
Euthanasia Considered: Professional Paternalism or Individual Freedom?

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EUTHANASIA CONSIDERED: PROFESSIONAL PATERNALISM OR INDIVIDUAL FREEDOM? EUTHANASIA: THE MORAL ISSUES. Edited by Robert M. Baird and Stuart E. Rosenbaum. Buffalo: Prometheus Books. 1989. Pp. 182. \$13.95.

*Reviewed by Michael S. Jacobs**

The relatively recent capability of medical technology to prolong human existence has posed a battery of difficult questions for society, ethicists, doctors, and lawyers. These questions are made even more difficult by the profound changes that have recently occurred both in the law and in medicine. For example, only nineteen years have passed since the first clear judicial recognition of the importance of informed consent as a precondition of medical treatment,¹ only twenty-four years since the first successful human heart transplant,² and only twenty-six years since the establishment of the federal Medicare³ and Medicaid⁴ programs.

One of the most troublesome of the new order of problems posed by the development of life-prolonging medical technology is whether individuals motivated only by humane concerns may ethically and lawfully permit, or even help to bring about, the death of one who is suffering greatly. We wonder, in other words, whether euthanasia is a moral and/or legal act.

"Euthanasia," a word derived from the combination of the Greek words *eu* ("good" or "easy") and *thanatos* ("death"), literally means "easy death."⁵ In

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1. See *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

2. On December 3, 1967, in Capetown, South Africa, Dr. Christiaan Barnard performed the first human heart transplant on Louis Washkansky, a 55-year-old grocer. Altman, *4,000 in U.S. Now Live with Another's Heart*, N.Y. Times, Dec. 1, 1987, at C3, col. 1. Mr. Washkansky survived for 18 days. *Id.* In 1987, the *New York Times* reported that an estimated 4000 Americans were living with someone else's heart and that surgeons were performing heart transplants in 95 American medical centers at an estimated rate of 1600 to 1800 per year. *Id.* As of that time, the longest living survivor of a heart transplant was Emmanuel Vitria of Marseilles, France, who lived for 18 ½ years after his operation. *Id.*

3. 42 U.S.C. §§ 1395-1395ccc (1988) (Medicare portion of the Social Security Act).

4. 42 U.S.C. §§ 1396-1396s (1988) (Medicaid portion of the Social Security Act).

5. WEBSTER'S NEW WORLD DICTIONARY 469 (3d ed. 1988); Koop, *The Right to Die: The Moral Dilemma*, in EUTHANASIA: THE MORAL ISSUES 69 (R. Baird & S. Rosenbaum eds. 1989). Webster's dictionary defines euthanasia as "an easy and painless death" or "an act or method of causing death painlessly, so as to end suffering; advocated by some as a way to deal with persons dying of incurable, painful diseases." WEBSTER'S NEW WORLD DICTIONARY, *supra*, at 469. The Euthanasia Society of America defines the term as "the termination of life by painless means for the purpose of ending severe physical suffering." Koop, *supra*, at 69.

general, advocates of euthanasia believe that for some terminally ill people, life holds so much pain and so little pleasure that an easy death—caused perhaps by an intentional overdose of barbiturates⁶—is clearly preferable to a prolonged and agonizing end of life.⁷ Opponents of euthanasia seem to fall broadly into two camps. Some believe that life is sacred and should be ended only by an act of divine providence, never by one of human will.⁸ Others claim, in more secular fashion, that if euthanasia were permitted, it could never be adequately controlled.⁹ Given our inability to eliminate conflicts of interest (between or among family members, medical personnel, and the patient) or to define fairly the critical terms (such as “terminally ill,” “so much pain,” or “so little pleasure”), we would cheapen human life by arrogating to ourselves the undefined power to end it.¹⁰

Two important distinctions are relevant to the euthanasia debate. The first is between active and passive euthanasia—that is, the distinction between overtly killing on the one hand, and permitting death on the other.¹¹ As the term implies, active euthanasia involves an explicit act, such as the injection of a lethal dose of a drug, on the part of someone—a physician for example—that leads directly to the patient’s death.¹² Passive euthanasia occurs

6. See Admiraal, *Justifiable Active Euthanasia in the Netherlands*, in EUTHANASIA: THE MORAL ISSUES 127 (R. Baird & S. Rosenbaum eds. 1989) (describing the Dutch practice of using a combination of barbiturate and curare to hasten death).

7. E.g., Rachels, *Active and Passive Euthanasia*, in EUTHANASIA: THE MORAL ISSUES 46 (R. Baird & S. Rosenbaum eds. 1989); Vaux, *Debbie's Dying: Mercy Killing and the Good Death*, in EUTHANASIA: THE MORAL ISSUES 30 (R. Baird & S. Rosenbaum eds. 1989).

8. E.g., Koop, *The Case of Karen Quinlan*, in EUTHANASIA: THE MORAL ISSUES 42 (R. Baird & S. Rosenbaum eds. 1989).

9. E.g., Gay-Williams, *The Wrongfulness of Euthanasia*, in EUTHANASIA: THE MORAL ISSUES 101 (R. Baird & S. Rosenbaum eds. 1989); Shewmon, *Active Voluntary Euthanasia: A Needless Pandora's Box*, in EUTHANASIA: THE MORAL ISSUES 130 (R. Baird & S. Rosenbaum eds. 1989) (“[T]his particular ‘slippery slope’ is not merely a theoretical possibility; it is a present reality.”).

10. E.g., Gay-Williams, *supra* note 9, at 101 (Euthanasia “could have a corrupting influence so that in any case that is severe doctors and nurses might not try hard enough to save the patient.”).

11. EUTHANASIA: THE MORAL ISSUES 10 (R. Baird & S. Rosenbaum eds. 1989) (editors’ introduction).

12. *Id.* This distinction has been set forth by the Judicial Council of the American Medical Association (“AMA”) in its *Report on the Physician and the Dying Patient*, a report accepted by the AMA at its Clinical Convention in December, 1973. The relevant section of the report states:

The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

AMA Grams, 227 J. A.M.A. 728, 728 (1974) (quoting JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, REPORT ON THE PHYSICIAN AND THE DYING PATIENT (1973)).

Some have criticized this distinction between active and passive euthanasia. See Rachels, *supra* note 7, *passim* (arguing that active euthanasia should be treated the same as passive euthanasia because allowing someone to die is just as bad—and sometimes more painful—than overtly killing

where the care giver deliberately fails to take steps that are necessary to prolong life, such as by failing to resuscitate a patient whose heart has stopped beating.¹³

The second distinction is between voluntary and involuntary euthanasia. Logically enough, voluntary euthanasia occurs when the patient explicitly consents to his or her death.¹⁴ On the other hand, involuntary euthanasia occurs when someone other than the patient makes the decision about the patient's death.¹⁵ Thus, allowing a comatose patient to die would be involuntary euthanasia unless, before he had become comatose and while still competent, that patient had made it clear that he wished to die should he ever fall into a permanent coma.

Surprisingly, perhaps, a significant percentage of Americans seems to favor active, voluntary euthanasia for the terminally ill.¹⁶ In March of 1988, the Roper Organization asked almost two thousand people whether a physician should lawfully be able to end the life of a terminally ill patient who requests it.¹⁷ Fifty-eight percent of those polled answered affirmatively, while only twenty-seven percent were opposed to the idea (with fourteen percent undecided).¹⁸ The same question put to a similar group by Roper in 1986 yielded almost the same set of responses: sixty-two percent in favor, twenty-seven percent against, and ten percent undecided.¹⁹ The results of these polls seem even more remarkable in light of the fact that the question asked by Roper did not describe the hypothetical terminally ill patient either as suffering or as being in great pain.²⁰

Perhaps the findings of the Roper Organization are not so surprising as they might appear. Roper's poll failed to provide its subjects with definitions of the words "terminally ill," "end the life," or "requests," thereby avoiding all of the thorny terminological problems that cause a good portion of the euthanasia debate. Moreover, there are much more difficult questions that can be

him).

13. EUTHANASIA: THE MORAL ISSUES, *supra* note 11, at 10.

14. *Id.* at 11.

15. *Id.*

16. *70% in Study Would Halt Life-Support if Terminal*, Chicago Sun-Times, March 28, 1991, at 6, col. 2 (reporting that doctors at two Boston hospitals found that 70% of the people surveyed would decide against life-sustaining treatment if they were "gravely ill and incompetent to speak for themselves").

17. ROPER ORGANIZATION, THE 1988 ROPER POLL ON VOLUNTARY EUTHANASIA 1 (1988) (copy on file in the offices of the DePaul Law Review).

18. *Id.*

19. *Id.*

20. *Id.* The Roper Organization asked:

Question: There is a great deal of discussion these days about the conflict between a doctor's moral obligation to a terminally-ill patient and the doctor's responsibility under the law. When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?

Id. (emphasis omitted).

asked about euthanasia than the question posed by Roper; questions that might perplex society every bit as much as they vex the doctors, lawyers, and ethicists who are increasingly required to find answers for them.²¹

How, for example, should a physician respond to a competent patient who, though severely and permanently disabled and in great and continuous pain, is not "terminally ill" but, nevertheless, requests the physician's assistance in ending his life? What should be done when one person requests physician assistance in ending the life of another person who is terminally ill but incompetent, such that his wishes about euthanasia were either not made known at all or were voiced only vaguely or ambiguously? What is the ethical response to the request of a parent who asks that certain lifesaving surgery not be performed on his newborn child, who will certainly die without the surgery, but whose physical and mental condition, even with successful surgery, will always be drastically compromised?

These are some of the difficult questions dealt with in *Euthanasia: The Moral Issues*.²² In nineteen separate essays, a distinguished assortment of physicians and philosophers provides a relatively broad perspective on cross-cultural approaches to euthanasia,²³ and on the utility of drawing distinctions between active and passive euthanasia on the one hand,²⁴ and between voluntary and involuntary euthanasia on the other.²⁵ These essays also focus on the moral differences between euthanasia for the adult patient and euthanasia for the infant or child.²⁶ Most of the essays are thoughtful, cogently argued, and

21. See Koop, *supra* note 5, at 70 (posing some perplexing questions now at issue in the euthanasia debate).

22. EUTHANASIA: THE MORAL ISSUES (R. Baird & S. Rosenbaum eds. 1989).

23. One of the essays, *Justifiable Active Euthanasia in the Netherlands*, by Pieter Admiraal, a Dutch physician, describes the practice in Holland of using a combination of barbiturate and curare to hasten the deaths of patients "who are in the terminal phase of an incurable, usually terminal disease." Admiraal, *supra* note 6, at 127. This practice is widely accepted in Holland—5000 patients per year are helped to die in this fashion—but it is not legal. An informal agreement has developed between Dutch prosecutors and the medical community that no prosecutions will be brought so long as certain defined guidelines have been followed by the physicians. *Id.* at 125.

Another essay, *Conclusions of a British Medical Association Review of Guidelines on Euthanasia*, sets forth in detail the position of the British Medical Association ("BMA"), the British analogue to the AMA, opposing euthanasia. The AMA's formal position, opposing active euthanasia, is described at several points in the book. *E.g.*, EUTHANASIA: THE MORAL ISSUES, *supra* note 11, at 11.

24. The editors' introduction to the essays describes the difference between active and passive euthanasia as the difference "between overtly killing and 'letting die.'" EUTHANASIA: THE MORAL ISSUES, *supra* note 11, at 10. In more practical terms, the difference might be described as that between administering a fatal overdose to one terminally ill patient and deciding not to resuscitate another.

25. The editors characterize voluntary euthanasia as involving "explicit consent by the patient" and involuntary euthanasia as involving "a decision for death by a person or persons other than the patient." *Id.* at 11.

26. See Englehardt, *Ethical Issues in Aiding the Death of Young Children*, in EUTHANASIA: THE MORAL ISSUES 141 (R. Baird & S. Rosenbaum eds. 1989).

useful in outlining the large moral dilemmas inherent in the euthanasia debate.²⁷

The book suffers, however, from its almost exclusive focus on the physician's perspective about the crucial moral dilemmas and from its complete lack of attention to the legal system's responses to them.²⁸ A comparison of the legal and medical perspectives would not only have been useful, but philosophically instructive as well. Thus, while many physicians no doubt recognize, and act upon, the importance of patient autonomy, the profession itself and many individual physicians believe strongly in the value of a paternalistic beneficence that periodically argues in favor of overriding the wishes of even the competent patient when medical treatment not desired by that patient could provide him with some distinct physical benefit.²⁹

27. The unfortunate exceptions to this standard are the two essays written by C. Everett Koop, the former Surgeon General of the United States. The first Koop essay, *The Case of Karen Quinlan*, was itself taken from a book by Dr. Koop written in 1976. See C. KOOP, *THE RIGHT TO LIVE; THE RIGHT TO DIE* 102-11 (1976). Using Koop's intensely personal and Christian view of life as its major point of reference, the essay praises the Superior Court's decision in *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (1975), modified, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976), denying the Quinlans' request to have Karen removed from her respirator. Koop, *supra* note 8, at 39. Koop's level of legal discourse was not only very unsophisticated but also was almost immediately outdated; on March 31, 1976, the New Jersey Supreme Court modified the Superior Court in the landmark case of *In re Quinlan*, 70 N.J. 10, 55, 355 A.2d 647, 671-72, cert. denied, 429 U.S. 922 (1976).

Koop's second essay, *The Right to Die: The Moral Dilemmas*, also taken from his book, argues in part that the moral dilemmas are amenable to religious solutions. Koop, *supra* note 5, at 80. Such an argument largely forecloses further debate, especially among those who do not share Dr. Koop's convictions.

28. In their introduction to the book, the editors pay lip service to the importance of the law in the larger debate about euthanasia. EUTHANASIA: THE MORAL ISSUES, *supra* note 11, at 10 ("law and morality are so intertwined . . . [that] [t]he legal issue . . . is never far in the background"). But with the exception of Dr. Koop's tortured interpretation of the *Quinlan* case, none of the essayists attempt to deal seriously with any of the important legal questions.

29. Koop, *supra* note 5, at 73; Duffy, Makovsky, Roberts, Sheets, Yalowitz, Cumming-Bruce, Sheler & Boroughs, *A Very Chilling Bedside Manner*, U.S. NEWS & WORLD REP., June 18, 1990, at 10, 10.

The recent dismissal of first degree murder charges against Dr. Jack Kevorkian, whose makeshift "suicide machine" was used by Janet Adkins to end her life, dramatically highlighted some of the profound ethical tensions raised for the medical profession by the issue of assisted suicide, which is perhaps the most extreme recognition of patient autonomy. See Wilkerson, *Prosecutors Seek to Ban Doctor's Suicide Device*, N.Y. Times, Jan. 5, 1991, § 1, at 6, col. 5. Mrs. Adkins suffered from Alzheimer's Disease, but, according to her personal physician, she was in a relatively early stage of the disease process, L.A. Times, Jan. 5, 1991, part A, at 26, col. 3, was physically fit and in good spirits, Wilkerson, *supra*, at 6, col. 5, and could have lived another seven to ten years if she had not taken her own life. L.A. Times, *supra*, at 26, col. 3. Her personal physician was convinced that because of her disease, Mrs. Adkins was not competent to choose suicide; he also believed that she was not terminally ill. Wilkerson, *supra*, at 6, col. 5. To Dr. Kevorkian and others, however, Mrs. Adkins was indeed competent. She had tried and rejected experimental drug treatment for her disease, was aware that the disease was progressing, and knew that she faced a future of severe dementia and disorientation. For her, Dr. Kevorkian's machine was a means to achieve the painless death that she sought. *Id.*

By contrast, the approach of the legal system has been decidedly more concerned with patient autonomy. It is clear, for example, from a growing and definitive body of case law, that competent persons have the right to refuse treatment initially, discontinue treatment already undertaken, and decline even lifesaving treatment.³⁰ These cases, while satisfactory in dealing with the rights of competent patients, do not provide adequate answers to the questions pertaining to incompetents. From the legal perspective, these are currently the most troubling questions. Who, if anyone, should be allowed to speak for the incompetent patient? What should be done when family members, usually the surrogate of first resort for the incompetent, disagree about whether, or how much, to treat the patient? What evidence, if any, of the patient's wishes—expressed during an earlier, competent time—should be heard? Is there any person or institution sufficiently free from conflicts of interest to whom the law can comfortably look for an objective opinion about prolonging an incompetent's life?³¹

Especially with respect to this last question, few doctors appear to realize the conflicts inherent in their professional role. Doctors are taught to save lives, not to end them; they are instructed in the benefits of using new technology, not in the benefits of forgoing its use; and they are encouraged by society

30. Last Term, the Supreme Court decided *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990), a case involving the constitutionality of a Missouri statute requiring a surrogate seeking to withdraw life-sustaining treatment from his terminally ill and incompetent ward to prove by "clear and convincing evidence" that the ward, if competent, would have agreed with that decision. *Id.* Before ruling on the incompetent person's rights, the Court recognized that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 2851 (emphasis added); accord *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300-01 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 193-94, 209 Cal. Rptr. 220, 224 (1984); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 430, 497 N.E.2d 626, 633 (1986); *In re Conroy*, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985); *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981).

In theory, the right of a competent person to refuse medical treatment is not absolute. In *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), the Massachusetts Supreme Court identified four "countervailing State interests" that could overcome a patient's choice: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." *Id.* at 741, 370 N.E.2d at 425. Saikewicz himself was an incompetent, mentally retarded patient, but those four interests have been mentioned in other cases involving competent patients, although in none of these cases have they been found sufficient to overcome the choice of a competent patient. *E.g.*, *Bouvia*, 179 Cal. App. 3d at 1142, 225 Cal. Rptr. at 304; *Bartling*, 163 Cal. App. 3d at 193-94, 209 Cal. Rptr. at 224.

31. Although the answers to these questions are not always clear, certain general principles have started to emerge. In the past five years, for example, a growing number of state and federal courts have permitted, or have announced that they would permit, the withdrawal of artificial nutrition and hydration from incompetent patients. *See Gray v. Romeo*, 697 F. Supp. 580, 589-90 (D.R.I. 1988); *Corbett v. D'Alessandro*, 487 So. 2d 368, 371-72 (Fla. Dist. Ct. App. 1986); *In re Estate of Longeway*, 133 Ill. 2d 33, 46, 549 N.E.2d 292, 298 (1989); *In re Gardner*, 534 A.2d 947, 952 (Me. 1987); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 441, 497 N.E.2d 626, 639-40 (1986); *In re Grant*, 109 Wash. 2d 545, 556, 747 P.2d 445, 451 (1987).

to make decisions for others, not necessarily to involve them in the process of medical decisionmaking. The philosophers and doctors whose essays appear in *Euthanasia* largely³² reflect this parochial view of physician power and responsibility.³³ Their collective wonder and dismay at what they consider to be the overinvolvement of "the courts" in issues that, to them, are strictly medical in nature³⁴ reflect the absence of an understanding on their part—and on the part of the editors as well—that neither society in general, nor the law in particular, regards doctors with the same untroubled neutrality that doctors ascribe to themselves.³⁵

By failing to challenge adequately the physicians' notion that they are the best and the most objective decisionmakers for the incompetent terminally ill, the book fails to offer a balanced presentation of one of the most important areas of the euthanasia debate. The moral issues surrounding euthanasia are no longer the exclusive province of the medical profession. Legal, consumerist, and social perspectives also inform the euthanasia debate. A book that fails to include these perspectives provides its readers with a picture of that debate that is both skewed and incomplete.

32. Some exceptions do exist. *E.g.*, Englehardt, *supra* note 26; Rachels, *supra* note 7; Rachels, *More Important Distinctions* in *EUTHANASIA: THE MORAL ISSUES* (R. Baird & S. Rosenbaum eds. 1989).

33. *E.g.*, Koop, *supra* note 5, at 75, 82.

34. *E.g.*, *id.* at 82 ("The medical profession has been disappointingly silent as they have heard the intellectual arguments, Supreme Court rulings, and population-concern pressures that have begun to alter the fundamental basis which has for so long set them apart as the proponents of the healing art.").

35. Thus, it appears to be inconceivable to some of the physician essayists, notably Doctors Koop, Shewmon, Kass and Pellegrino, that anyone other than doctors ought to be actively involved in the debate about euthanasia and it appears equally inconceivable to them that, despite the increased financial rewards available to doctors who continue treating terminally ill patients, anyone could properly question the medical profession's neutrality in this debate.