IS EUTHANASIA A CRIME?

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[Assignment: You are asked to respond to any of the issues raised by the provocative program "Who Lives-Who Dies," produced by James Earl Jones. Your task will be to write an analytical and persuasive essay focusing on the consequences of recent developments in medical technology. This paper requires the use of outside sources for support of your argument.]

(1) The issue of euthanasia, the termination of medical treatment to incompetent patients, is more pressing today than it has ever been in the past. It confronts more physicians more often and involves more types of medical interventions. The increasing number of legal decisions and changes in medical care confuse physicians about which practices are acceptable and which are not. As a result, more and more patients, who have no hope for recovery, are forced to stay alive, dependent on life-support systems and nutritional support. These benefits of continued life are perceived by patients as insufficient to justify the burden and cost of care. Therefore, physicians are called upon to make difficult decisions according to their best medical and ethical judgment. Euthanasia is not murder when it is practiced under appropriate conditions and specific situations, and these circumstances should be defined more clearly by law so fewer physicians go through the court system.

(2) The Quinlan case was the first case involving the withdrawal of life-sustaining medical care from a permanently incompetent adult. Karen Quinlan was a twenty-one year old who ceased breathing for two fifteen-minute periods. In the emergency room, she was resuscitated and placed on a respirator. One year after the event, she was in a persistent, vegetative state, respirator dependent, and receiving nutrition by nasogastric tube. After discussing the matter with his priest, Karen's father requested that the respirator be discontinued. Her attending physician refused, viewing this as a violation of medical ethics. In addition, the local prosecutor and the state attorney general threatened criminal proceedings (Emanuel 291).

(3) The court decision on this case managed to establish an analytic framework for other cases by considering three major questions: (1) Is there a right to terminate medical care? (2) For what types of patients can care be terminated? (3) What types of care can be terminated? The justices on the Quinlan court never specified a standard for terminating care. Yet, in answering the second question, the court stated that the guardian of a patient who would never "return to a cognitive and sapient existence" (Emanuel 293) could terminate medical care. The third question addressed Karen's artificial life-support apparatus. These decisions obviously cannot apply to all cases, but the
same questions are asked in every case, and their answers sum up to similar standards.

(4) In addressing the first question of whether there is a right to terminate medical care, certain criteria are established for each patient. For competent patients, the choice of terminating care is theirs alone, and they need no justification for their choice. The same is true for patients who have left advance instructions concerning their care if they become incompetent. However, as Joanne Lynn states, for incompetent patients who lack advance instructions, the courts have been less consistent in endorsing any guidelines (478).

(5) In the decade since the Quinlan case, three different criteria have been set as standards to follow when dealing with incompetent patients. The first standard distinguishes between ordinary and extraordinary care. Ordinary means of preserving life is medical care which offers "a reasonable hope of benefit for the patient" (Emanuel 295) and which can be used without excessive expense or pain. Extraordinary means of preserving life is medical care which cannot be used without great expense or pain, or which, if used, would not cause a reasonable hope of benefit (Emanuel 296). According to this definition, the courts agree there is a right to terminate extraordinary care. The second criterion, substituted judgment, holds that the incompetent's surrogate should try to "ascertain the incompetent person's actual interests and preferences," making a decision which "would be made by the incompetent person if that person were competent" (Areen 230). This is similar to the third standard, best interests, in which the patient's surrogate selects the appropriate medical care that will most benefit the patient (Lynn 480).

(6) Yet, each proposed standard is seriously flawed. The ordinary/extraordinary distinction has such a multiplicity of interpretations that it tends to be unhelpful. Trying to use substituted judgment to imagine what medical care an incompetent patient would want seems an impossible task. Also, there are no criteria by which to determine what medical care is in the patient's best interests and what is not (Emanuel 297). These standards need to be clarified clearly by the courts so that physicians can apply them more effectively to specific cases.

(7) For what types of patients can care be terminated? Until recently, decisions about whether care should be withheld or withdrawn concentrated only on terminally ill patients. "Terminal" in this debate, means a condition that will directly result in death within the foreseeable future regardless of whether medical treatment is undertaken or not. This is ironic
since the entire rationale of the Quinlan ruling did not depend upon her being terminally ill in the sense of death being imminent. In many ways, Karen Quinlan represents the more common case of the hopelessly, but not terminally ill patient: those who can live for many years with continuous, medical interventions and yet have no prospect of "enabling a return toward a normal, functioning, existence" (Emanuel 298).

(8) Still, there has been some move to permit the withdrawal of care from vegetative patients who are not terminally ill. This is most clearly voiced in a case in which a court authorized the withdrawal of gastric tube feedings from a forty-nine year old fireman left in a persistent vegetative state by a ruptured aneurism. He had no other illnesses and could have lived for thirty years or more. The court argued that his death would occur from natural causes following the removal of life-sustaining medical care (Lo 248). This demonstrates that the ethical justification for terminating care should permit the withdrawal of care from hopelessly, as well as terminally ill patients. Therefore, in summary of the second question, a competent patient in any state of health can refuse medical care. But medical care can also be terminated for terminally ill, incompetent patients and hopelessly ill, vegetative patients. The reluctance of courts to extend this position to non-vegetative, incompetent patients who are not terminally ill is also in question but not legally resolved.

(9) The third and final question tends to be the most controversial of the three; it addresses the types of medical care that can be terminated. The Quinlan case focused on the withdrawal of respirators, but this justification is not limited to that specific intervention. In the following decade, legal cases have sought to terminate many other types of medical care. Although not every form of medical care has been legally tested, there appears to be general agreement that any type of medical intervention can be ethically and legally terminated (Emanuel 300).

(10) Yet the withholding or withdrawing of artificial nutrition and fluids from a patient is an emotionally charged, controversial issue. A recent series of cases have tested whether artificial feedings constitute medical interventions or fall into the category of "basic human needs" (Meyers 125). Nourishment should be provided in the vast majority of cases as long as physically possible. However, in those rare cases where nourishment can only be provided through invasive means and cannot improve the patient's hopeless prognosis, it seems the law should not mandate continued medically provided nourishment.

(11) The Barber case has important implications and is a good example because, for the first time, a court
equated the discontinuation of I.V. feeding with the removal of a respirator or any other medical intervention. The patient had entered the hospital for an ileostomy repair. Within an hour after the surgery, he suffered heart failure. When the physicians assessed his condition as hopeless, the patient's wife requested that all life support machinery be removed. The respirator was removed, and the patient began breathing on his own. Two days later, the family requested that no medication be given and that everything be pulled out. The I.V. line was disconnected, and six days later, the patient died. The district attorney of the medico-legal office charged that this was murder, insisting that unlike other mechanical means of life-support, nutrition was an ordinary necessity of life. But the court acknowledged that developments in modern medicine have surpassed legal consideration on these issues and that physicians and families shouldn't have to make such difficult decisions without clear, legal guidelines. Nutrition was, in this case, declared a medical treatment and was to be used only if it benefited the patient (Paris 2243).

(12) Many other circumstances argue against continuing nourishment for patients. Thus in some cases, depending on the condition of the patient and the prognosis, continued nourishment is neither expected nor would be desired by the patient, if he or she were competent to express himself or herself. In other cases, nourishment may actually detract from the patient's dying with dignity. Or, as Siegler suggests, it may even be painful and invasive and require highly technical medical treatment for placement of the necessary tubes (130). Medical nutrition and fluids should be administered like any other medical intervention, and the decision not to provide them in certain circumstances should not be seen as violating medical ethics or the law.

(13) Since the Quinlan case, discussions about withdrawing and withholding care from patients have increased. Although there are a few areas of agreement, most issues remain unsolved. Attempts to set specific guidelines for physicians to follow in these cases have failed. The development of an understandable, ethical framework can make routine medical decision-making easier without creating unreasonable restrictions on the available choices. The issue of euthanasia is a complicated one, the tradition of medicine long, and, therefore, we need to create guidelines carefully but surely.
End Notes

1 An incompetent patient is one who does not have adequate ability, knowledge, or fitness to communicate his/her needs to the attending physician (Siegler 129).

2 Since it is only within the last twenty years that irreversible loss of brain function has been suggested as an alternative criterion for death, the issue of brain death is not considered as either hopelessly or terminally ill and remains a major controversy (Black 121).

Works Cited


