

Whose Life Is It, Anyway?

By Henry R. Ticknor
2014 Paxton Award Winner



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Henry Ticknor earned his BA in English from Hartwick College. He began teaching English at a central school in upstate New York but soon moved to Virginia, where he taught special education in a small independent school. After earning a M.Ed. from George Mason University, he joined the Fairfax County Public Schools. During his 26-year tenure there, he was a special education teacher, a middle school principal, an elementary school principal, and a central office administrator.

In 2001, he received a M.Div. from Wesley Theological Seminary in Washington, D.C. He was ordained as a Unitarian Universalist minister and served as a chaplain at Georgetown University Hospital and as a parish minister in Arlington, VA., Fairfax, VA., and Stephens City, VA.

Now retired, Henry resides in Winchester, Virginia, where he volunteers as a hospice patient and family visitor, is chair of the board of directors of the Winchester Little Theatre, and is a member of the national Mended Hearts Organization and Donate For Life. Additionally, he helps at the Virginia State Arboretum and the Smithsonian Conservation Biology Center. He joined the Winchester Torch Club in 2011.

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"It's not that I'm afraid to die, I just don't want to be there when it happens."
—Woody Allen

We humans are living longer and longer lives. A person born in the United States at the turn of the 20th century could expect to live 49 years. For their descendants born in 2013, life expectancy for both sexes and all races is 77 years, with men living to 75 years and women to 80 years. Indeed, the Psalmist was prescient in observing in Psalm 90, verse 10, "The years of our life are seventy, or even by reason of strength eighty."

Even with advances in medical treatment and technology keeping people alive longer and longer, however, at some point, we each must die. And even though modern medicine can, and often does, keep people alive on life-support for days, weeks, or months, we may wonder whether such an existence meets more than a rudimentary definition of what it means to be alive. Does the patient ever have the right to say, "Enough is enough"? What responsibility, if any, does the medical profession bear in carrying out such a wish?

This paper concerns the legal and moral issues associated with the purposeful taking of a person's life by means of active or passive suicide. Both physician-assisted suicide and voluntary, active euthanasia, it will be argued, are moral acts that ought to be legal, making it permissible for physicians to provide the knowledge and the means by which a patient may end his or her life.

Definitions

Euthanasia, a term denoting "the

action of inducing gentle and easy death," was introduced to the lexicon by the Anglo-Irish moral historian W.E.H. Lecky in 1869. In general usage, the term "euthanasia" is seen as synonymous with an easy death or what others refer to as a "good death." The word has many connotations, from Nazi death camps to Sarah Palin's oft-referenced "death panels" to a much-loved pet's final visit to the vet. In this paper, "euthanasia" means the act of painlessly putting to death a person who is suffering from an incurable, painful disease or condition.

However, some important distinctions need to be made for the purpose of clarity. The first is to differentiate between the terms "active" versus "passive" euthanasia and the second is to distinguish between "voluntary" and "involuntary" euthanasia.

In "passive" euthanasia, the patient refuses treatment and dies by simply succumbing to natural causes. "Passive" euthanasia is based on the fundamental ethical principle that informed, autonomous patients have the right to refuse any and all medical treatment regardless of the outcome.

In "active" euthanasia, also known as mercy killing, a physician carries out the final death-causing act, in conformity with the patient's wishes. Entirely voluntarily, without any reservation, external persuasion, or duress, and after prolonged and thorough deliberation, a person undergoing "active" euthanasia gives full consent for the medical procedure to be administered by a medical professional, in order to end intolerable and incurable suffering.

“Voluntary” euthanasia refers to putting a person to death in accord with his or her own free will or self-determination.

“Involuntary” euthanasia refers to putting a person to death without his or her explicit request.

“Voluntary active” euthanasia refers to actions by a physician intended to cause the death of a patient who has indicated a desire to end his or her life—a terminally ill cancer patient, for instance, who requests and receives a lethal injection administered by a physician.

In “physician-assisted suicide,” the physician provides the means by which a patient may terminate his or her life but does not actively participate in the life-ending act.

It is essential to recognize that there is no moral or legal justification for physician assistance in any kind of involuntary euthanasia. Furthermore, no serious advocate of physician-assisted suicide argues that physicians should be required to take part in helping patients die. Proponents of physician-assisted suicide recognize the right of individual physicians to decline to participate for religious or moral reasons.

If the distinction between active and passive euthanasia is merely arbitrary semantics, however, then there is no morally relevant reason why physicians cannot assist patients who want to die, respect for autonomy being the decisive issue.

A Brief History

Ian Dowbiggin, writing in *A Merciful End: The Euthanasia Movement in Modern America*, observes that, “The two great revolutions before the 1960s that affected Americans’ attitudes and expectations regarding euthanasia were the late nineteenth-century growth of scientific knowledge and the coming of progressivism” (7).

In the 19th century, most Americans died at home rather than in a hospital and were often surrounded by friends and relatives. “The doctor emerged as an important figure in the family circle, there to soothe and comfort the patient with words and (if necessary) the doctor’s job was to make the terminal stage easier for everyone, patient and loved ones alike” (Filene 4). At this time, religion and medicine blended together at the deathbed. But a shift was coming.

One of the first advocates of euthanasia was the lawyer and outspoken agnostic, Robert J. Ingersoll. In 1894, Ingersoll argued that an individual suffering from a terminal illness, such as terminal cancer, should have a right to end their pain through suicide. In an essay he observed, “[A man] being slowly devoured by cancer is of no use to himself nor his wife, children, friends and society and thus enjoys the right to end his pain and pass through happy sleep to the eternal dreamless rest” (qtd. in Dowbiggin 10). Although Ingersoll never advocated suicide as a means of avoiding life’s ordinary difficulties, he did view it as a rational choice in cases of terminal cancer.

In 1891 Felix Adler, another early advocate, argued that the terminally ill should “hold out for as long as possible” (qtd. in Dowbiggin 13), but when their pain and unhappiness became overwhelming, they deserved the right to die peacefully, and, furthermore, to have a doctor’s assistance.

The most prominent figure in the American euthanasia movement was Charles Francis Potter. A Unitarian Universalist minister, Potter was an outspoken advocate for euthanasia, claiming that he had witnessed too many of his parishioners die in terrible pain and anguish and that he had heard too many of his flock plead to be put out of their misery. Potter publicly advocated euthanasia as “humane and an example of individuals exercising control over their own destinies” (qtd.

in Dowbiggin 33). In 1938, Potter helped found the Euthanasia Society of America.

In the 1960s, life-prolonging medical technology brought a new urgency to the debate over death, terminal illness, and relief of suffering. Euthanasia again had a prominent place in the public agenda, now expressed in catchphrases such as the “right to die” and “death with dignity,” emphasizing patient autonomy and individual rights. During the late 1970s and the 1980s, public opinion shifted in favor of the right to die with dignity. Surveys showed that most Americans—75% in a 1996 Gallup poll—agreed with assisted dying for terminally ill patients (Carroll).

From the 1980s onwards, advocacy groups championed various means to get “aid in dying” laws in their states. In Washington and New York states, they went to court to challenge the laws that forbade helping people to die, arguing that such a ban was unconstitutional in that it denied the freedoms promised in the U.S. Constitution.

In the state of Washington, the “Death with Dignity Initiative,” led by the Unitarian Universalist minister Ralph Mero, qualified for the November 1991 ballot. This initiative proposed active medical help and would have allowed competent, terminally ill patients to ask for and receive a lethal injection from a doctor. The Act included strict guidelines and controls. Although early polling suggested the bill had a good chance of passing, it was defeated by a 54% to 46% vote.

In 1994, an Oregon group collected enough signatures to put their own “Death with Dignity Act” on the ballot. Unlike the other efforts, this proposal was only to allow physician-assisted suicide for the terminally ill. Again, it included checks and strict guidelines, and doctors could only prescribe the lethal drugs; the patients had to take

the dose themselves. The Act passed by a vote of 51% to 49% and became the first law of its kind anywhere in the world.

Four years later, the citizens of Washington again had the opportunity to vote on a Death with Dignity Act, and this time the measure passed. Thirty of the state's thirty-nine counties voted in favor of the initiative.

In 1997, the U.S. Supreme Court handed down two cases central to physician-assisted suicide. In both those cases (*Vacco v. Quill* and *Gregoire v. Glucksberg*), the court ruled unanimously that there was no constitutional right to physician-assisted suicide, either on the grounds of equal protection or personal liberty. Nevertheless, the court did not say that there could never be legitimate circumstances of physician-assisted suicide. The court noted that this question was too important to be decided once and for all, and it invited continued reflection on the matter by the states.

Arguments in Favor of Physician-Assisted Suicide

The case for euthanasia and physician-assisted suicide usually consists of two main arguments.

First, there is the claim of autonomy, that each of us possesses a right to self-determination. Just as each individual should be free to make important choices related to how one shall live his or her own life, so one should be free to choose the time and manner of death. Control over our own lives is one of the most important goods we enjoy. In health, we exercise daily control over how we shall live, making decisions that affect our lives and their quality. Generally, we take the making of these decisions for granted: It is our life, and how we live it and what we make of it is up to us. (Dworkin, Frey, & Bok).

The second argument holds that physician-assisted suicide and

euthanasia are merciful acts that relieve suffering and prevent an expensive, protracted death. For a person suffering end-stage cancer or AIDS, a physician's lethal prescription injection can be welcomed as a blessed relief. Focusing only on pain, however, ignores the many other varieties of suffering that can accompany chronic illness and dying: dehumanization, loss of independence, loss of control, a sense of meaninglessness or purposelessness, loss of mental capabilities, loss of mobility, disorientation and confusion, sorrow over the impact of one's illness and death on one's family, loss of ability even to recognize loved ones, and more. Often, these causes of suffering are compounded by the awareness that the future will be even bleaker. Unrelieved pain is simply not the only condition under which death is preferable to life, nor the only legitimate reason for a desire to end one's life.

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Many who support physician-assisted suicide and euthanasia argue that it protects people who do not want to suffer lingering, painful deaths; that it protects against debilitating conditions not easily managed by medicine; and finally that the state has no compelling interest in forcing the prolongation of life of someone in pain who wants to die. When death becomes the only way to relieve suffering, why not allow it to come in the most humane and dignified way possible? As one commentator asks, "Why is it considered ethical to die of 'natural causes' after a long heroic fight against illness filled with 'unnatural' life-prolonging medical interventions, yet unethical to allow patients to take charge at the end of a long illness and chose to die painlessly

and quickly?" (Orfali 140).

The concept of self-determination already gives competent patients the right to refuse any and all treatment, including life-sustaining treatment. In this matter, public policy comes down on the side of self-determination, recognizing the deep-seated place of that value in our society. Before any action can be taken, of course, the patient's physician must explore all of the physical, psychological, and spiritual reasons for the request and explain all of the options available. Only when an individual is deemed to be competent and fully informed can physician-assisted suicide be considered an option.

However, the individual's right to "self-determination" may be at odds with the values of a particular medical practitioner. Self-determination does not entitle patients to compel physicians to act contrary to the physician's own moral or professional values. Physicians are themselves moral and professional agents whose own self-determination or integrity must be respected as well. Even if performing assisted suicide or euthanasia were to become legally permissible nationwide, the care of a patient who requests aid in ending his or her life should be transferred to another physician if performing such a procedure conflicts with the physician's reasonable understanding of his or her moral or professional responsibilities.

Underlying the argument for physician-assisted suicide and euthanasia is the notion of a good death. Once pending death is accepted, is it not more humane to end life, quickly and peacefully, as can be done by physician-assisted suicide or euthanasia, when that is what the patient desires? Is not such a death perceived as better than a prolonged siege in which an individual may be stripped of his or her dignity? Many of us say that we would like to die in our sleep or of a massive heart

attack on the 18th green rather than from a protracted and terminal illness. Who among us wants to cling to life, in pain and subjected to a variety of medical interventions that rob us of our dignity and self-hood?

In his essay “Physician-Assisted Suicide Is Sometimes Morally Justified,” Dan Brock observes that “We care about how we die in part because we care about how others will remember us as we were in ‘good times’ with them and not as we might be when disease has robbed us of our dignity as human beings [...]. [A]ssisted suicide or euthanasia will be a more humane death than what they have experienced with other loved ones and might otherwise expect for themselves” (23).

Conclusion

The greatest human freedom is to live and die according to one’s own desires and beliefs. Balancing a reverence for life with a belief that death should come with dignity and with grace is the paramount challenge of our time.

Physician-assisted death should be one—and, most assuredly, not the only one, but one—of the options available to a patient facing a hard death. These options should include high-dose pain medication, cessation of life-sustaining therapies, voluntary cessation of nutrition and hydration, and terminal sedation. However, physician-assisted dying, whether it is called physician-assisted death or physician aid in dying or physician-assisted suicide, should be among the options available to patients at the end of life.

The most compelling reason for allowing physician-assisted suicide and euthanasia is derived from our right to privacy, liberty, and self-determination. Persons who are at the end stage of life should be afforded the right not only to extend their lives as long as possible but also to refuse procedures that prolong the dying process. The option of physi-

cian-assisted suicide provides patients with final control over how, when, and where they will die.

The right to self-determination in dying and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of the terminally ill patient to select the time and place of his or her death should be a legally protected right. If a competent, informed person who is terminally ill wishes to select the time and place of his or her death, providing the means for such a gentle passing should fall within the continuum of care. This includes instances when a physician is asked to provide the means for ending a life and when the nature of an individual’s disease course makes it necessary for a physician to directly cause the cessation of life.

Physician-assisted suicide is not about physicians ignoring their ethical standards and becoming killers. Nor is physician-assisted suicide about turning away from patients when they ask for help. It is about those individual lives in which suffering cannot be relieved without a complete loss of control and dignity. Will there be physicians who feel they can’t do this? Of course, and they shouldn’t be obliged to. However, if other physicians consider it merciful to help such patients by merely writing a prescription, it is unreasonable to place them in jeopardy of criminal prosecution, loss of license, or other penalty for doing so.

Most of us cherish life and do not wish to die. Many of us are willing to fight serious illness with every advance medicine can bring to our aid. Many will continue to struggle until their last breath, finding meaning in their suffering. However, for others a time will come when that struggle is too much and life becomes a meaningless existence supported artificially by a myriad of machines and treatments. Then, at their request, should not they be allowed to end their journey as quickly

and as painlessly as possible and to die with dignity and love? Should they not be permitted legally and morally to gently into that good night and thus to pass through to eternal dreamless rest?

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