

ON YOUR OWN TERMS: A COMPARATIVE STUDY OF
EUTHANASIA POLICY IN THE UNITED STATES AND
WESTERN EUROPE

by

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A THESIS

Presented to the Department of Political Science
and the Robert D. Clark Honors College
in partial fulfillment of the requirements for the degree of
Bachelor of Arts

June 2017

An Abstract of the Thesis of

Sarah McKenzie Anderson for the degree of Bachelor of Arts
in the Department of Political Science to be taken June 2017

Title: On Your Own Terms: A Comparative Study of Euthanasia Policy in the United
States and Western Europe

Approved: _____

John Davidson

In order to understand why the approaches to euthanasia policy in the United States and Western Europe are so radically different, this study provides a comprehensive overview of euthanasia and its variations, the legal precedent it holds, as well as the laws that govern its usage. The foundations of this study are the states of Oregon and Texas as the case studies which demonstrate the contradicting American approaches to euthanasia; and the nations of Belgium and the Netherlands as a representation of the European approach. This study concludes that, for a variety of social, political, and cultural reasons, the ways in which governments decide to legislate euthanasia policy vary immensely. These reasons include, religion and its contrasting importance within societies, political trends in opposing ideological directions, the importance of certain philosophical principles, and racial demographics.

Acknowledgements

I would like to thank Professor John Davidson for helping me to fully examine the specific topic and consider the various perspectives and contexts related to subject matter. Davidson's classes and unique worldview provided me with the inspiration for this work as well as for furthering my education in law. I would also like to thank Professor Helen Southworth for being both my Honors Representative and instructor in HC 477H as your help and insight to beginning the thesis process in the Honors College was immense. Additionally I would like to thank Alex Farrington for serving as my Secondary Reader and giving me greater perspective towards the topic.

I would also like to thank my family, as without their support I would not be in the place I am today. Thank you to my Mother Shannon for showing me what an amazing, ambitious, and determined young woman looks like. To my Father David thank you for always supporting me in my endeavors and dreams. To my brothers Colton and Kyle for always making me laugh and being there for me. You are all amazing.

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Source: Pewforum.com

Chapter 1: Background Information

Introduction

The first time I remember experiencing death was when my Grandmother died in December of 2001. At the time I was only six years old and could not completely understand what was happening, yet nonetheless there were still deep feelings of sadness and longing. As I grew older this situation would happen again with other family members and a friend during my teenage years. For myself death was unarguably a universal harm, this was a simple fact that I imagined everyone could agree with. Yet this perspective changed when I watched the film *How to Die in Oregon*, a documentary which covers the Oregon Death with Dignity Act, its implications, and the stories of a few who decided to use the law to facilitate their death. This film sparked an interest in me after I watched it as I had never heard of such a law let alone one that exists in the place where I have always lived. This thesis is the manifestation of my curiosity that began five years ago.

Rather than writing about the ethical concerns around euthanasia or where the right to die may come from I wanted to explore why euthanasia policy looks so different around the world. I have decided to look at the laws that exist in the United States and Western Europe to investigate why the respective legislation looks so different for such a universal inevitability. I will be focusing on Oregon's Death with Dignity Act as well as Texas's Advanced Directives Act in order to contrast the wide disparity in how euthanasia or physician assisted death (related to euthanasia, but different) is allowed in the same country. Similarly, to represent Europe I have chosen

to examine the laws of the Netherlands and Belgium to explore why these two nations have the most liberal euthanasia laws in the world, and show how deeply they vary from the laws in the U.S. I feel that exploring this topic further the understanding of not only euthanasia and why it exists but also the future of how euthanasia policy will be shaped.

Dissecting Terminology and the Concept of Dignity

The debates around the legal, moral, and ethical implications of end of life treatment, especially if that treatment results in the death of the patient, use terminology which is foreign and unclear to many. Without a proper understanding of how these treatments work and are used one cannot understand why they differ from one another and how they have been shaped through the social and political realm. This chapter will clarify and discuss all the different variations of euthanasia policy, which is pertinent to understanding how they function and operate in the current legal context.

The term dignity frequently appears in conversations regarding euthanasia or end of life treatments. Dignity itself is literally defined as “the quality of a person that makes him or her deserving of respect, sometimes shown in behavior or appearance.”¹ However within this debate dignity is used as an abstract philosophical concept denoting that an object which has dignity possesses because it has an innate sense of worth. As humans, our worth and sense of self comes from within us, thus we are placed higher than things with no understanding of value because without a conscious

¹ *Cambridge Dictionary*, s.v. “Dignity,” accessed February 28, 2017, <http://dictionary.cambridge.org/us/dictionary/english/dignity>

notion of value, dignity does not exist.² Humans feel dignity from their innate sense of worth and if we take this feeling away from them they lose self-respect.

If dignity is our inner sense of worth that entitles us to special treatments and consideration, it begs the question as to how we should allow dignity to shape our policy and moral guidelines. In an effort to maintain a fair and ordered society, the struggle for the maintenance of autonomy and self-respect is crucial. Preservation of patients' dignity in the context of end of life care is extremely important for physicians and hospital staff, as those patients are already in a vulnerable state. We all share

...the mutual recognition of the desire to be seen, heard, listened to, and treated fairly; to be recognized, understood, and to feel safe in the world. When our identity is accepted and we feel included, we are granted a sense of freedom and independence and a life filled with hope and possibility.³

Maintaining dignity at the end of life has never been easy. Due to the many advancements in medical technology of the last century, humans have the means to artificially maintain every bodily system far past the point at which they could function independently. Conditions like cystic fibrosis, Lou Gehrig's disease, and a variety of cancers which previously would have resulted in an immediate terminal diagnosis have treatments which can greatly extend the lives, comfort, and dignity of patients.

Ultimately these life sustaining treatments come to an end of effectiveness, as a relevant

² Raphael Cohen-Almagor, *The Right to Die with Dignity: An argument in Ethics, Medicine, and Law* (New Brunswick: Rutgers University Press, 2001), 17.

³ Donna Hicks, "What is the Real Meaning of Dignity? Few People Realize the Extraordinary Impact on Our Lives," *Psychology Today*, accessed February 22, 2017, <https://www.psychologytoday.com/blog/dignity/201304/what-is-the-real-meaning-dignity-0>.

condition will begin to aggressively take hold. The physical deterioration that a patient may experience is often inextricably linked with a feeling of loss of dignity.

While we have the means to extend the operating capacity of our bodies, regardless of disease or not, this does not negate the reality that at some point our physical beings will die, yet

...physicians are now able to keep the body functions long past its natural span, long after the mind and spirit have ceased to exist, sometimes almost indefinitely by artificial means,

which is referred to as living death.⁴ This state of living death is has been a direct factor in bringing euthanasia and physician assisted death out of the shadows because to many a state of living death is not a dignified state of being. Dignity is an essential part of the human experience as it sets us apart from the many other objects and things of value which populate this world, and in order to maintain this innate sense of worth during the end of life a movement for freedom in choice of death coalesced.

Although this work will not be considering the ethical concerns or debates around euthanasia it is worth noting some of the ways in which it is debated.

Euthanasia: Variations and Infamy

Euthanasia comes from the Greek word *thanatos* which means death and its prefix *eu* meaning good or easy thus euthanasia simply refers to a good and/or easy death.⁵ The term broken down is rather innocuous in its nature as essentially all anyone could ask for in death is one that is as good or easy as the process can be. Suicide has

⁴ O. Ruth Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia* (New York: Human Sciences Press, 1975), 14-16.

⁵ Russell, *Freedom to Die*, 17.

always been a controversial topic, regardless of the terms in which it was carried out.

Italian philosopher and theologian Sir Thomas Aquinas wrote that suicide is unlawful for a variety of reasons

...because every thing loves itself, it is thus proper for every thing to keep itself in being and resist decay as far as it can...every thing that is a part belongs to a whole, every man is part of a community, and as such is of the community. Therefore, he who kills himself injures the community...he who deprives himself of life sins against God.⁶

While Aquinas' views were the most commonly held at the time, Scottish Philosopher

David Hume wrote his own essay on the morality of suicide in contrast to Aquinas

earlier points. He states that

...suicide may often be consistent with interest and with our duty to ourselves, no one can question, who allows that age, sickness, or misfortune, may render life a burden, and make it worse even than annihilation. I believe that no man ever threw away life, while it was worth keeping.⁷

Suicide has always been a somewhat taboo topic, and while the conversation has evolved, the arguments both for and against are still rooted in these early works. They are frequently extended to the morality and legalization of euthanasia.

In the mid twentieth century the definition of euthanasia began to shift towards a greater emphasis on the idea of using it as a mercy death or merciful killing. As a medical term, euthanasia is the process of an outside actor, specifically medical personnel, who administers some mode or method of dying to a patient.⁸ (If the physician merely prescribes a lethal agent, leaving it to the patient to self-administer,

⁶ Thomas Aquinas, *Summa Theologiae*, 2A 2AE, question 64, article 5, tr. Michael Rudick. Quotation in introduction from Angelico Ferrua, *Sancti Thomae Aquinas vitae fontes praecipuae* (Alba, Italy: Edizioni Domenicane, 1968, 318).

⁷ David Hume, *On Suicide* (New York: Penguin, 2005), 6.

⁸ Russel, *Freedom to Die*, 16-19.

this is referred to as physician assisted death rather than euthanasia; this practice will be discussed separately.) However within this broad definition the spectrum of euthanasia can be lost using mercy killing as an interchangeable term.

The antonym of euthanasia is dysthanasia; the two share the same suffix of *thanasia* meaning death but *dys* means bad. At its essence the entire reasoning for practicing euthanasia is to avoid dysthanasia which is seen as a complete failure of medical science as well as the Hippocratic Oath.⁹ The prolongation of suffering is the worst way in which a physician could fail their patients as it is nearly always inextricably tied with a loss of personal dignity. In tandem, dysthanasia also refers to the use of extraordinary means in order to needlessly prolong the life, and ultimately the suffering, of a patient.¹⁰ Many physicians and medicinal personnel who support euthanasia follow the reasoning of Scottish philosopher Sir David Ross on this matter, finding "... 'the duty of nonmaleficence recognized as a distinct [duty] *prima facie* more binding' than the duty of beneficence."¹¹ In other words, the duty to avoid harm takes priority over the duty to render aid. In order to prevent dysthanasia there is a variety of modes by which euthanasia can be applied, and these methods do not necessarily denote themselves as mercy killings.

Euthanasia can be divided into two separate categories which allow for greater nuance when approaching the topic. The first category is *passive* or *negative* euthanasia,

⁹ Russell, *Freedom to Die*, 22.

¹⁰ Russell, *Freedom to Die*, 23.

¹¹ N. Ann Davis, "The Priority of Avoiding Harm," in *Killing and Letting Die*, ed. Bonnie Steinbock and Alastair Norcross (New York: Fordham University Press, 1994), 298-299.

and the second is *active* or *positive* euthanasia. Another distinction is made between *direct* and *indirect* euthanasia, which is only relevant in situations where active euthanasia is used. Furthermore is the distinction between *voluntary*, *non-voluntary*, or *involuntary* euthanasia, which is often at the heart of much of the controversy and case law regarding the legalization of the practice.¹² Although this paper will focus on active euthanasia it is critical to understand the difference between active and passive modes, as well as why one (passive) is typically not referred to as euthanasia at all.

Passive or negative euthanasia refers to inaction of an individual who knows that as a result of their inaction the patient's death will occur, and this may involve initial withholding of treatment or removing treatments. A commonly cited example of this would be the notion of "pulling the plug," which would result in the death of said patient on life-sustaining treatment.¹³ This is generally seen as a relatively uncontroversial method of death, as there is a clear social consensus that death is unavoidable. In instances like this the decision is seen as a private family matter when the family have collectively, come to the decision that this is the best option for their family member. Passive euthanasia is seen as a method of avoiding dysthanasia rather than actually killing; thus, calling it mercy killing does not accurately describe what is happening. More often it is referred to as "letting die," implying that in their inaction a physician is only allowing the patient to die as they would without any medical intervention beyond pain management.

¹² Russell, *Freedom to Die*, 19-24.

¹³ Cohen-Almagor, *The Right to Die with Dignity*, 81.

Mercy killing better describes the *active* or *positive* euthanasia, wherein direct intervention is taken in order to result in a patient's death. This most commonly manifests itself in administration of medication intravenously or orally which is taken in order to deliberately end a patient's life.¹⁴ In addition to mercy killing the term "elective death" is used for this practice, denoting far greater patient control and intervention in the situation than mercy killing does.

Within active euthanasia are the *direct* or *indirect* variations which again are similar but possess key differences. Direct active euthanasia refers to the deliberate inducing of death through particular medication when its sole purpose of administration is to promote death. In contrast, indirect active euthanasia is when the use of medication is for pain management rather than only administered for the causation of death, however there is an acknowledgement and understanding that this intervention will hasten the death of the patient.¹⁵ Unlike passive euthanasia both varieties of active euthanasia are highly controversial in their methods and applications.

Euthanasia, active or passive, is controversial regardless of its means. The often used "slippery slope" argument fiercely criticizes legalized euthanasia for its connection with the use of eugenics or the possibility of a compulsory state imposed euthanasia.¹⁶ However, in the promotion of ethical euthanasia, the practice is solely limited to circumstances involving (a) the request of the patient (*voluntary* euthanasia) or (b) the request of a patient's legal guardian, if the patient is in a vegetative state (*non-*

¹⁴ Russells, *Freedom to Die*, 23

¹⁵ Russells, *Freedom to Die*, 23.

¹⁶ Cohen-Almagor, *The Right to Die with Dignity*, 188-189.

voluntary euthanasia).¹⁷ Furthermore involuntary euthanasia (against the patient's expressed objections) will not be addressed, as that is simply murder and have zero legal standing anywhere in the world.

There is a variation of euthanasia which exists in the United States known as physician assisted death (PAD). It is often defined simply as euthanasia, but this lack of proper distinction promotes undue ignorance and fear around the practice.

Physician Assisted Death: Ethical and Patient Promoted

Due to the myriad of ethical fears as well as the negative connotations imminently associated with the term euthanasia it is relatively unpopular worldwide. Figure 1 shows the legality of euthanasia policy worldwide, and it can be seen that only three nations have legislation which allows for active euthanasia to legally occur, those being Belgium, the Netherlands, and Luxemburg; however in figure 1 Canada and Japan are also dark blue, although neither nation has legal active euthanasia. This is where physician assisted death (PAD) emerges as a legal alternative to state sanctioned euthanasia.

¹⁷ Russells, *Freedom to Die*, 21.

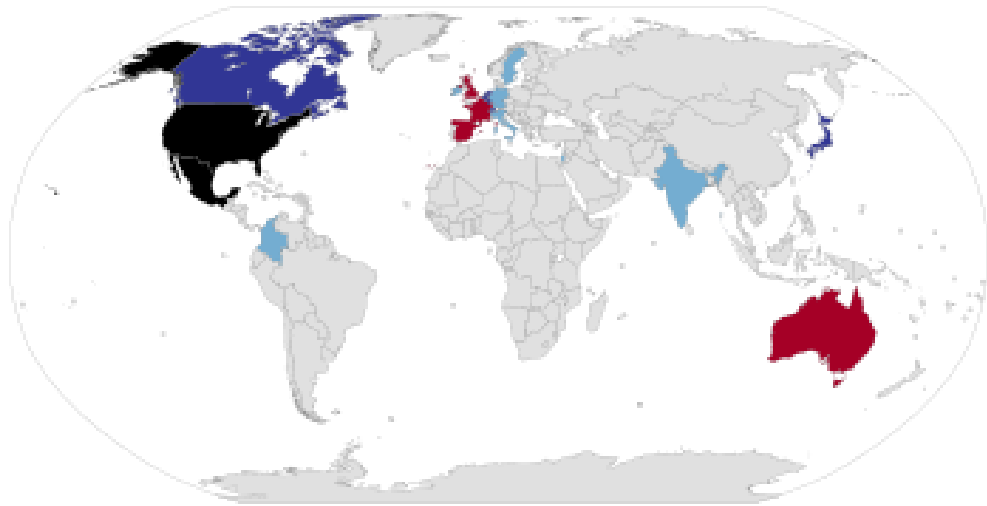


Figure 1: Current status of euthanasia laws worldwide. Dark blue indicates legal active euthanasia, light blue indicates legal passive euthanasia, black indicates laws vary based off administrative decisions, and red indicates euthanasia in all forms is illegal.

Although they are often grouped together as the same thing, as in figure 1, physician assisted death (originally physician assisted suicide), is separate from euthanasia. Euthanasia requires that an outside actor (i.e. a doctor) either administers the treatment that will result in the death of the patient or administers treatment that itself will not directly result in death but is given to hasten the process of death (active euthanasia); or that they deliberately stop or never start treatment of an individual that could potentially extend the life of said patient (passive euthanasia).¹⁸ The small difference in physician assisted death is that it requires that the patient must self-administer the medication which will result in their death and no one else is allowed to do so. Under all laws which permit physician assisted death the sole purpose of the

¹⁸ Cohen-Almagor, *The Right to Die with Dignity*, 80-82.

creation of them was to allow an ethical variation of euthanasia which would not make doctors, or any other individual, directly responsible for their patient's deaths.¹⁹

The reasoning behind the legalization of physician assisted death is to promote the best care available to patients both during their illness as well as during their death. The elimination of the doctor's active role in the administration of medication is intended to remove the caregiver of ethical responsibility for the death of said patient; however, these laws do require that a physician (often more than one) signs off on a prescription for the medication which will result in the patient's death.²⁰ Physician assisted death exists solely to remove and ease suffering for a patient and is highly regulated within the jurisdictions that allow it to occur, yet it does not come without its fair share of ethical controversies similar to those that it was trying to avoid.

One area of concern for physician assisted death directly concerns the role, or lack of a role, that the doctor takes in the process. As a physician's role is to heal their patient it can be believed that in prescribing any medication with the knowledge that its use will cause or hasten the death of a patient they are in essence doing harm.²¹ Due to this many doctors as well as other staff who may be involved in the process are hesitant in supporting the use of euthanasia or physician assisted death as a treatment. Figure 2 shows the results of an online poll of physicians in the United States conducted in 2013 by the online social media platform for doctors Sermo, which found of those polled

¹⁹ Steven J. Baumrucker, Matt Stolick, Gregory T. Carter, Paige Mingle, Karrie A. Oertli, and Gerald M. Morris, "Legal But Not Always Allowed: 'Physician Aid in Dying,'" *American Journal of Hospice and Palliative Care* 28 (2011): 449, accessed February 28, 2017, doi: 10.1177/1049909111412540

²⁰ Cohen-Almagor, *The Right to Die with Dignity*, 186.

²¹ Cohen-Almagor, *The Right to Die with Dignity*, 186-187.

48% of all physicians polled supported physician assisted death, which the remaining 52% were undecided or against. However most interesting in the Sermo poll is the fact that those responding physicians who specialized in hospice and geriatric care were the least likely to support physician assisted death with only 39% responding yes. However, the results of a New England Journal of Medicine poll varied from those of Sermo, indicating that of those physicians who responded, 68% did not support the use of physician assisted death nor would they participate in one.²²

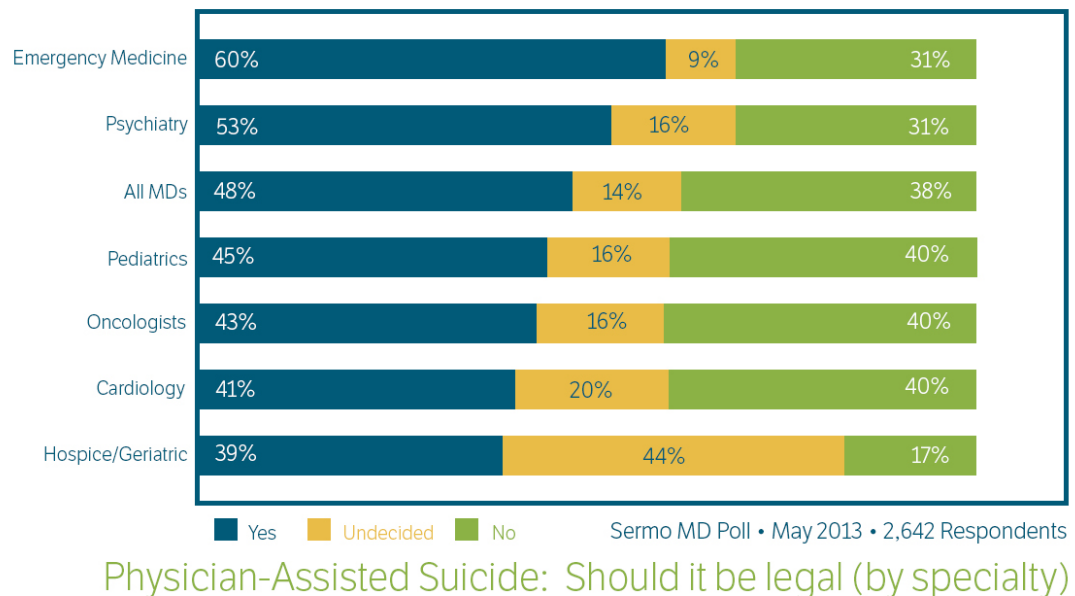


Figure 2: Results of Sermo poll “Should PAD be legal.”

Other concerns over physician assisted death, also applicable to euthanasia policies, include the potential for state abuse and the creation of mandatory death registries, as well as the potential for deliberate misdiagnosis of patients to persuade

²² Jonathan N. Alder, James A. Colbert, and Joann Schulte, “Physician-Assisted Suicide – Polling Results,” *New England Journal of Medicine* 369 (2013): e15, accessed March 1, 2017, doi: 10.1056/NEJMcld1310667.

them to consider physician assisted death. The fear of overzealousness is relatively unfounded, as it would require a serious erosion of social and cultural norms in both government and healthcare. In addition to this, it would mean a total breakdown the ethical systems which are put in place to regulate these industries; thus this abuse of physician assisted death is highly unlikely to happen.²³ Moreover, this fear is completely unfounded, as all physician assisted death legislation is built in with a variety of safeguards (discussed at greater length later). Despite these fears around physician assisted death, what these laws attempt to do is promote patients' sense of control and dignity in the death process, which, as discussed earlier, is considered by some to be imperative to both a successful society as well as stable individuals.

Physician assisted death is rarely called that by its advocates, and even less often referred to as physician assisted suicide, even though those are the original terms which were used to describe it. In the United States these policies are known as *Death with Dignity* and in Canada it is referred to as *medical aid in dying*, both of which are much softer than any of the original terminology. This language is easier to draw public support for, and it also highlights that physician assisted death is intended to maintain patient dignity and autonomy rather than to encourage death or killing.

Variety of Policy Choices

The goal of policies that legalize either euthanasia or physician assisted death is to maintain and promote patients' sense of worth before and during end of life treatment. These policy decisions pose the questions: Does life itself matter more than

²³ Cohen-Almagor, *The Right to Die with Dignity*, 187-202.

the quality of the life which is being lived? How could we possibly measure this?; and, to what extent should we allow a patient to choose whether or not their life is worth living?²⁴ Death is without question an uncomfortable topic for many to approach, yet that does not absolve us from confronting it personally as well as politically. Death is a universal part of the human experience, thus one would expect that regions with different governments but similar social and cultural background would approach the issue in a similar manner. However, even a superficial examination of different policies reveal that this is clearly not the case. Although death will occur for everyone, painless or not, the different ways in which we have decided to legislate one of the most personal processes that individuals go through speak towards small but significant variations in social and legal history.

²⁴ Cohen-Almagor, *The Right to Die with Dignity*, 53.

Chapter 2: Euthanasia and PAD in the United States

Congressional Approach to Euthanasia

Congress had little to say on euthanasia and its legality. Historically, euthanasia advocates have always targeted individual states as their main avenues towards the passage of active euthanasia. (The first bill of this kind appeared in 1906, when euthanasia advocates and physicians attempted to push through legislation in Ohio and Iowa which would legalize the practice.²⁵) On a federal level, death which is a direct results of another's actions falls under an umbrella of potential violent criminal acts and is presumptively illegal. However the federal government has allowed states to decide whether or not they wish to legislatively impose a variation of euthanasia, with the caveat that the federal government will not fund any acts that, even if used as a medical treatment, cause the intentional death of a patient. In 1997 congress passed The Assisted Suicide Funding Restriction Act of 1997, stating that

(1) The Federal Government provides financial support for the provision of and payment for health care services, as well as for advocacy activities to protect the rights of individuals.

(2) Assisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States and, under current law, it would be unlawful to provide services in support of such illegal activities.

(3) Because of recent legal developments, it may become lawful in areas of the United States to furnish services in support of such activities.

(4) Congress is not providing Federal financial assistance in support of assisted suicide, euthanasia, and mercy killing and intends that Federal funds not be used to promote such activities.²⁶

²⁵ Shai J. Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States* (Princeton: Princeton University Press, 2009), accessed March 1, 2017. ProQuest ebrary.

²⁶ The Assisted Suicide Funding Restriction Act, 42 U.S. Code § 14401(1997).

Thus Congress has made it clear they will not partake in any funding associated with euthanasia. However the Supreme Court has made a number of rulings on the matter which have been the catalyst towards the legalization of physician assisted death in the United States (but not physician *administered* euthanasia).

The Courts Take on Passive Non-Voluntary Euthanasia

In regards to the use of euthanasia there has been an extensive number of cases in the United States on the subject of euthanasia. Passive euthanasia was first addressed about in the New Jersey Supreme Court ruling *In the Matter of Karen Ann Quinlan* (1976). After a severe brain injury which left Quinlan in a persistent vegetative state, her parents requested that their daughter be removed from the ventilator which kept her alive, which her doctors refused to do.²⁷ In its ruling, the court sided with Quinlan's parents based on their personal knowledge of their daughter's wishes as well as testimony of private conversations which expressed this wish, although there was no physical or legal document to prove this

Our affirmation of Karen's independent right of choice..., would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight... Nevertheless we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.²⁸

²⁷ Robert S. Olick and Paul W. Armstrong, "In Re Karen Ann Quinlan," in *Courting Justice: Ten New Jersey Cases That Shook the Nation*, ed. Paul L. Tractenberg (New Brunswick: Rutgers University Press, 2013), 77.

²⁸ *In the Matter of Karen Ann Quinlan, an Alleged Incompetent*, 70 N.J. 10 (1976).

Thus the use of passive euthanasia was legally protected and has continued to be so, with courts across the country treating the Quinlan decision as persuasive precedent. It must be noted that while this ruling was progressive, the limits of it were very strict in the fact that it only applies to those facing of irreversible, painful, and certain imminent death. The court also recognized the distinction between self-infliction of deadly harm and a decision to withdraw artificial life support. However, it is noteworthy that Quinlan was in a persistent vegetative state at the time of the ruling and continued to be so, even after the withdrawal of extraordinary medical assistance, until her death in 1981.²⁹

A persistent vegetative state exists when the body is in an acute sleeplike state of unarousability trademarked by closed eyes, no utterance of meaningful sounds, and no adequate motor reaction to external stimuli.³⁰ This ruling allowed for other family members, situated similarly to Quinlan's parents, to make medical decisions for loved ones due to those individuals' permanent inability to do so for themselves, as long as there was a preponderance of evidence or evidence from an otherwise trustworthy source that this would be their preference. This ruling, while only binding law in New Jersey, has continued to be embraced nationally although it was narrowly tailored later by the Supreme Court.³¹

The Supreme Court of the United States later limited the terms of the Quinlan ruling in *Cruzan v. Director, Missouri Department of Health* (1990), which was the first

²⁹ Armstrong and Olick, "In Re Karen Ann Quinlan," 87-89.

³⁰ Cohen-Almagor, *The Right to Die with Dignity*, 20.

³¹ Armstrong and Olick, "In Re Karen Ann Quinlan," 89..

case heard by the court pertaining the issue of the right to die. Nancy Cruzan was a young woman in a persistent vegetative state similar to Quinlan's who was only kept alive by feeding tube. Cruzan's family requested artificial nutrition to be removed (passive euthanasia), which request was denied by both the hospital as well as the Missouri Department of Health. The state asserted it was in the public interest to keep Cruzan alive, as well as the fact that her family had no objective evidence to prove that Cruzan herself would have wished to die.³² When the case was taken to the Supreme Court of Missouri that Court ruled that no person may refuse life sustaining treatment for another person

...no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here.³³

While the Supreme Court of Missouri was simply upholding the standard set by the state legislature Cruzan's family continued their legal battle to challenge said rule.

When the case ultimately made it to the United States Supreme Court, the Court ruled 5-4 that the Constitution does not forbid Missouri for requiring a high burden of proof to show that a patient in a persistent vegetative state would want to die; that Missouri did not commit an error in stating that Cruzan's family did not have enough evidence to meet this burden, and that, while competent individuals are protected under the Due

³² T.A. Tucker Ronzetti, "Constituting Family and Death through the Struggle with State Power: Cruzan v. Director, Missouri Department of Health," *University of Miami Law Review* 46 (1991), 152-154.

³³ Cruzan v. Harmon, 760 S.W.2d 408 (MI, 1988).

Process Clause in their right to refuse medical treatment incompetent individuals are not, and thus Missouri's higher burden requirement was constitutional.³⁴

As part of their final ruling the court also stated that, in the absence of a will or advanced directive, the state's interest in preserving life outweighs the right to refuse treatment. However the concurring opinions of Justices O'Connor is slightly more liberal with its reasoning, stating that one may appoint a family member to protect their wishes in absence of a legal document. In O'Connor's opinion she states that as long as adequate safeguards are met it was well within a patient's liberty to delegate end of life choices to a decision maker if they were deemed incompetent to do so³⁵

These procedures for surrogate decision making, which appear to be rapidly gaining in acceptance, may be a valuable additional safeguard of the patient's interest in directing his medical care. Moreover, as patients are likely to select a family member as a surrogate...giving effect to a proxy's decisions may also protect the "freedom of personal choice in matters of . . . family life." In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.³⁶

The Courts Take on Active Euthanasia and PAD

The first case that was heard before the Supreme Court that argued the right to legal active euthanasia was *Washington v. Glucksberg* (1997). Physician Dr. Herald Glucksberg as well as four other doctors, three terminally ill patients, and the right to death organization Compassion in Dying, challenged Washington States ban against assisted suicide, codified in the states' Natural Death Act of 1979

³⁴ Ronzetti, "Constituting Family and Death through the Struggle with State Power," 155-159.

³⁵ Ronzetti, "Constituting Family and Death through the Struggle with State Power," 159.

³⁶ *Cruzan by Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

They assert a liberty interest protected by the Fourteenth Amendment's Due Process Clause which extends to a personal choice by a mentally competent, terminally ill adult to commit physician assisted suicide...the Federal District Court agreed, concluding that Washington's assisted suicide ban is unconstitutional because it places an undue burden on the exercise of that constitutionally protected liberty interest. The en banc Ninth Circuit affirmed.³⁷

The physicians, their patients, as well as Compassion in Dying argued that the Due Process Clause not only protects a competent individuals right to refuse medical treatment but it also allows for such patients, who are also terminal, to access medical assistance in hastening their deaths (physician assisted death). The Court unanimously sided with Washington State, with their majority opinion stating that the Fourteenth Amendment and the Due Process Clause do not protect suicide as a liberty due to both its lack of any standing in national tradition and the states legitimate interest in the prevention of suicide.³⁸ Suicide has historically been frowned upon in the United States; thus, claiming that there was a constitutional right to suicide would reverse hundreds of years of tradition.

The Court made it extremely clear in this ruling that they do not support, nor does the Constitution protect, the right to physician assisted death, euthanasia, or suicide. Their logic suggests that beyond a suicide ban being rational given the historical context in the United States, a ban also serves to protect vulnerable populations such as the disabled and mentally ill. The fear of legalizing assisted death also brought up the slippery slope concept: that legalizing this could eventually lead to

³⁷ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

³⁸ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

the practice of involuntary euthanasia.³⁹ However, the court also ruled that the legalization of aid in dying was not up to the federal government, but the states:

As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician assisted suicide and other related issues... In such circumstances, "the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance."⁴⁰

This rationale would later be challenged on another basis in the same year.

That same year the court ruled on *Vacco v. Quill* wherein Dr. Timothy Quill and a number of other physicians filed suit challenging the New York State ban on doctors assisting and providing the means for their terminally ill patients to commit suicide, as long as they are otherwise mentally competent (active euthanasia). Their reasoning was that the Fourteenth Amendment's Equal Protection Clause granted patients the right to kill oneself and seek assistance in doing so: thus, New York State's prevention of physicians aiding in their patients' deaths was unconstitutional.⁴¹ In contrast to *Washington v. Glucksberg*, which argued for a patient's right to access drugs or medical assistance for themselves to administer, this case was arguing for the rights of physicians to be able to assist in and provide the means to which would result in their patients' deaths and in their prevention of doing so New York State as well as others were violating the personal liberties of dying individuals.

The Court would unanimously rule that New York State's ban on assisting in or providing the means to facilitate another person's suicide was constitutional and no

³⁹ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

⁴⁰ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

⁴¹ *Vacco v. Quill*, 521 U.S. 793 (1997).

right to suicide or assistance in doing so exists within the Constitution. While they had the right to refuse treatment they did not possess the ability to forward their deaths prematurely. Similar to *Washington v. Glucksberg* the court held that there was no fundamental right to suicide within the constitution as this would be completely counter to national tradition. Furthermore they distinguished the difference between *causation* and *intent*. If a physician removes life sustaining treatment per the request of their patient their intent is to have the patient's illness be the cause of their death; however if a patient takes a medication or is injected with a drug prescribed by a physician which is intended to kill them then the physician is the cause of their death.⁴² For example removing a feeding tube and allowing ones inability to inject life sustaining nutrients caused by an illness, than the causation of death is a patients illness. Contrastingly if a physician injects a cancer patients IV with drugs that which they know will result in a patient's death than the physician is responsible for the death of the patient. The court once again ruled that the state has a legitimate interesting in prohibiting both suicide and a physician's provision of assistance in their patient's suicide, as maintaining a population is within a state's legitimate interests.

The federal government has made it clear that they will not condone or support the use of physician assisted death or euthanasia unless it involves either the removal of life sustaining treatment by a competent individual (voluntary, passive euthanasia); or an incompetent individual with evidence such as a living will or expressed desire that if in a persistent vegetative state they would want their life sustaining treatment removed

⁴² *Vacco v. Quill*, 521 U.S. 793 (1997).

(non-voluntary, passive euthanasia). They have also ruled that neither active euthanasia nor physician assisted death are not constitutionally protected, nor is there any expressed right or liberty to death as one chooses. States have a legitimate motivation in keeping their populations alive; thus, if a state chooses to enact a policy which allows individuals a legalized aid in death it is up to them to fund and defend it.

The First Physician Assisted Death Statute: Oregon's Death with Dignity Act

The early 1990's is when advocates first began to attempt to legalize some form of euthanasia policy in the United States by targeting historically left leaning states. First, taking the traditional route of drafting legislation for state legislatures to vote on they found immediate failure and saw none of these bills make it past the committee stage. Redirecting their efforts towards the voter initiative processes the first attempt at legalizing physician assisted death happened in 1991 in Washington, and failed. They then attempted again the following year in California; that effort also failed.⁴³ Advocates then drew their attention on Oregon in order to forward the passage of a legalized method of physician assisted death.

The success of the passage of the Oregon's Death with Dignity Act, in contrast with the Washington and California efforts, has been attributed to a variety of factors. While all three states are considered to be solidly left leaning Oregon has a special history of traditional liberal ideology, progressive advanced directive laws, as well as a historic attachment and respect for the ballot initiative process. Oregon was the second state (the first being South Dakota) to adopt the initiative and referendum process, and

⁴³ Cohen-Almagor, *The Right to Die with Dignity*, 158.

for years it was known as the Oregon System. Oregon also happened to be the location of the headquarters of the Hemlock Society, a right to die advocacy organization, as well as the home of many prominent right to die activists.⁴⁴

The Oregon Death with Dignity Act was the first of its kind that legalized the use of medical aid in dying (physician assisted death). Known as Measure 16 the act passed by a narrow 51% in favor vote and the Oregon Medical Association remained officially neutral on the act. It was opposed by a coalition of religious organizations led by the Catholic Church.⁴⁵

The Death with Dignity Act was challenged in court by a group of physicians and concerned citizens who claimed that the act violated the Due Process and Equal Protection Clauses because it failed to protect vulnerable patients. This led to a temporary enjoinder of the act in December of 1994 by the federal district court. The following year, the court struck down the act on the grounds that it violated the Equal Protection Clause. However this decision was vacated due to a variety of procedural reasons in the case of *Lee v. State of Oregon* in 1994.⁴⁶ While it was found to be legally sound after this the state still waited to begin implementation of the act until the decisions of *Washington v. Glucksberg* and *Vacco v. Quill* were made. During this time the act was again challenged by Measure 51, another ballot initiative intended to overturn the Death with Dignity Act, making it the first time a ballot initiative was

⁴⁴ Cohen-Almagor, *The Right to Die with Dignity*, 158-159.

⁴⁵ Cohen-Almagor, *The Right to Die with Dignity*, 159-161.

⁴⁶ *Lee v. Oregon*, 869 F. Supp. 1491 (9th Cir. 1994).

voted on twice in Oregon history. The measure to overturn the act was rejected by a 60-40 margin.⁴⁷

The terms of the Act are fairly less divisive and controversial than one may be led to believe due to the number of legal hurdles that it had to go through. It is highly procedural, but, ultimately, it allows for patients suffering from a terminal illness to receive prescriptions to self-administer a lethal dosage of drugs. Only a narrow class of individuals in very specific circumstances can take advantage of the Act's provisions

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner... (2) No person shall qualify under the provisions... solely because of age or disability.⁴⁸

The patient in question must first makes an oral request and then a written request to access the act, after which another oral request must be made in order for their physician to assist. After this, the written request must be signed and dated by the patient, witnessed by at least two other individuals (one of whom cannot be a relative, heir, or owner/operator of a health care facility where the patient lives or receives care from), and neither of whom may be the patients attending physician.⁴⁹ These provisions protect both the patient and the physician by insuring no coercion was going on nor was there any familial pressure being put on the patient.

The request may be withdrawn at any time and physicians are required to verbally and explicitly offer the patient the opportunity to change their mind about

⁴⁷ Cohen-Almagor, *The Right to Die with Dignity*, 161-163.

⁴⁸ 13 Oregon Revised Statute § 2.01 (1998).

⁴⁹ Cohen-Almagor, *The Right to Die with Dignity*, 166.

writing the prescription. The physician must inform the patient of the diagnosis, prognosis, potential risks, and probable result of taking the prescription including alternatives such as pain management and hospice care.⁵⁰ Between the first oral request and the writing of the prescription there is a mandatory fifteen day waiting period during which time the patient must be referred to a consulting physician to confirm that their condition is terminal and that they are mentally capable and acting voluntarily.⁵¹ If either the attending or consulting physician believes the patient is suffering from a psychological disorder they are required to refer the patient to a counselor.⁵² Finally the act makes it expressly clear that

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.⁵³

The patient must self-administer the medication and because of this no one but the patient themselves is directly responsible for their death. In addition the act requires the patient's family to be informed of their decision prior to their death and no attending or consulting physician can professionally suffer from their participation in the act.

Oregon's Death with Dignity Act was, and still is, ground breaking. It has led the way for other states, showing how to successfully pass and implement a legalized, regulated, and ethical form of physician assisted death; to date, Washington, California,

⁵⁰ 13 Or. Rev. Stat. § 3.01 (2) (1998).

⁵¹ 13 Or. Rev. Stat. § 3.01 (3) (1998).

⁵² 13 Or. Rev. Stat. § § 3.01 (4) (1998).

⁵³ 13 Or. Rev. Stat. § 3.14 (1998).

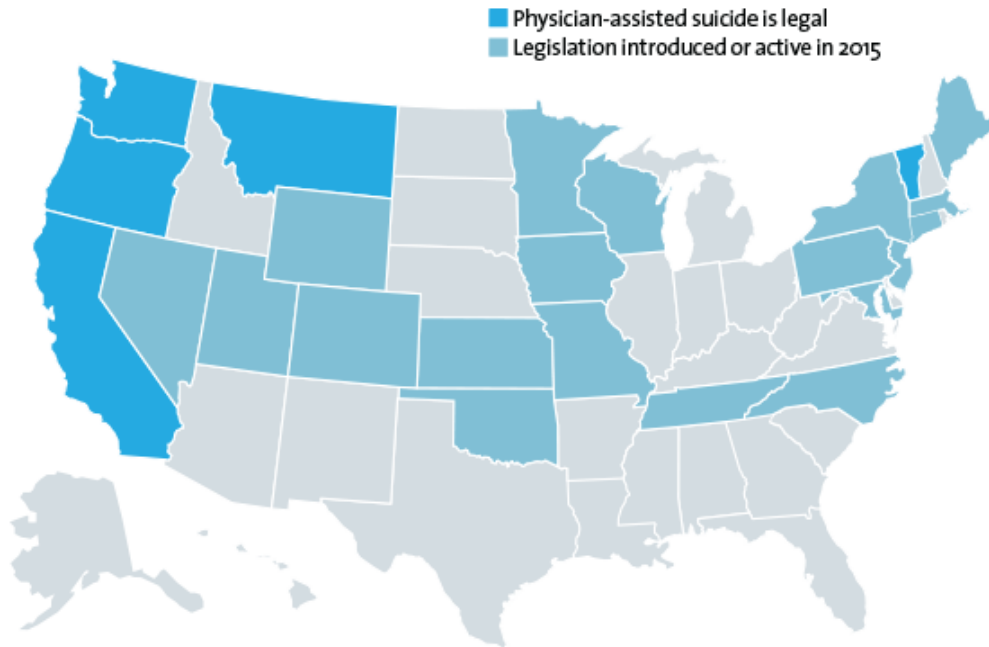
Vermont, Montana, and, briefly, New Mexico (before being overturned) have enacted variations of the Death with Dignity Act.

The Act would again be challenged in 2001 by US Attorney General John Ashcroft which attempted to prosecute physicians who wrote prescriptions for medications. He brought the prosecutions under the Controlled Substances Act on the grounds that physician assisted death was not a “legitimate medical purpose.”⁵⁴ The Supreme Court would rule in a 6-3 decision that while the Controlled substances act does give the government authority to regulate the use of drugs it does not give the Attorney General the ability to overturn state law to prosecute physicians for the legitimate use of pharmaceuticals.⁵⁵ While it is clear that the federal government will not fund any aid in dying treatment it will also not prevent states, as laboratories of democracy, from legislating it on such terms as they see fit. In the next section, we will see that similar to Death with Dignity are not the only way in which states have been able to regulate and rule on how they will allow physician assisted death to occur.

⁵⁴ *Gonzales v. Oregon*, 546 U.S. 243 (2006).

⁵⁵ *Gonzales v. Oregon*, 546 U.S. 243 (2006).

More and more Americans support the right of the terminally ill to end their lives on their own terms.



Source: Death With Dignity National Center

Mother Jones

Figure 3: States with legalized PAD. All states which introduced legislation in 2015 failed to pass.

The Texas Model: Legalized Passive Euthanasia

While Oregon may have been the perfect state to attempt to first legalize the use of physician assisted death in the United States, Texas may have well been one of the worst. A historically conservatively leaning state, it is also significantly less secular and much more racially diverse than Oregon both of which are factors that contribute to attitudes on PAD policies.⁵⁶ Despite this the 1999 the Texas Advanced Directives Act was passed and subsequently added to the Texas Health and Safety Code in order to aid

⁵⁶ Cogen-Almagor, *The Right to Die with Dignity*, 159.

in the resolution of conflict if the families or hospitals disagree about the continuation or stoppage of a patient's treatment.⁵⁷

The act essentially allows for physicians or hospitals that feel that the continuation of treatment is morally unethical, to follow a legal pathway which would result in the cessation of treatment for the patient and their death, even if that would be in contrast to a patient's living will or advanced directive; thus, passive non-voluntary euthanasia. Furthermore the patient must be comatose or in a persistent vegetative state. The patient must have a terminal, irreversible condition and their life-sustaining treatment must be by reasonable medical judgement the only means by which they are being kept alive.⁵⁸ If an institution or physician does proceed with ending a patient's life, a treatment to request is sent to an ethics committee. If the committee agrees to proceed with the request to end treatment neither the attending physician nor hospital is legally required to maintain life-sustaining treatment, only pain management. If the family does not agree with this decision and can find another physician or institution which will care for the patient they may be transferred

If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the ethics or medical committee has affirmed is medically inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer... This subsection does not authorize withholding or withdrawing pain management medication, medical procedures necessary to provide comfort, or any other health care provided to alleviate a patient's pain... The attending physician, any other physician responsible for the care of the patient, and the health care facility are not obligated to provide life-sustaining treatment after the

⁵⁷ Harris C. Jacobs, "The Texas Advance Directives Act-Is It a Good Model?" *Seminars in Perinatology* 33 (2009) 384, accessed March 1, 2017, doi: <http://dx.doi.org/10.1053/j.semperi.2009.07.006>.

⁵⁸ Jacobs, "The Texas Advance Directives Act," 386.

10th day after both the written decision and the patient's medical record...are provided to the patient or the person responsible for the health care decisions of the patient...except that artificially administered nutrition and hydration must be provided unless, based on reasonable medical judgment, providing artificially administered nutrition and hydration would: (1) hasten the patient's death; (2) be medically contraindicated such that the provision of the treatment seriously exacerbates life-threatening medical problems not outweighed by the benefit of the provision of the treatment; (3) result in substantial irremediable physical pain not outweighed by the benefit of the provision of the treatment; (4) be medically ineffective in prolonging life; or (5) be contrary to the patient's or surrogate's clearly documented desire not to receive artificially administered nutrition or hydration.⁵⁹

Since its passage the act has mostly been used in cases where the advanced directive or living will of a patient requests continued resuscitation yet physicians find it unethical to continue treatment. It is also used in pediatric medicine, wherein parents of a terminally ill newborn with an irreversible and incurable condition continue to request treatment.⁶⁰

While by no means a traditional model of euthanasia policy, at its core the Texas Advanced Directives Act was passed in order to protect the dignity of patients at the end of life as well as prevent undue suffering; in addition, the law also has underlying financial motivations inasmuch as end of life care can cost hundreds of thousands of dollars yet provide no additional lifespan. However the act does not provide patients the type of autonomy and dignity which Oregon's Death with Dignity act does. Texas's model was put in place in order to prevent patients and families without medical knowledge or understanding of the circumstances their relative is in from making unwise, medically unethical, and financially disastrous decisions, putting greater control

⁵⁹ Texas Health and Safety Code, Texas Advance Directives Act, Chapter 166, § 166.046. Vernon, TX.

⁶⁰ Jacobs, "The Texas Advance Directives Act," 388.

in physician's hands. The intent of the act is not to force a decision on families but rather to create an end of life decision plan which includes death rather than just indefinite treatment, as the law can simply be (and often is) evaded by moving the patient to a different facility.⁶¹ Furthermore the Advanced Directives act only applies to those who are comatose or are unable to express their desires (such as newborns); and the condition which is causing this state must also be terminal, irreversible, and will always requires life-sustaining treatment. These, while also providing a way in which patients families can avoiding the removal of treatment altogether, make it far more restrictive for patients and physicians, unlike Death with Dignity policies which put the matter directly in the hands of the patients (a far larger group of potential patients for that matter). Texas lawmakers would be quick to note that this policy is not anything close to euthanasia, however looking over the language clearly shows that it is non-voluntary passive euthanasia. Texas's methodology in the Advanced Directives act is bold and not without controversy, but neither it nor Oregon's Death with Dignity Act are as infamous as the euthanasia policy which exists in Europe.

⁶¹ Jacobs, "The Texas Advance Directives Act," 389.

Chapter 3: Euthanasia in Europe

The European View: Contrasting Opinions

Unlike the United States the sovereign nations of Europe do not have an overarching federal system. The closest comparison to this would be the European Union, a political and economic union of nineteen member states which seeks to create a unified and borderless Europe. Most of the European Union's actions have been a series of economic agreements, however, they have slowly been transitioning into drafting a more universal policy, to include, for example, the current move to promote the legally binding abolition of torture and capital punishment in all member states.⁶² Currently the European Union has no say on policy regarding euthanasia in its member states as it considers the issue to be too socially, culturally, and politically divisive to make or advocate for a universal law.

Today, of the three nations that have legalized euthanasia in the world all of them are member states of the European Union: the Netherlands, Belgium, and Luxemburg. In addition to these, nine member states have legalized aid in dying or some manner of physician assisted death similar to what is seen in Oregon and in the remaining seven member states, both euthanasia and PAD are illegal.⁶³ In the European context euthanasia is clearly better tolerated than it is in the United States, especially in nations where active euthanasia is legalized.

⁶² J. Lucy Pridgeon, "Euthanasia Legislation in the European Union: is a Universal Law Possible?" *Hanse Law Review* 2 (2006): 45.

⁶³ Pridgeon, "Euthanasia Legislation in the European Union," 45-46.

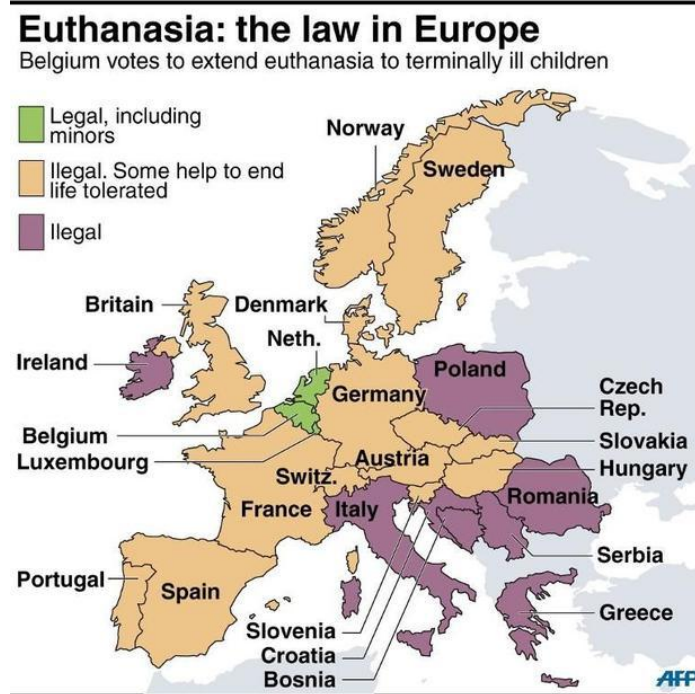


Figure 4: Euthanasia law in Europe. Not all states pictured are member states of the European Union.

Euthanasia in the Netherlands: Testing the Waters

The path to legalized euthanasia began in the mid twentieth century, when the Netherlands was seeing an increasing amount of public discourse on the topic as well as other issues in death and dying.⁶⁴ A number of doctors came out and acknowledged the practice happening within hospitals and nursing homes around the nation as an unregulated but unquestioned medical practice. The *Medical Power and Medical Ethics* committee was formed in 1972 to research the possible impacts of the legalization of euthanasia in the Netherlands, finding that drafting such a law would be a beneficial and fair option for end of life care.⁶⁵ The next year, the first legal case against a physician

⁶⁴ Pridegon, "Euthanasia Legislation in the European Union," 51.

⁶⁵ Alex Bood, John Griffiths, and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1999), accessed March 3,

for partaking in euthanasia took place after she injected her mother with a fatal dose of morphine per her request in the aftermath of a cerebral hemorrhage. The court ultimately sentenced her to one week in jail and a yearlong probation, standing that, while it is reasonable to actively seek to end one's life, the mode of IV injection which will result in immediate death is not a reasonable way to achieve death.⁶⁶ The case would result in the formations of the still active Dutch Association for Voluntary Euthanasia, which continues to advocate for the right to access to legalized euthanasia. In 1990 the Court of Leeuwarden found that physicians who partake in euthanasia are shielded from criminal liability as long as all substantive requirements are met. These requirements are:

- The request for euthanasia or physician-assisted suicide must be made by the patient and must be free and voluntary.
- The patient's request must be well considered, durable and consistent.
- The patient's situation must entail unbearable suffering with no prospect of improvement and no alternative to end the suffering. This patient need not be terminally ill to satisfy this requirement and the suffering need not necessarily be physical.
- Euthanasia must be a last resort.⁶⁷

In addition to this the court set up a number of procedural requirements which are to be followed, such as that no doctor has to perform euthanasia if they morally object to it, doctors must administer the drug themselves, the doctor must consult a second physician with no professional or familial relationship to the patient, there must be a full

2017, <http://ebookcentral.proquest.com.libproxy.uoregon.edu/lib/uoregon/reade.r.action?docID=437567>.

⁶⁶ Bood, Griffiths, and Weyers, *Euthanasia and Law in the Netherlands*.

⁶⁷ Cohen-Almagor, *The Right to Die with Dignity*, 132.

written record of the case, and the death must be reported to the authorities.⁶⁸ The court would later affirm that one's condition need not be a physical one, and that those who undergo extreme physiological distress could also access euthanasia in the Netherlands.⁶⁹ This ruling began the process of drafting and legalizing euthanasia in the Netherlands.

The 1990 ruling would serve as the legal protection against criminal prosecution for those physicians and others who choose to partake in euthanasia until 2002 when the government enacted formal legislation. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act regulates both euthanasia and physician aid in dying in the nation with all of the substantive and procedural requirements listed within.⁷⁰ This law is far more liberal than the Death with Dignity policies of Oregon and other states. Article 2 of the act outlines the rules of physicians who act according to the rules of care, namely that they

- a. should be convinced that the request of the patient was voluntary and well considered;
- b. should be convinced that the suffering of the patient was unbearable and without prospect of relief;
- c. should inform the patient about his or her situation and prospects;
- d. should come to the conclusion, together with the patient, that there is no reasonable alternative solution to the situation of the patient;
- e. has consulted another independent physician who has seen the patient and agrees with the evaluation of the physicians on points a to d;

⁶⁸ Cohen-Almagor, *The Right to Die with Dignity*, 132-133.

⁶⁹ Pridegon, "Euthanasia Legislation in the European Union," 52-53.

⁷⁰ Pridegon, "Euthanasia Legislation in the European Union," 53.

f. performed the euthanasia in a careful way.⁷¹

Unlike in the United States, the law places relatively little emphasis on patient autonomy and independence but rather outlines the way in which physicians who perform euthanasia will be protected.

The Netherlands has a far more liberal euthanasia policy than any which are seen in the United States. They do not require that one's condition is terminal nor does the law differentiate between physical and mental conditions. In the Netherlands as long as one's illness has no reasonable treatment or alternative which the patient is comfortable with then they are allowed to legally undergo euthanasia.

Euthanasia in Belgium: Legalized Aided Suicide?

Belgium's euthanasia debate began in 1996 when the Belgian parliament formed the Consultative Committee on Bioethics in order to explore the possibility of legalizing euthanasia. During this time the Belgium government saw a demand from patients to have this option available for them rather than having no other options besides natural death. While the committee found that legalizing euthanasia had overwhelming public support and that it should be within a patient's right to have access to euthanasia as a treatment, the government felt they did not have the adequate amount of time or data at that point to begin drafting a law.⁷² The committee delivered a second opinion in 1999

⁷¹ Johannes J. M. van Delden, "The Netherlands – Euthanasia as a Last Resort," in *Euthanasia: Volume II - National and European Perspectives*, ed. Johannes J. M. van Delden et. al, (Bruxelles: Council of European Publishing, 2004), 66-67.

⁷² Yvon Englert, "Belgium-Evolution of the Debate," in *Euthanasia: Volume II - National and European Perspectives*, ed. Yvon Englert et. al, (Bruxelles: Council of European Publishing, 2004), 13-14.

stating that artificial prolongation of life was unethical if a patient did not desire to continue living. The new parliament also felt they held greater leverage in being able to pass a law legalizing the practice; thus, they set out to do so in the early 2000's. January 20, 2001 a commission of Belgium's upper house of parliament voted in favor of legislation legalizing euthanasia, provided certain requirements were met.⁷³ Following this in the summer of 2001 two doctors were remanded into custody for being responsible for the euthanasia of one of their patients.⁷⁴ This was the catalyst that convinced parliament to seriously begin drafting a law which legalized the practice of euthanasia.

On May 28, 2002 Belgium legalized euthanasia in the Belgian Act on Euthanasia. The act, similar to that in the Netherlands, speaks little about patient autonomy or choice but rather serves as legal protection for doctors who choose to participate in euthanizing their patients. The substantive criteria are also very similar, in that:

- The patient be adult and conscious;
- The request be made of the patient's own volition, after reflection, and be repeated;
- There be no medical solution to the situation;
- The patient be experiencing constant, unbearable physical or mental suffering that cannot be relieved;
- The patient's condition as a result of accident or illness be serious and incurable.

⁷³ Raphael Cohen-Almagor, "First do no Harm: Pressing Concerns Regarding Euthanasia in Belgium," *International Journal of Law and Psychiatry* 36 (2013): 515, accessed March 3, 2017, doi: <http://dx.doi.org/10.1016/j.ijlp.2013.06.014>

⁷⁴ Englert, "Belgium-Evolution of the Debate," 14-16.

And in addition to this the physician's requirements are:

- Supplying the patient with information;
- Confirming the persistence of the symptoms and of the patient's wish;
- Consulting a second doctor;
- Consulting the care team and, if the patient so wishes, other parties.⁷⁵

The attending physician is required to consult one more physician if the patient's condition is physical and two more if their condition is mental. They are legally required to study the patient's medical record, examine the patient to understand the unbearable nature of their condition, and write a report on their findings. If the patient is found fit to access the law, then a physician must administer the drugs which will end their life (active euthanasia). No other persons besides their care team are required to know of the patient's intent until after the patient has died.⁷⁶ In 2014 the law was amended to allow euthanasia for chronically ill children under the same guidelines listed above. In Belgium, what matters is that the patient's condition is constant, unbearable, incurable, and if these three points are met, then anyone in the nation could access legalized euthanasia.

Euthanasia in Practice: What Does This Mean?

To summarize this chapter it is clear that the variations in euthanasia policy are immense. In the United States, access to euthanasia has depended primarily on state laws; however, there is a large amount of federal rule on how the practice may occur. In

⁷⁵ Englert, "Belgium-Evolution of the Debate," 22.

⁷⁶ Cohen-Almagor, "First do no Harm," 516.

states like Oregon that have physician assisted death, the legislation is rather limited as to who is allowed to access it. In addition, it comes with a myriad of waiting periods and reissues of statements in order to protect the patient while emphasizing patient choice and autonomy. In Texas one can be passively euthanized is only if physicians or the hospitals deem the patient's continued treatment to be morally unethical, unless a prior advanced directive or do not resuscitate order exists. Passive euthanasia can only occur if it contradicts the treatment plan which they or those responsible for their medical decisions choose.

On the opposite end of the spectrum the European Union has no say on what or how member states legalize euthanasia or physician assisted death; however, those states that have legalized euthanasia are well known to be very radical in their policies. The question that is posed here is this: given that death is a universal experience why do states choose to legislate end of life care in such dramatically different fashions, and what will that mean for the future of euthanasia or physician assisted death policy?

Chapter 4: Why Euthanasia Policy Radically Different in the United States and Western Europe

Introduction: A Myriad of Political, Cultural, and Social Reasons

While it is clear that the United States and Europe have extremely different approaches to the ways in which they choose to legislate end of life treatments the question of why what is pertinent. This work proposes a few key factors which have impacted how and why these policies have been shaped, which is ultimately rooted in the social, political, and cultural differences in the United States and Europe. The two regions are often considered to be relatively similar as well as the undeniable influence of Western European culture and traditions that the governing bodies within the United States; however these outside factors have a far greater impact than this connection.

First, because religion and the influence of Christianity is; often considered to be the main pillar of the discussion, I will examine the religiosity and practice of faith in both areas. Then I will look at the political variations of the U.S. and Europe, and how the political shift after World War II meant that the Belgians and the Danish focused on a committed effort towards secularization of government. By contrast the United States saw the opposite: with the political climate becoming increasingly religiously influenced and conservative over the last century. This is accompanied by the overall tendency for European politics to be more socially orientated (for the good of all) and American politics to reflect an idea of rugged individuality and struggle (the good of the self). This chapter also explores how racial demographics may impact the variation of policy. Finally this chapter will cover the ‘do no harm’ philosophy and how Europeans

use this as a means of explaining legalized active euthanasia and Americans manifest this concept as the justification to avoid death at all costs necessary.

Christian Traditions

The United States and Western Europe are dominated by the Christian faith and its traditions. In the U.S., 70.6% of the population identifies as Christian (primarily under the Protestant denomination) and 76% of Europeans identify as Christian (primarily under the Catholic denomination).⁷⁷ While this variation in denomination is important, both denominations have similar doctrine regarding euthanasia. The Roman Catholic Church has the *Declaration on Euthanasia* issued by the Congregation for the Doctrine of Faith in May of 1980. It states that euthanasia is a crime against human life similar to war, abortion, and murder. The declaration further asserts the value of human life is beyond our control, and that only God who gave us life may take it away.⁷⁸ The Protestant denominations, while not having a single formal doctrine as the Catholic Church does, similarly agree to these principles and all share essentially the same ideas. Therefore active euthanasia is expressly prohibited by the Christian faith and, by extension, so is physician assisted death, as both require human intervention to result in death. Passive euthanasia, however, is not, as it is only the removal of artificial and life-sustaining treatment. For example in the *Matter of Quinlan* the court cited the 1957

⁷⁷ Pippa Norris and Ronald Inglehart, *Sacred and Secular: Religion and Politics Worldwide* (New York: Cambridge University Press, 2004), 84-86.

⁷⁸ Franjo Šeper, *Declaration on Euthanasia*, Rome, Italy: the Sacred Congregation for the Doctrine of the Faith, 1980, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

allocutio of Pope Pius XII, wherein he instructed Catholic anesthesiologists that they were able to remove life sustaining treatment:

In ordinary cases the doctor has the right to act in this manner, but is not bound to do so unless this is the only way of fulfilling another certain moral duty... This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.⁷⁹

Nevertheless, religious doctrine is one of the most dramatic influencers as to why euthanasia and PAD policies are so different in these four cases.

Religious Influence and Secularization

Although the United States is officially a secular nation, its policies and politics are heavily influenced by religion, especially the Protestant Christian denominations, as they make up a majority of the religious American population. Of those who are religious, 70% report regular church attendance which has seen a 3% increase over the last three decades.⁸⁰ This is in contrast to Europe, where only 40% reported attending church regularly, and which had seen a 12% decrease in church attendance in the last thirty years.⁸¹ As the United States has become increasingly religious, Western Europe has seen a decrease, with this trend occurring during the years when euthanasia or physician assisted death policies were made. Although both regions have similar levels of those who identify as religious Americans clearly attend and participate in their faith more regularly than Europeans do.

⁷⁹ *In the Matter of Karen Ann Quinlan, an Alleged Incompetent*, 70 N.J. 10 (1976).

⁸⁰ Jeffrey Haynes, *An Introduction to International Relations and Religion* (London: Pearson Education Limited, 2007), 234.

⁸¹ Norris and Inglehart, *Sacred and Secular*, 72.

The United States has a history of social movements being tied directly to religion. For example prohibition was heavily influenced by religious doctrine as well as Jim Crow and anti- miscegenation laws.⁸² The traditional civil rights movement would later be heavily influenced and organized by religious leaders of the south and Black churches, most notably Black preachers of the Southern Christian Leadership Conference. Religion has had a clear influence on United States politics and civil liberties as Americans have used it to define themselves as well as their laws since the creation of the nation.

Europe has seen an increasing amount of informal religious disassociation (lower church attendance while remaining religiously identified) as well as an increasing liberalization of faiths. Although Catholicism is typically viewed as more conservative than Protestant traditions, most Catholic leadership in nations which have legalized active euthanasia policies often support them, such as in Belgium where the Catholic Church views ending suffering as more important than continuation of life.⁸³

Secularization is defined as the process by which industrialization causes faith and religion to play less of an important role in society and politics, which leads to a society of bureaucratization, rationalization, and urbanization.⁸⁴ This is an explanation as to why Europe has far less religious influence than the United States, as they were urbanized and industrialized throughout the last century at a faster rate. In addition to this, the Netherlands and Belgium, both of which are considered Catholic nations, have

⁸² Haynes, *An Introduction to International Relations and Religion*, 235.

⁸³ Rachel Aviv, "The Death Treatment: When Should People with a Non-Terminal Illness be Helped to Die?" *New Yorker* June 22, 2015, 6.

⁸⁴ Norris and Ingleheart, *Sacred and Secular*, 3.

seen an especially high rate of decrease in church attendance, both falling to under 20% of their populations attending weekly in 1999.⁸⁵ In 2010 30% of Belgians and 42% of Danes reported being religiously unaffiliated.⁸⁶ The lack of attendance as well as movement away from traditional Catholic doctrine explain how it can be that two of the three nations which have legalized active euthanasia policies are still Catholic dominated.

In contrast, the United States has seen an increasing amount of religious influence and participation; however, Oregon was still able to pass the Death with Dignity act. One reason for this is that Oregon is one of the most secular states in the nation, with 31% of its population reporting that they were unaffiliated or a-religious, and 61% reporting they were Christian.⁸⁷ The Pacific Coast is also the least religiously affiliated region of the nation as a whole, compared to the South which is the most religiously affiliated (in addition to being where Texas is.)⁸⁸ Only 18% of adults in Texas consider themselves to be unaffiliated or areligious while 77% of Texans reported being Christian.⁸⁹ The only way to access any mode of euthanasia in Texas could be legalized is through a form of passive euthanasia which can only be used if

⁸⁵ Norris and Inglehart, *Sacred and Secular*, 87.

⁸⁶ "Global Religious Futures Project," Pew Research Center, Washington, D.C. (2010) <http://www.globalreligiousfutures.org/religions/unaffiliated>, accessed March 5, 2017.

⁸⁷ "U.S. Religious Landscape Study," Pew Research Center, Washington, D.C. (2015) <http://www.pewforum.org/religious-landscape-study/state/oregon/#social-and-political-views>, accessed March 5, 2017.

⁸⁸ Norris and Inglehart, *Sacred and Secular*, 89-90.

⁸⁹ "U.S. Religious Landscape Study," Pew Research Center, Washington, D.C. (2015) <http://www.pewforum.org/religious-landscape-study/state/texas/#>, accessed March 5, 2017.

deemed medically unethical. This fits with the dominant faith doctrine of the state in contrast to Oregon's Death with Dignity Act.

Religion, specifically Christianity, clearly plays a role in how euthanasia and physician assisted death policies are formulated. Allowing human intervention to be the mode by which death takes place is in violation with Christian faith doctrine; however it plays far less of a role in Oregon, and even less than that in the Netherlands and Belgium. The Netherlands is one of the least religious nations in the world, which is a factor in explaining how it could be the first nation in the world to have legalized euthanasia. Belgium, while having a slightly higher religiously affiliated population, has a lower church attendance rate than the rest of Europe, as was where Catholic clergy first began straying away from traditional faith doctrine on the subject.

Political Trends

The movement toward a more secular populous in Europe, specifically in the Netherlands and Belgium, has been reflected in their political leanings and parties. As a response to the aftermath of the Second World War the politics of Europe changed, with an emphasis towards rebuilding, urbanization, and social justice.⁹⁰ This marked a movement towards secularization as well as a realigning of political leanings. Both Belgium and the Netherlands began to elect liberal socialist parties into parliament rather than Christian Democrats who had been in power since their nation's

⁹⁰ Maria T. Grasso, "Age, Period and Cohort Analysis in a Comparative Context: Political Generations and Political Participation Repertoires in Western Europe," *Electoral Studies* 33 (2014): 73, accessed March 6, 2017, doi: <http://dx.doi.org/10.1016/j.electstud.2013.06.003>.

inceptions.⁹¹ Post-World War II Europe saw an economic boom that led toward urbanization and post industrialization faster than it did in the United States due to the overwhelming destruction of the continent. Those who were born during this period were thus increasingly liberal and comfortable for voting more radical political leadership, such as the parliaments which spearheaded the legalization of euthanasia.⁹² This trend has since continued and become increasingly liberal, with more and more emphasis on personal autonomy.

An additional facet to this is the philosophy of secular humanism, popular in both Belgium and the Netherlands; it is one of the seven belief systems that are officially recognized by the Belgian government. Based on nineteenth century Freemasonry, secular humanism is a system of free inquiry, democracy, reason, science, and quality of life. It is taught in state schools in a course called Non-Confessional Ethics (referring to the Catholic practice of confession) which is taken from first through the twelfth grade, while such schools offer no religiously based equivalent.⁹³ That this philosophy plays such a major role in the lives of Belgians as well as being officially recognized by the state, suggests that the values of their society have a far greater focus on quality rather than quantity of life. This explains why the clergy of Belgium are often at odds with tradition Catholic doctrine, as well as why it now has the most accessible form of euthanasia policy in the world.

⁹¹ Aviv, "The Death Treatment," 8.

⁹² Grasso, "Age, Period, and Cohort Analysis in a Comparative Context," 75.

⁹³ Aviv, "The Death Treatment," 8.

Opposite to the trend of Europe, the United States has seen an increasing amount of religious influence and conservatism in the last century, especially in the last thirty years when both Oregon and Texas passed their respective policies. The emergence of the Religious Right in the 1970's came as a response to a loss of national identity felt by many Americans. This faction of American political identity is heavily influenced by Christian and faith based ideologies and advocates for a return to the core values of the United States which they believe to be Christian ones.⁹⁴ The religious right tends to vote within the Republican Party, which has since seen an increase in more faith based ideologies and radically conservative beliefs. A faith based conservative view clashes with the notion of euthanasia and physician assisted death as it is clearly in conflict with official church doctrine, and thus cannot and should not be legalized.

As covered earlier, in the United States, there is no doctrine or constitutional protection for the idea of quality of life similar to secular humanism in Belgium and the Netherlands. Both *Washington v. Glucksberg* and *Vacco v. Quill* expressly state that suicide is not within the national tradition of the United States, nor is there any right to death or right to suicide embedded within the Constitution. The concept of quality of life in the United States does not mean anyone has the right to end their life earlier through intentional means, but rather that everything will be done in order to care for and manage pain to increase life rather than end it.

The reason why Oregon was able to pass a Death with Dignity Act is that it has had far less influence from the Religious Right than Texas has. Oregon is a historically

⁹⁴ Haynes, *An Introduction to International Relations and Religion*, 242-245.

Democratic and liberal leaning state, valuing personal autonomy and choice over faith based doctrine. Texas is the exact opposite, as a traditionally conservative and Republican dominated state. This political trend is again a reflection of religious influence in both states, as political parties in the United States have become increasingly tied to religious affiliation or lack thereof since the emergence of the Religious Right.

Party affiliation among adults in Oregon

% of adults in Oregon who identify as...

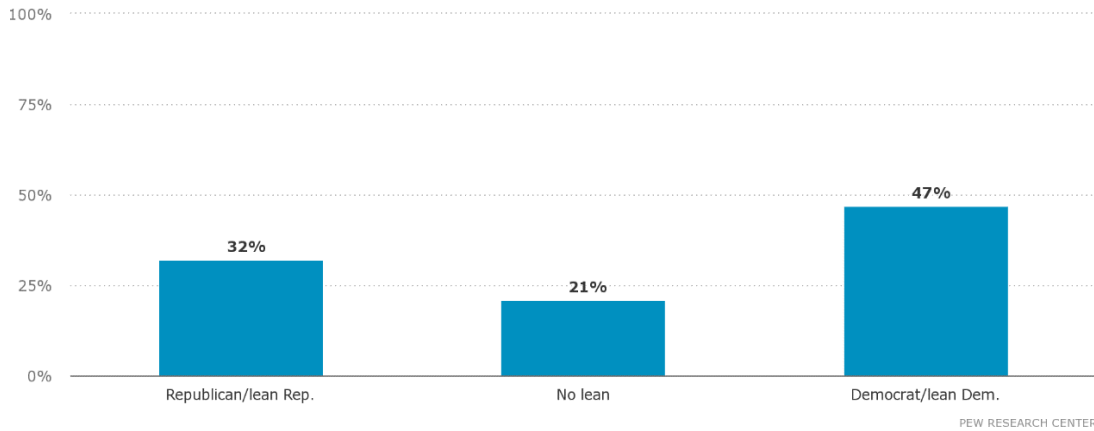


Figure 5: Party Affiliation of Adults in Oregon, 2015.

Party affiliation among adults in Texas

% of adults in Texas who identify as...

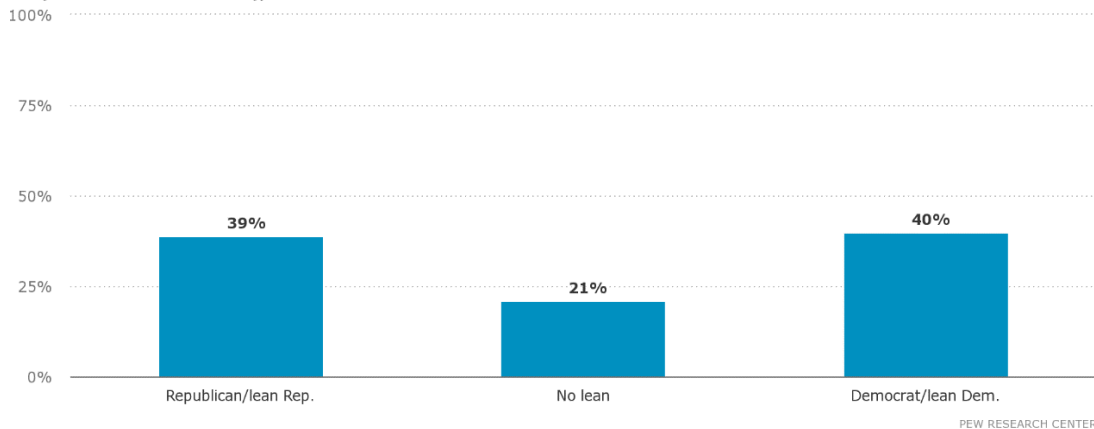


Figure 6: Party Affiliation of Adults in Texas, 2015.

The politics of both the United States and Europe have shifted due to a variety of their own independent factors, including religion, that have shaped how each

respective nation was able to form their policy regarding euthanasia. The Netherlands and Belgium, which saw a shift towards liberalization and a focus on personal autonomy and secularism, were able to pass the most liberal euthanasia policies in the world. Contrastingly Oregon, while more liberal and secular than Texas, still was constrained by the Supreme Court rulings and national shift towards conservatism in shaping their Death with Dignity Act. In comparison to Belgium and the Netherlands Death with Dignity is far more limiting and time consuming to access than their active euthanasia laws.

Influence of Race

One small but still significant point in comparing policies is that when surveyed whites of non-Hispanic origin are far more likely to be in support of legalized physician assisted death or euthanasia than minorities (specifically Blacks and Hispanics) are regardless of religious affiliation.⁹⁵ When the Death with Dignity Act was passed in Oregon 90% of the population was white, which in tandem with its political and religious leanings, can also be attributed as a factor in it was able to pass. Similarly the populations of Belgium and the Netherlands are majority white, 89% and 83% respectively. Texas however is one of the most racially diverse states with 56.7% of their population non-white according to the U.S. censuses in 2010. Of this the majority groups are Blacks and Hispanics which make up 11.8% and 37.6% of the Texas population.⁹⁶

⁹⁵ Cohen-Almagor, *"The Right to Die with Dignity,"* 159.

⁹⁶ *U.S. Census, 2010: Race and Hispanic Origin*, Washington: Government Printing Office, 2010.

These racial demographics can also be used to explain the variance in policy. If whites of non-Hispanic origin are more likely to support physician assisted death or euthanasia policies, Oregon would be a prime location to attempt to do this in the United States. However, the United States is ultimately far more racially diverse than the Netherlands or Belgium, thus there are still greater social limits to promoting legalized euthanasia. With racial homogeneity working with secularism and liberal tendencies these two factors can easily be attributed to the ways in which each government formatted their respective legislations. That is not to say that race or ethnicity will guarantee one to either support or be against euthanasia (whether it is active, passive, voluntary, non-voluntary etc.), rather when surveying populations it can be used to predict the outcome in which such legislation could have public support in a state.

Do No Harm and Quality of Life

One of the many reasons for pushing forward euthanasia or physician assisted death policies is to regulate and legitimize a common but unspoken reality of healthcare, the practice of underground mercy killings or physician assisted deaths. In an effort to maximize harm reduction physicians report aiding requesting patients with prescriptions or administering drugs which they know will cause the death of the patient.⁹⁷ A significant factor as to why PAD and legalized euthanasia exist are that they are an effort to reduce potential harm physicians and medical staff may cause through

⁹⁷ Roger S. Magnusson, "Underground Euthanasia' and the Harm Minimization Debate," *Journal of Law, Medicine, & Ethics* 32 (2004): 487, accessed March 5, 2017, doi:<http://go.galegroup.com/ps/i.do?p=AONE&sw=w&u=s8492775&v=2.1&it=r&iid=GALE%7CA122769231&asid=f4b3f843766efc3015a657ec44b9ca81>.

unregulated mercy killings through government oversight. Harm reduction matters, but how a society views harm reduction is how it chooses to shape its legal context.

The concept of do no harm is foundational in medicine as well as in American culture. Do no harm is directly influenced by religious affiliation and doctrine, which views death as a harm unless it is by God. If Christian doctrine views death via human intervention to be an act against God, then any nation or group influenced by this will tend to create policies that do not allow human intervention to take place beyond the cessation of treatment, as in Texas. While Oregon has less religious influence, it still recognizes itself as being part of a nation that is so influenced, and thus has to draft relatively conservative laws, even when allowing for legalized aid in dying. Quality of life is not seen as the ability to do certain things or exercise personal autonomy, but rather as the very fact of being alive.

Belgium and the Netherlands value the notion of secular humanism, (which believes in doing no harm and quality of life being a personal choice and definition rather than a political one) over religious doctrine. This is clearly reflected in the language of both their laws, which emphasizes that one's condition must be unbearable, incurable, and untreatable by *the patient's definition*, rather than a medical one. In the United States, to access any form of Death with Dignity or passive euthanasia you have to be terminally ill.

Quality of life means having a certain amount of joy, autonomy, and dignity which is defined by the self is more important than just being alive. As articulated by Justice Stevens dissenting opinion in *McDonald v. City of Chicago* (2010)

Government action that shocks the conscience, pointlessly infringes settled expectations, trespasses into sensitive private realms or life choices without adequate justification, perpetrates gross injustice, or simply lacks a rational basis will always be vulnerable to judicial invalidation... More fundamental rights may receive more robust judicial protection, but the strength of the individual's liberty interests and the State's regulatory interests must always be assessed and compared.⁹⁸

While the state has the right to hold certain interests it must balance this with the liberties of the people. In order to decide whether or not PAD or euthanasia policies are to be put in place there needs to be serious considerations towards at what point is the state's interest in keeping people alive removing autonomy, dignity, and prolonging suffering; and contrastingly at what point do governments need to limit the possible usages of the treatment in order to protect the vulnerable.

⁹⁸ *McDonald v. City of Chicago*, 561 U.S. 742 (2010).

Chapter 5: Conclusion

There is no doubt that euthanasia and physician assisted death are both complex and divisive issues which bring matters of religion, ethics, law, and politics all to the forefront of the conversation. In sum it is important to understand the differences between euthanasia pursued, through direct action (active euthanasia) or the withholding of assistance (passive euthanasia). As well as the difference between both types of euthanasia and physician assisted death, which, exactly as it suggests, is when a physician prescribes a means from the patient to end their own life. Physician assisted death also universally requires that one is terminally ill, while euthanasia as practiced in Europe does not. To also consider is the differences between voluntary (by the *expressed* will and consent of the patient) and non-voluntary (when a family member or caregiver is responsible for the medical decisions of a patient who cannot communicate their own will) and involuntary (against the wishes of the patient). Understanding the small but significant differences in the terminology is key to understanding the differences in law and policy, as well as integral to understanding how to navigate the potential ethical concerns one may have.

In the United States there is a clear federal guidelines in regards to how the government views euthanasia policy. The court rulings of *Matter of Karen Quinlan* and *Cruzan v. Missouri Department of Health* set precedents for how matters of passive euthanasia involving incompetent patients shall be handled, essentially saying that there must be sufficient proof such as an advanced directive or an appointed trustworthy individual that knows and can be responsible for the healthcare decisions of the patient

in an end of life situation. Additionally the rulings of *Washington v. Glucksberg* as well as *Vacco v. Quill* state that there is no constitutional right to suicide or euthanasia embedded within Fourteenth Amendment, however it is the state's decision to create policy regarding end of life options for patients if they so please to.

Oregon's Death with Dignity act allows for terminally ill people who are residents of the state as well as over the age of eighteen to access life ending medication through the aid of a physician. The rationale of the law rests on the premise that the medication has to be taken by the individual who will die. No physicians can be professionally hurt by or legally prosecuted for their actions taken in accordance with the law, nor shall the person's death be considered suicide.

Texas has a unique legal code known as the Advanced Directives Act which allows for physicians or hospitals treating certain patients with terminal and or chronic diagnosis, who, based on reasonable medical judgement could not survive without life-sustaining, to remove said treatment, even if that action clashes with the wishes of the family or those responsible for the medical decisions of the patient or the prior instructions of the patient. Essentially this is legalized, involuntary- passive euthanasia with strict rules and conditions that it can be applied to and multiple ways in which it can be avoided (such as the condition which states if a patient's family can find another physician or hospital to treat the patient then the removal of treatment will no longer be considered).

Unlike the United States, Europe has no overarching federal governing body for their nations, thus each sovereign state is free to legislate euthanasia or physician assisted death how they see fit. The first nation in the world to legalize active

euthanasia, the Netherlands, did so in 2002. Their law does not require that one be terminally ill nor does it require that one's condition is physical. In the Netherlands, what the law treats as is important is that the patient themselves feel that their condition is incurable and untreatable within reasonable means. If a physician chooses to aid them in their death, they must administer the drugs rather than the patient. The case of Belgium which has the most liberal euthanasia laws in the world, is similar. A patient's condition does not have to be terminal or physical, and what matters most is the patient's view that their condition makes life unbearable, is incurable, and untreatable within reasonable means as defined by the patient. The law also states that there is no age limit as to who can access euthanasia in Belgium; thus, children may qualify for it as well. Again, physicians must be the ones to administer the mode of death and the patient is expressly forbidden to do so.

The reasons why these policies are so radically different are essentially social, cultural, and political. Religion, especially Christianity, has far more influence in the United States than it does in Europe. Both Catholic and Protestant denominations hold the position that suicide and euthanasia are acts of violence against God, similar to abortion or murder. As a society the United States industrialized (as the development and modernization of cities, industries, and ways of life) after most Western European nations did, including the Netherlands and Belgium, one of the many factors influencing the religiosity of a population. In addition to this while Belgium and the Netherlands are considered Catholic nations, they have far lower church attendance than the United States, which is considered a Protestant nation. So, while Danes and Belgians claim to be Catholic, it is more an ethnic identity rather than a religious one.

Furthermore, the influence of religion impacted politics far more in the United States than Western Europe. In the twentieth century the U.S. saw a greater shift towards conservatism especially in the latter quarter of the century. The Religious Right took hold politically of the Republican Party which during this time and still today dominates the politics of Texas and the South as a whole. Contrastingly the Netherlands and Belgium saw a shift towards secularization in politics after the end of World War II, leading to political parties which favored development, urbanization, and the progression of social rights and liberties over the influence of religion. The philosophy of secular humanism is also extremely popular in the Netherlands and Belgium and teaches that no God or supreme moral code exists, rather than what is important is reason, science, and quality of life rather than quantity.

Race has somewhat played a role in this issue, as there is data that shows whites of non-Hispanic origin are far more likely to support legalized euthanasia or physician assisted death rather than minorities, especially Blacks and Hispanics. The Netherlands and Belgium are overwhelming white dominated, as well as the state of Oregon. Texas on the other hand is one of the most ethnically diverse states in the country, with nearly 40% of its population reporting themselves to be of non-white Hispanic origin. This racial demographic can also help to explain the huge variance in policy as a state with the racial diversity of Texas would find it far more challenging to pass legislation that legalized the practice simply based off lack of popular support.

Finally, the idea of quality of life rather than quantity of life is different in the United States and Western Europe. Influenced by the philosophy of secular humanism people in the Netherlands and Belgium view quality of life over quantity; it is more

harmful to keep someone alive if they are unwilling to be alive themselves.

Contrastingly in the United States death is viewed as the greatest harm, and any means which will prolong life will be taken, even if one's subjective quality of life is reduced significantly.

Oregon is a unique case, as, in terms of the factors listed above, it has a greater resemblance to the Netherlands or Belgium than to majority of the United States. It is one of the least religiously affiliated states, as well as having a long embedded tradition of liberalism. It is a solidly Democratic state and has had much less influence from the Religious Right than other regions of the country. It is extremely racially homogenous with the vast majority of its population being whites of non-Hispanic origin. These factors made it the perfect candidate for having a different perspective on euthanasia; however, it is still limited by the nation which it is in and the open hostility that the nation has towards this issue. Thus physician assisted suicide was the remedy to the challenge, as a way by which the ideas of personal choice and autonomy at end of life can occur for its citizens.

In sum, these factors explain how we now have great variance in the legal solutions to the most universal part of the human experience. Voluntary euthanasia and physician assisted death are not just matters of how one will die, but rather of how one can have control in the process of their death. In an effort to maintain a sense of worth it is critical that all people possess the ability to feel that they are able to make their own choices about their bodies during a time in life when everything seems out of control; for this is how a person maintains their own value and sense of self-worth. Having a sense of dignity is what drives this issue, and the way in which societies interpret how

to protect it during the end of life can be seen through how they legislate the question of allowing euthanasia or physician assisted death as a practice which they condone. The future of how these policies are made solely depends on how each nation or state, with its own unique social, cultural, and political influences, sees fit to best protect an individual's sense of self as their physical life is coming to an end.

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