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Public opinion polls conducted from 1936 to 2002 found that Americans support both euthanasia and physician-assisted suicide. Although public opinion regarding end-of-life decisions appears to have been influenced by the events of the times, Americans have consistently favored the freedom to end one's life when the perceived quality of life has significantly diminished, either by one's own hand or with the assistance of a physician. This paper indicates that existing policy regarding euthanasia and physician-assisted suicide conflicts with the American public's attitudes regarding the matter, as well as examines implications for social workers who serve clients facing end-of-life decisions.

Keywords: euthanasia, end-of-life decisions, physician-assisted suicide, death and dying issues

The concept of euthanasia inevitably provokes a moral dilemma for many Americans, because euthanasia gives individuals the freedom to choose whether to live or die. This article examines the opinions of a cross-section of the American public concerning the ethics of death and dying, attitudes toward euthanasia and physician-assisted suicide, and a patient's right to forego life-sustaining treatment. Before we interpret the results of studies on these issues, we briefly present definitions, discuss religious perspectives, and examine the history of euthanasia.

Euthanasia has been debated for many centuries. Two factors that have contributed to euthanasia's prominence in

modern culture are both an increasing sense of self-determinism and medical innovations that have the potential of substantially prolonging human life (Loewy & Loewy, 2000). Our findings indicate that existing policy regarding euthanasia and physician-assisted suicide unquestionably contradict the American public's attitudes regarding the matter.

To clarify essential terms, "passive euthanasia" is the withholding or withdrawal of artificial life support or other medical treatment and allowing a patient to die. "Physician-assisted suicide" refers to a physician's provision of the means (such as medication or other interventions) of suicide to a competent patient who is capable of carrying out the chosen intervention. With "active voluntary euthanasia," a physician administers a lethal dose of medication to a competent person who explicitly requests it. "Involuntary euthanasia" involves the intentional administration of medication or other interventions to cause a competent person's death, without informed consent or an explicit request. "Non-voluntary euthanasia" involves ending the life of an unwilling individual (i.e., a death sentence) or mentally incompetent person who is unaware of what is happening (Csikai, 1999). The decision to end life in the ways that the first two terms imply is often based on the judgment of disproportionate burden, that is, the judgment that treatment will be useless, cause the patient more pain and suffering, or not restore the patient to an acceptable quality of life (Vose & Nelson, 1999).

Literature Review

Religion and Culture

As Miller, Hedlund, and Murphy (1998) note, euthanasia is a significant factor in the religious beliefs and spiritual values of people worldwide. However, various cultures and religions view euthanasia and assisted suicide differently. The ancient Greeks believed it was morally acceptable to end one's life if one no longer considered one's life to be worthwhile (Snyder, 2001). This belief is similar to that of the Irish culture, in which death is often the most celebrated experience of the life cycle (Miller et al., 1998).

Christians also have a wide range of perspectives on eu-

thanasia. Some believe that it is acceptable to advocate for euthanasia, whereas others oppose the idea that individuals can choose to die (Darr, 2002). According to traditional Christian philosophy, euthanasia was considered immoral until recently and was universally condemned in all societies with Christian traditions. This philosophy held that even what may be considered a worthy end (i.e., the termination of pain and suffering) never justifies immoral or unethical means (Thorton, 1997). Some Catholics have argued that there is no moral difference between allowing someone to die and causing death by interfering with the biological process since the end result is the same (Heifetz, 1992). Similarly, Muslims believe that only Allah has the right to end life; both Hindus and Buddhists teach respect for life and the belief that euthanasia is an interruption of karma; Jews and Christians base their objections on the Biblical commandment, "Thou shalt not kill."

Despite religion's deep traditional opposition to euthanasia, some exceptions have been allowed. For example, in 1957 Pope Pius XII stated that if a patient is hopelessly ill, a physician may discontinue heroic measures, and, if the patient is unconscious, relatives may request the withdrawal of life support (Snyder, 2001). Similarly, many Protestants believe there is a choice in the matter, and some Jews believe that the withdrawal of artificial life support is permissible and that the patient's wishes are of primary importance (Darr, 2002).

Physicians and Organizations

A number of physicians oppose the practice of euthanasia and, instead, advocate pain-management techniques. Orr (2001) proposes that effective end-of-life care is an alternative to euthanasia and argues that patients who receive quality end-of-life care rarely request that their lives be ended. Despite this compelling argument, the literature suggests that some patients may still prefer their right to choose death. For example, Keown (2002) details the case of Ms. B, a quadriplegic who was denied the right to withdraw the assistance of her ventilator, who sued the hospital for unlawful treatment and won the right to end her life.

The Hemlock Society advocates the legalization of euthanasia (Snyder, 2001). This organization believes that the final

decision to terminate life ultimately is one's own, although it does not encourage suicide for emotional, traumatic, or financial reasons, or in the absence of terminal illness. Conversely, the National Hospice Organization supports a patient's right to choose, but believes that hospice care is a better choice than euthanasia or assisted suicide (Snyder, 2001).

Political Factors

The moral and political dilemmas of euthanasia date back to at least 400 B.C., with the Hippocratic Oath which states, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." Condemnations of euthanasia have additionally existed in English Common Law for over 700 years (Sarton, 1952). However, assisted suicide gained increasing public support beginning in the 1900s, a growth that was later dashed when reports of forced euthanasia in Nazi Germany surfaced. In these cases, adults and children who demonstrated symptoms of mental retardation, physical deformity, or other "inferiorities" were deemed "life unworthy of life" (Finkel, Hurabiell, & Hughes, 1993; Röder, Kubillus, & Burwell, 1995).

In the United States, euthanasia became a contested issue early in the 20th century. In 1906, the first bill to legalize voluntary euthanasia was introduced in the Ohio legislature but failed to pass. However, in 1914, the common-law right to self-determination gave individuals the right to refuse or stop treatment (McCormack, 1998). In 1936, the Gallup Organization administered its first nationwide survey on the subject and found that about half the American population favored mercy deaths under governmental supervision (Worsnop, 1997).

Politically, a myriad of reasons have been offered to support the right to die: the preservation of dignity, privacy, autonomy, self-determination, the liberty interests of the Fourth Amendment, and the reduction of degradation (Finkel et al., 1993). Although the judicial system has labeled euthanasia a crime, both the courts and the medical community seem well aware that a slippery slope exists between passive and active euthanasia. For example, whereas "pulling the plug" under the right circumstances has been viewed as passive euthanasia, ending artificial nutrition (removing a G-tube) has been linked

to "intentional killings" (Finkel et al., 1993). In addition, it has been suggested that there is more controversy surrounding active euthanasia than passive euthanasia because individuals are inclined to view removing treatment as worse than omitting treatment, thus favoring probable death associated with passive euthanasia over certain death associated with active euthanasia (Begley, 1998).

In 1991, Congress enacted the Patient Self-Determination Act, requiring all federally funded hospitals to advise patients about advance directives, living wills, and power-of-attorney declarations. This requirement has not been construed as a federal endorsement of euthanasia but, rather, as the provision of insights into a patient's wishes if the patient becomes incompetent or comatose.

It was perhaps not until 1990 that euthanasia became an issue of keen national debate, largely because of media attention generated by Dr. Jack Kevorkian (Csikai, 1999). On June 4, 1990, Jane Adkins, an Oregon woman in the early stages of Alzheimer's disease, killed herself with the help of a suicide machine devised by Kevorkian. Kevorkian faced murder charges stemming from his involvement in this situation, but the charges were subsequently dropped. In 1995, Oregon legalized the practice of euthanasia in response to a referendum it held in 1990. However, the practice was quickly made illegal after the law was challenged. The challenge is currently pending (Webb, 2000).

Soon after, the U.S. Supreme Court ruled that a person whose wishes were clearly known (i.e., had a "living will") has the right to refuse life-support treatment. Many states, for example, now permit living wills, surrogate healthcare decision-making, and the withdrawal or refusal of life-sustaining medical treatment (Balch, 2001). The legal controversy regarding physicians' involvement in their patients' end-of-life decisions touches people of all ages.

Previous Research

According to a study of the opinions of high school students, physician-assisted suicides that are thoroughly discussed with the patients are deemed more moral, acceptable, and "legal" than are assisted suicides that are merely accepted

or actively encouraged by physicians. Also, the presence of both physical and mental pain in a patient makes the patient's death more acceptable (Kaplan & Bratman, 1999). Wooddell and Kaplan (1999) found that the interaction among the physician, patient, and, to a lesser extent, the active and passive nature of the agent of death were more important than were a physician's actual actions in allowing or causing death to occur. It is interesting that the respondents tended to view the death of patients of the opposite gender as more acceptable than that of patients of the same gender.

Lachenmeier, Kaplan, and Caragacianu (1999) found that adults held similar views regarding euthanasia. That is, 6 in 10 adults would consider physician-assisted suicide if they were on life support or experiencing chronic pain; 50% would do so if they experienced a loss of mobility or independence, became a burden to others, or were diagnosed with a terminal disease; and 3 in 10 would do so if they were confined to a nursing home. Interestingly, the highest support for physician-assisted suicide occurred among Caucasian men, aged 50-55, who had some college education, had yearly incomes of \$35,000-\$60,000, and were Democrats, Protestants, and infrequent church attendees.

As euthanasia is examined from a variety of different standpoints, the patients' personal convictions must be considered. Physicians were asked why they thought patients request assistance to die. Their responses fell into the following categories: fear of uncontrollable symptoms (52%), actual pain (50%), loss of meaning of life (47%), loss of dignity (43%), being a burden (34%), and dependence (30%) (Stauch, 2000).

Bioethics

In 1997, the Institute of Medicine convened a panel to specifically examine questions related to end-of-life issues within the context of cultural diversity. Over the past three decades, end-of-life decision-making has been a focus of the field of bioethics. According to Field and Cassel's (1997) Institute of Medicine report, American medicine has failed to recognize the existence of the dying patient and has assumed that death is a medical problem that can be resolved using current technologies. The consideration of cultural differences

in bioethical practices surrounding death is an important area of inquiry because decision-making on end-of-life issues is made more complex by the diversity of the professionals and staff workers in long-term care facilities, hospitals, and nursing homes.

According to Field and Cassel (1997), end-of-life decisions are based on an orientation to the future and openness about discussing death, cultural conceptions of personhood and the self, the location of an individual within a social group, and feelings of appropriate behavior by healers. A potential patient for the limitation or withdrawal of unwanted therapy generally displays the following characteristics: (1) a clear understanding of the illness, prognosis, and treatment options that is shared with the members of the healthcare team; (2) a temporal orientation to the future and a desire to maintain "control" into that future; (3) the perception of freedom of choice; (4) a willingness to discuss the prospect of death and dying openly; (5) a balance between fatalism and a belief in human capacity that favors the latter; (6) a religious orientation that minimizes the likelihood of divine intervention (or other "miracles"); and (7) an assumption that the individual, rather than the family or other social group, is the appropriate decision maker (Field & Cassel, 1997). Ideally, healthcare providers offer patients choices regarding end-of-life decisions, rather than dictate answers, after they present information or scientific facts about the patient's prognoses. Since every end-of-life situation is unique, it is difficult for a scientific article such as this to discuss "ethics" in the broad sweep, considering that family, physicians, personal wishes, and religion all play a role in each individual's situation.

Method

The findings of this paper are based upon published public opinion polls from the Gallup Organization and *Public Opinion Quarterly*. Polling organizations use similar sampling techniques. For example, the standard Gallup sample consists of 1,000 face-to-face and telephone interviews. The sample design for face-to-face surveys is a replicated area-probability sample that selects subjects based on demographics from the block level in urban areas and segments of townships in rural

areas. After stratifying the nation geographically and by the size of the community, according to information derived from the most recent census, more than 350 different sampling locations are selected on a mathematically random basis from within cities, towns, and counties that have, in turn, been selected on a mathematically random basis. A more detailed discussion of this sampling procedure can be found in Gallup Organization (1996).

The Study

Questions

This article further evaluates Americans' attitudes toward euthanasia by examining the following questions: What are Americans' attitudes toward voluntary euthanasia, physician-assisted suicide, foregoing life-sustaining treatment, and end-of-life decisions? The answers to these questions should reflect the change in public sentiment toward euthanasia and physician-assisted suicide over the past 8 decades.

Findings

Attitudes toward voluntary euthanasia

As a social issue, euthanasia has generated both intense public debate and ever-changing public policy. From 1936 to 2002, a cross-section of the American public was asked the following question (see Table 1): "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?"

From 1936 to 2002, the number of Americans who supported voluntary euthanasia varied, but overall, support increased. From 1936 to 1950, voluntary euthanasia was supported by less than a majority of Americans, perhaps because of the atrocities of World War II (Finkel et al., 1993). However, after 1950, support for euthanasia rose to over a majority and has maintained this level of support to the present. From 1973 to 2002, a consistent majority of those polled supported voluntary euthanasia, perhaps because many Americans' political and moral beliefs were influenced by both a generally pro-euthanasia media as well as public statements on end-of-life matters by significant religious leaders, most notably Pope

Pius XII's 1957 proclamation. Another possible explanation for the increase in support for voluntary euthanasia was the prominence of the Kevorkian case (Gillespie, 1999).

Table 1
Attitudes Toward Voluntary Euthanasia, 1936–2002^a

Year	Yes	No	No Opinion
1936	46	54	0
1939	46	54	0
1947	37	54	9
1950	36	64	0
1973	53	NA	NA
1977	60	36	4
1978	58	38	4
1980	65	NA	NA
1982	61	34	5
1983	63	33	4
1985	64	33	3
1986	66	31	4
1986	75	NA	NA
1986	69	NA	NA
1988	66	29	5
1989	66	30	4
1990	69	26	5
1991	70	25	5
1997	58	37	5
1997	57	33	8
1998	59	39	2
1999	61	35	4
2001	65	NA	NA
2002	72	NA	NA

Question: "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?"

^aData reported twice in one year indicate that the question was asked twice in that year. Figures may not total 100% because of rounding.

Source: Poll data compiled by Benson (1999), Blizzard (2002), Gallup (1972a, 1972b), Gillespie (1999).

The personal stories of the individuals whose lives Kevorkian helped to end may have served to increase sympathy for euthanasia, and this national attention may have prompted many Americans to reexamine and perhaps alter their views on euthanasia. For example, Dutch citizens have widely accepted voluntary euthanasia, and the Dutch government legalized the practice in 2002 (Blizzard, 2002).

Attitudes toward physician-assisted suicide

From 1990 to 1998, a cross-section of the American public was asked the following question (see Table 2): "If a person has a disease that will ultimately destroy their mind or body and they want to take their own life, should a doctor be allowed to assist the person in taking their own life, or not?"

Table 2

Attitudes Toward Physician-Assisted Suicide, 1990–1998^a

Year	Should Be Allowed	Should Not Be Allowed	No Opinion
1990	51	44	5
1991	53	39	9
1993	50	47	3
1993	58	36	6
1998	52	44	4
1998	52	37	11

Question: "If a person has a disease that will ultimately destroy their mind or body and they want to take their own life, should a doctor be allowed to assist the person in taking their own life, or not?"

^aData reported twice in one year indicate that the question was asked twice in that year. Figures may not total 100% because of rounding. Trend data are not available before 1990.

Source: Poll data compiled by Benson (1999).

Recently, the debate has been whether the right to self-determination is the right to die, as well as the right to death through physician-assisted suicide. Stemming from this debate is the

belief that because no difference exists between letting someone die and killing him/her, patients must have the right to refuse or to receive treatment that would prolong their lives (Van Zyl, 2000).

Physician-assisted suicide is viewed as one of the most controversial types of euthanasia because it violates the Hippocratic Oath. Physician-assisted suicide literally means that the physician provides the means (i.e., medication) for suicide to a competent patient who is capable of carrying it out. Attitudes toward physician-assisted suicide were remarkably consistent during the period under study with only slight variation. During these years, those who agreed that physician-assisted suicide should be allowed were invariably in the majority.

Attitudes toward foregoing life-sustaining treatment.

From 1973 to 1991, a cross-section of the American public was asked the following question (see Table 3): "All doctors take an oath saying they will maintain, restore, and prolong human life in their treatment of patients. It is now argued by some people that in many cases people with terminal diseases (those that can end only in death) have their lives prolonged unnecessarily, making them endure much pain and suffering for no real reason. Do you think a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight, or do you think this is wrong?" (Benson, 1999).

From 1973 to 1991, the proportion of individuals who agreed that patients with terminal diseases should be allowed to forego life-sustaining treatment ranged from 62% to 85%. A possible explanation may be that more people than ever were suffering from painful terminal illnesses, such as cancer and AIDS, and more people were aware of how much suffering those with terminal diseases endured. A possible reason for the steady increase in support for euthanasia from 6 in 10 to 8 in 10 by 1991 is that medical technology had improved dramatically and Americans reasoned there was less need for euthanasia, as it would likely only occur in rare circumstances when a patient was truly terminal.

Table 3

Attitudes Toward Forgoing Life-Sustaining Treatment, 1973–1991^a

Year	Let Die	Wrong	Not Sure
1973	62	28	10
1977	71	18	11
1981	78	19	3
1982	68	20	11
1985	85	13	2
1987	84	13	3
1991	81	8	11

Question: "All doctors take an oath saying they will maintain, restore, and prolong human life in their treatment of patients. It is now argued by some people that in many cases people with terminal diseases (those which can only end in death) have their lives prolonged unnecessarily, making them endure much pain and suffering for no real reason. Do you think a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight, or do you think this is wrong?"

^a Figures may not total 100% because of rounding.

Source: Poll data compiled by Benson (1999).

Attitudes toward end-of-life decisions

With the graying of the baby-boom generation, end-of-life decisions are likely to remain a public issue for many years to come (Benson, 1999). A key component in any shift in public policy toward end-of-life decisions is how Americans perceive death. Between 1977 and 1998, a cross-section of the American public was asked the following question (see Table 4): "Do you think a person has the right to end his or her own life if this person has an incurable disease?"

By 1998, over 6 in 10 respondents believed that a person had a right to end his or her life if that person had an incurable disease (Benson, 1999). Consistent with these findings, from 1977 to 1998, support for euthanasia in the case of terminal

illness was favorably reported in the media and the political arena (Benson, 1999).

Taken as a whole, the trend data show a growth of support for various consensual practices that result in the death of terminally ill patients. One third to nearly two thirds of Americans have supported some form of end-of-life decision. Overall, since 1986, a majority of Americans believed that euthanasia should be allowed when a person has an incurable disease.

Table 4

Attitudes Toward End-of-Life Decisions, 1977–1998^a

Year	Should Be Allowed	Should Not Be Allowed	Don't Know
1977	38	59	3
1978	38	58	3
1982	45	50	5
1983	48	48	4
1985	44	53	3
1986	52	45	3
1988	50	46	4
1989	47	49	5
1990	56	38	6
1991	57	40	3
1993	57	39	5
1994	62	34	5
1996	61	34	5
1998	61	35	5

Question: "Do you think a person has the right to end his or her own life if this person...has an incurable disease?"

^a Figures may not total 100% because of rounding.

Source: Poll data compiled by Benson (1999).

Discussion

This examination of national poll data on the American public's attitudes toward euthanasia has revealed some striking trends. As Table 1 indicates, from 1936 to 1950, only 4 in 10 Americans believed that voluntary euthanasia should be

allowed for an individual with an incurable disease, even if the patient and the family requested it. Although we report data from 1936 to 2002, it was not until 1973 that fully a majority of Americans supported euthanasia.

From 1973 to 2002, the percentage of people who supported voluntary euthanasia varied, but overall support increased from over one half to fully three fourths of Americans surveyed. The concern about voluntary euthanasia, heightened by the events of World War II, may have led to opposition of euthanasia from 1936 to 1950. As is evident in Table 2, from 1990 to 1998, a consistent majority of respondents accepted physician-assisted suicide. Furthermore, as Table 3 indicates, from 1973 to 1991, during this period foregoing life-sustaining treatment became the most acceptable form of euthanasia. The acceptance of this course of action increased from 6 in 10 to fully 8 in 10 Americans. These findings dovetail neatly with the findings in Table 4, showing that from 1977 to 1998, an increasing proportion of Americans thought that life-and-death decisions should be allowed. This cross-section of the American public's views regarding euthanasia is at odds with current official policies regarding the matter: contemporary attitudes grow increasingly pro-euthanasia, while policy on the issue is not evolving to permit euthanasia as a legal practice. Over 50 years ago, opinions on life and death decisions were more closely aligned with official policy on the issue. In recent years, however, our findings indicate that official policy has not caught up with the growing pro-euthanasia views reported in public opinion polls.

In addition, a 1999 Gallup poll showed that 61% of Americans believed that physicians should be allowed to help terminally ill patients in severe pain commit suicide. These results were consistent with those of Gallup polls over the previous two years, in which 6 in 10 Americans approved of the concept of physician-assisted suicide (Gillespie, 1999). Many may speculate about the reasons for these statistics. One explanation could be the increase in education and awareness of advances in both medical technology and research on various chronic diseases. Americans are also more aware of the devastating psychological effects of disease on a person's overall well being; therefore, they may be more willing to make informed

decisions on end-of-life care. With this new knowledge, they may emphasize that sometimes the best option for a terminally ill patient is physician-assisted suicide or some other form of euthanasia.

Americans are far more reluctant to consider the idea of suicide as a way to end the pain of a terminal illness. Only 40% of those polled said they would consider committing suicide if they were terminally ill. On the other hand, 52% of those who were questioned approved of Kevorkian's involvement with the death of a Michigan man (Gillespie, 1999); of those who supported Kevorkian, 63% considered themselves liberal while 39% considered themselves conservative.

In line with this more recent poll, Americans who reported that physician-assisted suicide should be legal rose from 37% in 1947 to 61% in 1999 (Benson, 1999). Yet, the 1999 survey showed that fewer people would choose that course for themselves. An equal proportion (40%) said they would consider suicide if they were dying and in great pain and, in addition, they would help a terminally ill family member kill himself or herself (Benson, 1999).

Implications

Social workers face many ethical dilemmas concerning euthanasia and physician-assisted suicide and should be familiar with the social problems and concepts related to both, as well as shift in public opinion over time. If the number of individuals who believe that euthanasia and physician-assisted suicide is acceptable is increasing, it is likely that the number of cases of end-of-life decisions that social workers will encounter will also increase. Respect for personal choices and individual differences is the most important issue for social workers to keep in mind when their clients and clients' families are making decisions in regard to euthanasia.

The National Association of Social Workers (NASW) provides an ethical framework for the dilemmas a social worker may face based on the core values of service, social justice, dignity and self-worth, importance of human relationships, integrity, and competence. According to the Code of Ethics (NASW, 1999, section 6.01), social workers "should advocate for living conditions conducive to the fulfillment of

basic human needs." Therefore, from an ethical standpoint, social workers should be prepared to give patients information about pain-management techniques. In addition, they can provide assistance for terminally ill patients by helping them recognize the meaning of life and that they have control over the circumstances related to death and the commemoration to follow. As the NASW (1999) advises, social workers can be influential in informing the general population about end-of-life decisions by thinking the decisions through with them and helping their clients prepare advanced directives. America's diverse ethnic groups confront death and dying in markedly different ways. Because of this lack of a single approach to understanding and dealing with death (Rosenblatt, 1993), social workers must then approach each individual case with a fresh perspective. Educating patients on their available choices enhances their capacity to address their own needs when they suffer from a life-threatening illness.

Furthermore, although the NASW policy statement, "Client Self-Determination in End-of-Life Decisions," observes that social workers may counsel terminally ill clients regarding physician-assisted suicide, this policy is in conflict with most state laws that prohibit social workers from advising their clients in this matter. This policy statement does not provide guidance on when social workers should become involved or under what circumstances and for how long they should intervene in cases involving terminal illness. The policy also neglects to mention that providing advice on physician-assisted suicide constitutes an offense as defined in most state laws. Because laws regarding physician-assisted suicide change so frequently, it is critical that social workers be aware of the current state legislation (Manetta & Wells, 2001). This difference in policies and practices may complicate the work of conscientious social workers, since social workers can expect situations to arise for which the law does not provide clarity or leeway (Keigher, 2001). Moreover, the NASW policy statement does not provide guidance regarding the conditions under which a social worker should become involved with a terminally ill client.

Some practice techniques indicate that social workers should be cognizant of the fact that empathy is a critical tool

in dealing with clients who are confronted with the moral dilemma of euthanasia, which opens up such issues as human rights, familial responsibility, and moral decency (Leichtentritt & Rettig, 1999, 2001). Furthermore, they should be aware that end-of-life decisions affect all populations. Active communication among fellow professionals will facilitate the development of more effective and useful policies on this issue. This communication will also help to ensure that clients' values are respected and that decisions concerning life and death are made responsibly.

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