

# *Classification of Euthanasia*

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Physicians in the United States have for generation mastered the art of medicine. In contrast, the art of dying, *ars moriende*, has proven to be more difficult for physicians to master and put into practice, in part due to differences of personal beliefs, opinions and philosophies regarding ethical boundaries of life and death.

Every citizen of this great country of ours strives to live a “good life” and hopes to die with dignity a “good death”, or an “easy death”, the latter being a compound of two Greek words *eu* and *thanatos*, referred to in English as euthanasia. The following is a *classification of euthanasia*. There are at least four types of euthanasia, one of which is uniformly illegal, and the other three have varying acceptability.

First, *active euthanasia*, or mercy killing, is illegal in all the United States. One who intentionally ends the human life of another commits a murder. Active euthanasia is an accepted practice with respect to dying animals, but is strictly forbidden in humans. No matter how excruciatingly severe is the pain and suffering of the terminally ill, no other person is allowed to unilaterally terminate the life of the suffering and dying human being, even if the deliberate act is very well intentioned and merciful by either a close relative, friend medical professional. On the other hand, suicide is *not* considered illegal.

Second, *passive euthanasia*, which is legal in all the United States, denotes allowing the informed patient to die a “natural” death, as a consequence of the terminal illness, *without* or with limited and modicum support by the medical professional. Passive euthanasia is based on the concept of “self determination” where every competent adult is free to exercise control over his/her body without intrusion (right to refuse treatment) of the medical profession or the government. The death may not necessarily be a good or easy death. Advanced medical or health care directives, or so-called living wills, are utilized to expressly communicate the patients’ informed and witnessed requests and desires to the medical professionals.

Third, *statutory euthanasia* is legal in only one of the United States, Oregon. Here, the terminally ill patients take intentional active measures to end their lives prematurely (i.e. suicide), assisted by physicians, hence the term *physician-assisted suicide*, which is illegal in states other than Oregon. The term *statutory euthanasia* is less charged and ethically, morally and politically correct. The purpose of statutory euthanasia is preventative in nature, in that the intent of the dying patient is to avoid the pain and suffering of the terminal illness. The assistive role of the physician is to provide the dying patient with the medical knowledge, expertise, and compassion in accomplishing the drastic and deadly task.

Recently, the U.S. Supreme Court<sup>1</sup> dealt with the role of the physician in the care of patients at the end of life, and the control of medical practice by the State. The Court demonstrated respect for medical decision making and professional self-regulation. It held that the 1970 Controlled Substances Act (CSA) did not allow the Attorney General to declare illegitimate a medical standard for patient care and treatment which is specifically and statutorily authorized by the Oregon Death with Dignity Act, and that the CSA allows prescriptions for currently accepted medical uses and for legitimate medical purposes. In Oregon, therefore, the physician is permitted under strict scrutiny and statutory regulation to assist a competent terminally ill patient to permanently end his or her suffering, without fear of criminal prosecution.

Fourth, *legitimate medical euthanasia* is legal in all the U.S. It is based on the doctrine of “dual-effect”, and concerns the use of *lethal dosing*, or terminal sedation, by some medical professionals when practicing the art of dying, *ars moriende*. In 1997, the U.S. Supreme Court<sup>2,3</sup> stated that the administration of terminal sedation, i.e. lethal dosing, to a competent, terminally ill patient by the physician, which by its “dual effect” may hasten the patient’s death, is both ethical and legal as long as the terminal treatment is intended to relieve the pain and suffering of an agonizing terminal illness. Arguably, the terminal sedation or lethal dosing in some cases may represent active euthanasia or physician-assisted suicide. Nevertheless, lethal dosing is ethical and legal as long as a physician truthfully claims that the intent of the medical treatment is to relieve the pain and suffering and not to hasten death or kill.

It is incumbent upon physicians to master the *ars moriende*, the art of dying, and to provide the terminally ill with the choice of a good and easy death, so long as the potent medications prescribed are (1) for a currently accepted medical use and (2) for a legitimate medical purpose. Physicians across our nation are increasingly, although gradually, becoming familiar and comfortable in prescribing *lethal dosing* to the suffering and dying patients. Lethal dosing, which has been accepted by the medical profession, and is legal according to the U.S. Supreme Court, involves the administration to the terminally ill patient of increasing doses of painkiller, intended to relieve pain but knowing that it will probably hasten death. The role of the physician in practicing *ars moriende* is pivotal in achieving the desired dignified, good and easy death of the terminally ill patient.

Death, which will happen to all of us, need not be feared but celebrated. Death is indeed a part of our life cycle. Generally, it is the culmination and termination of a good life, and it could be both joyous and sad. The joy is the celebration of the lifetime achievement. Sadness should not have a monopoly on death, though it plays an important role in the process of healing and closure.

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<sup>1</sup> *Gonzales v. Oregon*, 126 S Ct 904 (2006)

<sup>2</sup> *Washington v. Glucksberg*, 117 S Ct 2258 (1997)

<sup>3</sup> *Vacco v. Quill*, 117 S Ct 2293 (1997)