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Euthanasia: A moral dilemma

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CHAPTER I

EUTHANASIA: A MORAL DILEMMA

Introduction

The purpose of this thesis is to examine the societal phenomenon known as euthanasia. This project will deal specifically with attitudes on a comparative basis among the cross sectional views of society. A euthanasia case, which received a great deal of newspaper coverage in 1949, in the state of New Hampshire will be reviewed, as well as compared to the numerous ideologies expounded by experts during the trial, in the fields of law, medicine, and theology. The focal points of the study will reveal the positive and negative arguments held on euthanasia as a moral dilemma. Specific emphasis will be placed on the contrasting viewpoints regarding the phenomenon to depict any change of attitude in society since the trial in 1949. Problems will also be examined as to the proposed legalization of euthanasia. It is not the intention of this project to delineate whether euthanasia should be sanctioned or voided by society, but to expound on the complexities involved within the acceptance or rejection of the phenomenon. Therefore, euthanasia will continue to be a moral dilemma until society re-examines its ethics and makes the existing laws more flexible in dealing with complex motivations.

Review of Literature.—There has been a great deal of investigation on this phenomenon, in that there are numerous magazines and newspaper articles describing individual euthanasian cases or situations, the pros or cons
of the issue, as well as the action taken by society in response to the issues involved. The following euthanasian case which occurred in 1949 will be utilized in this project as the basis of society's opinion during that time.\textsuperscript{1}

In Goffstown, New Hampshire, December 29, 1949, Dr. Herman Sander, Manchester physician, was charged with the first degree murder of a 59 year old cancer patient who died December 4, in what Sheriff Thomas F. O'Brien termed a mercy killing. The 40 year old physician was arrested after the sheriff and county solicitor, William J. Craig, had been told by the county medical referee that Mrs. Abbie Borroto had died of a lethal injection of 10 cubic centimeters of air in her veins.

Sheriff O'Brien said that Dr. Sander has admitted administering what he knew would be a fatal air injection. Mr. Craig corroborated the statement and said that Dr. Sander "then scrupulously" had noted the injection on Mrs. Borroto's medical record. The notation brought about the arrest. Apparently, said Mr. Craig the physician was "torn with pity" for his patient, who had wasted from 140 pounds to 80. Mr. Craig said that she died within ten minutes after the injection, but added that she probably would have died of the cancer within a matter of hours. The county solicitor characterized Dr. Sander as "a fine man, a good family man, without a malicious bone in his body: he just thought he was performing an act of mercy."

A routine study of the records during a staff meeting at the Hillsboro

\textsuperscript{1}Summaries of articles from the 1949 and 1950 New York Times newspaper will be utilized as the basis of the Review of Related Literature, because of the limited availability of data concerning euthanasia from various ethical viewpoints. The murder trial of Dr. Herman Sander, of Manchester, New Hampshire, is the subject of these articles. Due to the great amount of controversy which occurred during his trial, many experts from the fields of medicine, law, and theology were called upon to state their opinions about euthanasia.
County Hospital uncovered Dr. Sander's notation about the injection, said Mr. Craig. Hospital authorities notified Dr. Biron, who in turn, called the sheriff. Dr. Sander was arraigned at the home of Judge Alfred E. Poore of the municipal court. Dr. Sander pleaded not guilty and was taken to the Hillsboro County Jail. On December 30, 1949 Dr. Sander was released from jail on $25,000 bond, and said he hoped to resume his practice at once. He is scheduled to face the grand jury session that convenes the following week. Dr. Sander is being represented by a Manchester law firm - one of the partners is William J. Starr, Jr.

Dr. Robert E. Biron, County Medical Referee said that the ten cubic centimeters of air alleged in the murder charge to have been administered to Mrs. Borroto would not have been sufficient to cause death. He amplified this by saying that more air had been injected than the amount specified. Sheriff Thomas F. O'Brien, who formally arrested Dr. Sander, said Mrs. Borroto had received four separate injections of ten cubic centimeters of air.

On January 5, 1949 Dr. Herman N. Sander pleaded not guilty to an indictment charging him of first degree murder. During the brief hearing before Judge Harold E. Wescott of the Superior Court, it was disclosed that since Dr. Sander had agreed to discontinue his medical practice until the case had been completed he would be permitted to remain at liberty under the $25,000 bail fixed at the time of his arrest. The indictment, returned by the Hillsboro County Grand Jury, held that Dr. Sander "feloniously, willfully, and of his malice aforethought," had injected ten cubic centimeters of air "four times in succession," into the veins of Mrs. Borroto well knowing the air injections to be sufficient to cause death. The date for the first degree murder trial of Dr. Sander is scheduled for the end of next month, (February 20th), but before the trial, he will face a hearing before the State Board of
Registration in Medicine. The board will consider revocation of his license to practice.

On February 22, 1950, Dr. Sander's trial began after the selection of the jurors, which consisted of 15 carefully selected men. The jurors were sworn in by the court clerk and the indictment (150) words is read against Dr. Sander. The next day, the trial continued and Sheriff Thomas F. O'Brien testified for the prosecution, that Sander told him he took Mrs. Borroto's life in a weak moment. It also was disclosed that Mrs. Borroto's husband had approached Dr. Sander and begged him "to do something . . . even if it meant taking her life." Another witness, Miss Josephine Connor, record librarian at the Hillsboro County General Hospital testified that Dr. Sander did not anticipate any worse punishment than a reprimand from the medical profession. It was Miss Connor to whom Dr. Sander on December 12 dictated notations for Mrs. Borroto's chart that he had given her four ten cubic centimeter injections of air intravenously to Mrs. Borroto within ten minutes of her death. Miss Connor also testified that Dr. Sander knew he violated the law and willfully delayed the actual report of the events leading to Mrs. Borroto's death.

On February 27, 1950 an eye-witness of Mrs. Abbie C. Borroto's death told the jury in the "mercy-killing" trial that the patient was still gasping when Dr. Herman N. Sander injected air into her veins. Miss Elizabeth Rose, nurse to Mrs. Borroto testified the above. When Reginald F. Borroto, the dead woman's husband, testified, he denied that he had ever asked Dr. Sander to shorten his wife's life. The last witness for the prosecution testified on February 28. Miss Anita Ducharme, Assistant Medical Records Librarian at the Hillsboro County General Hospital, confirmed previous testimony of other witness for the prosecution. She said that Sander admitted injecting air into the veins of his patient, to cause death from an air embolism, but on the
victim's death certificate, it stated that death was due to carcinoma of the large bowel and metastasis of the liver, (cancer of the membrane like tissue lining a cavity and transfer of disease from one part of the body to another).

On March 2, 1950 the defense counsel opens its case by telling the "mercy killing" jury that Dr. Herman N. Sander would take the stand, would admit giving air injections to Mrs. Abbie C. Borroto, but deny they killed her or that he intended them to. Counsel said Dr. Sander and Dr. Albert F. Snay would testify that Mrs. Borroto was dead of cancer before the air was injected, but that "a doubt crossed Dr. Sander's mind" and he injected air to prevent any recurrence of pain. He did this, according to counsel, "on the impulse of the moment under severe emotional strain." Dr. Sander will admit making the notation on Mrs. Borroto's chart that he had injected ten cubic centimeters of air four times according to counsel, and she expired within ten minutes after the injections were started.

Counsel said that Dr. Sander would testify that he did not inject more than twenty-five to twenty-eight cubic centimeters of air and that he still believed cancer and not an air embolism was the cause of death. Mrs. Alice Sander, the doctor's wife, will tell the jury, counsel added, that at the time of the air injections, her husband was near physical and nervous exhaustion from overwork and from the effect of Mrs. Borroto's suffering upon him. Dr. Snay, the deceased's surgeon, testified that Mrs. Borroto appeared to be dead when he looked in on her on December 4, 1949 at 11:15 p.m., and he left her room as Dr. Sander came in. Dr. Sander then took Mrs. Borroto's pulse, but there was no response. There was on Mrs. Borroto's face an expression of pain, but there was no sign of life. Dr. Sander then thought of giving assurance that the pain which Mrs. Borroto had conquered would not return. On the impulse of the moment and under the impact of severe emotional strain that
he had been under, he called for a sterile syringe. While the nurse prepared the syringe, Sander watched Mrs. Borroto for any signs of movement - there were none - even after the first injection.

Dr. Sander left the room after administering the injections and notified the family of Mrs. Borroto's death. He also completed the death certificate, which stated that cancer was the cause of death. Dr. Richard Ford, Harvard Pathologist, who performed an autopsy on January 21, 1950, testified that the cause of death was due to cancer and bronchial pneumonia, not an air embolism. A number of character witnesses testified that Dr. Sander was a conscientious sympathetic doctor who did all he could to help or comfort his patients. Dr. Ford testified again on March 7, 1950 and stated that he had experimented on dogs, which indicated that 200 to 300 cubic centimeters of air injected rapidly within 25 seconds, were needed to kill average human beings. It would take more than forty c.c.'s to kill a woman even in Mrs. Borroto's weakened condition. Ford ended his testimony by stating that blood clots in the brain indicated that the final process of death was gradual over a period of hours rather than sudden.

On March 9, 1950, the defense and prosecution gave their closing statements to the jury for their decision or verdict. (It was the fourteenth day of Sander's trial). The jury consisted of twelve middle-aged and elderly men. They eventually reached the verdict within an hour and ten minutes after the case went to them. Sander was acquitted on all charges of first degree murder.

On April 19, 1950, the State Board of Registration in Medicine revoked Dr. Sander's license to practice in New Hampshire, but left a loophole for him to apply for re-instatement in two months. The decision of the five-man board was unanimous.

As a result of the large financial drain caused by the extensive murder
trial and revocation of his license, Sander was forced to take a menial job as a farm hand to wait out his suspension, but as it turned out, he was not granted his license to practice medicine in New Hampshire until 1957.

During the mercy killing trial of Dr. Herman Sander, society in general possessed a wide range of opinions on the topic of euthanasia. Numerous experts from the fields of theology, medicine, and law gave very strong opinions, either for or against euthanasia, especially during Sander's murder trial. Examples of their insights will be examined in the following (1950) New York Times Newspaper clipping:

Every year in the United States about twenty-five cases of euthanasia--"mercy killings"--are prosecuted in the courts. Many others take place, but are never reported. Since state laws do not distinguish between mercy killing and murder, those who commit euthanasia are prosecuted as murderers. During the past few decades, in the great majority of cases where a jury has been convinced that a death was a "mercy death," the person responsible was either acquitted or his sentence suspended.

The Euthanasia Society of America, Inc. which was formally founded in 1938, has been trying since then to sponsor a bill through various state legislatures legalizing voluntary euthanasia, but each attempt has been unsuccessful due to lack of support by state officials. It was during the beginning stages of Dr. Sander's trial that members of the society decided to seek legalization of euthanasia in the State of New Hampshire. The Euthanasia Society did not condone such illegal mercy killing as Dr. Sander was accused of, but they felt that if euthanasia was morally right, it should be legally right. The society does not condone illegal mercy killings. They did feel however, that their proposed law would be permissive and not mandatory. The request for euthanasia must originate with the patient and that
the patient may change his mind at any time.

The Euthanasia Society felt confident that their bill would not be rejected in the New Hampshire State Legislature due to the great support Dr. Sander received during his murder trial. Many of Dr. Sander's friends, neighbors and patients distributed petitions, as well as raised thousands of dollars to meet the heavy cost of his trial. Eventually, as has been done in previous attempts, the bill was defeated.

There are still more factions in conflict over this moral issue of euthanasia. These factions consisted of theologians vs. physicians. Their opinions are again represented in the same New York Times articles:

Dr. A. L. Goldwater, a noted physician in Manchester, New Hampshire gave his opinion during an annual meeting of the Euthanasia Society of America, Inc. He said that he had made overdoses of morphine available on occasion to incurable patients, and that other doctors did the same. Dr. Goldwater said that his custom in an incurable case was to prescribe a week's supply of morphine tablets and leave them on the patient's bedside table. "I tell him one tablet will ease his pain, but warn him to be careful because if he takes the whole bottle he may not wake up."

Another physician, Doctor Clarence Cook Little, celebrated cancer authority, suggested specific safeguards for a law legalizing mercy killings. Dr. Little, Director of the Roscoe B. Jackson Memorial Laboratory of Manchester, New Hampshire, said that for the incurably ill, but mentally fit, his safety factors would be: consent of the patient, consent of his next of kin, and the approval of a board of three medical judges set up by a state medical association. For mental defectives, the said procedure should be the same except for the patient's consent provision.

Within the various interdenominational philosophies expounded upon
within the field of theology, numerous ideologies from these religious sects are in conflict with each other on the issue of euthanasia. The following articles will provide more insight as to why: MSGR. John S. Middleton, Education Secretary for the Roman Catholic Archdiocese of New York condemned "mercy killing" as "murder," and that to enact a law permitting voluntary euthanasia would be disobeying the laws of God. Those who sought to legalize voluntary euthanasia are motivated by a "pagan mentality," and that it would be an "inhuman humanism" that called murder "mercy."

The Reverend Dr. John Hess McComb, Pastor of the Broadway Presbyterian Church stated the following: "Those who advocate the killing of sufferers from incurable diseases, are utterly disregarding the Sixth Commandment." God says, "thou shalt not kill." God, however, does permit and even commands the execution of criminals guilty of murder. He permits killing in self-defense and in war, but he gives no warrant in the Bible for the killing of those who are weary of living.

Every clergyman has seen instances in which incurable and painful diseases have actually done much good to those who suffer from them, in drawing closer to God, or making them willing to accept His Son as Saviour. Some of the noblest characters we have ever known have been ennobled by painful suffering. Moreover, God promises to recompense Christians who suffer undeservedly.

On the other hand, there are some theologians who feel the opposite of the Presbyterians and Roman Catholics: In a petition proclaiming their belief that a person suffering continual pain from incurable illness has the right to die, 379 Protestant and Jewish Clergymen called on the New Hampshire State Legislature to enact a law permitting voluntary euthanasia or "mercy killings." The clergymen declared: they no longer believed that God wills the prolongation of physical torture for the benefit of the soul of the sufferer. For one enduring continual and severe pain from an incurable disease, who is a burden to himself and his family, surely, life has no value.
They believed that such a sufferer has the right to die and that society should grant this right, showing the same mercy to human beings as to the sub-human animal kingdom. "Blessed are the Merciful."

Hypothesis and Variables Tested.—My leading ideas for this research project consist of the following: the goals of our culture rest on a credo of the sanctity of the human individual. The question is whether human beings may choose or make the conditions of life, health and death (death control, as in direct or indirect euthanasia) is as much a part of modern medicine as birth control and health control are. The true control of life puts the initiative in man's hands, that is, it is a matter of choice.¹

Is it suicide if an individual who is incurably ill and deterioratively suffering, desires to kill himself - aside from the fact that death is inevitable - is that suicide? Or is it an act of sacrificial love - such that their life at the present time is invaluable to themselves, and to concerned relatives - in that their suffering is causing them anguish.² Thus, a dilemma of life versus death exists: human existence or life is apparent by a consciousness of self. If we were to lack this salient factor, then we would be dead. But, what does it mean, to be "declared dead?" The once classical "criteria" for determining death no longer has the same meaning, since it is now possible to maintain artificially the cardiac and respiratory functions of an individual in a state of irreversible coma. Thus, in part at least he continues to live. At this point, let us say that one would be clinically alive if life was being artificially maintained through the functions of one vital organ, but that this same individual would be now classified as


²Ibid., p. 123.
socially dead, due to a lack of self.¹

Here is where the question transcends the purely medical realm of inquiry and we are forced to consider the very nature of human existence: what is man? Thus, a tension arises between that which is not under our control, the fundamental meaning and purpose of human existence, and that which is under our control, namely the marvelous ministration of sophisticated modern medicine the problem being that by preserving a man only in part, medicine may actually be depriving him of and thereby violating the very meaning and purpose of his life.²

This research project will also attempt to answer the following questions: has there been a significant change of attitudes on the subject of euthanasia as compared to the views expounded in 1949 - especially within the fields of theology, law and medicine?

It is my contention that there has been a change of attitude towards euthanasia. Further exposition of the leading ideas involved, will allude to the following: contemporary society's controversy on the issue of euthanasia is considered to be a felony and punishable to the fullest extent by law. (In this case, this means first degree murder punishable by death or life imprisonment.). If euthanasia is to be legalized, the law has to be changed, and precautions have to be taken to alleviate societal deviants from taking advantage of this law according to the special prerequisites devised.

From the theological point of view, euthanasia is blasphemous of all religious doctrines regarding the sanctity of life in challenging man's destiny as pre-planned by God alone! A final exposition at this point would

¹Ibid., p. 133.
²Ibid., p. 176.
include the right of self-determination, whereby the individual, alone, is the master of his destiny, to live or die as he so desires. If life is so precious as it is, why should the individual be dictated by society to die by the manner it prescribes, or should he (the individual) be free to decide for himself? In essence, these are some of the issues that will be expounded upon by this project. The variables tested for in this study will include specifically: age, sex, educational level attained, and profession.

Research Design and Definition of Concepts.--The research design utilized for this study will be explanatory in nature, since the availability of information is rather limited in certain aspects.

Euthanasia is an older societal phenomenon, and is not as prevalent as in earlier decades. There are only a few select books dealing specifically with the issue of euthanasia, such as J. L. Williams, The Sanctity of Life and the Criminal Law. Both the legal and moral issues are directly expounded upon in greater detail, as opposed to simply defining the term relating to its historical background and implementation. Most authors briefly describe its relationship to suicide, as well as the religious and legalistic ethics involved. There have been few efforts made to integrate all of these aspects in studying this phenomenon, and this is what I hope to contribute.

If an accurate understanding of the concepts utilized in this study are to be obtained, some of these constructs (higher abstractions of concepts) will have to be defined as follows:

1. **Euthanasia** (mercy killing) - Usually refers to voluntary death in cases of painful and incurable disease.

2. **Legal Dilemma** - Since there is no specific provision for it in Anglo-U.S.

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1Ibid., p. 119.
law, it is accounted either suicide (if performed by the patient himself) or murder (if performed by another).¹

**Incurable Disease** - Refers to a disease that cannot be cured, causes the patient much pain or suffering and the end result is death - it is just a matter of time.

**Felony** - Refers to a grave crime formerly differing from a misdemeanor under English common law by involving forfeiture in addition to any other punishment.²

**Life** - Is defined here as possessing an apparent consciousness of self.³

**Death** - Refers to an apparent lack of consciousness of self.⁴

**Clinically Alive** - Refers to the state of irreversible coma whereby life is partially maintained through the keeping alive of certain vital organs.⁵

**Socially Dead** - Refers to life being artificially maintained, but the individual lacks a consciousness of self.⁶

The types of data available would include magazine and newspaper articles, as well as various books which define, categorize and judge euthanasia—positively or negatively. Since euthanasia is an older societal phenomenon more data is available from 1929 until about 1970. This is due to the fact


²Ibid.


⁴Vaux, op.cit., p. 176.

⁵Ibid.

⁶Ibid.
that although this is not an unusual occurrence, most cases are not reported, and kept confidentially among those individuals involved. (This is due to the extreme penalty of the law in dealing with euthanasia cases.). The data presented is fairly accurate for the exception that there is little if no attempt to integrate all of the various facets involved in euthanasia, thus most of the information presented is indicative of the author's viewpoint.

Methods of Data Collection.--The types of techniques and tools to be used in the study will consist of the following: I will be interviewing various members from theological, legal and medical professions to discover their ideologies concerning euthanasia. Questionnaires, both of an open and closed end nature will be circulated through use of a clustered random sample of the population. As previously mentioned, the variables being tested will include, age groupings between 20-60 years of age, sex, and profession. These methods, as well as the use of the interview and observation, were chosen to increase effectiveness and accuracy of data collected as much as possible. Thus, to decrease invalidity of information gathered, random (clustered) samples will be utilized. Various statistical tests will be performed, such as the chi square and correlation coefficient et al will be administered to test relevance and accuracy of information gathered. The background information used to describe the occurrences and/or situations in the 1949 euthanasia case, being used for comparison of attitudes will be obtained from microfilm of the various issues utilized in the 1949 New York Times newspaper, which covered the case in its fullest extent.¹

¹Tbid.
Euthanasia is a Greek word meaning "easy or happy death," and is popularly known as "mercy death" which implies measures deliberately taken by a physician to curtail pain and suffering, in agonizing terminal and definitely fatal chronic conditions by the merciful infliction of death. This concept has been enlarged to include such action in incurable disease, particularly those in which the patient must endure torment, and extreme pain. On the other hand, euthanasia enters the field of eugenics in the form of infanticide which aims to improve the race by the elimination of children born with irreparable defects, or those grotesque creatures known as teratological anomalies.

Since there is no specific provision for it in Anglo-U.S. Law, it is accounted either suicide (if performed by the patient himself) or murder (if performed by another). However, a physician may lawfully decide not to prolong life where there is extreme suffering, and he may administer drugs to relieve pain, in the increasing doses necessary to overcome habituation, even though he knows that this may shorten the patient's life.

Although in modern times there are no recognizable parallels to these practices, ancient history affords many examples of euthanasia in the forms of infanticide, parricide, and suicide. Infanticide as a form of eugenics

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was a public policy in Sparta, where a father was by law compelled to submit his child to examination by a tribal council, which endowed it with an allotment of land if it were strong, but ordered it cast into a chasm as a useless burden to the state if it were the victim of gross mental or physical weakness. Pursuing the ideal of maintaining a high standard of physical fitness, other states and societies allowed the parents to expose a defective child. Such abandoned children were often found and reared by others, a situation that makes its occasional appearance in literature. There is no history of infanticide among the Jews, who reared even the blind and the crippled, and among whom parents had no power of life or death. In primitive or illiterate societies, when the population exceeded the food supply, the infirm among the young and old were sometimes clubbed to death, but a taboo against shedding tribal blood more often caused resort to abandonment. In the Dark Ages, those afflicted with hydrophobia (rabies) were smothered to spare their unspeakable agony. Although suicide as such was rare among primitive or illiterate peoples, except as warriors often destroyed themselves to avoid capture, disgrace, and torture, the old and infirm were commonly expected to wander away from the tribe to die by exposure or starvation.

Literature abounds in moral endorsement of euthanasia by such advocates as Socrates and Plato, who justified the elimination of maimed children or the off-spring of "inferior" parents and who also contended that no elaborate attempt should be made to keep alive invalids who had no future hope. In Aristotle's ideal state, defective children were not to be allowed to survive. Seneca, Epictetus, and Pliny the Younger more simply endorsed the right of every individual to an easy death, but in Thomas Moore's Utopia, the judge and ministers urge the disabled who cannot serve the community and who become a burden to others to terminate their unhappy state. Such philosophers as Immanuel Kant, David Hume, and Fredrich Paulsen have also been concerned
with the practice of euthanasia.

In modern day, Christianity's condemnation has brought euthanasia into disrepute on the ground that it is really morally reprehensible to produce a state of insensitivity in one who has not reconciled himself to his creator, and that it usurps God's power over creation and death, as St. Thomas Aquinas contended. Opposition to the practice is based also on more specific grounds. Contemporary thought draws a sharper distinction between the voluntary relief of individual suffering, and a policy of eliminating groups useless to the community. It is recognized that legalized euthanasia can be a dangerous weapon in the hands of criminals and may be employed by the unscrupulous to their profit. There is growing realization of the fact that many physically handicapped can make useful and even brilliant intellectual contributions to society. Medicine recognizes spontaneous remissions of incurable disease, while the dramatic advances of medical research - insulin in diabetes as a single example - can free untold thousands previously condemned to death.¹

The organized movement for legalization of euthanasia commenced in England in 1932, when C. Killick Millard founded the Voluntary Euthanasia Legalization Society (later called the Euthanasia Society). The society's bill was defeated in the house of lords in 1936, and so also was a motion on the same subject in the house of lords in 1950. The Euthanasia Society of America, founded in 1938, sponsored a similar measure which was defeated in the Nebraska assembly in 1938; there is also a Voluntary Euthanasia Society of Connecticut.²

The only country at the beginning of the 1960's to give direct sanction to a form of euthanasia was Switzerland, under federal code of 1937, lending assistance with a view to suicide was punishable only if the assister was impelled by selfish motives, so that a physician might provide, but not administer poison at the request of his suffering patient.¹

In the United States, euthanasia has considerable support in many cultured and professional groups, including physicians, jurists, social workers, and attorneys. Opposition is equally vigorous and funds support within the same ranks, and especially, in the general population.²

¹Ibid.

²Collier's Encyclopedia, op.cit., p. 466.
CHAPTER III

COMPLEXITIES INVOLVED IN AN EUTHANASIAN CASE

You will recall from Chapter I, that Dr. Herman Sander of Manchester, New Hampshire was charged with the first degree murder of Mrs. Abbie Borroto on December 29, 1949. On March 9, 1950, Dr. Sander was acquitted of the charge because of the testimony rendered by Harvard Pathologist, Dr. Richard Ford. His testimony revealed that Mrs. Borroto died before Dr. Sander mercifully administered the air injections, nor were those injections sufficient to cause her death.

Euthanasia is a subject which since earliest antiquity to the present day, has aroused emphatic opinions—both pro and con. It raises questions of man's relation to God, to his fellowman, to society, and of what is right, what is practical and what is humane. All of which makes it a very complex and fascinating topic. The following paragraphs will illustrate why this is so. Euthanasia may be achieved by direct or indirect methods. If it is direct, a deliberate action or "mercy killing" to shorten or end life, it is definitely - murder - as the law now stands. But, indirect euthanasia is another matter, the more complicated and by far the more frequent form of the problem. There are three forms it can take: (1) administering a death-dealing pain killer, (2) ceasing treatments that prolong the patient's life -


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or death, if you prefer, and (3) withholding treatment altogether.¹

All of medical manipulation must be viewed not as an end in itself, not even as a means for the preservation of life. It must be viewed as a means for enabling the individual to live a life that is more than merely biological, a life of dignity and freedom, a life appropriate to a human being. Whenever medicine threatens the end it rightly serves, we must refuse to pay the price. The concept of "dignity" is the informing principle derived from the ethics of a democratic and secular society when it attempts to describe the status of a human being and his place within the social order.²

The right to die in dignity is a problem raised more often by medicine's successes than by its failures. Consequently, there is a new dimension in the debate about "euthanasia." The old-fashioned question was simply this: "May we morally do anything to put people mercifully out of hopeless misery?" But, the issue now takes a more troubling twist: "May we morally omit to do any of the ingenious things we could do to prolong people's suffering."³

For doctors, this dilemma challenges the Hippocratic Oath which commits them to increasingly incompatible duties—to preserve life and to relieve suffering. This conflict of conscience is steadily magnified by the swelling numbers of elderly people. Medical genius and sanitation have resulted in greater longevity for most of our population. In consequence, the predominant forms of illness are now degenerate—the maladies of age and physical


³Joseph Fletcher, op. cit., p. 145.
failure - not the infectious diseases. Disorders in the metabolic group, renal problems, (involving, or located in the region of the kidneys.\(^1\)), malignancy, cardiovascular ills, are chronic rather than acute. Adults in middle life and beyond fill the beds of our hospitals, and the sixty-five and over class grows fastest of all. Under these circumstances, many people fear the prospect of senility far more than they fear death.\(^2\)

The religious objection of Euthanasia is principally the familiar one that killing falls under the ban of the Sixth Commandment. This theocratic morality is, however, no more successful in the present application than in those previously considered. The true translation of the Sixth Commandment is not "thou shalt not kill," but "thou shalt do no murder," as the Book of Common Prayer has it; and it is only by a stretch of words that a killing with the patient's consent, to relieve him of inexpressible suffering can morally be described as murder. If wholesale killing in war and the punitive killing of criminals are not "murder," surely a killing done with the patient's consent and for his benefit as an act of mercy can claim to be excluded from this ugly word. Even on the religious hypothesis of a soul, to release the soul from the tortured body and set it at liberty is surely to confer a benefit upon it and not an injury.\(^3\)

Thus, the associated concept in the Christian ethic is the sanctity of life of the individual in the social order. Both concepts point towards the confidence that life is of inestimable value. In the Christian ethic sanctity


\(^2\)Joseph Fletcher, op.cit., p. 154.

is not a quality added to life which men should observe and respect. The acceptance of life and identity as a gift of God is the recognition of sanctity. The status of all beings is found in their relation to the power by which they are. Ultimate sacredness is given to God alone, and thus, life itself or a "right to life" must not be approached in sacred terms.¹

Under the present law, voluntary euthanasia would, except in certain narrow circumstances, be regarded as suicide in the patient who consents and murder in the doctor who administers; even on a lenient view most lawyers would say that it could not be less than manslaughter in the doctor, the punishment for which, according to the jurisdiction and the degree of manslaughter, can be anything up to imprisonment for life.

More specifically, the following principles may be stated:

1. If the doctor gives the patient a fatal injection with the intention of killing him, and the patient dies in consequence, the doctor is a common murderer because it is his hand that has caused the death.

2. If the doctor furnishes poison (for example, an overdose of sleeping tablets) for the purpose of enabling the patient to commit suicide, and the patient takes it accordingly, and dies; this is suicide, and a kind of self-murder in the patient, and the doctor, as an abettor, again becomes guilty of murder...²

3. A case that may be thought to be distinguishable from both of those already considered is that of the administration of a fatal dose of a drug where this dose is in fact the minimum necessary to deaden pain. Where a patient is suffering from an incurable and agonizing disease, and ordinary quantities of a drug fail to render the pain tolerant, many doctors will give the minimum dose necessary to kill the pain; knowing that this minimum is at the same time an amount that is likely to kill the patient.

In other words, faced with the choice of either doing nothing or killing both the pain and the patient, the doctor chooses the latter course;

¹John C. Fletcher, op.cit., p. 219.
²Williams, op.cit., pp. 318-319.
knowing that in any event the patient has not long to live.\(^1\)

The theoretical statement of the law on the subject of euthanasia is misleading unless one bears in mind four practical factors relating to its administration.

In the first place, a charge against a physician of murdering through the administration of a humane overdose is inherently difficult to establish because of the nature of the evidence required. When the patient is gravely ill and has been receiving large doses of a drug over a considerable period it may be difficult to determine the amount of the final dose, if that is disputed, or whether death was due to it. Again, the line between a lawful though large dose of drug, and one so large as to be unlawful, may be a narrow one; so also is the line between curtailing life and bringing about death. Even if the law requires the line to be drawn, it is one of such inherent difficulty as to give much scope to the defense. Secondly, prosecuting authorities are naturally reluctant to take criminal proceedings against a doctor of repute for an act done in good faith in a situation of great difficulty, particularly when the evidence is such that the charge is unlikely to succeed.

Thirdly, a jury will be reluctant to convict a doctor in these circumstances, and may not only seize upon any defect in the evidence as a reason for acquitting, but may even acquit when the evidence and the judge's direction leaves them with no legal reason for doing so.

Fourthly, assuming that the worse happens and the doctor is convicted of murder, executive clemency will in all probability intervene to prevent the execution of the death penalty.\(^2\)

\(^1\)Ibid., p. 321.
\(^2\)Ibid., pp. 326-327.
It may be suggested that the most hopeful line of advance would be to bring forward a measure that does no more than give legislative blessing to the practice of euthanasia that the great weight of medical opinion approves. In other words, the reformers might be well advised, in their next proposal, to abandon all their cumbersome safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.\textsuperscript{1} Thus, the medical practitioner's sense of responsibility, sincerity, and honor would increase and a measure of this nature would also confer protection on the doctor (by the law) for this act if motivated by the strongest instincts of humanity.\textsuperscript{2}

While confining the new legalization of euthanasia to the case where the patient has consented, there would be no need to upset the present law whereby narcotics may be given to any extent necessary to deaden pain. A patient who accepts the relief afforded by these drugs must be taken to accept also the inevitable effects upon his body of their potent action. It would be inhumane and impracticable to expect the physician, in administering them, to bring to the forefront of the patient's mind their secondary effects.\textsuperscript{3}

In order to put the law beyond all possibility of doubt, it might be well to provide for this situation in a separate clause. It might also be expressly provided for the avoidance of doubt, that a physician should not be legally responsible for failing to prolong the life of one suffering from an illness involving severe pain and believed by the physician to be of an incurable, and fatal character.

\textsuperscript{1}Ibid., p. 339.
\textsuperscript{2}Ibid., p. 341.
\textsuperscript{3}Ibid., p. 344.
These various provisions might be worded in the following way:

1. For the avoidance of doubt, it is hereby declared that it shall be lawful for a physician whose patient is seriously ill-

   a. to administer to the patient drugs lawfully made and sold for the purpose of keeping patients insensitive to pain or of inducing sleep or unconsciousness, and to increase the dose of such drugs to the extent necessary to compensate for the establishment of the patient's tolerance thereof;

   b. to refrain from taking steps to prolong the patient's life by medical means - unless in either case it is proved that the act was not done, or the omission was not made in good faith for the purpose of saving the patient from severe pain in an illness believed to be of an incurable and fatal character;

2. It shall be lawful for a physician, after consultation with another physician, to accelerate by any merciful means the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient, and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character.

There should be included a section defining "physician" as any person licensed (or registered) for the practice of medicine in the state concerned.¹

Thus, if all of the above provisions for euthanasia became legalized, doctors would no longer be able to deceive their patients who are suffering from an incurable and extremely painful disease - especially those who desire to know the truth, or alternatives available. (If any.).²

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¹Ibid., p. 345.

²Ibid., p. 343.
CHAPTER IV

CROSS-SECTIONAL VIEWPOINTS OF SOCIETY AS COMPARED TO THE SAMPLE CASE SURVEYED

In this chapter, the cross-sectional viewpoints of today's society will be compared to the ideologies expressed by society in 1949. For the purpose of this research project, the cross-sectional viewpoints of society refer to opinions held by doctors, lawyers, theologians, and the general public.

In 1947, gallop pollsters circulated the following questionnaire on euthanasia to find out what the U.S. public thought of the issue: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" The results were as follows: Yes, 37%, No, 54%, no opinion, 9%. Youngsters were less shocked at the idea than oldsters. People in their 20's were divided about 50-50; people over 50 opposed euthanasia two to one.¹

This same questionnaire was circulated among the Atlanta University student body during the first semester 1971. The results were as follows: Yes, 45.28%, No, 47.17%, and no opinion, 7.55%. Due to the smallness of the samples utilized in these interviews and surveys, the responses received will serve as an indication of present society's viewpoint on euthanasia.

When the 1949 sample is compared with the responses received from the 1971 sample, the following observations can be surmised: the majority of people in the younger age categories are still against euthanasia, but the gap is narrowing between its total acceptance or rejection. This difference can be seen when the responses are comparatively placed as in Table 1.

During the second semester 1972, an identical survey was circulated among the Atlanta University Center Faculty. The purpose of this survey was to detect any change of attitude concerning euthanasia, and if the variable age would greatly alter the responses received. The results were as follows: Yes, 60.29%, No, 29.41%, and no opinion, 10.29%. The responses obtained from this sample indicate that there is a significant difference in attitude towards euthanasia when an age variable is added to the survey. This difference can be seen when the responses are placed as in Table 2.

When the 1949 sample is compared with the responses received in the 1972 sample, the following observation can be surmised: the majority of people representative of the older age categories support euthanasia as opposed to the 1971 sample where the younger population was surveyed and a negative response was obtained.

In Chapter I, conflicting viewpoints concerning euthanasia were expressed by various individuals from the fields of medicine, law, and theology. Their opinions represented the cross-sectional ideologies of society during the murder trial of Dr. Herman Sander in 1949. Individuals representing the same fields in today's society were interviewed for the purpose of obtaining their opinions on euthanasia. Their ideologies will be presented in the following paragraphs:

Dr. Asa Yancy, a prominent Atlanta physician, stated "I do not believe in euthanasia. All of my patients come to me for help to live, and not to die. . . . : I am strongly against it. . . ."¹

¹Asa Yancy, M.D., Private Interview at Spaulding Pavillion, Atlanta,
Dr. Clinton E. Warner stated "I am against euthanasia because it contradicts all medical principles . . .; I could conceive of situations where it could be applicable, but in 15 years of practice, a situation of this nature has never presented itself. . . ."¹

Dr. Charles Shorter, also of Atlanta, stated "I have no particular views on mercy killing . . .; I do all that I can to aid and comfort the patient to the end . . .; the thought of mercy killing never crosses my mind . . .; I could never do such a thing. . . ."²

Father Joseph F. Cavala, of the Sacred Heart Catholic Church here in Atlanta, stated "No one has the right to take another's life, but if the person requests it himself - then that is another matter. Life is valuable. . . .; all killing is extreme and I would tend to be against euthanasia for those reasons. I would also be afraid of mercy killings because of its varied extensions to the extreme, such as genocide, murder of the retarded, physically handicapped, deaf and blind - any type of individual in which another group would consider suffering. The Catholic Church teaches that life should be preserved within reasonable means, such that when extraordinary methods (elaborate machinery) are being utilized to partially keep an individual alive, that no obligation should be held to continually do so, and the individual should be allowed to die a natural death. . . ."³

Dr. Harry A. Finefield, Pastor of the First Presbyterian Church of Atlanta stated "I am generally opposed to euthanasia because of the rapid medical and surgical advances made in these fields. Perhaps in some isolated cases it could be justified, but I would have to think a long time about sanctioning it. The Presbyterian Statements of Social Issues for 1960-1969 says nothing (nor takes any official position) about euthanasia specifically. . . ."⁴

Dr. M. J. Jones, Director of the Gammon Theological Seminary at the Interdenominational Theological Center of Atlanta, quoted the Social Principle Statement, which was adopted by the United Methodist General Conference on April 25, 1972: "The beginning of life and the ending of

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¹Clinton E. Warner, M.D., Private Interview at 319 West Lake and Simpson, Atlanta, Georgia, May 1, 1972.

²Charles Shorter, M.D., Private Interview at 960 Hunter, Atlanta, Georgia, April 25, 1972.

³Father Joseph F. Cavala, Private Interview at the Sacred Heart Catholic Church, Atlanta, Georgia, April 27, 1972.

⁴Dr. Harry A. Finefield, Pastor, Private Interview at the First Presbyterian Church, Atlanta, Georgia, May 1, 1972.
life are the God given boundaries of human existence . . .; we applaud medical science for efforts to prevent disease and illness and for advances in treatment that extend the meaningful life of human beings. At the same time, we assert the right of every person to die in dignity, with loving care and without efforts to prolong terminal illness merely because the technology is available to do so . . ."1

Reverend Howard W. Creecy, Pastor of the Mt. Moriah Baptist Church here in Atlanta, stated "No one has the right to terminate another's life . . .; only God has the ultimate power to control the organism he created. If, however, a person possessing all of his emotional factors requests to die - then that is euthanasia . . .; when the doctor intervenes in behalf of the suffering patient, it is an emotional response to a psychological state and consequently a moral judgement is made instead of a medical one . . .; The Baptist Church has not taken any official position regarding euthanasia . . .; it is up to God to decide whether one lives or dies . . .."2

Rabbi Jacob M. Rothschild, of the Temple Synagog, stated "Man is not to assume the role of God to parenthetically take another's or his own life . . .; heroic methods should not be utilized if an individual is being kept alive by artificial means . . .; no deliberate action should be taken to end their life abruptly. The Jewish Church opposes euthanasia . . .; it was discussed hundreds of years ago in the Tanllid (Bible) by the church elders. They recognised the problem of keeping a person alive when there was extreme suffering and no hope of their survival. Their response to this problem was that one could not take deliberate action in helping an individual to die in peace, but passive action can be taken . . .; for example, if a gravely ill person was in a room, you could not take any deliberate action to put him out of his misery, (such as administering a poisonous drug, etc.). However, if noise was being made outside of the person's window, the individual could then close the window, or do anything to make the person as comfortable as possible (hence passive action) so that the person can eventually die in peace . . .."3

J. C. Dougherty, a prominent Atlanta attorney, stated "I have given euthanasia a great deal of thought, like other people who deal in public affairs, as a result of reading magazine and newspaper articles about it . . .; I feel that euthanasia would be a good thing if morally applied by putting a suffering person out of his misery . . .; if an indirect

1Dr. M. J. Jones, Director of Gammon Theological Seminary, Private Interview at Interdenominational Theological Center, Atlanta, Georgia, April 27, 1972.

2Reverend Howard W. Creecy, Pastor, Private Interview at the Mt. Moriah Baptist Church, Atlanta, Georgia, April 27, 1972.

3Rabbi Jacob M. Rothschild, Private Interview at the Temple, Atlanta, Georgia, April 28, 1972.
form of euthanasia is to exist, a national act passed by the congress is needed to change the existing law regarding it . . . ; I can foresee many problems arising if a law of this nature was passed only on a state basis, because people are extremely mobile today. Therefore, to prevent inter-state conflicts, concise regional legislation is necessary to prevent liabilities among doctors, relatives and the hospital, and if anything was to go wrong . . . .

It is interesting to note at this particular point of the paper, that all of the above individual responses concerning personal and institutional viewpoints on euthanasia, have the following three factors in common:

1. They all recognized euthanasia as a moral issue.

2. They were against direct forms of euthanasia, (a person taking the life of another), and they acknowledged an indirect form instead (such that no heroic or elaborate means--machinery, etc., should be utilized to partially keep an individual alive - they should be allowed to die in peace and in dignity.

3. If euthanasia is to exist, some type of legislation is needed to prevent unscrupulous implementation of this phenomenon for selfish means.

Older (and perhaps some of the younger) members of today's society no longer desire to suffer and to be kept alive by elaborate and expensive machinery for the sake of purely advancing medical science. It is out of sacrificial love and concern for their loved ones that they desire to cause no more mental anguish and financial strain then necessary. Thus, in essence, they desire to die in peace, and in dignity, because it is the act of dying that these people fear, and not death itself.

From the cross-sectional ideologies expressed by today's society, it is evident that support for indirect euthanasia is more probable than support for the more direct forms of it. This is because more discussions and arguments are being presented by euthanasian advocates on death and dying in

\[1\] J. C. Dougherty, Attorney at Law, Private Interview at 15 Chestnut Street, Atlanta, Georgia, April 28, 1972.
dignity - such that a more favorable atmosphere is steadily being created in support of this phenomenon, as opposed to the negative responses it received by the 1949 members of society.

Thus, as previously stated before, society now recognizes the fact that new legislation is needed to implement and regulate euthanasian practices to prevent its misuse.
CHAPTER V

CONCLUSION: THE RIGHT OF SELF-DETERMINATION

This chapter will attempt to clarify some misconceptions about death and dying. A definition of human existence will also be expounded upon, as well as society's incapability to cope with the reality of death. Death and dying are extremely personal phenomena that we as individuals must face at some time during our lives. Society should not have the right to prescribe to its members how they should and should not die. The individual should have the right of self-determination - the right to create and shape his own destiny.

Societal laws, which are orders of external human conduct, cannot possibly adjudge or even consider all the complex unconscious motivations which prompts action. As pointed out by Freud, "for the practical need of adjudging man's character, the action and the attitude consciously expressed in it are mostly sufficient." When we move from the realm of evaluation to that of prevention, knowledge of unconscious motivations, provided that it reaches a certain degree of generalization may be of great assistance to the legislator in his effort to formulate rules of preventive law. However, adoption of preventive rules, in spite of their great appeal must be considered with utmost caution. We must never lose sight of the fact that these rules tend to interfere with human liberty. The legislator is thus confronted with the difficult task of striking a proper balance between two aims: prevention
of undesirable acts and the preservation of individual freedom.¹

The American culture has adopted a rather conventional view of death such that it is an infringement on the right of life and upon the pursuit of happiness. This same culture places great value on youth, good looks, and health; such that the expectations of a long life is also expressed in funeral customs, which disguises the reality of death, and holds its unchangeable facility at arm's length.² Thus, the American culture inadvertently suppresses the fact and realities concerning death and dying.³

To be human is to be a "multi-dimensional unity," in relation to others, and to be one whose life is marked by a search for community. If a man is defined only as brain and body, his capacity to unify the varied forces and pressures which compete and conflict in him will be diminished. He is not merely body and soul, but the one who unifies, through relationships to others an array of different systems and processes: chemical, biological, psychological, spiritual, and historical.⁴ Thus, to be human is to die. Death is the limiting factor in man's existence, together with the condition of his freedom.⁵

Every day more than 5,000 Americans die. The majority of them are sent to hospitals or institutions where they are processed out of existence with the cool efficiency and emotional detachment that more and more is coming


³Ibid., p. 226.

⁴Ibid., p. 259.

⁵Ibid., p. 262.
to characterize modern life. They are certified, labeled, washed, plugged, wrapped, embalmed, clothed, and groomed by a series of specialists who are well-trained to process mechanically the body, but less skilled in the human aspects of caring for the dying and almost totally unprepared to provide psychological support for the survivors.

Many terminally ill patients and elderly persons are losing the privilege, some say the right, of dying at home. They are no longer the center of attention, in their final days because long before their bodies fail, they are losing their social roles and are removed from their families. They're denied the essential human act of controlling their environment and being the masters of their fate.

Psychiatrists say that man does not know his own death; consciousness ceases and only the living suffer. They theorize that the unconscious mind cannot conceive of one's own death happening naturally. It is always the result of a malicious act performed by someone else; and therefore, associated with guilt and retribution.

Probably for this reason, man always has feared death. Primitive man warded off evil spirits; medievalists danced to discourage the dreaded visitor, and modern man prefers simply to deny death's existence. Death is un-American, an affront to the national spirit of optimism, and the right of health, and the pursuit of happiness.¹

In very recent studies, it has been found that a person who is told he is going to die is likely to go through a series of psychological stages in dealing with that knowledge. At the same time, the feelings of his immediate

family are also to parallel those of the stricken person. Those stages include:

**Denial:** The first reaction to the communication that a person is going to die is a stunned disbelief that this is really happening. Patient and family often refuse to accept what they've been told. They often seek other doctors to refute their doctor's diagnosis.

**Anger:** As the shock begins to wear off, the patient and his family will begin to experience a sense of anger that they have been singled out for such a cruel fate. "Why me?" is their frequent question.

**Bargaining:** Anger tapers off into a stage of contrition. The patient will ask to be allowed to live just long enough to see his daughter married, or his son graduated or to finish the work that was interrupted by his illness.

**Depression:** Patient and family face up to the fact that death really is coming and nothing can stop it. A period of acute depression follows.

**Resignation:** The final stage is reached as death is faced and dealt with. The result is a quiet, dignified acceptance of it. One of the most tragic aspects of dying today is that too few people have any real understanding of the actual mental processes of dying. Armed with that ignorance and propelled by a strong sense of love and loss, they often turn the death of a relative into a form of excruciating emotional torture.¹

Attempts are being made to change death's image from a morbid event with ghoulish overtones to a potentially beautiful experience. Instead of deserting a dying person emotionally long before his biological functions cease, many health care professionals are urging the living, including children, to

understand life's final crisis and share it fully. The patient who is dying wants "freedom" from pain, escape from loneliness, and to be treated with dignity as a person.

Therefore, in view of the above statements, a comprehensive re-evaluation of medical and social ethics are needed to determine the alternatives available to both the patient and doctor in cases of terminal illness.

A comprehensive treatment of the ethics of prolongation of life should include evaluations of (1) euthanasia, deliberate decisions to end the life of the patient by painless and lethal methods, and (2) "anti-dysthanasia," the refusal to prolong death by decisions to suspend supports to life, and withholding interventions.

There exists, in theory and practice, a positive attitude towards deciding not to prolong death unreasonably in incurably ill patient, because there is no law or force of law which requires the prolongation of treatment beyond a point where it would be unreasonable to hope for the patient's recovery.

In conclusion of this paper, I hope that I have contributed a more integrative approach in studying this phenomenon euthanasia. Both positive and negative positions have been presented and it is now left to the reader to decide for himself with whom should the choice of life and manner of death remain? It depends upon each individual to decide on either the acceptance

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3. Fletcher, op. cit., p. 223.
4. Ibid., pp. 235-236.
or rejection of euthanasia. Thus, because of the great complexity of ethics involved, it would be too difficult a task for me to decide if this issue is morally right or wrong - that is why I entitled this paper "Euthanasia: A Moral Dilemma."

It is hoped that the key issues involved with euthanasia have been explained in such a manner as to insure complete comprehension of this phenomenon.

An interpretation of all of the statistical data collected from survey responses will be found in the Appendices.
INTERPRETATION OF STATISTICAL DATA COLLECTED

In Chapter IV, reference was made to three surveys regarding attitudes on euthanasia. The first survey was conducted in 1947 by the gallop pollsters. I thought that it would be interesting to utilize the same survey and circulate it among the Atlanta University faculty as well as student body. Thus, two surveys were conducted to serve the above purpose.

The first survey was conducted during the first semester of 1971. Its purpose was to discover the young adult’s attitude towards euthanasia in comparison with the results obtained from this same survey in 1947. Appendix A is an exact replica of the survey utilized. Appendix B indicates the variables utilized and the possible responses to the question asked. The number of surveys circulated was 221 and only 106 responses were actually received, 115 surveys were never returned by the respondents, therefore, the ratio of usable surveys were 106/221.

Of the three variables utilized in the survey, great emphasis was placed on age. I was interested to see if there would be a change of attitude between young adults (age ranging from 20-30 years of age), the older adults (age ranging from 31-64 years of age) in comparison with the results received in 1947 (Tables 1 and 2 indicate these differences).

Secondary emphasis was placed on the sex variable, such that perhaps sex would affect an attitude regarding euthanasia. Table 3 shows their responses and the totals of the male and female population sampled. According to these responses, sex is not a determining factor, but age is definitely.
### Table 1

**Euthanasia Survey Responses**

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No Opinion</th>
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</thead>
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<tr>
<td>1949 Survey</td>
<td>37%</td>
<td>54%</td>
<td>9%</td>
</tr>
<tr>
<td>1971 Survey</td>
<td>45.28%</td>
<td>47.17%</td>
<td>7.55%</td>
</tr>
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### Table 2

**Euthanasia Survey Responses**

<table>
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<tr>
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<th>Yes</th>
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<th>No Opinion</th>
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<td>1949 Survey</td>
<td>37%</td>
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<td>45.28%</td>
<td>47.17%</td>
<td>7.55%</td>
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<tr>
<td>1972 Survey</td>
<td>60.29%</td>
<td>29.41%</td>
<td>10.29%</td>
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</table>

### Table 3

**Results: Sex Distribution According to Response**

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</thead>
<tbody>
<tr>
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<td>25</td>
</tr>
<tr>
<td>No</td>
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<td>12</td>
</tr>
<tr>
<td>No Opinion</td>
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</table>

Total male population sampled = 65

Total female population sampled = 41

Total sample = 106
Appendix C is an exact replica of the second survey circulated among the Atlanta University Center Faculty during the second semester 1972. Appendix D indicates that the same variables and responses were utilized in its predecessor among the students. The number of surveys circulated was 160, but only 68 responses were actually received, 92 surveys were never returned by the respondents, therefore, the ratio of useable surveys was \( \frac{68}{160} \).

Appendix D also indicates their responses on the issue of euthanasia. I was rather surprised that the rate of non-response was much higher than those of the students, plus the fact that the students were not in favor of euthanasia. Appendix D also indicates the results of the survey on euthanasia, and an extremely positive responses are obtained in comparison with the ones received in 1947 and 1971 (Appendix A indicates these differences).

Table 4 indicates the results of the sex distribution according to response, the sizes of both male and female populations and the size of the total sample.

**TABLE 4**

<table>
<thead>
<tr>
<th>RESULTS: SEX DISTRIBUTION ACCORDING TO RESPONSE</th>
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<tr>
<td><strong>Male</strong></td>
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<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No Opinion</td>
</tr>
<tr>
<td>Total male population sampled</td>
</tr>
<tr>
<td>Total female population sampled</td>
</tr>
<tr>
<td>Total sample</td>
</tr>
</tbody>
</table>
APPENDIX A

SAMPLE SURVEY 1971-ATLANTA UNIVERSITY STUDENTS

Directions:

Please answer the following questions as candidly as possible. The results of your responses will be tabulated and used in a future research project. Please return your responses to:

Miss Marcia Y. Venters
P. O. Box 125
Atlanta University
Atlanta, Georgia 30314

Questions:

1. What is your present age?_____

2. What is your gender?_____Male or_____Female

3. When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?

   Yes_____No_____No Opinion_____

Thank you for your cooperation!
APPENDIX B

RESULTS: 1971 SURVEY ON EUTHANASIA
ATLANTA UNIVERSITY STUDENTS

Variables: Age, Sex and Classification
Responses: Yes, No, or No Opinion

Surveys Circulated: 221
Responses Received: 106
Rate of Non-Response: 115
Ratio Useable: 106/221

Results:
Yes = 45.28%
No = 47.17%
No Opinion = 7.55%
APPENDIX C

SAMPLE SURVEY 1972-ATLANTA UNIVERSITY
CENTER FACULTY

Directions:

Please answer the following questions as candidly as possible. The results of your responses will be tabulated and used in a future research project. Please return your responses to:

Miss Marcia Y. Venters
P. O. Box 125
Atlanta University
Atlanta, Georgia 30314

Questions:

1. What is your present age?_____

2. What is your gender?_____Male or_____Female

3. What is your present occupation?__________________________
(Please specify)

4. When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some means if (painless) the patient and his family request it?

Yes____ No____ No Opinion____

Thank you for your cooperation!

Note:

Please return your responses as soon as possible so that an accurate tabulation can be maintained!
APPENDIX D

RESULTS: 1972 SURVEY ON EUTHANASIA-ATLANTA
UNIVERSITY CENTER FACULTY

Variables: Age, Sex, and Occupation

Responses: Yes, No, or No Opinion

| Surveys Circulated | 160 |
| Responses Received | 68 |
| Rate of Non-Response | 92 |
| Ratio Useable | \( \frac{92}{160} \) |

Results:

Yes = 60.29%
No = 29.41%
No Opinion = 10.29%
BIBLIOGRAPHY

Books


Articles and Periodicals


