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Euthanasia – The Right To Choose

by Stacy Nalley

(Honors English 103)

The Assignment: Students were assigned to write eight-twelve page research essays on Holocaust-related topics that explored controversial aspects of this area of study.

Mr. Boxer was old and his health was failing. By most standards he'd lived a good life, surrounded by a loving family. Now, he was blind and terminally ill with an inoperable tumor. Despite the best medical care, he was in constant pain. After prayerful consideration, Mr. Boxer's family requested his doctor perform euthanasia. Moments after the lethal injection, Mr. Boxer's body relaxed, and he peacefully slipped from this life while his family held his body. Mr. Kauffler had much in common with Mr. Boxer. He was also old and terminally ill, with a life expectancy of only days. Regardless of the doctor's best efforts, Mr. Kauffler suffered tremendous pain. His wife had passed away six months before. In his conscious moments, he begged to end the suffering and join his wife. Unlike Mr. Boxer, however, Mr. Kauffler ended his life in intensive care and intensive pain. By the way, Mr. Boxer was a treasured family pet and Mr. Kauffler was a beloved grandfather.

Why do our laws allow for the more humane treatment of our animals than of our citizens? This complex issue raises complex questions – When is euthanasia murder and when is it mercy? Is passive euthanasia less humane than active physician-assisted suicide? Does the dignity afforded by euthanasia affirm or deny the sanctity of life? It is only after grappling with these tough issues that the question most central to this debate surfaces – Does each human have a right to make this deeply personal choice for themselves? The answer is a resounding yes! It is absolutely appropriate, under the proper guidelines, for a terminally-ill patient to choose physician-assisted euthanasia.

The difficulty in defining euthanasia illustrates the complexity of the issue. Webster defines euthanasia as a painless killing, especially to end a painful and incurable disease, mercy killing. The Greek translation is literally "good death." Crucial to this controversy is differentiating between active and passive euthanasia. In his essay, "Active and Passive Euthanasia," James Rachels summarizes the American Medical Association's position on passive euthanasia as "it is permissible, at least in some cases, to withhold treatment and allow a patient to die" and on active euthanasia as "it is never permissible to take any direct action designed to kill the patient"(643). While conceding that the primary objective of passive euthanasia is humanitarian, Mr. Rachels argues that it is often just the opposite. Rachels offers an example of a patient dying of cancer and in agonizing pain. Legally, a doctor may agree to withhold treatment so as not to prolong the patient's suffering. However, by withholding treatment, the patient may actually endure more pain and live longer than if more direct action were taken and the patient received a lethal injection. Professor Rachels effectively makes the point that the purpose and outcome of both methods of euthanasia is the same and the physician-assisted method is certainly more merciful(647).

While most agree that physician-assisted suicide leads to a more merciful death, many argue it can too easily cross the line and become murder. Terry Golway, in the essay entitled "The Culture of Death," gives readers a worst-case scenario of euthanasia run amok. Golway points to the Netherlands, where euthanasia is an accepted practice, shocking readers with the story of a psychiatrist prescribing death for a healthy mother in deep despair over the loss of her children. This example punctuates the importance of discerning mental competence when determining the appropriateness of physician-assisted euthanasia. Golway also raises the point that in Holland "900 to 1,000 patients a year die of 'involuntary euthanasia'"(690). Patients who are, one assumes, unable to make their wishes clearly known. Ellen Goodman, in her essay, "Who Lives? Who Dies? Who Decides?" finds this prospect equally troubling as she exemplifies 78-year-old Earle Spring, a seriously ill man living in a "gray area of
consciousness" (627). Mr. Spring's family felt he would not want to continue living in this state and petitioned for the withdrawal of his medical care. Before this request was granted, an intervention by an outside doctor and nurse determined that Mr. Spring expressed a "weak desire to live" (627) and his treatment continued. Ms. Goodman maintains when there is any doubt regarding a person's desire to live, that doubt must be honored. These assertions make the case for the proper administration and regulation of euthanasia.

The questions then become (1) Who should have the option to receive a physician's assistance with dying? and (2) How can it be regulated? Dr. Cecil McIver, in his essay, "Assisted Dying as a Moral and Ethical Choice: A Physician's View," presents evidence supporting his opinion that mentally competent, terminally ill patients suffering a great deal of pain should be able to end their lives with the assistance of a doctor. He adds that the Hemlock Society narrows that focus to include only "adults with a life expectation of six months or less" (632). Dr. McIver cites a study published in the Journal of the American Medical Association in which it was concluded, that despite the best care and pain management modern medicine could offer, 50 percent of patients experienced significant discomfort in their final days and were often in comas or in intensive care isolated from their families (632). The director of this study concluded: "our society needs to create a better vision of living well while dying," and "we live in a health care system focused on treating disease, and we do that very well, but we don't know when to stop" (633).

Additionally, Dr. McIver offers some advice on how to regulate this process. He states that while cumbersome requirements should be avoided, certain safeguards will ensure effective protection. These safeguards call for an experienced physician consulting with the doctor who is considering performing euthanasia. This consultant would "confirm that the patient was terminally ill, mentally competent, receiving optimum care, acting under no undue pressure and resolutely requesting assistance in dying" (639). Furthermore, Dr. McIver advocates the confidential review of such cases by a committee of the physician's colleagues.

Finally, Timothy Quill, in his essay "Death and Dignity," makes the case for the control and dignity that the choice of physician-assisted suicide affords the terminally ill. Dr. Quill describes a memorable personal encounter with euthanasia. His patient, Diane, was a fiercely independent woman diagnosed with acute leukemia. Even with aggressive, toxic treatment, she was given a slim chance for recovery. After careful consideration, she chose to deny treatment. She was then faced with avoiding a painful death. It became apparent to Dr. Quill that Diane's fear of a lingering death would hinder her ability to enjoy her remaining time (651). While Dr. Quill was not legally able to offer Diane direct assistance to a peaceful end, he was able to indirectly aid her. This dying woman's legacy to Dr. Quill was to strengthen his conviction that sometimes it is necessary for physicians to shed the traditional role of healer in order to truly serve their patients.

Ultimately, each person must struggle to determine the existence and extent of their own soul—a deeply personal issue that can only be resolved from within. As unique as each life, so too is each death. Let us honor this individual by allowing terminally ill patients the dignity of choice.

Works Cited


