

ABSTRACT

Terri Schiavo's Right to Die: An Overview of the Euthanasia Movement in Twentieth Century America

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The field of medical ethics has seen a tumultuous development in the 20th century. The Nuremberg Trials of the late 1940s contributed greatly to the standard of medical ethics by addressing the atrocities committed by the Nazis during World War II, particularly in regards to euthanasia and medical experimentation. From modern day to the Nazi era, the ethics regarding euthanasia have been contested and standards have been set that show that the issue has seen great growth from World War II to today. After setting an ethical standard through the Nuremberg Code, the issue of the legalization of euthanasia in the United States entered the public discourse throughout the remainder of the 20th century. Through powerful leaders and various national and global events, support for the euthanasia movement grew, reaching the point of legalization in favor of physician-assisted suicide in Oregon in the late 1990s. An important case for the euthanasia movement is that of Terri Schiavo, a young woman who fell into a vegetative state that led to a national legal battle in the early 2000s over her right to die. Through her husband's efforts, Schiavo was granted the withdrawal of a feeding tube, a form of passive euthanasia. The outcome of Schiavo's case demonstrated how much progress the euthanasia movement had made in the United States since World War II and how the ethical perspective of most Americans grew to encompass the right to die.

Terri Schiavo's Right to Die: An Overview of the Euthanasia Movement in Twentieth
Century America

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Introduction

Who decides whether or not an individual possesses the right to die? If the individual is in charge of this liberty, then he is in charge of every decision regarding his medical care and can request life-ending treatment. The argument seems simple enough until other factors come into play. For example, say a patient has verbally stated that if he were ever to enter into a vegetative state where life-sustaining treatment was required, he would choose to end his life rather than continue on treatment. If this patient has a living will, the document that will outline these wishes, then the desired course of action will be pursued and is clear; however, what if this patient, like many Americans, does not have a living will? Then the decision falls in the gray area and is subjected to judicial battles, causing tension and pain within the family of the patient and prolonging potential suffering. Throughout the twentieth century, there has been a movement to legalize euthanasia in the United States in order to grant every citizen the right to die.

The term “euthanasia,” defined as “the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma,” has been further categorized to clarify the various methods.¹ Euthanasia can be either active or passive. Active euthanasia involves the administration of life-ending treatment; passive euthanasia is the withdrawal or the withholding of treatment from a terminally ill patient that will result in their death. Euthanasia can also be voluntary, if the patient gives his consent; non-voluntary, if the patient is unable to give consent due to consciousness or age; or

¹“Euthanasia,” *Oxford Dictionary, Internet, available from* http://www.oxforddictionaries.com/us/definition/american_english/euthanasia, accessed 22 March 2015.

involuntary, the act of killing against the patient's will. Non-voluntary euthanasia is often referred to as "mercy killing" to soften the connotation and win wider appeal. Throughout the history of the euthanasia movement, many proponents and opponents of the various forms of euthanasia have shared their opinions and terminology has shifted to reflect change in this controversial issue.

The dilemma over the ethics of euthanasia for medical professionals stems from the Hippocratic Oath. This ancient oath outlines some of the key ethical principles that physicians and medical staff are expected to uphold in order to preserve the dignity of the patient and the quality of their medical care. The original version of the oath includes the following: "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art."² Following World War II, the World Medical Association (WMA) issued the Declaration of Geneva to reinstate order to the unstable state of global medical ethics resulting from Hitler's genocide against the Jews, mentally handicapped Germans and others he deemed impure. The original Declaration of Geneva includes mandates such as "The health of my patient will be my first consideration," "I will maintain the utmost respect for human life," and "I will not use my medical knowledge to violate human rights and civil liberties, even under threat."³ If an individual possesses the ability to choose euthanasia, termed the "right to die" by the latter half of the twentieth century, then the act of physician-assisted suicide – a form of active voluntary euthanasia – may not be in violation of the Declaration of Geneva.

² Hippocrates. *Oath of Hippocrates*, Internet, available from <http://www.medicinenet.com/script/main/art.asp?articlekey=20909>, accessed 22 March 2015.

³ National Institutes of Health, "World Medical Association International Code of Medical Ethics," Internet, available from <http://history.nih.gov/research/downloads/ICME.pdf>, accessed 22 March 2015.

However, many opponents of euthanasia believe that human beings are not sufficiently responsible or capable to determine that they are ready to die. This ambiguity clouded the issue for decades and continues today.

The Terri Schiavo case marked a pivotal moment in the history of the euthanasia movement. On February 25, 1990, Theresa Marie “Terri” Schiavo suffered a cardiac arrest that caused massive brain damage due to a lack of oxygen. After several months in a coma, doctors diagnosed Terri as being in a persistent vegetative state. Terri had the ability to breathe, move her limbs and see with impaired vision but physicians reported that she did not have mental awareness and required artificial nutrition to remain alive.⁴

In 1998, Michael Schiavo, Terri’s husband, petitioned through the Pinellas County Circuit Court in Florida to remove her feeding tube but was met with resistance by Terri’s parents, Robert and Mary Schindler. The Schindlers argued that Terri was still conscious and declared that they would continue to care for her regardless of her mental and physical state. The court ruled in Michael’s favor, determining that Terri would not wish to continue life-sustaining treatment.⁵ On April 24, 2001, Terri’s feeding tube was removed but was reinserted several days later due to intervention by a higher court led by Judge Frank Quesada.⁶ In 2003, a bill, called “Terri’s Law,” was signed into law by Florida Governor Jeb Bush that ordered the reinstallation of her feeding tube. This law was later deemed unconstitutional by Judge Baird of the 6th Circuit Court and was revoked.⁷ On February 25, 2005, a Judge George W. Greer of the Pinellas County Circuit Court ordered that Terri’s feeding tube be removed once more, sparking backlash that

⁴ Michael Paulsen, “Killing Terri Schiavo,” *Constitutional Commentary* 22 (2005), 585-595.

⁵ Ibid.

⁶ “Timeline,” *Terri Schiavo Life & Hope Network*, Internet, available from <http://www.terrisfight.org/timeline>, accessed 9 April 2015.

⁷ Ibid.

reached all the way up to Capitol Hill and President George W. Bush.⁸ The President signed legislation designated to keep Terri alive as appeals were made through the federal court system but the original decision was still upheld. On March 18, 2005, Terri's feeding tube was removed; thirteen days later on March 31, Terri Schiavo died.⁹

The autopsy report revealed that Terri's brain had been reduced to half the weight of a healthy brain. The irreversible damage caused by the lack of oxygen left Terri blind and removed all abilities for thought and emotion. Though Terri demonstrated visible signs of liveliness, including a limited ability to move her limbs and make incoherent vocal noises, her brain revealed that she was no longer capable of conscious thought. The medical examiner who conducted the autopsy report stated that "no amount of therapy or treatment would have regenerated the massive loss of neurons."¹⁰

The Schiavo decision reflects decades of debate over euthanasia in the United States. At the beginning of the twentieth century, many Americans did not concern themselves over the issue of euthanasia since it was rarely seen in the media. Halfway through the century, euthanasia arose in the public discourse after the revelation of Nazi medical experimentation during World War II. At this time, euthanasia was associated with criminality, inhumanity and murder. When the euthanasia movement began around this time in the United States, there was little popular support, especially given that most Americans were not even comfortable discussing the topic of death, natural or otherwise. Advocacy for euthanasia grew throughout the twentieth century, relying on determined leaders and national events to boost the legitimacy of the cause. By the close of the

⁸ Ibid.

⁹ "Retro Report: The Legacy of Terri Schiavo." YouTube, *New York Times*, n.d. Internet, available from <https://www.youtube.com/watch?v=O-rQ3tIabvM>, accessed 22 March 2015.

¹⁰ "Terri Schiavo," *Notable Names Database*. Internet, available from <http://www.nndb.com/people/435/000026357/>, accessed 22 March 2015.

twentieth century, the stage was set for the case of Terri Schiavo and the judicial decision to grant her the right to die.

In order to answer the question of how the American ethical perspective on euthanasia changed throughout the twentieth century, this thesis investigates the development of the euthanasia movement in America while incorporating the effects of the Nazi euthanasia program during World War II on the American movement's history. To do this, I used both primary and secondary resources. For primary sources, I relied on newspaper articles, documentaries, recorded interviews and various books written by Derek Humphry, a key player in the American euthanasia movement; the publication of these sources ranges from the early twentieth century to today. For secondary sources, I relied on numerous books that narrated the German euthanasia program and its aftermath and others that focused on the American euthanasia movement at various points in its history. I looked at these sources chronologically in order to provide a timeline of causes and effects within the movement.

In Chapter One, I outline the course of euthanasia carried out by the Nazis, starting in 1933 and concluding with the Nuremberg Trials and the Nuremberg Code that followed the end of World War II. Chapter Two provides an overview of the early stages of the American euthanasia movement from 1900 through the early stages of the first unified pro-euthanasia organization, the Euthanasia Society of America, in the 1950s. The expansion of the euthanasia movement between 1960 and 1980, culminating in the foundation of new societies and the division of the pioneering Euthanasia Society of America, is described in Chapter Three. The division of the euthanasia movement into the advocates of legislation and the advocates of death education is covered in Chapter

Four. Over the course of the twentieth century, the work of the euthanasia movement led to the American public's acceptance of euthanasia as an ethical practice, setting the stage in the beginning of the twenty-first century for the decision made in the Terri Schiavo case.

CHAPTER ONE:

Euthanasia in Nazi Germany, 1933-1947

Before observing the development of the American euthanasia program in the twentieth century, I focused on the actions committed by the Nazis during World War II and the repercussions felt in the United States. Nazi Germany enacted the most notorious euthanasia program of the twentieth century. Because of its scope and scale, it raised questions about the practice of euthanasia which shaped the discussion about this practice throughout the remainder of the century. Through the extensive involuntary euthanasia program, the Nazis cast a negative light over euthanasia as a whole, an influence that would hinder the American euthanasia movement in the 1940s. In this chapter, I will describe the Nazi euthanasia program and its opposition then I will conclude with an observation of the international principles concerning euthanasia established in the wake of World War II.

Nazi Euthanasia Program

Between 1933 and 1945, Adolf Hitler and the Nazi regime enacted the euthanasia program, a multi-stage program that sought to create a purer German race. The program commenced with the eradication of the mentally and physically handicapped children through starvation, lethal drug injections and gassings in specialized chambers. Beginning in the winter of 1938-1939, Hitler gave the command to Karl Brandt to select a group of doctors that would be tasked with euthanizing handicapped babies. According to Brandt, Hitler deemed those who qualified for euthanasia as “insane persons who were

in such a condition that they could no longer take any conscious part in life.”¹ Brandt gathered Nazi officials and like-minded physicians to form the Reich Committee for the Scientific Registration of Serious Hereditarily- and Congenitally-based Diseases.

The process of choosing the children who would be euthanized was veiled in secrecy and muddled by the bureaucratic process of confusing – and oftentimes purposely lost – paperwork. After a child with a handicap was born, medical staff completed paperwork and sent it to the Reich Committee. On reviewing the paperwork, the committee decided the fate of the child without ever meeting the child. The committee promised the parents that their child would receive the newest treatments but warned that the risks may be great. Parents agreed to relinquish their children out of exhaustion from the burden of caring for them or through the appeal of avoiding a “eugenic taint on their family pedigree.”²

Based on his perceived success of the children’s program, Hitler decided to extend the mandate to adults in the summer of 1939. Under the guise of needing to create more space in asylums for anticipated military casualties, a group of twenty leading psychiatrists gathered to establish the adult euthanasia program under the code name Aktion T-4. The leaders created several committees to facilitate the secrecy of the program: the Reich Association for Asylums to register asylum populations, the Community Patients Transport Service, Ltd. to transfer patients to extermination centers, and the Community Foundation for the Encouragement of Asylums to deal with the

¹ *US v. Brandt* (International Military Tribunal 1949), p. 893

² Michael Burleigh, *Ethics and Extermination: Reflections on Nazi Genocide* (Cambridge, United Kingdom: Cambridge University Press, 1997), 113-152.

logistics of euthanizing thousands of people.³ Under the Aktion T-4 plan, the criteria used to select candidates for euthanasia included the patients' abilities to perform simple tasks, whether they received visits regularly and the length of their institutional sentence. After euthanizing the chosen patients, medical staff sent out fake death certificates to the families claiming that the cause of death as an ailment, usually pneumonia; the families received the letters and forms after the body had already been cremated, conveniently ruling out the possibility of a funeral. Thus the families were kept in the dark about the true function of the Aktion T-4 Plan.⁴

In August 1941, Hitler stopped the euthanizing program. With over 70,000 mental patients murdered, the public grew suspicious of the regime due to confusing mistakes made by those involved with the secret. These errors included families who received multiple urns of ashes when they only had one family member in the asylum, death certificates claiming the cause of the death was appendicitis in patients who had previously had the appendix removed, and news that the cause of death was due to a serious long-term illness when the family had recently seen their loved one in good health.⁵ As a result of the failing program, public disquiet grew and the methodology of the regime changed to keep the public unaware of the mass euthanasia. Patients were no longer selected based on the mental incapacities; those in charge began to randomly choose patients, causing a fear in the asylums of unmerited death based on minor mistakes. During the Nuremberg Trials, Dr. Friedrich Mennecke confessed that “the

³ Florian Steger, “‘Transferred to Another Institution’: Clinical Histories of Psychiatric Patients Murdered in the Nazi ‘Euthanasia’ Killing Program,” *Israel Journal of Psychiatry and Related Sciences* 48.4 (2011): 268-273.

⁴ Benedict, Susan, Linda Shields, and Alison J. O’Donnell. “Children’s ‘Euthanasia’ in Nazi Germany.” *Journal of Pediatric Nursing* 24:6 (December 2009): 506-516.

⁵ Derek Humphry, *The Right to Die: Understanding Euthanasia* (New York, NY: Harper & Row, Publishers, Inc.), 23.

condition [of insanity] was not prevalent in the majority of cases [of euthanasia] among inmates in the concentration camps.”⁶

The Nazi euthanasia program exemplifies Social Darwinism. This movement emerged in the Western world in the late 19th century and sought to apply Darwin’s biological theories of natural selection to society. When applied to humans, Social Darwinists argue that the strong should see an increase in their wealth and power while the weak experience the opposite, destined to a life of poverty. Eugenics, derived from the Greek words meaning “of good birth,” can be divided into positive and negative eugenics. Positive eugenics is the encouragement of ideal births and negative eugenics is the discouragement of procreation in those deemed undesirable for the population.⁷ Through the euthanasia program, the Nazis established a negative eugenics movement that used mass murdering as their tool to create a more ideal population.

Propaganda flourished in Nazi Germany, aiming to shift public opinion to agreement with the regime’s decisions. When the nation was vulnerable due to the ongoing effects of World War II, propagandists offered the perspective of the strong and healthy suffering from the economic burden of caring for the weak; by offering medical care to the mentally insane, spaces and care were being robbed from the soldiers fighting to preserve the German nation.⁸ Various films such as *Die Sünden der Väter* (1935), *Erbkrank* (1936) and *Opfer der Vergangenheit* (1937) accentuated the situation, arousing anger by showing the resources that were used caring for the sick while the workers and care-providers were living in dilapidated housing. The truth was also skewed when the

⁶ *US v. Brandt*, p. 875

⁷ Karl Kessler, “Physicians and the Nazi Euthanasia Program,” *International Journal of Mental Health* 36.1 (Spring 2007): 4-16

⁸ Paul Weindling, *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent* (Boulder, CO: PalgraveMacmillan), 137-139.

films were set in psychiatric prisons where murderers and sex offenders were receiving care.⁹ These propaganda efforts successfully cultivated a sense of unity among Germans to support the country in the war by any means necessary.

Opposition to the Euthanasia Program

While the Racial Political Office of the Nazi Party worked hard to earn the public's favor, the program still faced significant opposition. Individual church leaders, such as the Jesuit zoologist Hermann Muckermann and other low-ranking clergy, openly denounced the euthanasia program as immoral and contrary to Christian doctrines. However, the German branch of the Catholic Church as a whole did not respond in a similar manner. The German Catholic Church worked behind the scenes in opposition to the program but would not make its opposition public in order to preserve the institution in the midst of a hostile political climate. Despite their fear of Hitler, the church still proved to be the biggest united opposition to the program.¹⁰

Because of the Nazis' "Final Solution" for the Jews and their efforts to create a purer race by euthanizing the mentally ill, a hostile relationship developed between the Catholic Church and the Nazi regime. By the beginning of the euthanasia program, the German Catholic Church had already suffered greatly from persecution by the Nazis, including property seizures and arrests of clergy members. As a result of the power the Nazis wielded over the church, Catholic officials were hesitant to publicly condemn the Nazi regime for fear of the consequences that would ensue. Out of the fear of

⁹ Michael Burleigh, "Racism as Social Policy: The Nazi 'Euthanasia' Programme, 1939-1945," *Ethical and Racial Studies* 14.4 (October 1991): 453-72.

¹⁰ Burleigh, *Ethics and Extermination*, 131-141.

persecution, the Catholic Church initially quietly opposed the Nazi murder programs but unrest was brewing among German Catholics.

In the summer of 1940, Catholic protests against the Nazi killing programs began to build. Since the church managed numerous hospitals, the Nazis pressured the church to relinquish the hospitals to the state. The Catholic protests began in a mild manner. For example, Archbishop Conrad Groeber of Freiburg, under the advice of Germany's Cardinal Adolf Bertram, wrote to the Nazi regime and offered to pay all costs to the state to care for the mentally ill patients who were chosen to be euthanized.¹¹ The directors of Caritas, the main organization in charge of health care services in the Catholic Church, wrote a letter of protest to the Nazi government in August of 1940 and sent Bishop Heinrich Wienken to personally discuss the situation. By referring to the commandment "thou shalt not kill," Wienken warned the Nazis that if the program was not terminated, the Catholic Church would publicly condemn the program. However, the Nazis did not waver, and on December 2, 1940, the Vatican declared that the Nazi policy defied Divine Law with the statement: "The direct killing of an innocent person because of mental or physical defects is not allowed."¹²

After the condemnation of the program, the Nazis began to fight back against the Catholic Church by expropriating religious houses. After his diocese was affected, the Bishop of Munster, August von Galen, decided to open the public's eyes by explaining the euthanasia program in depth. In his August 3, 1941 sermon, von Galen declared "If you establish and apply the principle that you can kill 'unproductive' human beings then woe betide us all when we become old and frail...woe to our German nation if God's

¹¹ Kessler: 4-16.

¹² Burleigh, *Ethics and Extermination*, 139.

holy commandment 'Thou shalt not kill' ...is not only broken, but if this transgression is actually tolerated and allowed to go unpunished."¹³ Von Galen took a strong stance, declaring the murders of the mentally ill to be illegal and encouraging all Christians to join him in his opposition to the Nazis. Von Galen's words gave Christians the responsibility to resist the taking of human life.

Von Galen's message spread rapidly throughout Germany. Von Galen showed the inhumanity of the program and declared that the morality of Germany was in danger due to the regime's violation of basic human rights. As a result of von Galen's sermon, many Catholics joined him in opposition and held public demonstrations against Hitler and the Nazis. Though the public unrest did not end the killings, the veil of secrecy was lifted from the euthanasia program, revealing Hitler's true intentions.¹⁴

The Catholic protests had a significant effect on the euthanasia program. The killings became public knowledge and sparked rebellion from the medical staff. Citizens living near the extermination centers now fully understood the operation behind the smoking chimneys, the unbearable smells and the continuous flow of full buses entering the camp and leaving empty. On August 24, 1941, Hitler halted the main euthanasia program. Though Hitler publically terminated the program, the euthanasia of handicapped children continued in secret; since the program was poorly documented, it is speculated that three thousand children died by starvation or lethal injection between 1941 and 1945.¹⁵ As far as the public knew, the euthanasia of handicapped children ceased in 1941 but the Nuremberg Trials following the end of World War II illuminated the extent of Hitler's program.

¹³ Burleigh, "Racism as Social Policy," 468.

¹⁴ Burleigh, *Ethics and Extermination*, 140-41.

¹⁵ Humphry, *The Right to Die*, 24-25.

Nuremberg: the Doctors' Trial

The Doctors' Trial, also known as *United States of America v. Karl Brandt, et al.*, took place from October 1946 to August 1947. Twenty-three defendants were put on trial after being accused of their involvement in Nazi human experimentation and mass murder. The defendants who were accused of collaborating in the euthanasia program included Karl Brandt, Kurt Blome, Viktor Brack and Waldemar Hoven. The formal charge against them was that:

Between September 1939 and April 1945 the defendants Karl Brandt, Blome, Brack, and Hoven unlawfully, willfully, and knowingly committed war crimes... in that they were principals in... plans and enterprises involving the execution of the so-called "euthanasia" program of the German ...the defendants herein murdered hundreds of thousands of human beings, including nationals of German-occupied countries. This program involved the systematic and secret execution of the aged, insane, incurably ill, of deformed children, and other persons, by gas, lethal injections, and diverse other means... Such persons were regarded as "useless eaters" and a burden to the German war machine... German doctors involved in the "euthanasia" program were also sent to Eastern occupied countries to assist in the mass extermination of Jews.¹⁶

The same men were also charged with the murdering of German citizens other than children:

Between September 1939 and April 1945 the defendants Karl Brandt, Blome, Brack, and Hoven unlawfully, willfully, and knowingly committed crimes against humanity... in that they were principals in...plans and enterprises involving the execution of the so called "euthanasia" program of the German Reich...the defendants herein murdered hundreds of thousands of human beings, including German civilians, as well as civilians of other nations.¹⁷

Karl Brandt, the personal physician to Hitler, was found to be active in the *Schutzstaffel*, or SS, the group responsible for many of the crimes against humanity that defined the Nazi Party, and was the Commissioner for Health and Sanitation; he was sentenced to

¹⁶ Douglas O. Linder, "The Nuremberg Trials: The Doctors' Trial, War Crimes," *Famous Trials*, University of Missouri Kansas City School of Law, 2015, Internet, available from <http://law2.umkc.edu/faculty/projects/ftrials/nuremberg/nurembergdoctortrial.html>, accessed 10 April 2015.

¹⁷ Ibid.

death and was hanged on June 2, 1948 at the Landsberg Prison in Bavaria. Kurt Blome, the Deputy of the Reich Health Leader and Plenipotentiary for Cancer Research in the Reich Research Council, was acquitted. Viktor Brack was a Senior Colonel in the SS and the Chief Administrative Officer in the Chancellery of the Fuehrer; Waldemar Hoven was the Chief Doctor of Buchenwald Concentration Camp. The tribunal sentenced both Brack and Hoven to death and both were hanged on June 2, 1948 alongside Brandt at the Landsberg Prison.¹⁸

The Ethical Aftermath of Nuremberg

On August 20, 1947, the verdict was delivered and the Doctors' Trial came to a close. Based on the actions of Karl Brandt and other significant Nazi players involved in atrocities outside the euthanasia program, significant steps were taken in the field of medical ethics that resonate today. Prior to the trial's end in 1947, Dr. Leo Alexander, an aide to the chief counsel at the trials and the author of the Nuremberg Code, submitted a document to the Counsel for War Crimes outlining the definition of legitimate medical research in order to set previously undeclared standards for ethical behavior in the pursuit of medical knowledge.¹⁹ Permissible medical experiments, as decreed by the Nuremberg Code, must meet the following ten requirements:

1. The voluntary consent of the human subject is absolutely essential.
2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

¹⁸ Ibid.

¹⁹ "Dr. Leo Alexander, 79; Nuremberg Trial Aide," *The New York Times*, 24 July 1985, available from <http://www.nytimes.com/1985/07/24/us/dr-leo-alexander-79-nuremberg-trial-aide.html>, accessed 10 April 2015.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an *a priori* reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.²⁰

The Nazi form of involuntary euthanasia violates these principles by neglecting to gain the patient's consent and by not avoiding physical and mental suffering, placing control in the hands of the physician and leaving the patient powerless. In contrast to Nazi Germany, the United States stood strongly against forms of involuntary euthanasia throughout the 20th century while making progress in terms of controlled voluntary euthanasia in the 1990s. Current legislation in the U.S. demonstrates the importance of upholding ethically correct behavior in relation to the Nuremberg Code.

Evidence of the Nuremberg Code is seen in today's Code of Federal Regulations Title 45 Volume 46, regulations issued by the U.S. Department of Health and Human

²⁰ *Trials of War Criminals before the Nuernberg Military Tribunals under Control Council Law No. 10, Vol. 2* (Washington, D.C.: U.S. Government Printing Office, 1949), 181-183.

Services for ethically correct medical research. The document includes themes that directly correlate to the Nuremberg Code; for instance, in Section 46.116 regarding informed consent: “No investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject of the subject’s legally authorized representative.”²¹ Though it has been nearly seventy years since the Nuremberg Code was put into action, the precedent it has set has lasted and proven to be a solid foundation for medical ethics.

The Nuremberg Code marked a shift in the physician-patient relationship. Before the Nuremberg Code, the basis for medical ethics was the Hippocratic Oath. The traditional Hippocratic relationship between the physician and his or her patient was characterized by passive compliance by the patient and a complete trust that the physician will act in the interest of the patient and not cause harm. The Nuremberg Code set the standard for what is an appropriate physician-patient relationship when conducting medical research. The Nuremberg Code emphasizes the importance of attaining the patient’s consent, shifting more control into the patient’s hands and away from the omnipotent physician; the Hippocratic Oath retains the physician’s power over the patient but clearly dictates that the physician shall not cause unnecessary harm or death.

Though this setting of medical research and experimentation is different than the common situation of a patient becoming sick and seeking his physician to get better, the Nuremberg Code places significant control in the hands of the subject that has translated into modern medical practices. By granting the subject the right to informed consent (principle 1 of the Nuremberg Code) and the liberty of allowing the subject to end the

²¹ “Protection of Human Subjects,” *Code of Federal Regulations* Title 45, Public Welfare, 2009 ed.

experiment if he feels he cannot continue (principle 9), the dynamics of the relationship dramatically shifted. The subject or patient is no longer at the whim of the physician but holds the power to preserve his mental or emotional health.

I chose to describe the Nazi euthanasia program in my first chapter because it stands as a key example of the extremes that can result from the legal practice of euthanasia. After discovering the truth behind Hitler's euthanasia program, many Americans feared that if any form of euthanasia were to be legalized in the United States, physicians would abuse their powers and follow the path of the Nazis. By the time of the Terri Schiavo case in the late 1990s, some Americans still held this mindset and protested the actions to remove Terri's life-sustaining treatment. However, by this time, most Americans felt comfortable with the safeguards set in place, such as the requirement of clear and convincing evidence of the patient's wishes in order to withdraw treatment from a patient in a vegetative state, and no longer feared that American physicians would act in a manner similar to the Nazis.

CHAPTER TWO:

Euthanasia in the United States, 1900-1960

Even before the Nazis' grotesque experiment with euthanasia caused the international community to act, an early debate over the practice began in the United States at the beginning of the twentieth century. In the first six decades of the twentieth century, American views on euthanasia shifted from nearly complete opposition to a substantial minority that vocally expressed its support of the legalization of euthanasia. The idea of the right to die, a key factor in the Terri Schiavo case in the 1990s, entered the American conversation on euthanasia in this era.

1900-1917

At the beginning of the twentieth century in the United States, the ethical debate over euthanasia drew both support for its legalization and opposition to this practice that many associated with murder. The public's view was negative: based on the Christian concept of the sanctity of life, many opposed euthanasia and sought to preserve every individual's life. Christian and Jewish Americans viewed euthanasia – or as it was more commonly known, mercy killing – as a direct rebellion against God's will. However, the viewpoint of the physicians was changing from adamant opposition to a more flexible open-mindedness. As the firsthand witnesses of death and suffering, physicians began to see the justice behind euthanasia as a treatment that spared pain. For terminally ill patients experiencing debilitating pain, some physicians believed that they would be

ethically correct in ending the patient's suffering by gently putting him or her to death. Yet the public still opposed the legalization of euthanasia. Throughout the first half of the twentieth century, the American euthanasia movement developed into a concrete organization, the Euthanasia Society of America, and experienced a turbulent growth.

In 1915, with the decision of one physician, the entire nation was confronted with the reality of euthanasia. On November 12, 1915, Anna Bollinger gave birth to a baby boy afflicted with severe handicaps, including the lack of an anal orifice that if left unfixed, would lead to the child's death in a matter of days. Dr. Harry J. Haiselden, the chief of staff at Chicago's German-American Hospital where the child was born was immediately called in to serve the parents and the infant patient. Going against all precedents, Haiselden shocked the entire nation by advising against surgery and advocating passivity to let the child die.¹ With the consent of the Bollingers, Haiselden's advice was taken and the child died on November 17, 1915.²

The Bollinger baby's death sparked a series of public declarations both in favor of and in opposition to Haiselden's actions. Many spoke out against Haiselden, denouncing his actions out of a belief that the physician's first responsibility is to keep his or her patients alive and thus condemning euthanasia. Haiselden's opponents believed that by refusing treatment, he had violated the Bollinger baby's constitutional right to life.³ As more voices entered the debate, the central question became the definition of life itself and whether an individual must possess the potential for "happiness, intelligence, and

¹ John Gerdtz, "Disability and Euthanasia: The Case of Helen Keller and the Bollinger Baby," *Life and Learning XVI* (2006): 491-493.

² Ian Dowbiggin, *A Merciful End* (New York, NY: Oxford University Press, 2003), 24-25.

³ Angus McLaren, "Book Reviews: The Black Stork: Eugenics and the Death of 'Defective' Babies in American Medicine and Motion Pictures since 1915 by Martin S. Pernick," *Canadian Bulletin of Medical History / Bulletin Canadien D'histoire de La Médecine* 14, no. 1 (January 1, 1997): 165-66.

social usefulness.”⁴ Euthanasia, now fully in the public arena, remained a controversial topic for the rest of the twentieth century.

Following Haiselden’s actions, a film titled *The Black Stork* opened to the public in 1916 that featured a dramatization of the Bollinger case. As portrayed in the film and seen in interviews, Haiselden’s view was that euthanasia and eugenics – the belief and practice of improving the genetic quality of the human population – were closely related and that in order to achieve a better American population, reforms needed to be made to support the mercy killing of the disabled. In a scene from *The Black Stork*, a fictional Dr. Dickey, played by Dr. Haiselden himself, stands over a weak newborn while a nurse offers a blanket for warmth; he refuses to give the blanket to the infant, then walks away, denying care to the child he deems handicapped. A quote from the silent film states, “There are times when saving a life is a greater crime than taking one.”⁵ Haiselden, a strong advocate for eugenics, capitalized on the Bollinger case to spread his ideas of creating what he deemed a purer race. The close association between eugenics and euthanasia would surface again in later decades with the continued discussion of euthanasia.

By 1917, more pressing issues faced the country as World War I became the nation’s central focus, directing attention away from the euthanasia discussion. Americans were more concerned about the fear of communism, race riots, and the League of Nations and the debate over euthanasia diminished in the period of high political tension. The topic of euthanasia would resurface again after the conclusion of World War I.

⁴ Ian Dowbiggin, *A Merciful End* (New York, NY: Oxford University Press, 2003), 28.

⁵ “The Black Stork,” Dir. Leopold Wharton and Theodore Wharton, . 1917, *YouTube*, Internet, available from <https://www.youtube.com/watch?v=9m6OCT8YmfU>, accessed 10 April 2015.

Success for the Euthanasia Movement in the Interwar Period

Between World War I and World War II, the tide shifted in the euthanasia debate. According to a poll conducted in 1939, about 40 percent of the Americans said they supported the legalization of government-supervised mercy killing of the terminally ill.⁶ With the public leaning towards favoring the legalization of euthanasia, several figures stepped in to channel the energy of the interwar period and to soundly establish the euthanasia movement. Among these were Charles Francis Potter, Inez Celia Philbrick and R. L. Mitchell.⁷

After a quiet decade in the 1920s, the 1930s saw the renewal of ethical discussions regarding suicide and controlled dying.⁸ In the midst of the economic hardships of the Great Depression, the proponents of euthanasia found receptive ears as more Americans revisited the topic of euthanasia. The pro-euthanasia argument was boosted by reports of various mercy-killing trials in the media throughout the 1930s. Several cases dealt a potent message through the words of suffering patients. For instance in 1935, Ann Becker, a young woman suffering from injuries related to a car accident, pleaded to the Erie County Medical Association, “In the name of mercy I ask you to appoint a doctor to take my life.”⁹ As Americans heard such pleas directly from those who were suffering in the popular press, the argument in favor of euthanasia became personalized. Americans began to question their stance when they felt the guilt of prolonging someone’s life when they specifically asked for a gentle, merciful death.

⁶ George H. Gallup, *The Gallup Poll: Public Opinion, 1935-1971* (New York, NY: Random House, 1972), vol. 1, 151

⁷ Dowbiggin, 37-51.

⁸ Stephen Louis Kuepper, “Euthanasia in America, 1890-1960: The Controversy, the Movement, and the Law.” (Ph.D. diss., Rutgers The State University of New Jersey - New Brunswick, 1981).

⁹ “The Right to Kill,” *Time*, 25 November 1935, 39-40.

As the public's momentum developed, several leaders stepped in to direct the dialogue and make progress in favor of the legalization of euthanasia. Born in 1885, Charles Francis Potter grew up in a strict Baptist family and went on to become a Baptist minister at the age of 23. However, his personal philosophy quickly diverged away from the fundamentalism of his upbringing and led him to the euthanasia movement. In the 1910s, Potter moved away from the Baptist church and became a Unitarian pastor; gaining a reputation for controversial beliefs by supporting women's equality, the League of Nations, eugenic strategies, and birth control. Potter even claimed that science, in particular Darwinist biology, was superior to religious doctrines.¹⁰ In 1925, Potter served as a religious adviser to lawyer Clarence Darrow in the landmark Scopes trial on evolution. Abandoning the beliefs instilled in him as a child, Potter ultimately resigned from his position as a Unitarian priest to further develop his liberal philosophy.¹¹

From the minds of Potter and two fellow theologians, Curtis W. Reese and John H. Dietrich, humanism emerged in the first few decades of the twentieth century. Humanism was a type of religion based on Unitarianism and liberal modernist Protestantism that rejected theism in favor of a naturalist religion that centered on humanity. In 1933, Potter and other Unitarian ministers signed the "Humanist Manifesto," a doctrine that defined Humanism as "those actions, purposes and experiences which are humanly significant" while outlining the goal of life as "the complete realization of the human personality."¹² To Potter, euthanasia directly related to humanism. In his career as a priest, Potter saw many parishioners suffering in pain at the

¹⁰ Dowbiggin, 38.

¹¹ Dr. Charles Francis Potter, interviewed by Henry Hazlitt and William Bradford, *Columbia Broadcasting System*, 1951, available from <http://search.alexanderstreet.com/view/work/1786623>, accessed 10 April 2015.

¹² DeWitt, Dale. "Charles Francis Potter." *Humanist*, November 1, 1962, 80-81.

end of their lives, begging for someone to end their misery; as a result of these experiences, Potter saw euthanasia as the humane treatment and deemed euthanasia an example of humans exercising control over their own personal futures. According to Potter's beliefs, if women were granted the liberty to control their fertility by using legal contraception, humans should also possess the freedom to decide when, where and how they will die.¹³

Potter's support for euthanasia extended beyond voluntary mercy killing and into the realm of utilitarianism, the theory that the correct course of action prioritizes utility. In 1935, Potter argued that disabled infants, the incurably insane, and the mentally retarded were deserving of mercy killing. Referring to these humans as "monsters," Potter declared that the deaths of the members of this subpopulation would be socially desirable, saving the nation millions of dollars and preventing the reproduction of individuals considered eugenically unfit.¹⁴ The work of Potter coincided with several other significant euthanasia supporters in the 1930s.

Concurrently with Potter's efforts, Inez Celia Philbrick, a Nebraskan physician, left her legacy as one of the most adamant and relentless supporters of euthanasia in the twentieth century. Like Potter, Philbrick was also Unitarian, frequently criticized Christian fundamentalism, and supported women's rights, birth control, and eugenic sterilization.¹⁵ Philbrick's opinion on euthanasia was influenced by significant firsthand experiences with the suffering associated with imminent death. In 1936, a close friend to Philbrick died from cancer. During the last several months of her life, her friend lived a

¹³ Kuepper, 106-108.

¹⁴ Dowbiggin, 44.

¹⁵ "Dr. Inez Philbrick, 70, Fights for the First 'Mercy-Killing' Law," *The Milwaukee Journal Green Sheet*, 17 February 1937, 12

life of tremendous pain and was confined to her bed. For fear of the legal repercussions for Philbrick, the friend refused a lethal dosage and after great suffering, died naturally.¹⁶ After her death, Philbrick decided to work towards the legalization of euthanasia.

For Philbrick, euthanasia, eugenics and birth control all correlated with her feminist philosophy. Darwinist theory suggested that women, as the bearers of children, must exercise sexual selection in choosing male partners that will produce the most viable offspring. Such responsibility conferred superiority, according to Philbrick, and thus women should be engaged in the euthanasia movement. As she wrote, “the purpose of euthanasia is to remove from society living creatures so monstrous, so deficient, so hopelessly insane that continued existence has for them no satisfactions and entails a heavy burden on society.”¹⁷ Much like Potter, Philbrick took on a utilitarian viewpoint towards euthanasia. To her, euthanasia and birth control promoted eugenics.

In 1937, Philbrick took to political action by contributing to Legislative Bill No. 135. Written for the Nebraska legislature, this bill outlined a moderate version of Philbrick’s stance on eugenic euthanasia. Under this bill, consenting adults who suffered from an incurable, terminal disease could apply to a district judge for a merciful death.¹⁸ With the approval of a three member committee and the completion of all requirements, the patient would be granted a lethal injection. Because the bill raised the possibility of non-voluntary euthanasia, it was never considered by the state legislature of Nebraska. Philbrick later moved to Ohio where she believed a euthanasia law stood a better chance but continued to be unsuccessful in her efforts.

¹⁶ Dowbiggin, 46.

¹⁷ Ibid., 48.

¹⁸ Shai J. Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States* (Princeton, NJ: Princeton University Press, 2005), 115-116.

Ann Mitchell stood alongside Potter and Philbrick as an important leader in the euthanasia movement. While Potter and Philbrick provided the dialogue and the public relations, Mitchell provided the financial assistance to sustain the euthanasia movement. Mitchell was diagnosed with psychosis, a mental illness that she believed to be hereditary. As a result of her suffering, Mitchell concluded that all patients who suffered from mental disorders were helpless against their genetic disease.¹⁹ Her own personal affliction shaped her view that the legalization of euthanasia demonstrated the merciful and economical course of action.

Mitchell took interest in the English pro-euthanasia organization called the Voluntary Euthanasia Legislation Society (VELS). Based on the VELS' success in introducing bills to Great Britain's House of Lords, Mitchell took action to create a similar group in the United States. Mitchell contacted Charles Potter to discuss this idea, and Potter quickly began to recruit prominent individuals. On January 16, 1938, the National Society for the Legalization of Euthanasia (NSLE) was founded with around 200 members.²⁰

After its creation, the organization was renamed the Euthanasia Society of America and began work on a model euthanasia bill. The bill argued that the legalization of euthanasia for terminally ill patients suffering in pain would be merciful. Though eugenicists favored extending euthanasia to patients that might not be able to make the decision to die on their own, such as unconscious geriatric patients, the insane, and disabled children and infants, the resulting bill was very moderate and only outlined voluntary euthanasia, in order to stand a chance in the legislation. A moderate bill could

¹⁹ Lavi, 108.

²⁰ "Sanction is Sought for 'Mercy Deaths,'" *New York Times*, 17 January 1938

lay the foundation for pursuit of the legalization of involuntary euthanasia. Under this initial bill, candidates for euthanasia had to be twenty-one years or older, of “sound mind,” and suffering from severe pain caused by an incurable disease. After meeting these requirements, the patient with the backing of his or her physician would have to petition a court. The court would then appoint a committee of three members to evaluate the patient; with a two thirds majority, the patient would be granted the right to euthanasia. The physicians who performed euthanasia on patients who successfully completed the process would be spared any liability.²¹

The bill failed to find a state politician to sponsor the bill because many legislators did not want to jeopardize their political clout. Both Catholic and Protestant groups expressed anti-euthanasia sentiments, viewing it as murder or a treatment that could easily be abused if legalized; interviews conducted by newspapers around the nation expressed a common thought that human beings are not responsible enough to make decisions regarding death.²² Despite what the ESA perceived as public support, the climate simply was not fit for political reform through the legalization of euthanasia at this time.

Yet the ESA remained hopeful. Based on the trends in the movement, members of the ESA compared their predicament to the birth control movement and the women’s suffrage movement, implying their faith that the euthanasia movement would eventually be as successful as these earlier movements.²³ However, the ESA and the euthanasia movement hit roadblocks with which these other movements never had to deal.

²¹ Dowbiggin, 57.

²² Kuepper, 126.

²³ Dowbiggin, 61.

Roadblocks: 1940s – 1950s

From the 1940s through the 1950s, the American euthanasia movement hit a number of unexpected obstacles that halted the momentum built up during the 1930s. As World War II progressed, news of Nazi atrocities, and specifically Hitler's euthanasia program, fell on American ears, shocking the entire nation. The ruthless killings conducted by the Nazis against the mentally and physically handicapped created an unforgettable image in the minds of Americans. The defenders of euthanasia in the US found that many citizens considered the American euthanasia movement to be related to the Nazi murders. If the ESA and the supporters of euthanasia ever wanted to see any legal action taken in their favor, they would now have to overcome the public's mindset that the American movement was seeking the same results as the Nazi regime.

In the 1940s, news began to spread to America that Hitler and the Nazi regime had developed a ruthless euthanasia movement that had killed thousands of German citizens against their will and without the consent, or even knowledge, of the families.²⁴ This news put the American proponents on the defensive, forcing them to constantly deny that they shared the same philosophy of euthanasia as the Nazis. The Nazi euthanasia program, Aktion T-4, was the first step in the Nazi "Final Solution," the plan to eradicate the population of European Jews and other citizens deemed "undesirable" in order to create a purer, more ideal population.²⁵ The eugenics movement propagated by the Nazis horrified Americans and created a strong emotional response that would prove difficult to overcome by the supporters of eugenics and euthanasia. Americans feared that if physicians were allowed to legally practice euthanasia, the country would follow a

²⁴ Burleigh, *Ethics and Extermination*, 131-141.

²⁵ Vivien Spitz, *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans*, (Boulder, CO: Sentient Publications, 2005), 235-37.

similar path as Germany did, threatening the safety of handicapped and severely ill citizens; out of this fear, the public was unreceptive to the euthanasia proponents' claims that legalizing euthanasia would serve as a victory for personal freedom.²⁶

Following Hitler's declaration of the termination of the euthanasia program in 1941, the ESA issued a public statement to the press in 1942 condemning the Nazi's "wholesale slaughter of innocents" and reaffirmed that they solely supported voluntary euthanasia.²⁷ Once the United States entered World War II in December 1941, the ESA was aware that they must stand united with the country by condemning Hitler's actions of non-voluntary euthanasia.

Shortly after this declaration, the ESA chose a committee in 1943 to draft a bill outlining the legalization of involuntary euthanasia for those deemed undesirable to society. After the project failed, Eleanor Dwight Jones advised that the ESA put all legislative activity on hold from 1943 until the end of the war, knowing that this time was not fit for pressing the legalization of any euthanasia. After the war had ended, Jones quickly resumed the legislative activity of the ESA and set out to build support for a more palatable voluntary euthanasia bill intended for New York, working with Robert Latou Dickinson, another important leader in the ESA.²⁸

From 1946 – 1950, Dickinson served as the president of the ESA. Dickinson's principal contribution to the American euthanasia movement was his leadership role in the "Committee of 1776 Physicians for Legalization of Voluntary Euthanasia in New

²⁶ Kuepper, 142.

²⁷ Dowbiggin, 72.

²⁸ James Reed, *From Private Vice to Public Virtue: The Birth Control Movement and American Society Since 1830*, (New York, NY: Basic Books, 1978), 161-162.

York State.”²⁹ The committee produced a petition that reached the hands of every member of the state’s legislature by the end of 1947. The actions of the committee brought national attention to the ESA but with that attention came a response from the American Medical Association (AMA). In 1950, the AMA issued a statement declaring that the majority of American physicians “do not believe in [euthanasia].”³⁰ The condemnation of the AMA and nearly every physician in the United States struck another serious blow to the euthanasia movement. After the AMA’s announcement, many physicians that had signed the petition through the Committee of 1776 backed away, denying their involvement or proclaiming that they did not understand what the petition had said.³¹

In the late 1940s, several significant cases of mercy killings were highly publicized to the American public. One case, that of Dr. Hermann Sander, caught the entire nation’s attention. Sander made history as the first physician to go on trial for mercy killing in America. On December 4, 1949, Sander gave a lethal injection of 40 cubic centimeters of air to Abbie Borroto, a woman dying of cancer.³² The patient had suffered significantly towards the end of her life, dropping her weight from 140 to 80 pounds, completely losing her ability to eat and developing a resistance to painkilling medicines. In February 1950, Sander’s trial began and was publicized to the entire nation and other countries around the world. Sander was condemned by significant Catholic and Protestant leaders but also gained some supporters, including prominent leaders in the ESA and the VELS. Despite predictions that Sander would be punished for his actions,

²⁹ Ibid.

³⁰ American Medical Association, *Los Angeles Times*, 10 March 1950. Cited in Kuepper, “Euthanasia in America,” 229.

³¹ Dowbiggin, 76-77.

³² “Med School’s Ford Testifies For Sander Defense Today” *The Harvard Crimson*, 7 March 1950.

the jury acquitted him on March 10, 1950 based on the conviction that Mrs. Borroto may have been dead when Dr. Sanders administered the fatal injection, avoiding the issue of mercy killing.³³

The results of the Sanders trial helped to create a short-lived climate that favored the euthanasia movement. Eleanor Dwight Jones and Charles Potter established a state chapter of the ESA in Connecticut in January 1950 called the Voluntary Euthanasia Society of Connecticut (VESC). In 1959, the VESC successfully introduced a voluntary euthanasia bill to the state legislature. Because the bill was unclear on certain circumstances in which euthanasia could be practiced, many unanswered questions doomed the bill to defeat.³⁴ Attempts to form a state chapter in New Hampshire in the aftermath of the Sanders trial also met with defeat; the momentum built up from the Sanders case quickly dispersed and the ESA was left once again in a stalemate.

Overall, the 1940s and 1950s witnessed tremendous setbacks and frustration for the euthanasia movement. In 1952, the ESA sent a petition to the Human Rights Commission of the United Nations declaring that the right to die should be considered a basic human right for patients dying of an incurable disease.³⁵ With 2,500 signatures from both Great Britain and the United States, the rejected petition demonstrated the growing acceptance of euthanasia in the Western world. By the end of the 1950s, the ESA recognized that American opposition to euthanasia was strong. However, big changes loomed on the horizon. During the 1960s, the country would see a shift in perspectives as well as a great increase in medical technology that would completely change the dialogue on euthanasia.

³³ Humphry, *The Right to Die*, 42-44.

³⁴ Dowbiggin, 80.

³⁵ "Murder or Mercy?" *Newsweek*, 3 February 1958, 56.

CHAPTER THREE:

A Period of Prolonged Success, 1960-1980

Coming out of the stagnancy of the 1950s, the 1960s and 1970s were filled with great changes for the proponents of euthanasia. All around the world, crises were taking place that caused Americans to think more about the topic of death. A combination of the persistent fear felt during the Cold War, the tragic deformities caused to newborn babies as a result of the use of thalidomide and the war in Vietnam shifted the public's view of death from an event to be feared to a topic deserving a more open discussion. As Americans began to see death as a more personal experience, they believed that every individual possessed rights in regards to their death and the conversation on euthanasia also changed. Americans viewed death as a personal liberty that protects against interference in one's life rather than a process over which the state should exercise control. Citizens began to expect privacy in their own death, an opinion that directly affected the euthanasia movement. As a result of this great transformation of opinion, the term "euthanasia" was eased out of the dialogue in favor of the term "right to die." However, the traditional supporters of euthanasia did not disappear; they now found themselves mixed in among citizens who had no interest in eugenics but sought the right to refuse treatment in favor of a more comfortable, dignified death. The pool of advocates grew and lost its homogeneity while the bonds of unity amongst the pro euthanasia group weakened. As more Americans began to see their death as a personal choice, the

foundation was being set that would affect the political and ethical climate surrounding the Terri Schiavo case in the 1990s.

A New Perspective on Death and Dying

Up to the 1960s, the topic of death remained taboo in the public arena. However, as the times changed, the stigma surrounding dying began to receive attention. Researchers began to show an interest in exploring the emotions relating to death felt by the elderly and the terminally-ill.¹ Studies showed that these groups feared prolonged dying more than death itself, feeling anxiety towards a long, drawn-out and painful dying process. One particular study conducted in 1958 by Wendell Swenson, a psychologist at the Mayo Clinic, demonstrated that those who feared death the most tended to be less religious, less connected to family and friends and had fewer leisure activities to fill their time.² A trend was seen among researchers in the early 1960s: many elderly and dying patients used denial to cope with their anxiety.³

Daniel Cappon, a psychiatrist at the University of Toronto, conducted a study in 1960 that compared attitudes among dying and healthy individuals. Cappon's study asked three questions: How much information did the patient want? What was the preferred mode of death? What was the subject's view of euthanasia?⁴ The results showed that across both healthy and sick patients, most people wanted minimal information. The majority also preferred a faster death over a prolonged death and favored euthanasia.⁵

¹ Kenneth L. Woodward, "How America Lives with Death," *Newsweek*, 6 April 1970, 81-88.

² Wendell Swenson, "Attitudes Toward Death in an Aged Population," *Journal of Gerontology* 16, no. 1 (January 1961), 50.

³ Humphry, *The Right to Die* 65-66.

⁴ "Attitudes of and Towards the Dying," *Canadian Medical Association Journal* Vol. 87, (29 September 1962), 695.

⁵ *Ibid.*, 698.

In 1969, a study was produced that contributed greatly to thanatology, the results of which are still useful today. In this year, psychiatrist Elisabeth Kubler-Ross published *On Death and Dying*, a book that contained interviews with terminal patients and described the emotional process of dying. From her research, Kubler-Ross inferred that grief and dying is characterized by five stages. Already alluded to by earlier research, the first stage is denial. During this stage, the patient often rejects his prognosis out of shock. Once the patient overcomes his denial, the second stage is anger, often directed at physicians, family, friends or self as a result of the thought of impending loss. The third stage is bargaining; usually directed towards the medical staff or God, this stage is characterized by making an offer to improve some aspect of the patient's life in exchange for wellness or a delayed death. Following bargaining is depression; the patient can no longer deny his fate and must deal with the cards he has been dealt. The final stage is acceptance when the patient has come to terms with the upcoming loss and has reached a state of quiet expectation.⁶

Through the work of Kubler-Ross and other researchers, the subject of death and dying received greater attention and its negative connotation began to be resolved. Kubler-Ross's five stages gave Americans data to use when they had to deal with loss, easing the process along by providing guidance. Kubler-Ross helped many to see that death need not be frightening or painful but a peaceful passage when the dying and his or her loved ones come to terms with the inevitable outcome. Though she was not involved in the euthanasia movement, Kubler-Ross helped set a sturdier foundation for its future development by working to bring death and dying into the public dialogue.

⁶ Elisabeth Kubler Ross, *On Death and Dying* (New York, NY: Macmillan, 1969), 38-39.

Philosophical Shifts within the Euthanasia Movement

On February 24, 1957, Pope Pius XII shook up the American national dialogue over euthanasia. In a speech to an international gathering of anesthesiologists, Pope Pius XII declared that there was “no reason that dying persons should endure unusual pain.”⁷ While physicians should never use pain reducing drugs with the intention of killing or against the patient’s will, Pius asserted that they should be free to use these drugs to reduce the pain of a patient, even if it shortened the patient’s life. According to the pope, no dying patient should be forced to pursue long-term medical treatment for the sole reason of extending his or her life, thus making what is known as passive euthanasia permissible among Catholics.⁸ Through his words, Pope Pius XII contributed to the philosophical context of euthanasia, an area of the argument where the euthanasia advocates had not found much success.

In 1962, the Protestant theologian Joseph Fletcher joined the conversation as the unofficial chief philosopher of the euthanasia movement.⁹ As the founder of the field of biomedical ethics and the theory of “situational ethics,” the theory that there is no absolute moral code for physicians to follow, Fletcher was the ideal candidate to win acceptance for euthanasia.¹⁰ In his 1954 book *Morals and Medicine*, Fletcher interpreted the Sixth Commandment, “thou shalt not kill,” to instead mean “thou shall do no murder.”¹¹ In favor of euthanasia, he stressed that patients facing death who are threatened by a loss of integrity have the right to choose how their death shall occur.

⁷ Dowbiggin, 98.

⁸ John A. Behnke and Sissela Bok, *The Dilemmas of Euthanasia* (Garden City, NY: Anchor Books, 1975), 169.

⁹ Humphry, *The Right to Die*, 78.

¹⁰ Joseph Fletcher, *Situation Ethics: The New Morality* (Philadelphia, PA: Westminster Press, 1966).

¹¹ Joseph Fletcher, *Morals and Medicine* (Princeton, NJ: Princeton University Press, 1954), 170.

In regards to mercy killing, Fletcher argued that it was justified for “an incorrigible ‘human vegetable,’ whether spontaneously functioning or artificially supported, [who] is progressively degraded while constantly eating up private or public financial resources in violation of the distributive justice owed to others.”¹² According to his argument, the needs of healthy individuals are worth more than the needs of individuals who cannot speak or care for themselves. As a result of his extreme thoughts on involuntary euthanasia, few agreed with Fletcher.¹³ In the heated debate of Fletcher’s ideas, the topic of patient autonomy emerged.

Patient autonomy, the right of patients to know the truth about their health and treatment and the consequential freedom to act according to how they see fit, was strongly supported by Glanville Williams. A member of the Euthanasia Society of America (ESA) and the British Voluntary Euthanasia Legislation Society (VELS), Williams believed the main issue at play to be personal liberty.¹⁴ Affirming Fletcher’s interpretation of the Sixth Amendment, Williams declared that if the execution of criminals and the killing associated with warfare is permissible, so should be the merciful killing of a patient when given full consent.¹⁵ Williams also believed that people were entitled to be given the release of death from interminable and incurable pain and as such, physicians should not be prosecuted if assisting in a merciful death when given consent.¹⁶

¹² Dowbiggin, 103.

¹³ Paul Ramsey, a professor of religion at Princeton University, disagreed with Fletcher’s philosophy, arguing that Fletcher was changing the medical profession into a “killing business.” Ramsey, “Freedom and Responsibility in Medical and Sex Ethics: A Protestant View,” *New York University Law Review* 31 (1956): 1189-1204.

¹⁴ Glanville Williams, “Euthanasia and Abortion,” *University of Colorado Law Review* 38 (1966): 178-201.

¹⁵ Glanville Williams, *The Sanctity of Life and the Criminal Law* (New York, NY: Knopf, 1968), 346-347.

¹⁶ *Ibid.*, 349.

Williams also held the opinion that euthanasia should be legal for the elderly suffering from dementia and for children born with serious complications that greatly decrease their quality of life. Though he supported these forms of euthanasia, Williams acknowledged that they would never be accepted unless society's values were overthrown. In justifying the mercy killing of infants, Williams stated that infants cannot feel the dread of expected death and thus this form of euthanasia is less cruel due to their decreased level of consciousness.¹⁷ During this time, multiple cases went to court regarding parents that ended their children's lives out of mercy; thus Williams' argument would help to realign the law and the reality of the day.¹⁸

Throughout the 1960s, not many citizens agreed with Fletcher, Williams, and other proponents of radical forms of euthanasia. The ESA observed the public's reaction to the main philosophical debates and worried that the movement to legalize euthanasia had run out of gas in the beginning of the decade.¹⁹

Under new leadership in the mid-1960s, the ESA made changes to help the group gain public appeal. One major update was to modernize the philosophy of voluntary euthanasia. Previously, the ESA had endorsed the idea that a terminally ill patient going through severe pain should be able to decide whether or not to end his or her life; opponents criticized this idea on the grounds that the patient in question would not be fully sound of mind and thus should not be given the heavy responsibility of such an important decision. The ESA soon adopted Pope Pius XII's philosophy, saying that a patient should be allowed to die if that is his or her desire rather than pursue extensive

¹⁷ Ibid., 350.

¹⁸ Such cases included Charles Collins' murder of his son in Maine in 1952, William Jones' electrocution of his wife in 1952, and John Peyto's murder of his wife in 1953. In each case, the defendant claimed to have killed out of mercy. Humphry, *The Right to Die*, 61.

¹⁹ Kuepper, "Euthanasia in America," 310.

medical treatment.²⁰ This change appealed to two major factions: those who supported passive euthanasia but were not completely in support of active euthanasia and those who fully supported active euthanasia that saw this shift as a step forward in swaying public opinion. As a result of the change in philosophy, the unity of the ESA was reinvigorated.²¹

The new ESA leadership also revised its goals. The group decided to set aside any goals for legislative reform and focused on education, research, and a public dialogue to work through the ethical questions of the right to die. To achieve these new goals, the ESA sought to work with graduate students in the field of theology, law and medicine to discuss topics such as suicide, grief therapy and caring for the dying. Speakers from the ESA also began to appear on television and radio talk shows, reaching a broader audience. The actions taken by the leadership in the ESA gave the group new life.²²

Change in American Culture

As the country trudged through the tumultuous 1960s, turmoil and antiestablishment sentiment affected the reputation of euthanasia. The attitudes of different demographics towards any form of establishment led many to support the euthanasia movement. Various groups began to petition against discrimination and in favor of individual rights and privacy, setting the foundation for a burst in support for euthanasia. The continued unrest in the 1970s further added to this foundation: as inflation and unemployment rose and the country saw defeat in Vietnam, American

²⁰ Dowbiggin, 107-108.

²¹ Humphry, *The Right to Die*, 81.

²² Kuepper, 311-12.

optimism fell. Citizens' trust in medicine, science and technology fell, causing them to open their minds to unconventional methods such as euthanasia.²³

Public faith in organized medicine decreased throughout the 1970s. Before this time, the public placed great trust in health care providers, believing that their health was improving as physicians prescribed more and more treatment.²⁴ In the seventies however, growing criticism that medicine was based on greed, cold-heartedness and an overemphasis on technology replaced the former sentiment; between 1965 and 1973, physicians' public esteem dropped from a 72 percent approval rate to 57 percent.²⁵ The thalidomide tragedy of the 1950s serves as a key example of the shift in public opinion. Physicians administered this drug to pregnant women as a treatment for morning sickness.²⁶ However, women who took this drug gave birth to infants with severely shortened limbs. The tragic results of this drug convinced many that medicine needed to be regulated to prevent such unfortunate oversights.²⁷

Change in technology also caused an increased distrust in medicine. In the early twentieth century, many people died from infectious diseases at a younger age and most commonly died in the home.²⁸ By the 1970s, life expectancies had risen greatly due to improved medicine and technology. However, the technology had begun to make patients uncomfortable. Treatments such as the use of respirators and iron lungs, artificial feeding through intubation and transplanting organs from a cadaver to a living patient seemed

²³ Humphry and Clement, 27.

²⁴ Paul Starr, *The Social Transformation of American Medicine* (New York, NY: Basic Books, 1982), 379.

²⁵ Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan Dee, 1988), 68.

²⁶ "Thalidomide Drug Tragedy," *Encyclopedia of Disasters: Environmental Catastrophes and Human Tragedies* (Westport: Greenwood, 2008).

²⁷ Ibid.

²⁸ Russel D. Wright, *Life and Death in the United States* (Jefferson, NC: McFarland and Co., 1997) 26-27.

dehumanizing to the public. The extreme treatments caused Americans to believe that physicians were actually prolonging suffering rather than working to end it.²⁹ In a 1972 survey in *Life* magazine of 41,000 readers, 91 percent believed that “a terminal patient should be permitted to refuse treatment that artificially extended life.”³⁰

As a result of the deteriorating public opinion of medicine, in 1973 the American Medical Association adopted a “Patient’s Bill of Rights” that outlined the patient’s right to refuse treatment and to be informed of all the implications of treatment; this document was dispersed to hospitals and medical clinics around the country.³¹ Though the AMA did not adopt this measure in connection with the euthanasia movement and maintained its opposition to mercy killing, the action ended up benefitting the ESA by publicly granting patients the right to reject care.

Cancer had a great effect on public opinion concerning death, dying, and treatment. Throughout the first half of the twentieth century, physicians and researchers had found great success in curing diseases such as tuberculosis, syphilis, the plague, cholera and diphtheria.³² Riding this wave of success, leaders in the medical field declared in 1971 the advent of a “war on cancer” to cure the disease affected so many Americans.³³ Between 1930 and 1960, five-year survival rates for cancer improved from one in five to one in three but Americans continued to lose hope in the future of good health.³⁴ As physicians put more effort into the “war on cancer,” yielding little results,

²⁹ Filene, 5.

³⁰ *Life*, 11 August 1972, 38-39.

³¹ Humphry, *The Right to Die*, 101.

³² Starr, 346-347.

³³ James Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987), 233-234.

³⁴ *Ibid.*, 234.

Americans lost hope and shifted their opinion in favor of a more comfortable, dignified death rather than a prolonged death.³⁵

Around this time, momentum was building for the women's movement. Fighting for the right to make decisions concerning their own body in issues such as birth control and abortion, the leaders of this movement sympathized with the euthanasia movement. Already dealing with the topic of death and dying in issues such as abortion, these women sought to broaden their scope of view and address death under all circumstances.³⁶ Throughout the 1960s and 1970s, more and more women joined the right-to-die movement and contributed another perspective to the philosophy behind euthanasia.

Legislation and the Living Will

As more citizens began to discuss death and dying and as education in the field of thanatology increased throughout the mid-twentieth century, the euthanasia movement experienced a change in rhetoric. Overshadowed by the cruelties committed during World War II, the term "euthanasia" was too closely associated with Nazism and thus the leaders of the ESA decided that it needed to be replaced. In 1974, the Euthanasia Society of America changed its name to the Society for the Right to Die (SRD) and the Euthanasia Educational Council, a subdivision of the ESA, followed suit and became the Concern for Dying.³⁷ Instead of mentioning "euthanasia," proponents now used the "right to die" in speech. By expounding the right to choose one's death, the movement resonated with citizens that believed that one is in charge of his or her body and no one

³⁵ Dowbiggin, 113.

³⁶ Filene, 68-70.

³⁷ Dowbiggin, 118.

should be able to decide how that person shall die.³⁸ Following the public attitude of the 1960s and 1970s, the concept of the living will emerged. A living will documents a patient's request to end treatment that is being given solely to extend life when the patient is unable to express this desire or to verbally make the decision to end his or her life. In the case of Terri Schiavo, Schiavo lacked a living will; if this had been drafted before her accident, it would have been clear which actions needed to be taken after she became unable to communicate and the controversy surrounding her death would have been prevented.

California became the first state in the country to recognize the living will as a legal document with the 1976 Natural Death Act.³⁹ Many states quickly followed suit and by 1985, thirty six out of fifty states had recognized the living will.⁴⁰ After the success of the living will, leaders within the euthanasia movement disagreed over the future of the ESA. While many reveled in the success of establishing a document that allowed for passive euthanasia, others believed that it was simply an early step in a long battle to legalize other forms of euthanasia. The group divided over the matter of whether to pursue increased legislation in favor of euthanasia or to focus on educating the American public on death and dying. With arguments over the goals and strategy, the unity that the group had enjoyed for years began to dissolve through the 1970s.

Walter Sackett, a physician attempting to pass bills in favor of passive euthanasia in the Florida legislature, favored the push for legalization. Sackett sought to gain legalization in order to spare physicians from prosecution when assisting patients in

³⁸ Filene, 9-10.

³⁹ George J. Annas, *Standard of Care: The Law of American Bioethics* (New York, NY: Oxford University Press, Inc., 1993), 110.

⁴⁰ Humphry, *The Right to Die*, 109-114.

dying. Polls from the 1960s revealed that between 60 and 80 percent of American physicians withdrew treatment from patients wishing to die.⁴¹ Sackett himself admitted in 1972 that he “[had] let hundreds of people die.”⁴² In 1973, the news broke that more than forty handicapped newborns had been allowed to die with the consent of the parents in the nursery at the Yale-New Haven Hospital.⁴³ The chief of staff at the hospital defended these actions by claiming physicians allowed patients with no hope of improvement to die fairly frequently, an accepted practice in the medical community. The reality of the situation in the American health care system contradicted the law.

Florence Clothier, a peer to Fletcher and Sackett, became another significant leader in the euthanasia movement. Clothier joined the euthanasia movement after holding a leadership role in the birth control movement and after her husband passed away following a long, painful battle against cancer.⁴⁴ Clothier believed that there was a strong connection between family planning, birth control, abortion, and euthanasia; in her words “some of these things concern the beginning of life and some the end, but they all concern the *quality* of life.”⁴⁵ Clothier argued that the reason the public was hesitant to support the euthanasia movement and the right to die was due to the Judeo-Christian commitment to prolonging life.

Clothier also supported involuntary active euthanasia, a type of euthanasia that many Americans opposed. Due to her experiences working with physically and mentally retarded children, Clothier believed that physicians should be able to end the life of an

⁴¹ Robert H. Williams, “Our Role in the Generation, Modification, and Termination of Life,” *Archives of Internal Medicine* 124 (1969), 229-230.

⁴² Dowbiggin, 123.

⁴³ Raymond S. Duff and A.G.M. Campbell, “Moral and Ethical Dilemmas in the Special Care Nursery,” *New England Journal of Medicine* 289 (1973), 890-94.

⁴⁴ Florence Clothier, “Confronting Mortality: When Is the ‘Quality of Mercy’ Strained?” *Perspectives on Aging* 4 (1975), 3-7.

⁴⁵ *Ibid.*

infant with severe handicaps that would be confined to a vegetative state within an institution and that under such extreme circumstances, the parents should not even be consulted but should be told that the infant died during or shortly after birth.⁴⁶ When the handicaps weren't as severe, she believed that the parents should play a role in deciding whether or not to end the child's life.⁴⁷ Clothier's views stemmed from economics: when hospitals were relieved from cases of incurable children, the resources used to care for that child could now go to a child with a more promising chance at living a higher quality life.⁴⁸ Clothier believed that education about active voluntary and involuntary euthanasia should begin after the legalization of voluntary passive euthanasia. The radical perspective of Clothier served to divide the ESA as more moderate members disagreed with her philosophy.

The Great Divide

Around this time, the disagreements over the goals of the euthanasia movement became significant. The ESA divided into those that supported the legalization of active euthanasia and those that sought to establish the right of the individual to refuse treatment through passive euthanasia. Led by Joseph Fletcher, the faction of the group that favored pushing for legalization became the Society for the Right to Die (SRD).⁴⁹ The other division believed that no further legislative reform was needed beyond the acceptance of living wills. In 1978, this group, formerly known as the Euthanasia Educational Council (EEC) became the Concern for Dying (CFD) and focused on increasing end-of-life care

⁴⁶ Dowbiggin, 141.

⁴⁷ Ibid.

⁴⁸ Clothier, 6.

⁴⁹ Kuepper, 313.

and improving communication between patients, their families and their health care providers.⁵⁰ The SRD and the CFD remained allies until 1980.

Aside from conflicting philosophy and personalities, the issue of funding also contributed to the separation of the two factions. The CFD grew increasingly worried that as the SRD pursued controversial legislation on active euthanasia, benefactors would turn away from the organization.⁵¹ The president of the CFD decided to end the financial support of the SRD in 1979 due to reservations concerning the SRD's intent to pursue legislation.⁵²

The split between the SRD and the CFD revealed how the euthanasia discussion stood in flux. Both sides agreed that decisions needed to be made to further the movement but questions surrounding the future goals of the movement, assisted suicide, active euthanasia and government involvement in dying remained unanswered. After the CFD ended its financial support of the SRD in the late seventies, the affiliation between the two formally dissolved.

Events of the 1960s and 1970s contributed to a new understanding of the process of dying. From Kubler-Ross's stages of grieving to the ability to dictate life-sustaining treatment through a living will, Americans began to understand death better and saw that they had a say over the treatment of their body under particular circumstances. The development of the living will and the establishment of a process that would allow patients to end unwanted treatment if they were to enter a vegetative state directly correlated to the later decision made in the Terri Schiavo case.

⁵⁰ Ibid., 313.

⁵¹ Humphry, *The Right to Die*, 115-116.

⁵² Ibid., 115.

As the nation moved into a new decade, further development lay ahead for the euthanasia movement. Advocacy for the right to die would find more support abroad as an international euthanasia movement spread beyond the United States and Great Britain. Before Terri Schiavo, two other women lent prominence to the argument over euthanasia. The tragedies of Karen Ann Quinlan and Nancy Cruzan, women who suffered from accidents that left them in vegetative states without the ability to communicate to others, gave faces to the movement for death with dignity. Through the eighties, more and more Americans came to support the individual's right to die but conflict arose over what it meant to truly exercise this right.

CHAPTER FOUR:

A Whirlwind of Change, 1980-2000

After the Concern for Dying and the Society for the Right to Die parted ways in 1980, the breadth of the euthanasia movement expanded as advocates incorporated new terms such as “physician-assisted suicide” and as fledgling pro-euthanasia movements, including Derek Humphry’s Hemlock Society, appeared around the country. As Americans became educated in the topic of death with dignity and as various court cases ruled both in favor and against mercy killing, more citizens took a stance on this issue. With the tragedy of Karen Ann Quinlan and Nancy Cruzan, the foundation of the Hemlock Society and the AIDS epidemic, the euthanasia discussion became increasingly complex. Change in public opinion and court decisions, combined with the Quinlan and Cruzan cases, demonstrated that removing life-sustaining treatment in particular individuals aligned with patients’ wishes and thus paved the way for the Terri Schiavo case at the end of the century.

Expansion of the Euthanasia Movement through Tragedy

As tensions grew between the SRD and the CFD in the 1970s, tragedy befell a twenty-one year old woman in New Jersey. After a night of partying, Karen Ann Quinlan fell into a coma on April 14, 1974, most likely due to the combination of alcohol with Valium, a tranquilizer drug.¹ Quickly taken to the hospital, medical staff connected her to a respirator and inserted a feeding tube to keep her nourished and hydrated. Before

¹ Humphry, *The Right to Die*, 107-108.

reaching the hospital, she suffered from a prolonged period of respiratory failure that left permanent damage to her brain. After several months of being in a coma, Quinlan's parents, Joseph and Julia, decided that they no longer wanted to pursue treatment and went to court to have their daughter taken off the respirator and allowed to die.² On March 31, 1976, the New Jersey Supreme Court ruled 7-0 in favor the Quinlans, stating that an individual may decide to end life-sustaining treatment under certain circumstances based on the constitutional right to privacy.³ Surprising to everyone, she continued breathing without the aid of the respirator; thus, she continued to be fed through artificial nutrition. Karen Ann Quinlan continued living in a vegetative state for nine years after being removed from her respirator and died of pneumonia on June 11, 1985.⁴

Quinlan's situation attracted national and international attention as the public argued over whether Quinlan's right to privacy implied a right to die. To the public, euthanasia no longer evoked the image of Nazi terror and the cruel murder of innocent minorities; the act of passive euthanasia in Quinlan's case demonstrated a justified death for a woman with a dim prognosis. The New Jersey Supreme Court ruling released this young woman from discomfort and eased Quinlan's parents of the burden of seeing their daughter suffer as medical bills grew.⁵

When Joseph and Julia Quinlan went to court to fight for their daughter's rights, they argued as devout Catholics that the life-sustaining treatments being used on Karen were "extraordinary" measures that should be discontinued based on Pope Pius XII's

² Samuel L. Greenberg, *Euthanasia and Assisted Suicide: Psychosocial Issues* (Springfield, IL: Charles C. Thomas Publisher, Ltd., 1997), 21-24.

³ Timothy E. Quill, "Death and Dignity: A case of individualized decision making," *New England Journal of Medicine* 324 (1991), 691-694.

⁴ Greenberg, 24.

⁵ Filene, 22-25.

statements earlier in the twentieth century.⁶ When the New Jersey Supreme Court ruled in favor of the Quinlans, advocates of the right-to-die received the initial legal step towards legalization of euthanasia. This decision held true to the 1965 *Griswold v. Connecticut* and 1973 *Roe v. Wade* rulings by the U.S. Supreme Court that declared that Americans held a constitutional right to privacy, first to contraception and abortion and now to the right to die.⁷ In the Quinlan decision, the court stated that “Karen’s right to privacy may be asserted on her behalf by the guardian under the peculiar circumstances here present,” though Quinlan had not signed a living will or stated her end-of-life wishes.⁸

Opponents to euthanasia viewed the ruling as an injustice to the sanctity of life and thus rallied together to fight back against the euthanasia movement. Emerging in the 1970s, a pro-life organization led by Catholics found unity in the aftermath of the Quinlan case. This organization sought to reverse the decision made in *Roe v. Wade* in conjunction with its goal of limiting the progress of the euthanasia movement. As the movement grew, various subgroups formed to fight for the right to life, driven by conservative activists in the New Right and a renewed Christian fundamentalism. After the nation elected Ronald Reagan, a pro-life advocate, as president in 1980, the movement opposing euthanasia stood as a strong force to combat.⁹

Members of the right to life movement connected abortion with the right to die, troubling euthanasia advocates. The majority of the euthanasia movement had no interest in pursuing the issue of abortion and was frustrated by the pro-life technique of associating euthanasia with such a controversial hot-button issue in order to lose public

⁶ Dowbiggin, 146.

⁷ Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven, CT: Yale University Press, 1978), 294.

⁸ Quill, 693.

⁹ Dowbiggin, 147-148.

appeal.¹⁰ Leaders of the SRD faced off against Catholics and the New Right in state capitals while working on legislation in favor of living wills. The conflict between these two forces was seen in California when the first living will legislation, the California Natural Death Act, passed in 1976 filled with compromises that left both sides unhappy.¹¹ The failure of the pro-life movement to prevent the passage of such a bill only pushed the group to work harder in order to prevent similar legislation in other states.

In the late 1970s and early 1980s, actions overseas led to the formation of an international organization that later hindered public approval of the right to die. In 1976, euthanasia advocates formed the Japan Euthanasia Society and invited other organizations around the world to join them at the first and second International Euthanasia Conferences.¹² The success of these two conferences led to the foundation of the World Federation of Right-to-Die Societies in 1980. This global organization included eighteen participating countries within twenty-seven total constituent organizations, including the SRD but not the CFD.¹³ Americans viewed the World Federation as a liberal group since European constituent groups tended to be more in favor of active euthanasia. One constituent within the World Federation, the English group EXIT, proposed a “how-to” suicide manual in 1979 that but quickly canceled the manual due to strong backlash; the same group soon after found themselves involved in a scandal when two members of EXIT were found guilty in assisting in the deaths of several people who were not terminally ill.¹⁴ The actions of EXIT tarnished the reputation

¹⁰ Dirk Johnson, “Foes of Abortion View ‘Right to Die’ as Second Battle over Life and Death,” *New York Times*, 31 July 1990, 8-9.

¹¹ Filene, 98-105.

¹² Dowbiggin, 148.

¹³ Humphry, *The Right to Die*, 117.

¹⁴ “EXIT’s Guide to Suicide Starts a Storm,” *London Observer*, 14 September 1980, A12.

of the entire World Federation in the early 1980s. Despite its approval of such manuals as EXIT's proposed guide, the CFD hesitantly joined the World Federation in 1982; as the global organization grew more radical, the moderate CFD became increasingly apprehensive about its involvement and drew further away from the World Federation and the SRD.¹⁵

In 1980, the foundation of a new euthanasia organization shook up the CFD and the SRD. Created by the British-born Derek Humphry, the Hemlock Society started as a small euthanasia organization on the American West Coast.¹⁶ Humphry's career as an activist began after writing *Jean's Way*, a book that detailed how he had helped his first wife die when she was suffering from cancer.¹⁷ He then went on to found the Hemlock Society with his second wife, Ann Wickett. The Hemlock Society's took a concrete stance by officially supporting active euthanasia for the terminally ill and assisted suicide, pressuring the CFD and SRD to also declare their stance on these issues; the Hemlock Society also stated as its principles that the organization as a whole did not condone suicide for emotional, traumatic or financial reasons but solely supported suicide for those suffering from a terminal illness.¹⁸ The Hemlock Society became very popular throughout the 1980s, growing to an estimated 39,000 members in 1990 and eventually influencing the SRD to dissolve that same year, its agenda picked up by the Hemlock Society.¹⁹ Though the SRD formally ended in 1990, it still remained an active organization throughout its last decade.

¹⁵ Humphry, *The Right to Die*, 117-18.

¹⁶ Humphry and Clement, 108.

¹⁷ Jennifer McDougall, *Euthanasia: A Reference Handbook* (Santa Barbara, CA: ABC-CLIO, 2008), 134-135.

¹⁸ Humphry, *The Right to Die*, 116-17.

¹⁹ Humphry and Clement, 113.

After the Hemlock Society became an established group, Humphry published a guide in 1981, inspired by EXIT's failed manual, entitled *Let Me Die Before I Wake*. This guide provided its readers with methods for nonviolent suicide and stories of people who had attempted suicide.²⁰ In 1991, Humphry followed up with *Final Exit*, a similar guide to suicide with updated information and details about drugs, lethal dosages and using items such as a plastic bag.²¹ Shortly after the publication of these two successful books, Humphry retired from the Hemlock Society with no negative effect on the group.²² In 1994, the Hemlock Society helped to successfully pass the Oregon Death With Dignity Act, an act that would allow physicians to assist in a dying patient's suicide by providing lethal drugs.²³

After a scandalous divorce from Ann Wickett and her resulting suicide, Humphry retired from the Hemlock Society in 1992 but continued to write and research in support of euthanasia. Humphry aimed to legalize the right to assisted suicide, followed by the legalization of mercy killing. In 2000, Humphry defended his argument with utilitarian arguments, a theme similar to the early days of the euthanasia movement in the first half of the twentieth century, by suggesting that America's elderly "[put] a strain on the health care system" by depriving healthier patients of resources and thus held a responsibility to die.²⁴ Humphry and the Hemlock Society had a tremendous influence on the right-to-die movement but many Americans did not agree with his radical and economic justifications of euthanasia.

²⁰ Derek Humphry, *Let Me Die Before I Wake: Hemlock's Book of Self-Deliverance for the Dying* (Los Angeles, CA: Hemlock Society, 1984).

²¹ Greenberg, 108.

²² Humphry and Clement, 115.

²³ Greenberg, 141.

²⁴ Humphry and Clement, 339.

As Humphry worked to publicize physician-assisted suicide, an increased rate of suicide and the AIDS epidemic built public interest in this type of voluntary euthanasia. Throughout the 1980s, a surge of suicides emerged in America, particularly among the elderly. Americans over the age of sixty-five made up 13 percent of the population but comprised nearly 20 percent of the nation's total suicides, raising the question of whether this age group was happy with the health care they were receiving particularly when nearing death.²⁵ While these suicide rates rose, a terrible new killer was entering the scene.

First identified in 1981, the Acquired Immune Deficiency Syndrome (AIDS) spread rapidly through the United States and soon became the leading killer of men in their twenties, thirties and forties.²⁶ The human immunodeficiency virus (HIV) is responsible for causing AIDS by attacking the body's immune cells, wiping out the immune system and leaving the individual vulnerable to other diseases. In fear of a painful death, patients with AIDS often committed suicide. With no cure for AIDS, these patients typically die slowly and in great pain from cancer or another infection with symptoms such as seizures, blindness and memory loss.²⁷ In the hopes of preventing this outcome, many AIDS patients viewed suicide as a death with dignity.

As AIDS spread, the CFD and the SRD joined with AIDS organizations to spread the living will and explain legal rights to these patients.²⁸ Membership in the Hemlock Society rose sharply as AIDS patients joined the fight to legalize physician-assisted

²⁵ Herbert Hendin, *Suicide in America* (New York, NY: Norton, 1995), 81-82.

²⁶ Mirko Grmek, *History of AIDS: Emergence and Origin of a Modern Pandemic* (Princeton, NJ: Princeton University Press, 1990), 32.

²⁷ *Ibid.*, 41.

²⁸ Lee R. Slome, "Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease," *New England Journal of Medicine* 336 (1997), 417-421. The SRD aligned with AIDS organizations in the late 1980s, before its dissolution, following the foundation of Humphry's Hemlock Society.

suicide.²⁹ Through working with AIDS patients and focusing attention on their painful deaths, euthanasia activists demonstrated to Americans just how limited their freedom over death was.

Philosophical Differences among Euthanasia Advocates

During the eighties, the various euthanasia organizations solidified their philosophical principles in order to clearly establish the similarities and differences amongst one another. The CFD continued to uphold its moderate position by emphasizing education and dialogue over confrontation and legislation, keeping its distance from the topic of active euthanasia and by expounding the complexities of the issue of death with dignity. Another case developed throughout the 1980s that would demonstrate the clear disagreement between the various goals of the euthanasia movement.

On July 25, 1973, a young man named Dax Cowart and his father found themselves in a terrible accident in Kilgore, Texas, when their car's ignition sparked a pocket of propane gas. A huge fireball developed that killed Cowart's father and left Dax trapped within the burning vehicle. Cowart suffered from second- and third-degree burns that destroyed his extremities and left him in excruciating pain.³⁰ While on the way to the Parkland Memorial Hospital in Dallas, Cowart begged in agony for death. During his recovery, Cowart continued this plea to be allowed to die due to the terrible pain he was suffering from. Seven years after the fateful night, Cowart, blind and severely crippled,

²⁹ "Changing the Rules on Dying," *U.S. News and World Report* (9 July 1990), 22.

³⁰ Dowbiggin, 154-55.

still lived dependently in a hospital without the ability to perform simple functions.³¹ By this time, Cowart had unsuccessfully attempted to commit suicide two times with the intent to keep trying.³²

In 1984, the CFD released a documentary about Cowart's accident and recovery, known as "Dax's Case", to demonstrate to Americans that freak accidents can occur to anybody and at any time.³³ The film served as juxtaposition to Karen Ann Quinlan's life: while Quinlan was granted the right to die without her verbal consent, Cowart was continuously denied death by withholding unwanted life-extending treatment regardless of his pleas. However, Cowart's story does not have an unhappy ending. After completing rehabilitation, Cowart married, completed law school and started his own business. Though he was blind and had poor hearing, he still found success and overcame his handicaps.³⁴

Though the CFD utilized his situation to support the euthanasia movement, Cowart stands as a fitting example for both sides of the right to die argument. One on side, by begging repeatedly to be released from his suffering and allowed to die yet constantly being refused by medical staff, Cowart resembles a powerless victim that has lost his ability to make decisions regarding his personal comfort. On the other side, if Cowart had been granted his wish to die, he wouldn't have found the success that he later achieved after he fought his battle through rehabilitation, demonstrating that death may not have been the right course of action for this man. Cowart demonstrates the numerous

³¹ Dax Cowart and Robert Burt, "Confronting Death: Who Chooses, Who Controls?" *The Hastings Center Report* 28 (1998), 14-24.

³² Ibid.

³³ "Dax's Case," videorecording, Filmmakers Library, 1984.

³⁴ Dowbiggin, 155.

complexities of the right to die; in later years, Cowart went on to support the right to die and argued that physicians should have ended his life when he requested it.³⁵

In the mid-1980s, disagreement arose between the CFD and the Hemlock Society. The CFD opposed the various works by the Hemlock Society – and the EXIT manual – that guided readers through suicide. Leaders in the CFD believed that readers would misunderstand the suicide guides and take an incorrect dosage of medication that would cause paralysis or brain damage without death.³⁶ In 1985, the CFD leaked a story to the press of a mother who blamed her son’s failed suicide on Humphrey’s book, causing tension between the Hemlock Society and the CFD.³⁷ As the decade progressed, the CFD became increasingly moderate, especially when it came to issues such as the living will.

As the CFD wavered in its support of the living will, the document seemed to be losing its potency with the American public. The living will failed by using vague language and not covering treatment over a wide range of circumstances. Health care professionals began to shift their recommendation from the living will to the power of attorney, the process of naming another individual to make decisions when one becomes unable to make those decisions.³⁸ Many political leaders and health care experts, such as U.S. Supreme Court Justice Sandra Day O’Connor and gerontologist Joanne Lynn, suggested that the power of attorney was more fitting than the living will.³⁹

As the status of the living will was in flux, the relationship between the CFD and the SRD also seemed to be changing in the late 1980s. Many leaders in the SRD,

³⁵ Cowart, “Confronting Death,” 20.

³⁶ “Suicide for the Terminally Ill: A Need for New Thinking,” *Concern for Dying Newsletter* (Fall 1980), 4.

³⁷ Dowbiggin, 156.

³⁸ Joseph Carey, “The Faulty Promise of ‘Living Wills’,” *U.S. News and World Report* (24 July 1989), 63-64.

³⁹ Filene, 157.

particularly physicians, began to withdraw their support of physician-assisted suicide and active euthanasia and disagreed with Joseph Fletcher that the SRD should follow a similar path as the Hemlock Society.⁴⁰ As these leaders became more vocal in their opposition to active euthanasia, they proposed a reunion. The SRD members that supported active euthanasia, including Fletcher and Smith, disliked the idea but agreed to be receptive to a merger so long as the agenda of the SRD remained strong and assertive in favor of active euthanasia. After long negotiations, the stubbornness of this component of the group, along with the influence of the growing Hemlock Society, resulted in the termination of the SRD in 1990.⁴¹

The discussions between the SRD and the CFD resulted in the foundation of a new organization, the National Council on Death and Dying (NCDD). The NCDD underwent two name changes between 1991 and 2000, eventually settling on the name Partnership for Caring.⁴² Many of the radical former leaders in the SRD resigned their positions in the new organization because they were unhappy with the increasing conservatism. The group itself was dedicated to ending suffering, improving the quality of life for dying patients and establishing communication in regards to end-of-life decisions; by backing away from legislation and the physician-assisted suicide/active euthanasia debate, Partnership for Caring focused on supporting living wills and improving care for the dying.⁴³

⁴⁰ Filene, 108-14.

⁴¹ Dowbiggin, 157-58.

⁴² In 1991, the NCDD became Choice in Dying and included the legalization of physician-assisted suicide as one of its goal. When the group changed names again in 2000, the new Partnership for Caring removed physician-assisted suicide from its agenda. Partnership for Caring, Inc., "Position Statement: 'Leaving Our Differences at the Door,'" Found at <http://www.partnershipforcaring.org/> on 10 April 2015.

⁴³ Greenberg, 110-112.

After the dissolution of the SRD, various groups picked up the more extreme side of the argument by working towards legalization. The Hemlock Society and other similar new organizations, including the California-based Americans for Death with Dignity, the Euthanasia Research and Guidance Organization (ERGO), and the Dying Well Network in Washington State, continued to push for legislation regarding active euthanasia or assisted suicide.⁴⁴ As public interest in death and dying continued to grow throughout the 1990s, these groups would lead the campaign to legalize the right to die while Partnership in Caring backed away from the legislative arena.

The End of the Century

The 1990s marked a new chapter for the euthanasia movement. With the SRD no longer in the picture, the state-by-state fight over legislation of physician-assisted suicide took center stage. As mentioned earlier, in 1994, Oregon passed the first law in American history legalizing physician-assisted suicide. However, the success seen in Oregon did not represent the nation as a whole. Following the Oregon decision, similar bills were defeated in Michigan and Maine; in 1997, the Supreme Court ruled against a constitutional right to physician-assisted suicide.⁴⁵ During this decade, a case similar to that of Karen Ann Quinlan arose that would take the right to die all the way to the top tier of the judicial system.

On the night of January 11, 1983, Nancy Cruzan's car slid off an icy road in Missouri.⁴⁶ The crash left Cruzan unconscious with no heartbeat or respiration. After

⁴⁴ Humphry and Clement, 116.

⁴⁵ John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge, UK: Cambridge University Press, 2002), 194-207.

⁴⁶ Humphry and Clement, 117-18.

receiving medical care, Cruzan was left in a permanent vegetative state for the next seven years. When it became certain that she would never regain her mental capacities, Cruzan's parents requested the hospital to remove her breathing and feeding tubes, similar to the Quinlan case. The hospital refused this request without a court order so the Cruzans went to the Missouri courts. The Missouri Supreme Court argued that since Nancy did not have a living will, her wishes were not clear; the case then went on to the U.S. Supreme Court where in 1990, the justices upheld the earlier decision to reject the parents' request in a ruling of 5 to 4.⁴⁷ Chief Justice William Rehnquist wrote the majority opinion, stating that "the Court recognized that a competent person had a right to refuse life-sustaining hydration and nutrition based on the liberty interest of the 14th Amendment" but since Cruzan did not clearly express her wishes before the accident, her parents could not legally decide to end her care.⁴⁸

Following the Supreme Court's decision, new evidence was found that supported the parents' request. Several witnesses provided statements regarding Nancy's wishes before her accident, including a roommate who testified to a conversation held with Nancy where she stated that if she were ever in such an accident, she would not like to "live like a vegetable."⁴⁹ The Cruzans went back to court with the new evidence and were successful. Nancy's tube was removed on December 14, 1990, and nearly two weeks later, Nancy died at the age of thirty-three.⁵⁰

⁴⁷ *Cruzan v. Director, Missouri. Department of Health*, 497 US 261 (Supreme Court 1989).

⁴⁸ Greenberg, 25-26.

⁴⁹ *Ibid.*, 26.

⁵⁰ Tamar Lewin, "Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die," *New York Times* (27 December 1990), Found at <http://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html>.

Along with the Cruzan case, several other significant events occurred in the late eighties and nineties that put the right-to-die debate in the center of national attention. In 1988, an article published in the *Journal of the American Medical Association* entitled “It’s Over, Debbie” told the story of an anonymous gynecology resident who injected his ovarian cancer patient with an overdose of morphine sulfate when the patient requested to die.⁵¹ In response to the article, both sides of the euthanasia debate condemned the resident. By not taking any caution when administering a lethal dosage to a patient with whom he had little familiarity, the actions of the resident upset euthanasia advocates.⁵² However, the article served to bring to light the fact that many physicians participated in active euthanasia.

Several years later, news broke about a similar case of physician-assisted death. Jack Kevorkian, an ostracized pathologist who focused on death, believed that all patients should be able to receive lethal treatments without government interference, regardless of their level of competency.⁵³ In 1990, Janet Adkins, a member of the Hemlock society recently diagnosed with Alzheimer’s disease, met with Kevorkian and he assisted her in dying.⁵⁴ Much like the gynecology resident, Kevorkian was condemned for assisting in a woman’s suicide without approval by other physicians and without knowing her medical history.⁵⁵ The Hemlock Society supported Kevorkian as a leader in the medical field serving to gain recognition for the practice of physician-assisted suicide; Derek Humphry stated that “they were on separate paths to the same goal: Kevorkian’s to alter the

⁵¹ George D. Lundberg, “‘It’s Over, Debbie’ and the Euthanasia Debate,” *Journal of the American Medical Association* 259 (1988), 2142-43.

⁵² Dowbiggin, 166.

⁵³ Michael Betzold, “The Selling of Doctor Death,” *New Republic* (26 May 1997), 22-28.

⁵⁴ G. Borger, “The Odd Odyssey of ‘Dr. Death,’” *U.S. News & World Report* 109 (27 August 1990), 27.

⁵⁵ “The Doctor’s Suicide Van,” *Newsweek* (18 June 1990), 46-49.

medical profession's attitude, and Hemlock's to change the law."⁵⁶ After Adkins's assisted suicide, Kevorkian went to trial but the charges were dismissed; over the next eight years, he assisted in nearly one hundred suicides.⁵⁷

News from Europe provided evidence of what many Americans feared would result if euthanasia became legalized. Beginning in the 1970s in the Netherlands, physician-assisted suicide and voluntary active euthanasia became legal. In 1990, the Dutch government decided to examine the practice of euthanasia in reality. The results of the study, the Rummelink Report, showed that more physicians practiced euthanasia than the government expected. The 1991 Report showed a high rate of non-voluntary euthanasia, accounting for more than 1 percent of total deaths in the Netherlands.⁵⁸ A second report in 1995 showed that there were nearly 1,000 cases of physicians practicing mercy killings on incompetent patients, violating the guidelines.⁵⁹ The data raised the issue of obtaining clear consent before allowing a physician to assist in the death of any patients. Critics of euthanasia argued that if a similar system was used in the U.S., euthanasia would be used "to rid hospitals and nursing homes of difficult or inconvenient patients."⁶⁰

The battle between euthanasia advocates and their opponents heated up along the west coast in states such as Washington, California and Oregon. When the tide seemed to favor the right to die, the pro-life movement – led by the Roman Catholic Church – banded together and increased their public opposition, pulling the advantage away from

⁵⁶ Humphry and Clement, 136.

⁵⁷ Dowbiggin, 167.

⁵⁸ P.J. Van der Maas et al., "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," *New England Journal of Medicine* 335 (1996), 1706-11.

⁵⁹ Gerald Dworkin et al., *Euthanasia and Physician-Assisted Suicide* (Cambridge, UK: Cambridge University Press, 1998), 123.

⁶⁰ Dowbiggin, 169.

the right-to-die groups; John Cardinal O'Connor, Archbishop of New York, compared the push to legalize physician-assisted suicide with the "small beginnings" of the Nazi euthanasia program.⁶¹ In 1991, the Washington State Initiative 119, a bill proposing the legalization of physician-assisted dying, was defeated, 53.6 percent to 46.4 percent; a similar bill, the California Proposition 161, was defeated shortly after in 1992 by another close margin, 54 to 46 percent.⁶² Following the defeat in Washington and California, Oregon designed an act that was narrower in scope and that included clear safeguards to protect against abuse in order to sway voters.⁶³ In 1994, the Oregon Death with Dignity Act passed, 51 to 49 percent, demonstrating that the public still remained divided over the ethics behind physician-assisted suicide.⁶⁴ The law was enacted on October 27, 1997, and states that terminally-ill residents of Oregon may end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.⁶⁵

Elsewhere in the country, courts ruled over the right to die. In 1997, two cases reached the federal Supreme Court that questioned New York State's and Washington State's prohibitions against physician-assisted suicide. The laws equate assisting another person to commit suicide with manslaughter. The Supreme Court upheld both states' laws and did not find that the Constitution granted a right to die, ending the debate over a constitutional right to physician-assisted suicide.⁶⁶ The decision made by the Supreme

⁶¹ "Foes of Euthanasia Measure Gain Ground in Washington State," *New York Times* (4 November 1991), A25.

⁶² Humphry and Clement, 342-343.

⁶³ Greenberg, 146.

⁶⁴ Keown, 167.

⁶⁵ *Ibid.*, 169.

⁶⁶ George J. Annas, *Some Choice: Law, Medicine, and the Market* (New York, NY: Oxford University Press, 1998), 224.

Court was followed by two failed initiatives to legalize physician-assisted suicide in Michigan and Maine, marking another blow to the euthanasia movement.⁶⁷

By the close of the twentieth century, the euthanasia movement seemed to be constantly halted by legislative and judicial roadblocks, their only true success in Oregon. Advocates of euthanasia were stumped by the failure of physician-assisted suicide bills when Gallup surveys indicated that public support of physician-assisted suicide was increasing from 37 percent in 1947 to 69 percent in 1990.⁶⁸ Poll results also showed that many Americans agree with a conceptual right to die but when asked about specific medical situations, support decreases.⁶⁹ By the last few years of the century, the movement felt frustrated with the constant obstructions but when looking back over the century as a whole, the change experienced demonstrated that more Americans understood the ethical implications of the right to die, mercy killing and physician-assisted suicide. At the dawn of the twentieth century, Americans associated euthanasia with Dr. Haiselden and the concept of eugenics. Around the time of World War II, euthanasia became characterized by Nazis that evoked images of horrendous medical experimentation and murder. The American euthanasia movement separated itself from this strongly negative connotation and gained public support, shifting from “euthanasia” to the “right to die” and getting Americans to be more comfortable with death and dying. By the close of the century, public awareness had grown, patients used legal practices such as the living will and power of attorney to achieve their wishes concerning death under appropriate circumstances and Oregon stood as the pioneer state in legalizing

⁶⁷ Dowbiggin, 173.

⁶⁸ *Ibid.*, 175.

⁶⁹ Henry R. Glick, *The Right to Die: Policy Innovation and Its Consequences* (New York, NY: Columbia University Press, 1992), 85.

physician-assisted suicide. With a sturdy foundation, the euthanasia movement would continue to push for increased education over death and dying and for the legalization of physician-assisted suicide in other states in the twenty-first century. As the twentieth century came to a close, the decision made for Terri Schiavo loomed over the horizon.

Conclusion

At the dawn of the twenty-first century, Terri Schiavo's case riveted the American nation and the entire euthanasia movement. Before the accident, Schiavo made her wishes clear to her husband, Michael Schiavo, that she would choose to be released from "unwanted, intrusive medical procedures" if she were ever in a vegetative state.¹ However, Terri's parents, Robert and Mary Schindler, argued that they would continue to care for her regardless of her state and of her wishes. The Schindlers fought the court decisions made that favored Michael and Terri's wishes to remove her feeding tube. As the Schiavo's case traveled through the Florida state courts and federal courts, the media caught wind of the controversy and the story jumped to national headlines. Millions of Americans took sides, calling Michael a murderer for having Terri's feeding tube removed and accusing the Schindlers of abusing their daughter's right to medical autonomy. Schiavo became the most publicized case over the right to die in the U.S., and the euthanasia movement heralded the 2005 ruling in her favor as a great success. Terri's statement of her wishes to Michael demonstrated that she did possess the right to die and the subsequent legal battles set an important precedent for subsequent legal cases.

As of 2015, Vermont, Washington, Montana and Bernalillo County in New Mexico have joined Oregon in legalizing physician-assisted death.² To qualify, patients

¹ *Robert and Mary Schindler v. Michael Schiavo*. Supreme Court of the United States. 25 March 2005. *FindLaw*. Internet, available from <http://euthanasia.procon.org/sourcefiles/EmergencyApplicationForStaySchiavo.pdf>, accessed 30 March 2015.

² "Death with Dignity Around the U.S." *Death with Dignity National Center*, Internet, available from <http://www.deathwithdignity.org/advocates/national>, accessed 9 April 2015.

must be terminally ill and have a prognosis of six months or less to live. In these states and Bernalillo County, physicians are safe from legal prosecution for prescribing lethal medications if all guidelines are followed. Patients in Montana and Bernalillo County must have a court ruling that mandates their request. The law dictates that the only individual allowed to prescribe such a treatment is a licensed physician, either a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and that physicians are not required to provide such a treatment if a patient requests it.³ These laws attempt to compromise on such a controversial issue by limiting those able to administer a lethal treatment and by stipulating that the patient must be terminally ill, decreasing the amount of potential patients for this treatment.

The Death with Dignity Act in Oregon became a law on October 27, 1997 and was not followed by a similar bill for many years. In the interim period, Dr. Jack Kevorkian became a well-known name for his assistance in numerous suicides; in 1999, he was sentenced to prison on charges of second degree murder.⁴ Years later, in 2008, Washington's Death with Dignity Act passes with a majority of 57.91 percent, going into effect several months later in March 2009.⁵ Montana's Rights of the Terminally Ill Act was upheld in the *Baxter v. Montana* ruling in December 2009.⁶ In November 2012, a death with dignity initiative in Massachusetts was narrowly defeated by a 51 percent

³ "Physician-Assisted Suicide Fast Facts," *CNN*, Internet, available from <http://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html>, accessed 30 March 2015.

⁴ Dirk Johnson, "Kevorkian Sentenced to 10 to 25 Years in Prison," *New York Times* (14 April 1999), Internet, available from <http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html>, accessed 10 April 2015.

⁵ "Death with Dignity Act," *Washington State Department of Health*, Internet, available from <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>, accessed 9 April 2015.

⁶ *Baxter v. Montana* (2009), *American Bar*, Internet, available from http://www.americanbar.org/content/dam/aba/migrated/aging/PublicDocuments/baxtr_v_mont_sum.authch_eckdam.pdf, accessed 10 April 2015.

margin voting against it.⁷ Vermont signed into law another successful bill, the Patient Choice and Control at End of Life Act, in May 2013.⁸ In the 2014 case of *Morris v. Brandenburg*, Bernalillo County in New Mexico upheld an individual's right to die.⁹ While more laws supporting physician-assisted suicide passed, the slight margin of victory demonstrates that many Americans still adamantly oppose this form of euthanasia.

On January 1, 2014, a young woman with terminal brain cancer was given the unfortunate prognosis that her time was limited. Deciding to end her life in the way that she deemed fit, Brittany Maynard moved from her home state of California to Oregon to comply with the residency requirements of the state's Death with Dignity Act. The radiation treatment for her cancer would have left her with first-degree burns on her scalp and would not have prevented her imminent death. Brittany decided to accept that her time was limited and chose to live a higher quality of life for a shorter amount of time. The entire nation heard Brittany express her attitude about her right to decide when it was the right time for her death. In her words: "I've had the [life ending] medication for weeks. I am not suicidal. If I were, I would have consumed that medication long ago. I do not want to die. But I am dying. And I want to die on my own terms."¹⁰ The cases of Brittany Maynard and Terri Schiavo were both widely publicized but the two women differ in the fact that Maynard was able to publically speak her opinion while Schiavo could not.

⁷ "Physician-Assisted Suicide Fast Facts," *CNN*.

⁸ "Death with Dignity Around the U.S."

⁹ "Physician-Assisted Suicide Fast Facts," *CNN*.

¹⁰ "My Right to Death with Dignity at 29," *CNN*, Internet, available from <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/index.html>, accessed 31 March 2015.

Brittany Maynard served as a voice for those who choose death with dignity through social media, a shift in public opinion, and the media's attention. By demonstrating that the choice to die was hers and hers alone, Brittany likely set a precedent asserting the patient's autonomy that will be referenced in the years to come in similar cases. A Harris Poll conducted in the weeks following Maynard's death showed that support for a person's right to die increased to 74 percent from 70 percent in 2011; the poll also revealed that 72 percent of Americans supported physician-assisted suicide, a 5 percent increase since 2011.¹¹

The frequency of bills such as Oregon's Death with Dignity Act has increased since the late nineties and many more states are likely to follow suit as the public continues the trend of becoming more comfortable with death.¹² As more individuals become educated in living wills, advanced directives, medical autonomy and cases regarding the right to die, the movement to legalize physician-assisted suicide will likely continue this recent trend of pushing for legislation. Radical thinkers who favor forms of non-voluntary euthanasia are nearly unheard of today but their argument may not have disappeared.

Terminally ill, conscious American citizens now have feasible options to end their lives with dignity and reasonable comfort like Brittany Maynard. What about patients in a vegetative state that are unable to communicate? When considering Terri Schiavo, her wishes were granted to cease life-sustaining treatment, but when her feeding tube was removed, she died from starvation and thirst over a period of thirteen days. For Terri, the

¹¹ Dennis Thompson, "Did Brittany Maynard change minds about right-to-die laws?" *CBS News* (December 5, 2014).

¹² So far in 2015, death with dignity-related bills have been proposed in 22 state legislatures. "Death with Dignity Around the U.S."

autopsy results showed that her brain was damaged to the point where she no longer possessed the ability to feel emotions or have thoughts so she did not necessarily suffer after her feeding tube was removed. However, similar vegetative patients exist who cannot communicate for themselves but still possess the brain functions to sense hunger, thirst, discomfort and pain. If these patients followed a similar route as Terri, they would be facing a long stretch of days starving to death. Down the road, legislation may be passed that will enact forms of highly specific active euthanasia that pertain to cases such as Terri's: when the decision has been made to pull the plug and end the patient's life, perhaps medication will be administered to hasten the process and prevent unnecessary suffering, a mindset that relates to the original thought behind mercy killing. If legislation such as this were to move forward, it is likely that it will run into extensive red tape but it is difficult to predict how the ethical perspectives of the American public will change in the decades to come.

In the middle of the twentieth century, if an American citizen wanted to die, his or her only legal option was suicide. No matter what his wishes were, physicians were legally required to provide any means necessary to extend his life, regardless of how invasive or demeaning the patient might find that treatment. Today, Americans have options. It may still be complicated to end one's life, as a reflection of the magnitude of the decision, but it is possible to die with dignity and in a reasonable amount of comfort. From fears of unfathomable medical experimentation coming out of World War II to a fully legal decision to die by a lethal treatment, the United States today has seen a tremendous shift in ethical perspectives that is likely to keep developing in the future.

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