mostly, but not always, when their illnesses are terminal). Two men—Derek Humphry (1930– ) and Dr. Jack Kevorkian (1928–2011)—have been active in furthering the cause of mercy death, or assisted suicide.

Derek Humphry is an Englishman now residing in the United States. In 1975 Humphry, while still living in England, assisted his first wife, Jean, in committing suicide when she was dying of cancer. This was perhaps a somewhat strange action because both of them resided in the country where the modern-day hospice was brought to life. Humphry wrote a book about it called *Jean's Way.* In 1980 in California, Humphry founded the Hemlock Society, which is famous for two things: (1) working to change laws so that doctors can legally help terminally ill patients to commit suicide and (2) giving advice to people who have decided to die on their own when doctors cannot or will not help.

The Hemlock Society attempted to introduce legislation in both California and Washington that would legalize assisted suicide, but both measures failed. After these failures, Humphry and his second wife wrote *The Right to Die: Understanding Euthanasia* in 1986. He then wrote his most famous and best-selling book, *Final Exit,* in 1991, which, as *Playboy* described it in its interview with Humphry, "is nothing short of the last self-help book you'll ever need."[13] He has published a fourth book, *Dying with Dignity: Understanding Euthanasia.* Humphry is currently assisting a group called Californians Against Human Suffering with their initiative, which was on the ballot in California in November 1992 and did not pass.

Dr. Jack Kevorkian, from Detroit, Michigan, is much more famous and controversial than is Humphry. A retired pathologist, Kevorkian has helped over 130 people to commit suicide, few of whom, interestingly enough, could have been classified as terminally ill. He has been brought to trial several times and acquitted of assisting suicide. It should be noted that in all of these cases, Dr. Kevorkian provided the means, but the people themselves administered their own suicides. However, on September 17, 1998, Dr. Kevorkian helped Thomas Youk, suffering with Lou Gehrig's disease (ALS), to die and videotaped the whole event. He then went on television during *60 Minutes* and showed the whole event and answered questions as well. He was found guilty and sentenced to jail for taking Mr. Youk's life. Kevorkian served eight years on a 10–25-year prison sentence for second-degree murder. He was released on parole in 2007 on the condition that he would not engage in assisted suicides or give advice on such matters. He was unsuccessful in a 2008 run for the U.S. Congress in Michigan's 9th congressional district. Kevorkian died June 3, 2011.

# COURT DECISIONS.

The first physician-assisted suicide law in effect in the United States was the "Death with Dignity" law in Oregon. The law was first passed in 1994 but was prevented from going into effect by a court injunction; reaffirmed by voters in November 1997, it finally went into effect. Interestingly, a study was done in its first year of 1998, and the fears surrounding the passing of the law were discovered to be unfounded. Only 15 terminally ill people used it to end their lives without suffering any painful, lingering deaths that opponents had warned about.[14] Currently, four states have laws allowing physician-assisted suicide.

# LACK OF AUTONOMY OF PATIENTS IN MEDICAL CARE.

Dr. Christopher Meyers, director of the Kegley Institute of Ethics at California State University, Bakersfield, California, and an expert in medical ethics who consults with Bakersfield area hospitals, stated in an article in the *Bakersfield Californian* newspaper, " . . . who other than a truly desperate person would choose to spend his or her final moments in the back of a Volkswagen van sucking on carbon monoxide, as many of his [Dr. Kevorkian's] clients have done? What could create such desperation? A realization that soon one will be facing pain and loss of identity and dignity, with little or no control over either the disease process or how one's final days are to be lived." He goes on to say that physicians and pharmacists have a monopolistic control over pain medication, and physicians also have the same kind of control over drugs that might hasten death and medical technologies that can vastly improve a dying person's quality of life: "The point is, when one is gravely ill and/or in need of hospitalization, nearly all aspects of personal control are lost."[15]

Dr. Meyers abhors the fact that patients in need of autonomous relief have to turn to a man of such questionable taste and judgment as Dr. Kevorkian, but he also sees no future remedy of the medical establishment granting autonomy to its patients. He therefore believes that physician-assisted suicide should be made a legal option.

## HEALTH CARE PERSONNEL HAVE PRACTICED FORMS OF ASSISTED SUICIDE.

It is certainly not unknown that some doctors in the United States and other countries of the world (e.g., Holland and Sweden) have at times practiced some form of assisted suicide. A recent controversial study of 850 nurses revealed that 141 of them had received requests from patients or family members to engage in assisted suicide. One hundred and twenty-nine of these said they had carried out these practices at least once, and 35 said they had hastened a patient's death by only pretending to carry out life-sustaining treatment that had been ordered.[16] Despite the inconclusiveness of the study and the small sampling of nurses surveyed, the answers of the nurses are indicative of their need to help patients when they are in pain, deteriorating, and dying. Some nurses have said that if the real facts were known, the figures would be much higher than reported.

## STRONG DESIRE FOR GREATER AUTONOMY AND CONTROL OVER LIFE AND DEATH.

There is and has been over the last ten years a greater desire on the part of people who are suffering painful, deteriorating, or terminal illnesses to have autonomous control over their bodies and lives. For instance, one of the people who was assisted in suicide by Dr. Kevorkian was a woman, 43 years old, who had discovered that she had Alzheimer's disease. She wanted to die before she had to suffer as her mental condition deteriorated. Several of Kevorkian's "patients" had muscular dystrophy and were tired of trying to live such a limited, handicapped existence. None of these people was a terminal case, but many patients who are terminal, due to cancer and other fatal diseases, also have requested the right to choose not to suffer any further and want to be able to have physicians help them die.

## Suggested Safeguards for Mercy Death

Whether or not any of us believes that mercy death is morally justified, it seems inevitable that in the future, near or distant, it will become a widespread practice that is partially or completely legal. It is important, therefore, that some careful legal safeguards be proposed before this happens; otherwise, ethics and the law may be caught by surprise, as they have been already by the actions of Dr. Kevorkian and the two circuit courts of appeals' decisions. Besides, as columnist Ellen Goodman (1941– ) has said, "Most Americans support legal, assisted suicide for the most personal of reasons. We just might want it someday."[17]

## SAFEGUARDS IN THE OREGON LAW.

The Oregon law allows doctors to write prescriptions for aware adult, terminally ill patients who have asked for them both orally and in writing. There is a 15-day waiting period; two witnesses and a second doctor are required; patients must be informed about other options; and they must take the drugs themselves. On January 17, 2006, the Supreme Court voted to uphold Oregon's physician-assisted suicide law.

# SAFEGUARDS PROPOSED BY DR. MEYERS.

In Dr. Christopher Meyers's discussion of the lack of autonomy problem and physician-assisted suicide, he has presented several safeguards:

- (1) The first request for death assistance must occur at least two months prior to the provision of such assistance; (2) the request must be repeated twice more in two-day and one-week intervals; (3) all requests must be initiated by the patient and cannot come as the result of a question from any other party; (4) all requests must be witnessed in writing by someone who has no economic interest in the patient's life or death and who can attest that the request appears to be made by a competent person who is not under undue influence from medications or from pressure from family or loved ones; and (5) the request for death assistance must be reversible at anytime. The patient must be informed that such a reversal, if it were requested during the death-assisting procedure, could worsen his or her medical condition."[18]

# RUSSELL'S SAFEGUARDS.

O. Ruth Russell (1946– ), in her article "Moral and Legal Aspects of Euthanasia," published in 1974 in the *Humanist* magazine, states her belief that (1) any law legalizing physician-assisted suicide should be permissive rather than mandatory or compulsory; (2) there can be no secrecy; (3) there has to be a written, notarized request; (4) an advisory panel is to be used; (5) several doctors must be involved; (6) a waiting period will be required; and (7) it will be a criminal offense to falsify any documents, coerce patients or next of kin, or perform any malpractice involving any act of euthanasia.

## Evaluation of Safeguards

Most of the safeguards mentioned earlier are significant, but some are more necessary than others, and there may be additional ones that should be included. The following safeguards should be a part of any law that permits physician-assisted suicide.

# PERMISSIVE RATHER THAN COMPULSORY OR MANDATORY.

Any law that authorizes physician-assisted suicide should, of course, be permissive rather than mandatory. No one but the person desiring assistance or his or her designated agent should request it. Further, no one should be forced or coerced in any way to request such assistance, and physicians or other health care personnel should not be required to carry out any such request against the dictates of their moral conscience.

# A WRITTEN REQUEST.

There must be no secrecy involved. Everything must be done in the open and aboveboard. Any such request should be made in writing by the person requesting, and this request should be witnessed by disinterested persons and notarized. An advanced directive could be used for this purpose, or additional pages or sections could be added to them, although it may not be necessary that such requests be notarized. Any such request can be revoked by the patients or their designated agents at any time, either orally or in writing, but patients should be warned, as Dr. Meyers suggests, that revocations after the process has begun may result in the worsening of the patients' condition.

## A WAITING PERIOD.

There should be a waiting period, and Dr. Meyers's suggestion of two months, from the time of request to actually providing assisted suicide, is a fair one. Meyer's insistence on the necessity of repeating the request two days later and one week later and perhaps one month later as well is sound. There could be places provided on any form used where patients or their agents could repeat or verify the initial request. Before and during this waiting period, other options, such as hospice care, appropriate pain control, and whatever other appropriate care is available, should be carefully explained.

## COUNSELING.

Also, before and during the waiting period, a trained counselor should be made available to aid patients in making their decisions and to ensure that they are rationally competent to request assisted suicide and are not being forced or coerced in any way by families, friends, or health care personnel. If there is a serious question of mental competency, psychiatrists or psychologists could be called in to present their findings.

## MORE THAN ONE DOCTOR.

More than one doctor should be involved in the diagnosis and prognosis of patients' illnesses and lives, and patients will have to be fully informed concerning their condition.

## ANY ABUSE OF SAFEGUARDS PUNISHABLE AS A CRIMINAL OFFENSE.

Any coercion of patients or next of kin, falsification of documents, or performance of any malpractice involving any act of mercy death should be deemed criminal offenses punishable by law.

## ASSISTED SUICIDE SHOULD BE PAINLESS.

It should go without saying that any mercy death or assisted suicide should be painless (which is why physicians should administer it) and performed in a comfortable, pleasant place of the patient's choice.

## OTHER POSSIBLE SAFEGUARDS.

Additional safeguards could involve having a judge or court commissioner approve the mercy death after hearing and seeing all of the evidence including the patient's own words if that is feasible. If not, then the words of patients' families and designated agents should be heard. Also, there could be, as Ms. Russell has suggested, a panel or committee, such as a bioethics committee, of disinterested persons, that could hear and see all of the evidence and advise all those involved. Either of these, especially the court situation, could prove to be restrictive of patients' autonomy, but either certainly would make it harder for a questionable mercy death to be carried out.

## Concluding Remarks on Mercy Death

Neither mercy death nor physician-assisted suicide is being advocated here but merely practical suggestions for legal safeguards. What would pretty much eliminate the need for these actions is an expansion of the hospice approach, especially as it involves pain and symptom control. It is probable that if suffering people, terminal or otherwise, were rendered as free as possible of pain and discomfort, there would be less need for mercy death, physician-assisted or otherwise. Yet to establish a more sensible approach to pain and symptom control would

require radical changes in the training of physicians and to a lesser extent pharmacists. These professionals would then have to give autonomy to those patients and their families who are now in real need of such control. Dr. Meyers thinks it is unlikely that such changes will take place in the near future, and as long as they don't, people will continue to request assisted suicide and to seek out people such as Dr. Kevorkian. If mercy death is to be allowed and legalized, then there needs to be a guarantee that it will be conducted as morally and legally as possible.

# Cases for Study and Discussion

### CASE 1 Man Trapped by Fire in His Car

A truck overturns on one of our major highways, and the engine catches on fire, engulfing the cab, where the driver is trapped. A highway patrol officer arrives on the scene and realizes that no one can get near enough to the cab to get the driver out. The driver sees the patrolman and begs the officer to shoot him so that he won't have to suffer the horror of burning to death. The officer is close enough to kill him instantly. What should he or she do?

### CASE 2 Paralyzed Brother Wanting to Die

A 24-year-old man named Robert who has a wife and child is paralyzed from the neck down in a motorcycle accident. He has always been very active and hates the idea of being paralyzed. He is also in a great deal of pain, and he has asked his doctors and other members of his family to "put him out of his misery." After several days of such pleading, his brother comes into Robert's hospital ward and asks him if he is sure he still wants to be put out of his misery. Robert says yes and pleads with his brother to kill him. The brother kisses and blesses Robert and then takes out a gun and shoots him, killing him instantly. The brother later is tried for murder and acquitted by reason of temporary insanity. Was what Robert's brother did moral? Do you think he should have been brought to trial at all? Do you think he should have been acquitted? Would you do the same for a loved one if you were asked?

### CASE 3 67 Year-Old Woman Wanting to Die

A 67-year-old woman has been sick for the last ten years with heart, lung, and kidney problems that have given her a great deal of pain and discomfort. In her own words, her life is "a misery" and "not worth living." Her children all are grown, and she lives alone with her husband, who is 68. She has talked with him on several occasions during the past two years, begging him to help her to die. She has told him that she is tired of living and that she gets no pleasure from her life anymore. On this particular morning, they discuss her life and death for four hours, and again and again she begs him to help her to die. Finally, he gives in to her wishes and takes her out to the garage, puts her in their car, turns on the engine with the garage door closed, and goes back into the house for about an hour. At the end of the hour, he takes her out of the car, calls the police, and tells them what he has done. They arrive on the scene and arrest him for murder. Did the husband do the right thing? Did the wife have the right to request this action of her husband? Did he have an obligation to satisfy her request? Should he have been arrested?

### CASE 4 Dr. Kevorkian

Dr. Kevorkian originally invented a suicide machine that he could hook up to an intravenous line that is inserted into a person's arm, so that the person can push a button or release a clamp and administer a fatal but painless dose of chemicals. More recently, he used carbon monoxide that the people can inhale until they die. Few of the people who used his machine or the carbon dioxide were terminally ill people. For example, one 43-year-old woman had just been diagnosed as having Alzheimer's disease, one had severe pelvic pain, and another had multiple sclerosis. Do you think that what he was doing was moral or immoral? Why? Would it make any difference to your decision if the people had been terminally ill? Do you agree with what was done to the doctor legally? Why or why not? If you were asked by someone you loved to help him or her die, and you had the means, like Dr. Kevorkian, to do so, what would you do? Why? Would you like doctors to have the right to assist

people in committing suicide? Why or why not? Would the people have to be terminally ill, in your opinion, or not? Why?

# MERCY KILLING

Mercy killing is similar to mercy death in the sense that it involves a direct action taken to end someone's life; the difference is that mercy killing is not done at the person's request. People who perform mercy killing may assume that the person they are going to kill wants this act to be done, but they don't know for sure, nor do they have the person's explicit request or permission to perform the act. Very often the decision to go ahead with a mercy killing is based upon a belief that the "victim's" life is no longer worth living because he or she is existing as a mere mindless organism, not as a full human being.

Therefore, **mercy killing** can be defined as the termination of someone's life, without that person's explicit consent, by a direct means, from a motive of mercy; that is, in an attempt to end suffering and/or a "meaningless" existence. Obviously, the greatest moral problem associated with mercy killing is that, as opposed to allowing someone to die mercy death, in this case the patient's consent cannot be obtained nor can his or her desires be known for sure. *Mercy killers* must come to a decision about someone else's life without the person's permission or acquiescence.

## Arguments Against Mercy Killing

Many of the arguments that have been used in relation to mercy death and allowing someone to die apply also to mercy killing. Again the main aspect that distinguishes mercy killing from the other two categories is the lack of consent on the part of the "victim."

# DIRECT VIOLATION OF THE VALUE OF LIFE PRINCIPLE.

Mercy killing is a direct violation of the value of life principle, especially because, unlike defense of the innocent, war, and capital punishment, it usually involves taking the life of an innocent person. As in the mercy death situation, the argument here is that murder is murder regardless of motive; therefore, mercy killing is nothing less than premeditated murder. This argument is even more convincing here than in the case of mercy death because in this case people either haven't given or can't give their consent to having their lives terminated.

# THE DOMINO ARGUMENT.

Because the consent of patients cannot be obtained, an outside decision about the worth, value, or meaning of their lives has to be made, and according to this argument against mercy killing, this sets a dangerous precedent. In the first place, who has the right to decide whether any person's life is worthy, has value, or is meaningful? What standards are to be used when making such a decision? Won't the sanctioning of such an action set a dangerous precedent for the elimination of old, senile people, for example, because they may be considered ***useless*** by a youth-oriented society? Can we allow such decisions to be made? If so, by whom should they be made? This is certainly one of the more serious problems related to mercy killing, and it is one that does not affect either allowing someone to die or mercy death to so great an extent. In both of the latter cases, the individual decides what the worth of his own life is, whereas in mercy killing one person decides for another.

# THE POSSIBILITY OF FINDING CURES.

Both this argument, which states that mercy killing should not be authorized because cures may be found, and the criticism of this argument are the same as those for allowing someone to die and mercy death.

# Arguments for Mercy Killing

## MERCY FOR THE "LIVING DEAD."

The main argument for mercy killing is that it is not a violation of the value of life principle because in most cases the people killed are not fully alive as human beings; rather, they are existing as mere organisms, a network of organs and cells. It is an act of mercy, a proponent of mercy killing might argue, to end the life of those people, who, although not brain dead, have suffered 80 percent brain damage. Even if such people recover from their comas, the damage to their brains is so extensive that their lives will never again be normal. They will have a plantlike existence, exhibiting no personality or real human consciousness whatsoever; therefore, it is an act of mercy to end their existence.

The main criticism of this argument is that one actually is murdering such people. Because they cannot be declared dead under any acceptable medical or legal criteria, a dangerous precedent is set when someone is sanctioned to directly end their lives. It is one thing to allow them to die by refusing to use any extraordinary means to save them if they are attacked by pneumonia or kidney or heart failure; it is quite another, however, to directly murder them, even out of a motive of mercy.

## FINANCIAL AND EMOTIONAL BURDENS.

People with extensive brain damage, along with many other sick and injured people, are financial and emotional burdens upon their families and on society. Such burdens often are tremendous, and, some argue, they serve no significant purpose because patients in such situations gain absolutely nothing from their maintenance except the continuation of what is assumed to be a minimal and worthless existence.

The main criticism of this argument is that finances should not be a determining factor where human life is concerned. It is true that the emotional burden often is difficult to bear, but here again we should not sanction the sacrifice of one human life simply to ease the emotional burden upon another.

## THE PATIENT'S DESIRE TO DIE.

Another argument for mercy killing is that if patients with brain damage could communicate with us, they would say that they would rather be killed than linger on as burdens to their families and society or to exist as organisms without consciousness.

The main criticism here, however, is that we cannot *know* any of this for certain because the patients cannot communicate. It is possible that advance directives could be revised so as to include mercy killing as well as allowing someone to die, but it might be very difficult to get such documents legalized. Faced with such a directive, the state probably would feel that it had the obligation to preserve and protect human life rather than authorize the execution of innocent people, regardless of the status of their existence.

## THE POSSIBILITY OF ESTABLISHING LEGAL SAFEGUARDS.

One of the strongest arguments against both mercy death and mercy killing is that if such actions were sanctioned they undoubtedly would be abused. For example, if it were legal to perform mercy killing on people who had reached a certain point in their illness or a certain age, wouldn't such a law invite abuse by people who wanted such things as organs to transplant, inheritances, or the elimination of personal financial burdens, and couldn't it become an instrument of revenge or of other motives usually connected with killing that is not "mercy" oriented? As we have seen, it is possible to establish safeguards similar to those that have been suggested for mercy death or assisted suicide.

The main criticism of this argument is that although most of these safeguards provide for mercy death, few of them would be of any use in protecting people against mercy killing against their wills. Any legislation that would give power to the state or to certain individuals to take the lives of those who were too "unworthy" or too "useless" to live would be extremely hard to enforce, and there would be little protection for helpless, innocent human lives.

# Cases for Study and Discussion

### CASE 1 Abortion Baby Born Alive

A doctor who was performing a legal abortion on a woman five months pregnant noticed that the "aborted fetus" actually was alive, so he held the fetus's head inside the woman's vaginal canal until the fetus suffocated. The doctor's thinking was that the fetus was intended to be killed or born dead during the abortion, and that its being born alive was an error that could result in an unwanted or deformed child. Therefore, he felt that he had performed an act of mercy. What do you think about the doctor's action?

### CASE 2 Sister Pulls the Plug on Her Sister

Laura, a 19-year-old woman, fell into a coma because of an overdose of drugs and alcohol. She was given emergency treatment at a hospital and was placed on a respirator, which stabilized her breathing. She remained in a deep coma, and when she was tested by neurologists and neurosurgeons it was discovered that about 70 percent of her brain was irretrievably damaged. She was not brain dead, however: She reacted to pain, her eyes sometimes would open and her pupils contract, she would at times thrash about, and her EEG showed some brain activity. She was in a PVS. Because she could not be pronounced dead in any medical or legal sense, the hospital and doctors refused to take her off the respirator or to stop any other treatments they were giving her. At one point Laura's sister was alone in the room with her and, thinking that Laura wouldn't want to live on in this way, she disconnected the respirator and caused her sister's death. Discuss in detail your reactions to the sister's decision.

### CASE 3 Tay-Sachs Diseased Child

Before much was known about **Tay-Sachs disease**, Betty and Irv, a young Jewish couple, gave birth to a son who had this disease. They were told by their doctor that the boy would become very sick and slowly degenerate over a period of about a year, and then he would become blind and suffer convulsions. They were also told that there is absolutely no cure for the disease and that their son was sure to die. After watching the child for about six months, Irv was not able to stand it any longer. He put a pillow over his son's face and suffocated him. Under these circumstances, do you feel that Irv was justified in performing a mercy killing? The couple wanted another child. Given that they have a one-in-four chance to produce another Tay-Sachs child, what should they do?

### CASE 4 A 75-Year-Old Man Shoots His Wife Who Has Alzheimer's Disease

A 75-year-old man in Florida, a state containing many retired and sick senior citizens, shot his wife twice in a mercy killing. The wife was suffering from Alzheimer's disease and osteoporosis (a degenerative bone disease). The couple was well off because the husband was a retired engineer. He had hired several women to care for his wife, who often was disoriented, irritable, and confused. The wife did not deal well with these women and was constantly embarrassing her husband by showing up in public, sometimes half-dressed and confused. One day she sought him out at a condominium owners' meeting and was particularly confused and troublesome. He took her back to their condominium and sat her down on a couch. He then picked up a pistol he owned and shot her in the back of the head once and then a second time because he thought she might still be alive. The man was arrested for murder in the first degree, tried, convicted, and sentenced to a minimum of 25 years in prison (Florida law for a first-degree murder conviction).

Several points about this case should be noted:

- **1.** There was no evidence that his wife had asked for death, nor that he had asked her if that was what she had wanted.
- **2.** He showed very little remorse in court, stating that he believed he had acted morally.
- **3.** The prosecuting attorney stated that the husband's sentencing was correct because allowing him to go unpunished would set a dangerous precedent in Florida: Any time confused or sick old people become hard to care for or deal with, someone could mercy kill them with impunity.
- **4.** Despite being well off, at no time did the husband look into or attempt to place his wife in one of the many facilities established to care for Alzheimer's patients.

Because the husband was 75 and not well, many people, including his daughter, thought that his sentence should be commuted or that he should be pardoned because he would probably die in prison. His case was referred to a commission appointed by the governor to make recommendations concerning the husband's situation, but the commission ruled that he should remain in prison. Several years later the governor commuted his sentence, and he is now out of prison. Do you think that what the husband did was moral or immoral? Why? Do you think this case was handled correctly? Why or why not? Do you feel that the husband should have been prosecuted at all? Why or why not? Do you feel that he tried all available alternatives before killing his wife? If not, what should he have done? Do you think his sentence should have been commuted or not? Why? How is this case different from the preceding cases we looked at in the mercy death section of this chapter? Are the other cases more justifiable than this one? Why or why not?

# Chapter Summary

- **I.** Definition of terms
  - a. ***Euthanasia*** is a confusing and ambiguous term because it is subject to emotionalism. The word originally meant **"a good death."** More recently it has come to mean **"mercy killing."**
  - b. Because this term is so confusing, it has been replaced in this book by three phrases: **"allowing someone to die," "mercy death,"** and **"mercy killing."**
  - c. **Allowing someone to die** involves both not starting curative treatment when no cure is possible and stopping treatment when it is no longer able to cure a dying patient. It means allowing a dying patient to die a natural death without any interference from medical science and technology.
  - d. **Mercy death** is the taking of a direct action to terminate a patient's life because the patient has voluntarily requested it—essentially an assisted suicide.
  - e. **Mercy killing** is the taking of a direct action to terminate a patient's life without his or her permission.
  - f. It should be noted that neither mercy death nor mercy killing is legal in the United States or in most countries throughout the world.
  - g. **Brain death** occurs when a patient has a normal heartbeat and normal respiration but has suffered irreversible and total brain damage.
    - 1. The criteria for brain death are unreceptivity and unresponsiveness, no spontaneous movements or breathing, no reflexes, and a flat EEG.
    - 2. When patients are declared brain dead, removing life-support equipment or stopping treatment obviously cannot be the cause of their death, so this does not constitute allowing someone to die, mercy death, or mercy killing.
  - h. A **persistent vegetative state (PVS)** results from damage to the cerebral cortex, or neo-cortex, which controls the cognitive functions. A PVS patient is not brain dead but lacks, and will permanently lack, even those minimal functions that make a life human.
- **II.** **Allowing someone to die**
  - A. This problem has become more crucial in the twenty-first century because of the availability of advanced lifesaving and life-supporting technology and procedures.
  - B. There are a number of arguments against allowing someone to die.
    - 1. Some say it is tantamount to abandoning a dying person, though this need not be the case if we distinguish carefully between the "curing and healing" and "comforting and caring for" aspects of medicine.

        - 2. Cures may be found or miracle cures may occur.
        - 3. We can never choose death over life—we can never opt for death. Medicine must save lives, not end them. There is a difference, however, between accepting death as inevitable and choosing it.
        - 4. Some argue that allowing someone to die interferes with God's divine plan. One also can ask, however, which constitutes interference with God's plan: allowing someone to die when his or her time has come or prolonging the person's death? The argument can be used to support either side.
    - C. There are a number of arguments for allowing someone to die.
        - 1. Individuals have rights over their own bodies, lives, and deaths. One also can argue, however, that their freedom is not unlimited.
        - 2. Patients have the right to refuse treatment, and we should not overrule this right—treatment often will not cure a particular patient, and sometimes it is worse than the disease.
        - 3. Allowing someone to die will shorten suffering; however, it also will shorten the person's life.
        - 4. Patients have the right to die with dignity. The phrase **"dying with dignity,"** however, can cover up abandonment, mercy death, and mercy killing.
    - D. **Extraordinary means** to keep people alive are those that involve a grave burden for oneself or another, and they vary according to circumstances involving persons, places, times, and cultures. Such measures as radical surgery, radiation therapy, respirators, and heart machines probably fall into this category when they are used merely to prolong dying.
    - E. **Ordinary means** also are difficult to define, but for terminally ill patients they would include controlling pain and other symptoms as opposed to performing radical surgery or using respirators or heart machines.
    - F. ***Appropriate*** or ***inappropriate*** care are perhaps more suitable terms than ***ordinary*** and ***extraordinary*** due to the confusion surrounding the latter terms. Thus, people could decide what would be appropriate or inappropriate care depending upon the particular situation of a patient.
    - G. **The Patient Self-Determination Act (PSDA)**, effective December 1991, was passed with a view to giving patients a number of rights:
        - 1. The right to considerate and respectful care.
        - 2. The right to make decisions involving their health care, including the following:
            - a. The right to accept or refuse treatment.
            - b. The right to formulate advance directives and appoint a surrogate to make health care decisions on their behalf.
        - 3. The right to acquire the information they require to make treatment decisions.
    - H. **Advance directives**.
        - 1. Three cases, the Quinlan, Cruzan, and Schaivo cases, were instrumental in raising the consciousness of many people concerning the need for advance directives.
        - 2. Various directives have been the living will and health care proxy, the natural death act declaration, and the durable power of attorney for health care (DPAHC).
- **III.** The **hospice approach** to care for the dying can solve most of the problems surrounding allowing someone to die, and often it can eliminate the necessity for mercy death and mercy killing.
    - 1. There is an emphasis upon comforting and caring for patients rather than upon curing and healing them.
    - 2. The team approach is utilized to provide support for patients and their families.
    - 3. Hospices take a unique approach to pain and symptom control.
        - a. They recognize the difference between acute and chronic pain.
        - b. They recognize that pain has four levels—physical, mental or emotional, sociological, and spiritual—and they attempt to treat all four levels.
        - c. They utilize the preventive rather than the reactive approach to pain control.
    - 4. They utilize outpatient and home care wherever possible, using the team approach to provide all levels of support.
    - 5. Where this is not possible, hospices provide homelike, humanized inpatient care in comfortable surroundings.

- 6. They attempt to provide freedom from financial worry for patients and their families.
- 7. They provide bereavement counseling before, during, and after a patient's death.
- 8. This approach allows patients to experience a natural death in peace and dignity while receiving support from their families, friends, the medical community, and society in general.
- 9. This approach also obviates most of the need for mercy death and mercy killing, at least so far as it concerns suffering, terminally ill patients.

- **IV. Mercy death** (voluntary dying or assisted suicide)
  - A. The arguments against mercy death are much like those used against suicide except that in the case of mercy death the issue is further complicated by the fact that someone else has to do the killing.
    - 1. The argument of irrationality has less force here than in the case of suicide because of the patients' pain and suffering and because they are going to die soon anyway. However, one can legitimately ask whether patients in extreme pain and suffering can ever be rational in choosing death.
    - 2. The religious argument remains the same except that the situation is further complicated by the fact that someone else has to do the killing; the mercy motive, it is argued, does not justify murder.
    - 3. The domino argument has additional force in that if mercy death is allowed, mercy killing may soon follow.
    - 4. The justice argument in this case involves the guilt and other negative feelings of the person who has to do the killing, and it also involves the burden of guilt placed on family members because they couldn't do anything to prevent their loved one from wanting to die.
    - 5. That a cure may be found is another argument presented here.
    - 6. One can argue that the hospice alternative has eliminated the need for mercy death; however, some patients may not want any treatment, hospice treatment included, and therefore it can be argued that they should be allowed to choose death.
  - B. The arguments for mercy death are much like those for suicide.
    - 1. Patients should have the freedom to decide about their own deaths, and the person who performs the act merely carries out the patient's wishes.
    - 2. We do the same for dumb animals, and we owe our fellow humans at least as much consideration and mercy.
  - C. Changes in attitude toward mercy death.
    - 1. Events reflecting a change in attitude:
      - a. Active advocates for mercy death, such as Derek Humphry and Dr. Jack Kevorkian
      - b. Court decisions of two circuit courts of appeals and the Oregon law
      - c. Lack of autonomy of patients in medical care
      - d. Health care personnel who have practiced forms of assisted suicide
      - e. Strong desire for greater autonomy and control over one's life and death
    - 2. Suggested safeguards for mercy death
      - a. Those in the Oregon law
      - b. Those proposed by Dr. Christopher Meyers
      - c. O. Ruth Russell's safeguards
    - 3. Evaluation of safeguards:
      - a. Law should be permissive, not mandatory.
      - b. There should be a written request.
      - c. There should be a waiting period.
      - d. There should be counseling.
      - e. More than one doctor should be involved.
      - f. Abuse of safeguards should be a criminal offense.
      - g. Assisted suicide should be painless.
      - h. Other possible safeguards include having a courtroom judge or commissioner or a panel hear the request and its evidence.

- **V.** Mercy killing
  - A. **Mercy killing** is the termination of someone's life without that person's explicit consent by a direct means out of a motive of mercy.

- B. There are several arguments against mercy killing.
  - 1. It is a direct violation of the value of life principle—murder is murder, regardless of motive.
  - 2. Because the consent of patients cannot be obtained, mercy killing involves an outside decision about the worth of their lives and sets a dangerous precedent for eliminating others who may be considered "useless" to society. Who should be entrusted with decisions concerning the worth of people's lives?
  - 3. Cures may be found, or patients may come out of deep comas; if we kill them, we eliminate these possibilities.
- C. There are several arguments for mercy killing.
  - 1. We are not violating the value of life principle because most of those who undergo mercy killing are not fully alive human beings; rather, they are mindless organisms.
  - 2. The longer people continue to "merely exist," the greater the financial and emotional burdens on the family and on society.
  - 3. If patients in such situations could make their wishes known, they would say that they wanted to die. The only trouble with this argument is that we cannot know this for sure because the patients cannot communicate with us.
  - 4. Legal safeguards can be clearly established so as to prevent abuses of legalized mercy killing.

## Ethics Problem *Did Medical Personnel Kill Patients in the Aftermath of Hurricane Katrina?*

Were dozens of patients' deaths the result of mercy killings at New Orleans Memorial Medical Center? The ferocious hurricane plus poor responses from city, state, and FEMA officials led to a disastrous evacuation of the medical facility. According to one news source, "By the third day without water, sanitation and power to run medical equipment; dwindling food supplies; and temperatures reaching 110 degrees, caregivers began debating among themselves about euthanasia."[19] The hospital was surrounded by flood waters, and many of the patients and staff were evacuated by helicopter or boat. The sickest patients were left behind with staff who planned to stay until help arrived. But help was not forthcoming, and those in the hospital were on their own. It has been alleged that doctors and nurses administered lethal doses of medication to up to 34 people in the aftermath of Katrina. Legally, this is second-degree murder.

What should be done in cases of forced abandonment? What obligations do doctors have to patients? If indeed these were mercy killings, given the circumstances, did the doctors and nurses act compassionately or did they kill their patients? Review the sections on mercy death and mercy killing, and do an Internet search on the Katrina situation. Take a position on this issue, have reasons to support your views, and discuss.

## Views of the Major Ethical Theories on Allowing Someone to Die, Mercy Death, and Mercy Killing

Describe as fully as you can how each of the major ethical theories—ethical egoism, utilitarianism, divine command theory, Kant's duty ethics, Ross's *prima facie* duties, and virtue ethics—probably would deal with the moral issues of allowing someone to die, mercy death (assisted suicide), and mercy killing.

"Assisted Suicide: Pro-Choice or Anti-Life?" Richard Doerflinger,

"Death and Dignity: A Case of Individualized Decision making," Timothy E. Quill, M.D.

## Critical Thinking Questions

- 1. From ancient times philosophers have taught that living a good life entails that one close his or her life well. In the light of modern medical technology do you believe that Advance Directives help people control their final days and hours and end their lives with dignity? Discuss the above statement.
- 2. Analyze if physicians should assist patients with suicide. Give reasons for your answer.
- 3. Is mercy killing morally justified? Give reasons for your answer.
- 4. How did the court justify the decision to remove Karen Ann Quinlan from the respirator? After Quinlan was taken off life-support she lived for 10 years in a persistent vegetative state. Do you think the court would have made the same decision had they known the result? How will this judgment affect the judgment of similar cases in the future?
- 5. Why have dramatic advances in medicine forced us to take an increasingly harder look at allowing someone to die, mercy death, and mercy killing? Substantiate your answer with specific examples.
- 6. Discuss if mercy death is significantly different from mercy killing. Or, in certain situations is mercy killing morally preferable? Give reasons for your answer.
- 7. Analyze one of the issues dealing with allowing someone to die utilizing one of the major ethical theories. Evaluate the same issue according to a different moral theory. Did you reach the same conclusions? Can contradictory views be morally justified from different ethical perspectives? How can moral disagreement on important issues be resolved? Explain your answer.

# Notes

1. From a presentation given by Dr. Lamerton, M.D., at Bakersfield College, April 10, 1975.

2. David Kaplan, “Is It a Wonderful Life?” *Newsweek* (April 15, 1996), 62.

3. Ibid.

4. Henry K. Beecher et al., “A Definition of Irreversible Coma,” *Journal of the American Medical Association* 205, no. 6 (August 1968), 85–88.

5. John Behnke and Sissela Bok, *The Dilemmas of Euthanasia* (Garden City, NY: Anchor Books, 1975), 157–59.

6. Pope Pius XII, “The Prolongation of Life,” *Pope Speaks* 4 (1958), 393–98.

7. Peter Annin and Marc Peyser, “A Father’s Sorrow,” *Newsweek* (September 2, 1996), 54.

8. *The Bakersfield Californian* (October 2003), A5.

9. Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* (Briarcliff Manor, NY: Stein and Day, 1978), 221–29.

10. *The Bakersfield Californian* (December 7, 2005), A13.

11. Ibid.; Kaplan, “Is It a Wonderful Life?”

12. Richard Lamerton, “Euthanasia,” *Nursing Times* (London), February 21, 1974.

13. David Scheff, “Playboy Interview with Derek Humphry,” *Playboy* (August 1992), 49–144.

14. *The Bakersfield Californian* (February 18, 1999), A3.

15. Christopher Meyers, *The Bakersfield Californian* (April 28, 1996), B7.

16. Ellen Goodman, *The Bakersfield Californian* (April 12, 1996), B4.

17. Meyers, *The Bakersfield Californian,* B7.

18. O. Ruth Russell, “Moral and Legal Aspects of Euthanasia,” *The Humanist* 34 (July–August 1974), 22–27. See also Russell’s *Freedom to Die: Moral and Legal Aspects of Euthanasia* (New York: Human Sciences Press, 1975).

19. ‘‘Euthanasia in Katrina Aftermath?” World Net Daily, October 13, 2005. www.wnd.com/?pageId=32833.