

Lesson 11

Euthanasia

In 1975, twenty-one-year-old Karen Ann Quinlan went into a coma after having a few drinks at a party. She had eaten very little in the days before the party and had also taken some drugs—perhaps tranquilizers. She was rushed to the hospital, where doctors connected her to a respirator. Unfortunately, by this time, the lack of oxygen had caused permanent brain damage. Her parents convinced that Karen would not have wanted to be kept alive by artificial means, asked the hospital to disconnect her from the respirator machine. The hospital refused. The resulting controversy and court battles brought the issue of euthanasia to the public's attention. The New Jersey Supreme Court ruled that the hospital had violated Karen Quinlan's right to privacy. As a result, she was removed from the machine and moved to a nursing home to die in peace. More recently, the Terri Schiavo case has renewed interest in the development of legal guidelines for euthanasia.

In 2015, California legalized physician-assisted suicide, joining a handful of other states where physicians are permitted to prescribe lethal medication for terminally ill patients. In 2016, as the California law took effect, Canada also legalized assisted suicide. The model for most of this legislation is the physician-assisted suicide law in Oregon, which holds that a doctor may prescribe lethal medication to a patient who has fewer than six months to live, according to the judgment of two independent doctors. The patient must be competent, must have a clear and continuing request made orally and in writing, and must be able to take the drug without assistance. In the United States, physician-assisted suicide legislation has been subject to referenda and has been litigated in the courts. This practice was not legal in the United States a

generation ago, but it is slowly becoming accepted. In Europe, active euthanasia—where instead of simply prescribing lethal medication, the doctor administers the lethal injection—is legal in the Netherlands, Belgium, and Luxembourg. Active euthanasia is not legal in the United States. In California, assisted suicide legislation was propelled into the limelight by the case of Brittany Maynard, a young woman with brain cancer who moved from California to Oregon to avail herself of Oregon’s assisted suicide process. She killed herself in November 2014 at the age of 29. Brittany’s case raised awareness and provoked controversy. An ethicist at the Vatican, Ignacio Carrasco de Paula, claimed that the act was reprehensible; Brittany Maynard’s mother claimed that sort of condemnation was “more than a slap in the face.” Brittany’s case and the attention it generated led to the passage of California’s assisted suicide law in 2015.

Since the state of Oregon legalized physician-assisted suicide, the state has kept detailed records. According to the state of Oregon, a slowly growing number of patients in Oregon obtain lethal prescriptions and take them. According to data published in February of 2016, in the eighteen years that assisted suicide has been legal in Oregon, 1,545 people have obtained lethal prescriptions, and 991 patients have died as a result of these prescriptions. In 2015, there were 218 prescription recipients, resulting in 132 deaths. Of those who completed suicide, 78 percent of these assisted suicides were 65 years old or older, with a median age of 73. Most were white (93.1 percent), well-educated (43.1 percent had at least a baccalaureate degree), and had cancer (72 percent). This data—and the case of Brittany Maynard—points toward the ethical question of whether access to assisted suicide is fairly distributed. Affluent people may have better access to the procedure than the poor or disenfranchised. In some states, assisted suicide remains illegal. And some people remain adamantly opposed to the practice.

In the Netherlands, euthanasia has been legal since 2002, when the Termination of Life on Request and Assisted Suicide (Review Procedures) Act took effect. The law in the Netherlands stipulates that physicians must exercise “due care” in assisting in suicide or when terminating life on request. According to the law, “due care” means that the physician

- holds the conviction that the request by the patient was voluntary and well-considered.
- Holds the conviction that the patient’s suffering was lasting and unbearable.
- Has informed the patient about the situation and its prospects.
- Holds the conviction, along with the patient, that there was no other reasonable solution for the situation.
- Has consulted at least one other independent physician who has seen the patient and has given his or her written opinion on the requirements of due care.
- Has terminated a life or assisted in a suicide with due care.

This law applies only to adults; euthanasia for children is not legally permitted. However, some doctors have argued in favor of euthanasia for infants when they suffer from “unbearable and hopeless pain” and when their parents agree in consultation with doctors. A protocol has been proposed for dealing with infant euthanasia, the Groningen Protocol. Although infant euthanasia remains a legal gray area in the Netherlands, adult euthanasia is regulated, and detailed records of the practice exist. The government was notified in 2014 that 242 individuals were assisted with suicide and 5,033 were actively euthanized—with 31 other cases involving a combination of assisted suicide and active euthanasia. Most of these cases (3,888) involved patients with cancer, while 81 were for dementia and 41 were for psychiatric disorders. The issue of euthanasia for dementia and psychiatric disorders is especially controversial, as the mental competency of those requesting death is up for debate. Is mental illness a sufficient cause for

suicide or a euthanasia request? The report indicates that the number of cases has increased yearly for the past five years. In 2010, there were 3,136 total notifications of euthanasia or assisted suicide; in 2014, that number increased to 5,306, which is an increase of nearly 70 percent.

In Belgium, a euthanasia law became effective on January 1, 2002. The Belgian law differs somewhat from the Dutch law in two ways. First, it allows advance directives —documents by which patients dictate health care decisions in advance of treatment in case they are incapacitated. Second, it promotes “the development of palliative care.” Palliative care focuses on pain management and alleviating the symptoms of disease. Euthanasia may seem like a radical remedy for pain management, but the idea is that the euthanasia discussion helps focus attention on patient autonomy and solutions for pain management.

European opinion and law about euthanasia remain divided. With its history of Nazis gassing some 100,000 people who were deemed physically or mentally handicapped, Germany has criticized Dutch approval of the practice as a dangerous breaching of a dike. Still, 80 percent of Dutch citizens support the law as the best way to allow people to control their own lives.

Assisted suicide is also legal in Switzerland, and people from countries where it is illegal often go to Switzerland to commit suicide, a controversial practice that has been described as “suicide tourism.” A March 2010 episode of PBS’s Frontline featured the story of Craig Ewert, an American who was diagnosed with ALS (Lou Gehrig’s disease) and who traveled to Switzerland to end his life. Ewert explained, “If I go through with it, I die, as I must at some point. If I don’t go through with it, my choice is essentially to suffer and inflict suffering on my family and then die—possibly in a way that is considerably more stressful and painful than this way. So I’ve got death, and I’ve got suffering and death. You know, this makes a whole lot of sense to me.”

Euthanasia has been a controversial topic for decades. The discussion of euthanasia involves issues of patient rights, life and death, the proper function of doctors, the ethics of suicide, and the overlap between law and morality.

What Is Euthanasia?

Euthanasia comes from the Greek ‘*eu*’ and ‘*thanatos*’, meaning "good death." Euthanasia has come to mean painlessly bringing about the death of a person who is suffering from a terminal or incurable disease or condition.

Euthanasia can be classified as active or passive, voluntary or involuntary. Combining these two dimensions, a particular act of euthanasia can fall into one of four categories: active voluntary, passive voluntary, active involuntary, and passive involuntary.

Although physicians in the United States are permitted to withhold treatment for a dying patient, the law prohibits active euthanasia. This position is consistent with both that of the American Medical Association (AMA) and the British Medical Society. The AMA states:

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain or cease or omit treatment to permit a terminally ill patient to die when death is imminent... Even if death is not imminent but a patient is beyond doubt permanently unconscious... it is not unethical to discontinue all means of life-prolonging medical treatment. [which] includes medication and artificially or technologically supplied respiration, nutrition, or hydration.- AMA Council on Scientific Affairs and Council on Ethical and Judicial Affairs (1990)

Voluntary euthanasia requires that the patient be competent, rational, and able to make his or her own healthcare decisions. The distinction between passive and active euthanasia is less straightforward since it often depends on the intention of the person acting.

In his article at the end of this chapter, James Rachels asks whether the distinction between active and passive euthanasia is morally justified. J. Gay-Williams, in "The Wrongfulness of Euthanasia," argues that passive euthanasia is not strictly euthanasia since it does not involve intentional killing; instead, it is an effort to spare a person "additional and unjustified suffering" by withholding further treatment.

Philosophers on Euthanasia

The contemporary philosophical debate on euthanasia has been influenced primarily by ancient Greek and Judeo-Christian views on death. Greek physicians regarded health as a human ideal par excellence. Because human worth and social usefulness depended on one's state of health, chronically sick people were expendable. Plato favored euthanasia of deformed and sickly infants because they would be a burden on the polis. The early Stoics taught humans to quit life nobly when they were no longer socially beneficial. The Stoic attitude toward dying is reflected in John Hartwig's article "Is There a Duty to Die?"

Not all Greek philosophers agreed with the Stoics. Aristotle believed that willful euthanasia was wrong. Virtue, he argued, requires that we face death bravely rather than take the cowardly way out by quitting life in the face of pain and suffering. The Pythagoreans, who wrote the Hippocratic oath, also opposed euthanasia because we are the possessions of the gods. To kill ourselves is to sin against the gods:

Never will I give a deadly drug, not even if I am asked for one, nor will I give any advice tending in that direction.—Hippocratic Oath

The theme that God owns humans is found in Hebrew scriptures (Gen. 2:2-27). As creations of God, no human has the right to destroy his or her life or wantonly take the life of another. This understanding of human life as inherently precious and belonging to God has been immensely influential on the Jewish, Christian, and Islamic views on euthanasia. In the Jewish tradition, death should never be hastened; physicians who kill patients, even if they intend to relieve pain and suffering, are considered murderers. According to the Islamic religion, illness, and suffering are part of God's will. Taking a life interferes with God's will.

In Buddhist philosophy, self-willed death, even in cases of suffering and pain, violates the principle of the sanctity of life. It is also wrong because (1) suffering is a means to work out bad karma, and (2) a person who assists in suicide or euthanasia will be negatively affected by that participation. Hinduism also teaches that suffering should be endured. Those who deliberately shorten their lives will carry their negative karma into later life. The Dalai Lama teaches:

Your suffering is due to your own karma, and you have to bear the fruit of that karma anyway in this life unless you can purify it. In that case, it is considered to be better to experience the karma in this life of a human where you have more abilities to bear it in a better way than, for example, an animal who is helpless and can suffer even more because of that!

Thomas Aquinas incorporated the Aristotelian and biblical prohibition against euthanasia and suicide into his natural law theory, arguing that suicide is unnatural and immoral for three reasons:

First, everything naturally loves itself, the result being that everything naturally keeps itself in being. Second, because every part, as such, belongs to the whole ...

and so, as such, he belongs to the community. Hence, by killing himself, he injures the community, as the Philosopher [Aristotle] declares.

Thirdly, because life is God's gift to man and is subject to His power, Who kills and makes to live. Hence, whoever takes his life sins against God... For it belongs to God alone to pronounce the sentence of death and life.

Immanuel Kant regarded suicide and voluntary euthanasia as immoral. Suicide does not fulfill the requirements of the categorical imperative because it involves a contradiction of exercising our autonomy to destroy our autonomy by destroying ourselves. People who want to end their lives also show a lack of respect for themselves by viewing their lives as a means only rather than an end. The prohibition of euthanasia remained pretty much unchallenged right up to the end of the nineteenth century.

The Contemporary Debate Over Euthanasia

It was not until the end of the nineteenth century that the public began questioning the prohibition of euthanasia. Public debate over euthanasia turned to horror when it was learned that in Nazi Germany, up to a hundred thousand mentally ill and disabled children and adults "considered incurable according to the best available human judgment" were, to use official language, "granted a mercy death." The memory of this terrible event still haunts Germany, which now prohibits euthanasia.

The public debate over euthanasia resumed with the development of new life-sustaining technologies such as mechanical respirators. In 1957, troubled by the ethical problems involved in resuscitating unconscious individuals, the International Congress of Anesthesiology sought moral guidance from Pope Pius XII. The pope responded that physicians should not act without the consent of the family. Physicians also have a moral and ethical duty to use ordinary, but not

"extraordinary," measures to prolong life. The pope's position was supported by the Catholic Church's "principle of double effect."

The principle of double effect states that if an act has two effects, one intended (in this case, to end pain and suffering) and the other unintended (the death of the patient), terminating treatment may be morally permissible if it is the only way to bring about the intended effect. This distinction between passive euthanasia and active euthanasia has remained unchallenged for years.

Public opinion began shifting in favor of legalized euthanasia in the early 1970s. In 1973, 58 percent of Americans supported legalized euthanasia. By 2005, this figure had risen to 75 percent. The debate gained momentum with the 2005 Terri Schiavo case. Terri Schiavo had suffered irreversible brain damage and had been in a persistent vegetative state since 1990. Her husband requested that the feeding tube be removed. Her parents disagreed with the decision. The courts repeatedly rejected the parents' request to make the hospital reinsert the feeding tube that kept their daughter alive.

Support for physician-assisted suicide, on the other hand, is somewhat lower, having declined since reaching a high of 65 percent in 2001 to 45 percent in 2011. Support for legalizing euthanasia and physician-assisted suicide tends to be higher in other Western countries. Support for euthanasia is especially high in France and the Netherlands, where active voluntary euthanasia has been legal for several years.

Support for euthanasia of incurably ill people is also high in China, where, in some parts, there is a tradition of euthanizing unwanted infant girls. However, despite pressure from some groups to legalize it, euthanasia remains illegal in China. Although the Buddhist repugnance of killing has influenced Japanese views on euthanasia, the influence of the Shinto religion's glorification of

self-willed death for the benefit of the country has led to a more permissive attitude toward euthanasia than in other Buddhist countries.

Legislation

Active euthanasia is illegal in the United States, although Oregon, Washington, and Montana permit physician-assisted suicide under certain circumstances. The 1976 California Natural Death Act was the first law in the United States to address the issue of decision-making on the part of incompetent individuals. The act allows adults, under certain circumstances, to make decisions in advance about the kind of treatment they will receive at the end of their lives.

Most people do not have a living will. A Pew Research study found that only 29 percent of Americans had either prepared written advanced directives regarding their medical care or appointed a durable power of attorney for health care. Thus, it is not surprising that many terminally ill patients end up being kept alive despite their apparent wishes or despite family requests to terminate treatment.

In the 1990 landmark case *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court ruled that every competent individual has a constitutional liberty right to be free of unwanted medical treatment if there is "clear and convincing evidence" of the patient's desire to have the medical treatment withdrawn. The Court left it up to the states to decide for incompetent individuals.

In 1994, the citizens of Oregon approved Ballot Measure 16 (the "Oregon Death with Dignity Act"), which legalized euthanasia under certain conditions. The Oregon Death with Dignity Act took effect in 1997 following a lengthy court appeal process. Since then, more than 500 people—mostly cancer patients and people over the age of 70 have chosen to end their lives. The conditions of the law, which requires that:

- Patients must be in their final six months of terminal illness.
- Patients must make two oral requests and one written request to die, separated by two weeks.
- Patients must be mentally competent to make a decision.
- Two doctors must confirm the diagnosis.

Oregon's Death with Dignity Act was challenged in 2002 by U.S. Attorney General John Ashcroft, who charged that prescribing barbiturates to induce death is illegal under the Controlled Substances Act. The U.S. District Court ruled in favor of Ashcroft v. Oregon. The case was appealed to the U.S. Supreme Court. In 2006, the Court in *Gonzales v. Oregon* ruled in favor of Oregon, stating that the Controlled Substances Act does not give the attorney general the power to prevent physicians from prescribing controlled substances to patients for euthanasia if the law of the state permits it.

Oregon, Washington, and Montana are the only states where physician-assisted suicide is legal. Physician-assisted suicide is also legal in the Netherlands, Switzerland, Luxembourg, Thailand, and Belgium and is tolerated in several other countries. Although the law in the Netherlands permits euthanasia only for medically classified physical or mental diseases and afflictions, many people are critical of this law because it has too much potential for abuse. Indeed, active euthanasia is involved in an estimated 3 to 5 percent of deaths in the Netherlands. In 2008, medical authorities in the Netherlands reported the fourth consecutive annual increase in the number of euthanasia cases, up from 1,815 in 2003 to 2,700 in 2010. Unlike Oregon law, physicians in the Netherlands are not required to determine whether the patient is of "sound mind" or competent to make such a decision. A Dutch study found that at least 50 percent of these patients were suffering from serious depression or dementia when they requested

euthanasia.' Children who are "hopelessly ill" or handicapped are also the target of euthanasia in the Netherlands, leading to the charge that the Dutch have already started down the slippery slope to involuntary euthanasia.

Criteria For Death

This last claim points toward the problem of trying to adopt the standpoint of one who is suffering and whose death we are contemplating. This issue came up in the past decade in the controversial case of Terri Schiavo, a severely brain-damaged woman who was allowed to die in 2005 after more than a decade of being kept alive by a feeding tube. Schiavo was twenty-six years old when she suffered a cardiac arrest on the morning of February 25, 1990. Her husband, Michael Schiavo, called 911. Emergency personnel arrived and resuscitated her. However, Schiavo's brain had been deprived of oxygen for some time, and she remained in a persistent vegetative state (or PVS) for the next fifteen years. A persistent vegetative state is often defined as one of "unconscious wakefulness" that lasts for more than a few weeks. A person in this state has lost all cerebral cortex function but retains a basic level of brain stem function. In contrast, someone who is not totally brain dead but who is in a coma is unconscious but "asleep." His or her brain stem functions poorly, and thus, this person does not live as long as someone in a persistent vegetative state.

Schiavo's case was contentious because of the difficulty in determining what was in her best interests and what she would have wanted for herself. The legal dispute involved the question of whether Schiavo's parents could prevent her husband—who had been appointed her legal guardian—from removing her feeding tube. Her husband claimed Schiavo would not want to be kept alive artificially with minimal chance of recovery and had expressed such wishes orally before her cardiac arrest. Her parents disagreed, claiming that Schiavo's Catholic faith prohibited

this sort of euthanasia. Over the ensuing years, Schiavo's parents repeatedly challenged Michael Schiavo's guardianship in court and were repeatedly denied—with Schiavo's feeding tube being removed and reinserted on multiple occasions. The legal battle surrounding Schiavo's care would eventually involve the Florida legislature and courts, as well as the U.S. Congress, which passed controversial legislation in 2005 to intervene in the case. Ultimately, Schiavo's case was fast-tracked to the U.S. Supreme Court. The Court refused to intervene, and Schiavo's tube was removed.

Terri Schiavo died on March 31, 2005, at age 41. An autopsy later revealed that her brain had shrunk to half its normal size and thus that she had not been conscious or aware. Over the years, some claimed that Schiavo seemed to follow their motions and respond to their voices. However, we know from her autopsy, as well as earlier brain scans, that she had no conscious function and that these were autonomic or reflexive responses. Even though her body might have continued its basic functions for decades, the medical evidence strongly suggests that Schiavo's consciousness permanently ceased in 1990. The Schiavo case points to one of the problems of thinking about death and euthanasia. When does "death" occur?

Years ago, the New York Times reported on the case of a judge who was presiding over a similarly disputed medical situation. The dispute concerned whether a woman's respirator could be disconnected. The judge was reported to have said, "This lady is dead and has been dead, and they are keeping her alive artificially."

Did the judge believe that the woman was alive or dead? She could not be both. He said that she was dead but also that she was being kept alive by machines. If the woman was dead, then machines might have been keeping some of her bodily functions going but could not have been keeping her alive. Perhaps the judge meant that, given her condition, she should be allowed to

die. If so, then he should not have said she was dead. We confuse questions about whether someone is dead or ought to be considered dead with other questions about whether it is permissible to do things that might hasten death.

We need not believe that an individual is dead to think it justifiable to disconnect a respirator and let him or her die. Only if someone is not dead can we then sensibly ask whether we may let that person die. It seems useful here to consider how we determine whether someone is dead to distinguish this issue from other issues more properly related to euthanasia.

Throughout history, people have used various means to determine whether a human being is dead, and those means were a function of what they believed to be essential aspects of life. For example, if the spirit was considered essential and was equated with a kind of thin air or breath, then the presence or absence of this “life breath” would indicate whether a person was living.

When heart function was regarded as the key element of life, and the heart was thought to be like a furnace, people would feel the body to see if it was warm to know whether the person was still living. Even today, with our better understanding of the function of the heart, other organs, and organ systems, we have great difficulty with this issue. One reason is that we can now use various machines to perform certain bodily functions, such as respiration and blood circulation. Sometimes, this is a temporary measure, such as during surgery. However, the person may have lost significant brain function in other cases. In this latter case, it is important to know whether the person is considered alive or dead.

Determining a precise condition and test for death became even more problematic in the past half-century with the advent of heart transplants. Surgeons could not take a heart for transplant from someone who was considered living, only from someone who had been declared dead. Was an individual whose heart function was being artificially maintained but who had no brain

function considered living or dead? We still debate this today. As transplantation science and life-support technologies were developing in the 1960s and 1970s, some courts had difficulty in figuring out how to apply brain death criteria. In some cases, defendants who were accused of murder attempted to argue that since the victim's heart was still beating after an initial assault, the assailant did not kill the victim—but that a subsequent transplant procedure or removal from life-support did. Since the 1980s, the courts have clarified that brain death is the appropriate criteria for use in such cases.

In 1968, an ad hoc committee of the Harvard Medical School was set up to establish criteria for determining when a person should be declared dead. This committee determined that someone should be considered dead if he or she has permanently lost all detectable brain function. This meant that if there was some nonconscious brain function, for example, or the condition was temporary, the individual would not be considered dead. Thus, various tests of reflexes and responsiveness were required to determine whether an individual had sustained a permanent and total loss of all brain function. This condition is now known as whole-brain death and is the primary criterion used for the legal determination of death. This is true even when other secondary criteria or tests, such as loss of pulse, are used.

Whole brain death is distinguished from other conditions, such as persistent vegetative states. In PVS, the individual has lost all cerebral cortex functions but has retained some good brain stem function. Many nonconscious functions based in that area of the brain—respiratory and heart rate, facial reflexes and muscle control, and gag reflex and swallowing abilities—continue. Yet the individual in a permanent or persistent vegetative state has lost all conscious function. One reason for this condition is that the cerebral cortex's oxygen rate is much higher than that of the brain stem, so these cells die much more quickly if deprived of oxygen for some time. The result

is that the individual in this state will never regain consciousness but can often breathe naturally and needs no artificial aid to maintain circulation. Such an individual does not feel pain because he or she cannot interpret it as such. Because the gag reflex is good, individuals in this condition can clear their airways and thus may live for many years. They go through wake and sleep cycles in which their eyes are open and closed.

If we use whole-brain death criteria to determine whether someone is dead, then neither a person in a persistent vegetative state nor a person in a coma is dead. In these cases, euthanasia questions about whether to let them die can be raised. On the other hand, if someone is dead by whole brain death criteria, then disconnecting equipment is not any form of euthanasia. We cannot let someone die who is already dead.

Physician-Assisted Suicide

In 2014, there were 42,773 suicides in the United States, which is approximately 1.6 percent of all deaths. Of those suicides, 7,693 were older than 65 (and 5,079 were between the ages of 15 and 24); 33,113 males committed suicide compared to only 9,660 females. It is estimated that there are twenty-five nonfatal attempts for every actual suicide.

Just as questions can be raised about whether suicide is ever morally acceptable, so also can questions be raised about whether it is morally permissible for physicians (or others, for that matter) to help someone commit suicide. Physician-assisted suicide also poses problems for doctors who take the Hippocratic Oath to “not harm.” In some ways, it looks like active euthanasia. Whereas in passive euthanasia, the doctor refrains from trying to do what saves or prolongs life; in active euthanasia, the doctor acts to bring about the death by some cause or means. However, the causation by the doctor in physician-assisted suicide (i.e., the prescription

of potentially lethal medication) is not immediate or direct but rather takes place through the action of the patient.

Americans are split over whether physician-assisted suicide—a type of active euthanasia in which a physician assists the patient in bringing about his or her death— should be legal.

Because of laws against euthanasia, most physicians who help patients die do not go public. One notable exception was Dr. Jack Kevorkian, who saw himself as a defender of liberty. In 1990, Kevorkian helped Janet Adkins, an Oregon woman who was suffering from the early stages of Alzheimer's disease, to end her life. The vision of Adkins lying dead on the crisp white sheets in the back of Kevorkian's rusting '68 Volkswagen van has become permanently etched onto the American psyche. Since 1990, Kevorkian presided over the deaths of more than 130 people. In April 1999, a Michigan judge sentenced Kevorkian to ten to twenty-five years in prison for second-degree murder. Kevorkian was released on parole in 2007. He died in 2011.

Many families of people he helped to die speak highly of Dr. Kevorkian. In addition, Dr. Kevorkian's patients can be seen pleading to be allowed to die in the videotapes he made of them before their deaths. His critics have a different view, however. They say that at least some of the people who wanted to die might not have done so if they had received better medical care—if their pain were adequately treated, for example. Some of the people were not terminally ill. One was in the early stages of Alzheimer's disease, and another had multiple sclerosis. The primary physician of another patient who claimed to have multiple sclerosis said the patient showed no evidence of this or any other disease; the patient had a history of depression, however. The medical examiner determined another patient to have no trace of an earlier diagnosed cancer. In still another case, a woman had what has come to be called "chronic fatigue syndrome" and a history of abuse by her husband.

The publicity surrounding Kevorkian sparked intense debate over the morality of physician-assisted suicide. Kevorkian's detractors dubbed him "Dr. Death." Surgeon General C. Everett Koop denounced him as "a serial killer who should be put away." Kevorkian's opponents also pointed out that he is a pathologist, not a psychiatrist. Kevorkian hardly knew his, unlike healthcare workers, who have known their patients for a long time.

Some critics have pointed out that Kevorkian's patients were predominantly women, who may have been worried about the impact of their diseases on others as much as the difficulty of the diseases themselves. In fact, according to data on suicide cited above, three times as many women as men attempt suicide, though men succeed three times more often than women.

Some suggest that women's suicide attempts are more of a cry for help than an actual desire to die. The choice of assisted suicide may also appear to women as a requirement of feminine virtues of care and service toward the family. However, the data on assisted suicide in Oregon, for example, do not indicate a gender gap in assisted suicide; in 2015, 56 men and 76 women were assisted in committing suicide—and an approximate 50–50 gender split is common for the past decade of record keeping on the issue.

The American Medical Association continues to oppose physician-assisted suicide. The Hippocratic Oath contains the following claim: "I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect." This statement goes on to say that a physician should not provide abortion to women. Indeed, many people see a connection between the ethics of abortion and the ethics of euthanasia and suicide. They argue that a consistently pro-life position is opposed to all of these things (along with the death penalty and war, in most cases). However, the medical profession does not have the same problem with abortion as it does with physician-assisted suicide. The American Medical Association continues to reject

physician-assisted suicide as unethical. The organization's position on physician-assisted suicide states:

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Euthanasia for Infants and The Disabled

Death is usually thought of as a bad thing. But could it be that in some cases, death is a mercy? Consider the case of an infant, Sanne, who was born with a severe form of Hallopeau-Siemens syndrome. The disease caused the infant's skin to blister and peel, leaving painful scar tissue in its place. The prognosis was for a life of suffering until the child would eventually die of skin cancer before reaching her teenage years. The hospital refused to allow the infant to be euthanized, and Sanne eventually died of pneumonia. In such a case, would it be more humane to end the infant's life actively?

Modern medicine has made great strides in treating newborn and premature infants. According to one recent study in the UK, "overall survival among those born between 22 and 25 weeks rose from 40 percent in 1995 to 53 percent in 2006." However, while newborn survival is better, premature infants still tend to struggle with complications and disability. That same study also noted, "the proportion of such infants who experience severe disability as a result has not changed. That stood at 18 percent in 1995 and was 19 percent in 2006." In the United States, according to the Centers for Disease Control and Prevention, Each year, preterm birth affects

nearly 500,000 babies—that's 1 of every eight infants born in the United States. Preterm birth is the birth of an infant before 37 weeks gestation. It is the most frequent cause of infant death, the leading cause of long-term neurological disabilities in children, and costs the U.S. healthcare system more than \$26 billion each year.

One obvious remedy for this situation is finding ways to decrease preterm birth through better prenatal care. Another remedy would be expanding social resources to support preterm infants and their families, especially those with severe disabilities.

Despite the progress in care for preterm infants, some seriously ill newborns do not fare well. Some have severe defects and cannot survive for long, while others will live but with serious impairments. Thus, improvements in medicine that have enabled us to save the lives of newborns have also given us new life-and-death decisions.

One issue to consider here is the patient's quality of life. Parents who consider letting severely disabled infants die struggle with questions about the quality of life their child is likely to have. A further useful consideration is the impact of expensive and possibly futile health care on the rest of the family. An influential philosopher, Peter Singer, has argued that it is possible to imagine killing a disabled newborn and "replacing" it with another healthy baby in a subsequent pregnancy to achieve a net outcome of happiness. Singer notes that we allow women to abort disabled fetuses, and he sees very little difference between abortion and euthanasia for infants. Singer argues that "killing a disabled infant is not morally equivalent to killing a person. Very often, it is not wrong at all." One of Singer's points is that disabled infants lack the sort of mental capacity that would give them moral status as "persons" who have a right to life. This is one of the bioethics questions in Lesson 10.

Singer's approach has prompted criticism and protest. Some donors—including former presidential candidate Steve Forbes—threatened to withdraw funding from Princeton University when Princeton hired Singer to teach ethics. Disability rights advocates have been especially critical of Singer. Harriet McBryde Johnson argues that Singer is advocating genocide against the disabled. She explains that the problem is Singer's "unexamined assumption that disabled people are inherently 'worse off,' that we 'suffer,' that we have lesser 'prospects of a happy life.' Catastrophe looms because of this all-too-common prejudice and his rare courage in taking it to its logical conclusion."

Those who advocate euthanasia for infants often focus on the question of the well-being of the infant, arguing that the lives of some disabled infants are miserable and hopeless. As indicated earlier, in the Netherlands, there is a quasi-legal protocol for considering active euthanasia for newborns—the Groningen Protocol. That protocol focuses on infants with a hopeless prognosis and extremely poor quality of life. This latter designation specifically includes "severe cases of spina bifida," a birth defect in which the spinal column does not fully close in development; the most serious cases result in death or, if treated, may leave the person with "muscle weakness or paralysis below the area of the spine where the incomplete closure (or cleft) occurs loss of sensation below the cleft, and loss of bowel and bladder control."

In some cases, spinal fluid builds up and can cause learning problems. In such cases, it is not clear whether medical assistance is in the infant's best interest. However, people have survived spina bifida and can enjoy life and contribute to their communities.

The question of quality of life and disability points toward various issues, including the kinds of functions we view as normal and healthy. It also points toward reflection on how we view suffering, caregiving, and dependency. The care-ethics standpoint acknowledges the importance

of caregiving and dependency. Indeed, we are all dependent for the first few years of life, and there will be moments of dependency in our future, in illness and old age. What value do we place upon care and dependency? Other approaches to ethics—including the Kantian approach especially—emphasize autonomy. As we shall see, autonomy is a central question for discussions of end-of-life care, assisted suicide, and euthanasia.

One significant problem here is whether we can accurately predict or judge the quality of an individual's life. Several authors have pointed out that it is difficult for those of us with normal functions to judge the quality of life of the disabled. Those in the disability rights movement will also argue, as Tom Shakespeare does, that judgments about the quality of life depend on social context; in nurturing societies with ample resources to support people with different abilities, some "impairments" may not be "disabling." Shakespeare emphasizes that the primary focus should be on providing adequate health care—and not so much on euthanasia.

Even with better health care and social supports, there do seem to be truly hopeless cases, such as that of the infant Sanne mentioned previously. Even skeptics about making such quality-of-life judgments, such as John Robertson—a professor of law and ethics—admit that there may be obvious cases, "a deformed, retarded, institutionalized child, or one with incessant unmanageable pain, where continued life is itself torture. But these cases are few."

In many other cases, it is not clear what counts as suffering or hopelessness. Cases in which an infant born with Down syndrome was left untreated and died have drawn intense criticism.

Down syndrome (also called trisomy 21) is a genetic anomaly that causes mental retardation and sometimes physical problems as well. In one case, a child had a reparable but life-threatening blockage between the stomach and the small intestines. The parents refused permission for surgery to repair the problem, and the doctors followed their wishes and let the infant die. Critics

protested that this surgery was simple and effective, and the infant, although developmentally disabled, could have led a generally happy life.

Choosing not to treat in such cases has been interpreted as not using what would be considered ordinary means of life support—ordinary because the benefits to the patient would outweigh any burdens. Such cases have been criticized for their “buck-passing”—that is, shifting responsibility for the death to nature, as though in this situation, but not elsewhere in medicine, we should “let nature take its course.”

Two different moral questions can be raised about such cases. The first asks: who would be the best to decide whether to provide or deny certain treatments? The second asks: what are the reasons to provide or deny care? Some people insist that the primary decision makers should be the parents because they are not only the most likely to have the infant’s best interests at heart but also the ones most likely to provide care for the child. We can imagine situations where parents would not be the most objective judges. They might be fearful, disappointed about the child’s health conditions, or disagree about the best action. A 1983 presidential commission that was established to review medical ethics problems concluded that parents ought to make decisions for their seriously ill newborns, except in cases of decision-making incapacity, an unresolvable difference between parents, or a choice that is not in the infant’s best interests. (According to this commission, if treatment is futile, it is not advised.) While the commission gives priority to parental decision-making, it also sets forth a more general and objective standard for surrogate decision-making,

Permanent handicaps justify a decision not to provide life-sustaining treatment only when they are so severe that continued existence would not be a net benefit to the infant. Though inevitably somewhat subjective and imprecise in actual application, the concept of “benefit” excludes

honoring idiosyncratic views that might be allowed if a person decides about his or her treatment. Rather, the net benefit is absent only if the burdens imposed on the patient by the disability or its treatment would lead a competent decision-maker to choose to forgo the treatment. As in all surrogate decision-making, the surrogate must evaluate benefits and burdens from the infant's perspective.

Types of Euthanasia

If you were approached by a pollster who asked whether you supported euthanasia, you would do well first to ask what he or she meant and to what kind of euthanasia he or she was referring. It is important to distinguish what is called passive euthanasia from what is called active euthanasia. Passive euthanasia refers to withholding or withdrawing treatment and letting a patient die. Thus, passive euthanasia can also be described as “letting die” or “allowing to die.” Sometimes, this is called “letting nature take its course.” This might include either withdrawing care (as in removing a feeding tube) or withholding care (as in not prescribing antibiotics to cure an infection). Active euthanasia refers to a more active intervention that aims to bring about the death of a person—a lethal injection, for example. Physician-assisted suicide is yet another thing—as the physician merely prescribes the lethal medication without administering it himself or herself. A further set of concepts focuses on whether euthanasia is given to those who request it and consent to it or not. Voluntary euthanasia implies that the patient consents. Nonvoluntary euthanasia describes euthanasia for those who are unable to give consent (infants or those with severe brain damage). Involuntary euthanasia implies that the killing is done in violation of the patient's will. There is no moral justification for involuntary euthanasia, which can also be called murder.

- **Passive euthanasia:** Stopping (or not starting) some treatment, which allows the person to die. The person's condition causes his or her death.
- **Active euthanasia:** Doing something such as administering a lethal drug or using other means that cause the person's death.
- **Voluntary euthanasia:** Causing death with the patient's consent, knowingly and freely given.
- **Involuntary euthanasia:** Causing death in violation of the patient's consent.

Advance Directives

Sometimes, when a patient cannot express his or her wishes, we can attempt to infer what the person would want. For example, we can rely on the person's past personalities or statements. Perhaps the person commented to friends or relatives as to what he or she would want in specific medical situations.

In other cases, a person might have left a written expression of his or her wishes in an advance medical directive. One form of advance directive is a living will. The living will specify that one does not want extraordinary measures used to prolong life if one is dying and unable to communicate. However, such a specification leaves it up to the physician—who may be a stranger—to determine what is extraordinary. Another directive is called a durable power of attorney. In this case, the patient appoints someone close to him or her who knows what he or she wants under certain conditions if he or she is dying and unable to communicate. Patients are generally advised to have one or two alternate appointees for durable powers of attorney.

The person with durable power of attorney need not be a lawyer but serve as the patient's legal representative to make medical decisions for him or her in the event of incapacitation. The form for durable power of attorney also provides individualized expressions in writing about what a

patient would want done or not done under certain conditions. The appointed person will also be the only one to permit for “do not resuscitate” (DNR) orders or orders not to revive the patient under certain conditions. DNR orders can be controversial, particularly when a patient’s family requests that physicians take all possible measures to save the patient. This causes conflict, especially if the physician believes that resuscitation attempts will be futile or even make the patient worse off. At the very least, however, these directives have moral force to express patients’ wishes. They also have legal force in those states that have recognized them. There is some dispute about whether advance directives are effective. One study published in 2010 maintains that advance directives are usually followed. However, an editorial accompanying that study in the New England Journal of Medicine indicates that there are important limitations—including the impossibility of imagining all healthcare options in advance and our preferences may change.

If enforced, living wills and durable powers of attorney can give people some added control over what happens to them in their last days. Congress passed the Patient Self-Determination Act, enacted in December of 1991, to further ensure this. This act requires that healthcare institutions participating in the Medicare and Medicaid programs have written policies for providing individuals with information about and access to advance directives, such as living wills.

Hospice-Palliative Care

The modern hospice movement was founded in 1967 by British physician Cicely Saunders to help people die with dignity rather than fear. The first hospice program in the United States opened in 1974. The philosophy behind hospice is to provide palliative care- pain relief, comfort, and compassion to the dying. As such, hospice has been active in the development of pain control. Hospice also emphasizes attention to the patient's and family's emotional needs.

There are currently about 5,000 hospice programs in the United States. According to the National Hospice and Palliative Care Organization, More than 1.5 million terminally ill patients received hospice services in 2010, up more than eightfold from 1990.

Hospice is opposed to the legalization of euthanasia. "If one of our patients requests euthanasia," Saunders wrote, "it means we are not doing our job." Saunders continued:

We are not so poor a society that we cannot afford time, trouble, and money to help people live until they die. We owe it to all those for whom we can kill the pain that traps them in fear and bitterness. To do this, we do not have to kill them. ... To make voluntary [active] euthanasia lawful would be an irresponsible act, hindering help, pressuring the vulnerable, abrogating our true respect and responsibility to the frail and the old, the disabled, and dying.

Hospice believes that providing terminally ill people with better palliative care allows them to live their last days in relative comfort and dignity. Advocates of euthanasia maintain that while the hospice program is wonderful for many people, there are still cases in which pain cannot be controlled, and euthanasia should be an option.

Moral Issues

Sanctity of Life

Most Western philosophers believe that human life has intrinsic worth. Legalizing euthanasia, it is argued, will weaken this respect for human life. If life has intrinsic worth, our right not to be killed cannot be overridden, even at our own request.

A variation of this theme is the religious argument, cited by Islam, Judaism, and Christianity, that our lives are a gift from God and, therefore, we are not free to end them on our own terms.

However, physicians are continuously working to prevent death and suffering. Does this interfere

with God's will? Furthermore, those who do not believe in God argue that people are not owned by God. As beings with intrinsic moral worth, we have inalienable rights that cannot be waived by anyone else. One of the most fundamental of these rights is the right to autonomy.

Autonomy and Self-Determination

Autonomy requires two conditions: freedom from outside control and moral agency. Autonomy is one of the two key principles in the euthanasia debate. Autonomy requires that, in general, physicians respect a competent person's choices in determining his or her medical treatment, including euthanasia. If euthanasia is a positive right, physicians may even have a duty to assist their patients in dying.

Some ethicists argue that autonomy and self-determination have been given too much weight in the euthanasia debate and that people do not have the right to do anything they want. In addition, the leap between claiming that people have a right to end their lives and the claim that it is morally acceptable for physicians to assist in this process is not as self-evident as most advocates of active euthanasia would have us believe.

There is also the danger that making euthanasia available will compromise our autonomy. Some people may feel pressured by circumstances, such as lack of medical insurance or family support, into requesting euthanasia.

Nonmaleficence and the Principle of Ahimsa

The principle of nonmaleficence, or "do no harm," is one of the strongest moral principles. In the Buddhist prohibition against euthanasia, ahimsa is the deciding principle. On the other hand, argues that the principle of nonmaleficence and the duty to relieve pain and suffering may, at times, require euthanasia.

Compassion and the Principle of Mercy

The principle of mercy is based on the duty of nonmaleficence. It states that we have a duty both (1) not to cause further pain and suffering and (2) to relieve pain and suffering. Most philosophers agree that the first part of this duty justifies the refusal of futile and painful treatment, even though withdrawing or withholding such treatment may result in an earlier death for the patient. Some agree that pain relief is a universal duty of physicians and that this duty may entail a positive obligation to use active euthanasia when it is the only way to end pain and suffering.

Hospice, on the other hand, maintains that the appropriate response to suffering is compassionate care, not conceding to a patient's request to be put to death. The Vatican likewise opposes euthanasia. In the Terri Schiavo case, Pope John Paul II stated that feeding tubes are "morally obligatory" for most patients in persistent vegetative states as long as the feeding tube "provides nourishment" and "alleviates suffering."

Death with Dignity

The expressions "death with dignity" and the "good death" are often heard in euthanasia debates. The number one fear of many people is not fear of dying or of pain, but of loss of control and dignity! Advocates of euthanasia argue that respect for the dignity of life entails allowing a person to die with dignity as well, rather than spend the last days of life hooked up to machines and wasting away.

Some opponents of euthanasia believe that good death involves courageously accepting the suffering entailed in dying. Gay-Williams, for example, maintains that survival or the inclination to continue living is a natural human goal. Since human dignity comes from seeking our ends, euthanasia is a violation of human dignity and therefore, diminishes our humanness.

Quality of Life: Pain and Suffering

Human life is more than mere biological existence. It could be pointed out that the ability to be in relationships with family and friends, to have hopes for the future, and to live without constant pain are all basic goods. When isolation, pain, and suffering outweigh any expectation of enjoying the goods of life, the quality of that life becomes a negative value and death may be preferable.

Pain, however, such as that associated with most cancers, can be relieved in up to 90 percent of cases. Despite this, many terminally ill people are not offered palliative care. A national survey found that 59 percent of people gave the quality of end-of-life care a fair or poor rating when it comes to making sure patients were as comfortable and pain-free as possible at the end of life." This is blamed, in part, not on the lack of effective pain relievers, but on Western society's opiophobia-fear of drug addiction and abuse.

There are also other types of suffering, such as lifelong disability, loneliness, and depression. Should there be a moral distinction between wanting to die because one is depressed or facing a chronic illness and the pain associated with a terminal illness?

Another issue is determining the quality of life of incompetent patients, such as people in comas and young children with disabilities. Who, if anyone, should decide if their lives are worth living? If we answer that euthanasia should be voluntary only, we must ask ourselves if it is fair that incompetent people be doomed to lives of suffering and hopelessness. We should also ask if it is fair that society and families be forced to bear the burden of maintaining the lives of hopelessly ill people.

Ordinary Versus Extraordinary Treatment

The AMA, while opposing euthanasia, allows the withdrawal of extraordinary treatment.

Ordinary medical treatment includes measures that have a reasonable hope of benefiting the

patient, whereas extraordinary treatments provide no reasonable hope of benefiting the patient.

This brings up the question of just when treatment becomes extraordinary. How should we draw the line between prolonging life and prolonging the dying process? Is using chemotherapy on an ailing eighty-five-year-old with cancer ordinary or extraordinary treatment? Also, what counts as a reasonable hope? Is continuing to keep a patient in a coma on artificial life support, even though there is only slight hope of recovery, ordinary or extraordinary treatment?

The Principle of Double Effect: Letting Die Versus Actively Killing

The traditional distinction between active and passive euthanasia rests on intention. In active euthanasia, the intention is to cause the death of another person. In passive euthanasia, there is a "double effect": the death of the person is an unintended consequence of the intended effect—the elimination of pain and suffering.

Some philosophers claim that this distinction is hypocritical and that physicians are morally responsible for both intended and foreseen consequences. Some argue that knowing that high doses of painkillers may hasten a person's death is an action as much as administering a lethal injection on request. Both involve decision and action on the part of the physician. Indeed, he claims there may be cases in which active euthanasia is the more humane alternative.

The Physician's Role as Healer

Some opponents of physician-assisted suicide and euthanasia, argue that expecting physicians to be agents of death runs contrary to their training as healers and comforters and may damage trust in the patient-physician relationship.

This argument, however, does not rule out euthanasia. The act of euthanasia could instead be left to others, perhaps people like Dr. Kevorkian or "death technicians" who specialize in it.

Patient Competence

Two of the problems in deciding who should be a candidate for euthanasia are: (1) determining if a patient is rational and competent to make such a decision and (2) determining whether it is a sincere request for death or a cry for help. What, in other words, are the patient's real intentions? Furthermore, if the patient is incompetent, how do we determine what is in the patient's best interests? Some people argue that physicians or close family members can usually be counted on to respect a patient's self-determination and question the insidious effect of cultural biases on these decisions.

Some claim that the request, especially in cases in which the patient can carry out the suicide without assistance, is often a cloaked request for help. Suicide prevention workers point out that people who are suicidal often feel a sense of depression, hopelessness, and despair. Rather than seeking to end their lives, the request to die is an expression of that despair and, as such, is a cry for help.

Justice and the Principle of Equality

Some opponents of euthanasia maintain that it is always unjust because it involves the death of an innocent person. Others maintain that the duty of justice may require euthanasia, especially in cases in which keeping a person alive is tremendously expensive.

Some express concern that euthanasia may be unjust because it unfairly targets certain groups. In societies that hold up self-sacrifice as a virtue for women, women are especially vulnerable to pressures to put the needs and desires of others before their own. The physician-assisted death of Judith Curren, who was later alleged to have been abused by her husband, is just one case in point.

Another concern is our society's negative view of people who are disabled and the tendency to devalue their lives. While it may be countered that disabled people fall outside the scope of

euthanasia because they are not terminally ill, the facts show that infants and children with disabilities, such as Baby Doe, are vulnerable to euthanasia. A study of infant deaths at the special-care unit of the Yale-New Haven Hospital between 1970 and 1972 revealed that of 299 deaths, 14 percent were associated with the withholding or withdrawal of treatment in cases of severe congenital disorders.

Burdens to Society and a Duty to Die

The majority of Dutch and American doctors favor physician-assisted suicide for a patient in excruciating pain." However, they differ in their justifications for euthanasia. Dutch doctors are more likely to support physician-assisted suicide in cases in which a patient finds life meaningless; American physicians are more likely to consider a patient's fear of being a burden as a justification for euthanasia.

We can argue that when costly medical resources are needed to sustain human life, the principle of justice may warrant involuntary active euthanasia. End-of-life costs account for 10 percent of total healthcare spending in the United States and 27 percent of Medicare expenses. Medicare spent \$55 billion in 2010 for hospital and physician care during the last two months of a patient's life. Up to a third of this expense had no meaningful impact on the patient. In contrast, it costs only a few dollars to deliver a lethal injection.

The baby boomers, those 78 million Americans born between 1945 and 1961, are the largest generation in American history. The aging baby boomer population can be expected to drive up healthcare costs in the next few decades. Others argue that the burden to family and society creates what he calls a "duty to die". According to some, there comes a time in life when we have a duty to let go. In a nonegalitarian society, however, where the lives of certain groups are valued

less than others, a duty to die might come into conflict with the principle of justice by unfairly targeting certain people, such as women, the poor, and the disabled.

The Finality of Death versus the Hope of Recovery

Although rare, there are cases in which a patient comes out of a coma or makes a miraculous recovery despite a prognosis of imminent death or irreversible brain damage. Jackie Cole suffered a stroke and massive bleeding in her brain. The doctors predicted that without artificial life support, she would be dead within a few days. Before slipping into a coma, she had made it clear that she did not want to be kept alive by artificial means. The court, however, refused her husband's petition to have life support withdrawn. Six days later Cole awoke from the coma and slowly began to recover.

What is the reasonable cost of sustaining hope? Do cases like Jackie Cole's justify spending millions of dollars keeping comatose people alive in hopes that a few of them will come out of it? Gay-Williams, an opponent of euthanasia, says yes. If euthanasia is legal, we are more likely to give up hope as well as not put as much effort into research for new cures.

Slippery Slope Argument

Even if euthanasia can be morally justified in principle, there may still be problems when it comes to legalizing it because of the difficulty of drawing the line between who should and who should not be eligible. If there is no definite line to stop abuses, it will be easy to slip down the slope toward greater and greater acceptance of euthanasia. A report from the Netherlands found that Dutch physicians "sometimes act without patient requests in performing euthanasia and that there was a sense among some patients that they had a duty to die." The right to euthanasia, in other words, can slip into a duty to die. If euthanasia is an option, it will also be easy to redefine

chronic medical conditions as terminal illnesses to justify the euthanasia of people who have Alzheimer's or children with genetic disorders, a practice that has already begun to some extent.

Conclusion

The moral issues surrounding euthanasia are complex. Many of the relevant principles come into conflict with one another and need to be carefully weighed. A further complication is the uncertainty of medical prognoses and the presence of subjective factors in assessing patients' requests for euthanasia. In addition, public policies on euthanasia need to be drafted within the wider social context. As with abortion, the judgment that euthanasia, or at least certain types of it, is morally acceptable does not imply that the law should permit it.