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Journal Title: Annals of internal medicine.

Volume: 121 **Issue:** 10

Month/Year: 11-15-94**Pages:** 793-802

Article Author: Emanuel, Ezekiel

Article Title: The history of euthanasia debates in the United States and Britain.

ISSN: 0003-4819

ILL Number: 97325274



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The History of Euthanasia Debates in the United States and Britain

Ezekiel J. Emanuel, MD, PhD

■ Debates about the ethics of euthanasia and physician-assisted suicide date from ancient Greece and Rome. After the development of ether, physicians began advocating the use of anesthetics to relieve the pains of death. In 1870, Samuel Williams first proposed using anesthetics and morphine to intentionally end a patient's life. Over the next 35 years, debates about the ethics of euthanasia raged in the United States and Britain, culminating in 1906 in an Ohio bill to legalize euthanasia, a bill that was ultimately defeated.

The arguments propounded for and against euthanasia in the 19th century are identical to contemporary arguments. Such similarities suggest four conclusions: Public interest in euthanasia 1) is not linked with advances in biomedical technology; 2) it flourishes in times of economic recession, in which individualism and social Darwinism are invoked to justify public policy; 3) it arises when physician authority over medical decision making is challenged; and 4) it occurs when terminating life-sustaining medical interventions become standard medical practice and interest develops in extending such practices to include euthanasia.

Ann Intern Med. 1994;121:793-802.

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In the midst of divisive public debates, we frequently look to history and past epochs to gain guidance and understanding, to explore the genesis of our ideas and practices, and to critically compare them with alternatives. In the debate over euthanasia, commentators have examined ancient Greece and Rome, where "many people preferred voluntary death to endless agony. This form of 'euthanasia' was an everyday reality . . . [and] many physicians actually gave their patients the poison for which they were asked" (1-5). For instance, "the Stoic founder, Zeno committed suicide in his old age prompted by the agonizing pain of a foot injury" (3). Pliny the Younger, whose letters recorded the details of everyday life in first-century Rome, described a typical case:

[Titius Aristo] has been seriously ill for a long time . . . He fights against pain, resists thirst, and endures the unbelievable heat of his fever without moving or throwing off his coverings. A few days ago, he sent for me and some of his intimate friends, and told us to ask the doctors what the outcome of his illness would be, so that if it was to be fatal, he could deliberately put an end to his life (6).

This widespread acceptance of euthanasia in ancient Greece and Rome was challenged by the minority of physicians who were part of the Hippocratic school and had pledged "never [to] give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect" (1-4). The ascent of Christianity, with its view that man's life was a trust from God, reinforced the Hippocratic position on euthanasia (2, 4, 5) and culminated between about the 12th and 15th centuries in the consistent opposition to euthanasia among European physicians (2). There has also been extensive study of euthanasia in 20th-century Germany (7-11). Both proponents and opponents of euthanasia and physician-assisted suicide have frequently cited these historical examples in support of their positions (12-15).

Yet, ancient Greece and Rome and 20th-century Germany are of limited relevance in helping us to understand contemporary U.S. debates about euthanasia. Ancient Greece and Rome were pagan societies with slaves and cultural values that celebrated aristocratic and martial virtues; they also had no well-developed medical professions. Germany in the early 20th century considered the "Volk" more important than the individual and had no democratic tradition. Such differences between these societies and our own minimize their usefulness in illuminating contemporary interest in euthanasia.

Little known and studied, however, are the debates on euthanasia and physician-assisted suicide that occurred in the United States and Britain during the late 19th and early 20th centuries (16, 17). Given the continuity of cultural traditions and political values between this era and our own and the fact that organized medicine originated in that period, examination of these past debates on euthanasia may help illuminate the justifications currently offered for euthanasia and arguments against it.

Early Modern Discussions of Euthanasia

Possibly the first reference to euthanasia in the English literature was made in 1516 (16) when Sir Thomas More wrote in *Utopia*:

They console the incurably ill by sitting and talking with them and by alleviating whatever pain they can. Should life become unbearable for these incurables the magistrates and priests do not hesitate to prescribe euthanasia . . . When the sick have been persuaded of this, they end their lives willingly either by starvation or drugs, that dissolve their lives without any sensation of death. Still, the Utopians do not do away with anyone without his permission, nor lessen any of their duties to him (18).

In the 17th century, Francis Bacon extended his belief that science should help relieve man's estate by arguing that the physician's duty was to "not only restore the

health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve a fair and easy passage" (19). Over the next 200 years, as part of a general attack on religious authority, writers such as John Donne, Montesquieu, and other English and French philosophers attacked prohibitions against suicide (16). Although they did not explicitly advocate euthanasia, the arguments they invoked could have been extended to justify this practice. For instance, David Hume wrote an essay titled "On Suicide," in which he argued "that Suicide may often be consistent with interest and with our duty to ourselves, no one can question, who allows that age, sickness, or misfortune, may render life a burden, and make it worse even than annihilation" (20).

Although intellectuals voiced interest in euthanasia and suicide, "there does not seem to have been any impact on medical practice" or any stimulation of a broader, sustained public interest in these topics; they did not resonate with public attitudes and seem to have had no practical repercussions (16).

Anesthesia and Proposals for Euthanasia

The 19th century witnessed a revolution in the use of anesthesia (16, 21). Morphine was isolated early in the century. In 1846, John Warren did the first operation with ether anesthesia (Figure 1). In 1848, Warren published *Etherization; With Surgical Remarks*, in which he suggested that ether might be used "in mitigating the agonies of death" (22). He described etherizing a 90-year-old woman to treat the "pain of mortification . . . [and pain] of the abdomen with convulsive twitchings of the limbs . . . with perfect relief." During the U.S. Civil War, physicians became more experienced in the use of hypodermic morphine to relieve pain and this practice spread (16, 21). In 1866 in the *British Medical Journal*, Joseph Bullar reported using chloroform to palliate pain during the deaths of four patients (23). Warren and Bullar never recommended using ether, chloroform, or morphine to end a patient's life but only to relieve "the pains of death" (22).

However, just as physicians deemed the use of narcotics and anesthetics for pain relief (21) appropriate medical practice and began endeavoring to study "the management of the dying [and] the treatment best adapted to the relief of the sufferings" (24), the discussion changed significantly. In 1870, a nonphysician, Samuel D. Williams, addressed the Birmingham Speculative Club on the topic of euthanasia (25). Going beyond the suggestions of Warren and Bullar, Williams advocated the use of chloroform or other medications not just to relieve the pain of dying, but to intentionally end a patient's life:

The main object of the present essay being merely to establish the reasonableness of the following proposal:—That in all cases of hopeless and painful illness, it should be the recognized duty of the medical attendant, whenever so desired by the patient, to administer chloroform or such other anaesthetic as may by-and-by supersede chloroform—so as to destroy consciousness at once, and put the sufferer to a quick and painless death; all needful precautions being adopted . . . to establish, beyond the possibility of doubt or question, that the remedy was applied at the express wish of the patient (25).

Such an isolated speech, made before a provincial club by a relatively obscure person, might have vanished un-

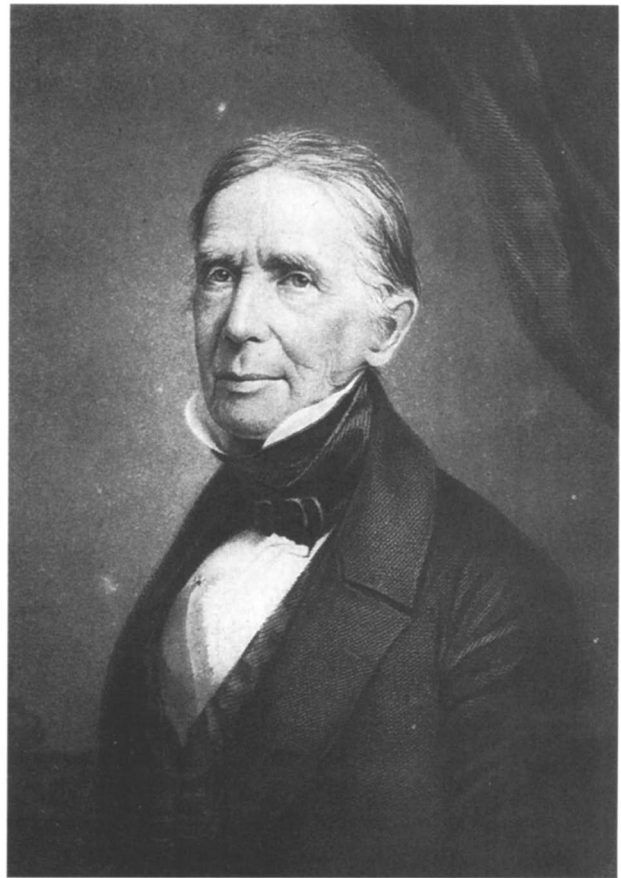


Figure 1. Dr. John C. Warren, Professor of Surgery, Harvard Medical School, author of *Etherization; With Surgical Remarks*. (Courtesy of the Boston Medical Library.)

noticed from the public arena, like the suggestions of More and Bacon. Williams's speech, however, was not ignored. It was reprinted as a book in 1872 (25) and favorably reviewed and quoted at length in the widely circulated *Popular Science Monthly* (26). Williams's arguments were praised by the most prominent British literary and political journals of the day (27–30) as "remarkable" for their "considerable ingenuity" and "plausibility." Yet, many of these journals rejected his views because "so great would be the danger that such a practice would be abused" (28).

Williams's proposal seemed to touch a deep but unarticulated view. The latter third of the 19th century in Britain and the United States is now known as the Gilded Age and was characterized by an individualistic conservatism that praised laissez faire economics, scientific method, and rationalism and opposed authority, reverence for tradition, and sentimental attachments. It was a time of industrialization, intense corporate competition, and unprecedented strikes and clashes between labor unions and the corporations trying to crush them. It was also a time in which free market policies caused wild economic oscillations and major depressions were sparked by the panic of 1873, the droughts of the 1880s, and the stock market crash of 1893. This raw individualism, economic competition, and rationalism was reinforced and sanctioned by appeals to Darwinism (31). After publication of *Origin of Species* in 1859, intellectuals rushed to incorporate Darwinism into their theories; Darwin's book

gave the imprimatur of rigorous science to sociology, economics, and other disciplines. Primarily through the work of Herbert Spencer in Britain and William Graham Sumner in the United States, the concepts of "survival of the fittest" and "struggle for existence" became "the store of ideas to which solid and conservative men appealed when they wished to reconcile their fellows" to the practices and hardships associated with the era's individualism and laissez faire policies (31-33). As one historian said, social Darwinism "serves students of the American mind as a fossil specimen from which the intellectual body of the period [1870-1900] can be reconstructed" (31).

19th Century Physicians and Euthanasia

Publication of Williams's euthanasia proposal prompted much discussion within the medical profession. The *Medical and Surgical Reporter* ran an article in 1873 that asked "Whether, when a patient is past all hope, a victim to a fatal disease, entailing great agony . . . [and] he and the family alike beseech us to 'put an end to his misery,' we ought to do so?" (34). In April 1879, the South Carolina Medical Association heard a report from its Committee on Ethics regarding active euthanasia; the association vigorously debated the issue, as well as whether to keep its discussion secret (35, 36). Over the next few years, other medical societies debated euthanasia; British and U.S. medical journals included editorials about it that often referred to Williams's original proposal (37-40).

In the 1870s and 1880s, most physicians held the view that "opium is administered to the dying, as an anodyne to relieve pain . . . [not to throw] the patient into a sleep from which he may not awake" (41). Dr. Wilhite of South Carolina was typical in arguing that "physicians might soften suffering, but not hasten death" (35). An 1884 editorial in the *Boston Medical and Surgical Journal* was more poetic:

Perhaps logically it is difficult to justify a passive more than an active attempt at euthanasia; but certainly it is much less abhorrent to our feelings. To surrender to superior forces is not the same thing as to lead an attack of the enemy upon one's own friends (38).

Although anesthesia, the germ theory of disease, improved diagnostic tests, and effective surgical operations were helping allopathic physicians of the 1880s to consolidate their authority as well as their control over licensing and medical school training requirements, their authority was far from secure (42). They faced the old challenges from Sectarians—homeopaths and Eclectics—as well as new ones from practitioners of Christian Science and osteopathy. In this precarious position, allopathic physicians perceived Williams's ideas on euthanasia as another effort to undermine them. In a characteristic editorial, *The Journal of the American Medical Association* attacked Williams's proposal as nothing more than an attempt to make "the physician don the robes of an executioner" (38).

Early Efforts to Legalize Euthanasia

By the 1890s, the euthanasia debate had expanded beyond the medical profession to include lawyers and social

TOPICS OF THE TIMES.

Dr. Norton on Euthanasia. NOW it is Dr. CHARLES ELIOT NORTON whom an unfortunate impulse has moved to express belief in the "right" of one person to decide that these, those, or the other circumstances not only justify, but in reason oblige, him to confer the boon of death upon a suffering fellow-mortal. This curious delusion has fastened on many people before, but few indeed of them have been euthanasiaists as bold as Dr. NORTON seems to be. After denying that human life is always and necessarily "sacred," and charging the physician with having carried too far his commendable desire to prolong the existence of his patients, Dr. NORTON declares, (1) that no thinking man would hesitate—"hesitate" is actually the word he uses!—to give a fatal dose of laudanum to "the victim of an accident from the torturing effects of which recovery was impossible"; (2) that no reasonable man would hesitate to hasten death in a case where a cancer has reached the stage of incessant pain and the patient wants to die; and (3) that it is plain duty to shorten, not to prolong, the life of "an old person whose mind has become a chaos of wild imaginings productive of constant distress not only to the sufferer, but to all who live with and attend him." Adequate and accurate characterization of propositions like these is difficult, especially when they come from a man like Dr. NORTON. Perhaps it is enough to call attention to several points wherein his premises are either scientifically wrong or wherein they credit science with more knowledge than it possesses. In the first place, nature has herself very carefully provided that in the vast majority of instances her children of all degrees shall have "euthanasia," and a majority almost equally vast of the seemingly exceptional cases are not exceptional at all, for in them, while the body protests, the mind is either indifferent or oblivious. There is the best of reason, for example, to believe that the man torn to pieces by a tiger does not suffer in the least. And where would Dr. NORTON get his physicians who could always tell with certainty the outcome of an accident or disease? Few indeed are the proverbs with as much truth in them as has the one, "While there is life there is hope," and it is an utter waste of time to worry about the few cases where a man with perfect wisdom would be justified in giving the "happy death" to another, since the man with perfect wisdom is yet to be invented—or developed.

Figure 2. Editorial published in *The New York Times* on 6 January 1906 commenting on Charles Eliot Norton's endorsement of euthanasia.

scientists (43). The antagonism between physicians and lawyers was present even then; lawyers attacked physician authority with a call for greater patients' rights. Beginning in about 1890, New York lawyer Albert Bach frequently

spoke at conferences in support of euthanasia. At the 1895 Medico-Legal Congress, for instance, he endorsed euthanasia on the grounds that patients should have the right to end their lives (44). Simeon Baldwin, in his 1899 Presidential Address to the American Social Science Association, justified euthanasia by attacking the "pride of many in the medical profession to prolong such lives at any cost of discomfort or pain to the sufferer" (45). (Mr. Baldwin was later to become President of the American Bar Association and to actively oppose the nomination of Louis Brandeis to the Supreme Court because of the latter's progressive policies.) Physicians vigorously contested these points, claiming, among other things, that accepting them would "bring the profession into discredit" (46-51).

At the turn of the century, this debate entered the lay press and political forums (52). Probably the most notable event occurred in 1905 or 1906. Charles Eliot Norton, a renowned Harvard professor, delivered a speech advocating euthanasia. His position inspired a wealthy woman, Anna Hill, whose mother was suffering from cancer, to campaign for the legalization of euthanasia in Ohio. Ohio State Representative Hunt introduced "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons," a bill to legalize euthanasia that prompted significant interest (53, 54). *The New York Times* reported on the bill (55), carried editorials condemning both the bill and Norton's role in inspiring it (Figure 2) (56), and published charged letters for and against euthanasia (57-59). Attacking Norton, Hill, and Hunt, the *British Medical Journal* asserted that "America is a land of hysterical legislation" in which

every now and again [the legalization of euthanasia] is put forward by literary *dilettanti* who discuss it as an academic subtlety or by neurotic "intellectuals" whose high-strung temperament cannot bear the thought of pain. The medical profession has always sternly set its face against a measure that would inevitably pave the way to the grossest abuse and would degrade them to the position of executioners (60).

Hunt's bill was rejected by the Ohio legislature, 79 to 23. (It was reported in the *British Medical Journal* (60) and the *Medical Record* (54) in 1906 and by Reiser (17) that an even more extreme bill to legalize euthanasia not just for incurable adults but also for "hideously deformed or idiotic children" was introduced into the Iowa State Legislature by Dr. R.H. Gregory. An extensive search of newspapers from the time and of the Iowa legislative record failed to corroborate these reports.)

After 1906, the intensity of the British and U.S. interest in euthanasia dwindled, although, as one editorialist wrote, the issue was "like a recurring decimal" with periodic reappearances (61-65). This waning of interest occurred in a time when individualism and "social Darwinism" were in full retreat (31) and were being replaced by the belief that government should promote the general welfare; this belief was embodied in the Progressive movement in the United States and in the election of the Liberals in Britain (31, 33). This was also a time in which the medical profession had almost completely "consolidated its authority" (42) over medical education and practice.



Figure 3. Dr. C. Killick Millard. Dr. Millard proposed a model bill to legalize euthanasia in Britain in his Presidential Address to the Society of Medical Officers of Health. He became the secretary of the Voluntary Euthanasia Legislation Society in Britain in 1935. (Courtesy of the Wellcome Institute Library, London.)

The Voluntary Euthanasia Society of Britain

During the 1930s, the debate on euthanasia revived, this time with much more vigor in Britain than in the United States. Dr. C. Killick Millard, an early advocate of compulsory vaccination and birth control, used the occasion of his Presidential Address to the Society of Medical Officers of Health in Britain to propose a bill for the legalization of euthanasia (Figure 3) (66, 67). Millard gave a scholarly speech that reviewed the history of practices and attitudes toward euthanasia and suicide. His intention was to take Samuel Williams's ideas about euthanasia and "bring the proposed reform more within the range of practical politics" by proposing an actual statute (66). In 1935, growing interest in the subject (68, 69) was further fueled by the London *Daily Mail's* publication of an unnamed "elderly country physician's" confession that during his career he had practiced euthanasia on five patients. In both Britain and the United States, newspapers and magazines competed with each other, printing patients' requests for euthanasia, physicians' testimonials about past episodes of euthanasia, and denunciations of the stories by medical organizations. *Time* ran a typical magazine article portraying a suffering patient who desired euthanasia (Figure 4) (70-74).

In Britain, Millard's views prompted the creation of the

Voluntary Euthanasia Legislation Society, which was organized to campaign for the legalization of euthanasia (75, 76). The leaders of this society were all prominent physicians, and the society's first meeting was held in the British Medical Association House in London (77). The idea of legalizing euthanasia was vigorously debated in many public forums and in British and U.S. medical journals (78-85). A bill to legalize euthanasia was debated in the House of Lords in 1936. After two Lords who were also physicians spoke against it, the bill was rejected 35 to 14 (86, 87).

This defeat, the outbreak of World War II, the discovery of the Nazi death camps, and the recognition of the role German physicians had played in genocide all served to quell but not to completely eliminate consideration of euthanasia (88). In the late 1950s, Ganville Williams and Yale Kamisar revived the debate over the ethics of euthanasia in the British and U.S. legal literature (89-91). In 1969, the first bill since 1936 to legalize euthanasia was introduced into the British Parliament. Still, this interest in euthanasia never sparked widespread public discussion nor concern within the medical profession. In the 1970s and early 1980s, euthanasia became a subject of more extensive academic debate (92) in many countries and a point of public contention, especially in the Netherlands (93). With the increasing acceptance of patient autonomy and the right-to-die in the United States, and the publication in 1988 of "It's Over, Debbie" in *The Journal of the American Medical Association* (94), the euthanasia debate has once again become a matter of public concern in the United States, Britain, and other countries.

The Arguments for Euthanasia

Although the mere occurrence of debates about euthanasia in Britain and the United States during the 19th century is fascinating, of even greater interest is the fact that the arguments and justifications advanced both for and against euthanasia have hardly changed in over a century. Some elements of style and phrasing aside, articles written on the topic in 1894 could be dated 1994.

Past U.S. and British advocates typically adduced the same four arguments used today to justify euthanasia: 1) It is a human right born of self-determination; 2) it would produce more good than harm, mainly through pain relief; 3) there is no substantive distinction between active euthanasia and the withdrawal of life-sustaining medical interventions; and 4) its legalization would not produce deleterious consequences. As Eugene Debs and Dr. Milard claimed in 1913 and 1931, respectively, patients have a right to control the manner of their death and, more specifically, terminally ill patients have the right to a quick and painless death with physicians' help.

Human life is sacred, but only to the extent that it contributes to the joy and happiness of the one possessing it, and to those about him, and it ought to be the privilege of every human being to cross the River Styx in the boat of his own choosing, when further human agony cannot be justified by the hope of future health and happiness (64).

The proposition merely is that individuals, who have attained to years of discretion, and who are suffering from an incurable and fatal disease which usually entails a slow and painful death, should be allowed by

MEDICINE

The Right to Kill (Cont'd)

Fortnight ago the London *Daily Mail* published an anonymous confession by a "kind-eyed, elderly country doctor" stating that, for mercy's sake, he had done away with two defective newborns and three agonized adults (TIME, Nov. 18). Last week the storm of controversy and comment b'low up by the *Mail's* story roared on in the world Press. In England famed William Ralph Inge, morose one-time dean of St. Paul's Cathedral, signed his name to an opinion that euthanasia



© Buffalo Times, Acme

ANNA BECKER

"For 749 horrible days. . ."

(painless death) administered to incurables is "not contrary to Christian principles." This was also signed by three other churchmen including St. Paul's present dean, Very Rev. Walter Robert Matthews.

In Buffalo, N. Y. an alert newshawk turned up a willing candidate for euthanasia. She was Anna Becker, 34, a one-time nurse who was badly hurt in an automobile crash two years ago. Her teeth were knocked out. Her gums had failed to heal, she could eat no solid food and because of unhealed internal injuries even liquid food caused searing pain. Her legs swelled and hurt if she stood on them for a few minutes. She had been awarded damages of \$6,000, of which she had collected nothing because of an insurance guarantor's bankruptcy. At the reporter's instigation she dictated a letter to the Erie County Medical Association. Excerpts:

"In the name of mercy, I ask you to appoint a doctor to take my life. I am constantly in pain. I want to die. A competent physician could certainly kill me with less pain than I endure in an hour.

"For 749 horrible days since the crash, I have thought of death and would have taken my own life long ago if I had the courage."

The medical society had an easy answer: the law forbade. Of three Buffalo clergymen of three different faiths, two expressed themselves in favor of euthanasia. In Washington, a U. S. Public Health surgeon declared that mercy killing was outlawed in this clause of the oath of Hippocrates: "If any shall ask of me a drug to produce death I will not give it nor will I suggest such counsel." In Kansas City, Mo., Dr. Logan Clendening (*The Human Body*), who likes to pooch-pooch the fears of hypochondriacs, said the question was outside the medical profession's province. In Chicago, Editor Morris Fishbein of the *American Medical Association's Journal* spoke his mind thus:

"Any dying person is irrational and not responsible for what he says. If he recovers, his attitude is entirely different. . . . I deplore the publicity that this [Miss Becker's] case has received and I feel that no editor would have featured this extremely morbid story if it had been in his own family. It is very unhealthy for American psychology."

Figure 4. Article published in *Time* on 25 November 1935 recounting a patient's request for euthanasia and reactions from physicians and others.

law-if they so desire and if they have complied with the requisite conditions-to substitute for the slow and painful death a quick and painless one. This, I submit, should be regarded not merely as an act of mercy, but as a matter of elementary human right (66) [emphasis in the original].

It was further claimed that euthanasia would promote patients' well-being by relieving them of pain and would reassure others that death would not be painful. As Albert Bach stated in 1896:

There are also cases in which the ending of human life by physicians is not only morally right, but an act of humanity. I refer to cases of absolutely incurable, fatal and agonizing disease or condition, where death is certain and necessarily attended by excruciating pain, when it is the wish of the victim that a deadly drug should be administered to end his life and terminate his irremediable suffering (44).

Proponents went on to observe that no substantive ethical distinction existed between active euthanasia and the practice of withdrawing life-sustaining treatments or giving narcotics for pain relief, which some call passive euthanasia. If these latter interventions were deemed ethical, active euthanasia should be also. So Samuel Williams argued in 1872:

The very medical attendant who would revolt from the bare idea of putting a hopelessly suffering patient to death outright, though the patient implored him to do so, would feel no scruple in giving temporary relief by opiates, or other anaesthetic, even though he were absolutely sure that he was shortening the patient's life

by their use. Suppose, for instance, that a given patient were certain to drag on through a whole month of hideous suffering, if left to himself and Nature, but that the intensity of his sufferings could be allayed by drugs, which nevertheless would hasten the known inevitable end by a week;—there are few, if any, medical men who would hesitate to give the drugs; . . . Is it not clear that if you once break in upon life's sacredness, if you curtail its duration by never so little, the same reasoning that justifies a minute's shortening of it, will justify an hour's, a day's, a week's, a month's, a year's; and that all subsequent appeal to the inviolability of life is vain? (25).

Finally, proponents claimed that the legalization of euthanasia would not be a "slippery slope"; the justification of euthanasia for terminally ill individuals who request it was the individual's good, and this would not apply to involuntary euthanasia for incompetent patients or to killing the retarded or criminals for the good of society:

As regards any application of this principle to the elimination of the unfit or the degenerate, the imbecile, etc. as such, we find no such suggestion . . . It would be entirely out of keeping with the consistently expressed individualism. . . . The fact that [euthanasia] may be justifiable, perhaps even a duty of humanity, under certain circumstances, exceptional circumstances, if you like — to yield to the pleas of the sufferer himself for "the end of pain," in no sense supports the idea that any person or persons may properly decide to eliminate the degenerate or the imbecile against or in the absence of his express consent and desire [1906] (53).

The Arguments against Euthanasia

British and U.S. opponents of euthanasia a century ago made counter-arguments 1) challenging the assumption that most deaths were painful; 2) emphasizing the willingness of practitioners to stop treatments and use pain medications; 3) maintaining the distinction between active and passive euthanasia; and 4) enumerating the adverse consequences of legalizing euthanasia. Most critics of euthanasia noted that the justification for euthanasia was empirically false. Citing many authorities, including Sir William Osler, they vehemently claimed that death—and the approach of death—are not usually painful and that advocates "unconsciously exaggerate the amount and intensity of suffering that patients undergo in many mortal illnesses" [1906] (43, 62).

Opponents argued that although in the past physicians may have been overly aggressive in prolonging life, contemporary physicians were willing to withdraw futile interventions and to treat pain aggressively. For instance, in *The Lancet* in 1899, a physician described a patient with painful uterine cancer whose "death struggle was an awful and most pitiable experience" (95). He then asked "would it be justifiable to use morphia hypodermically? or to what extent would the inhalation of chloroform be admissible in mitigation of so great agony and distress?" (95).

A correspondent replied that physicians are not only justified in using, but are duty-bound to use, hypodermic morphine (96). Similarly, the editors of *The Lancet* replied that "it would have been perfectly justifiable for him to have used morphia hypodermically and patients are frequently kept under chloroform cautiously administered for hours to mitigate the sufferings . . . [A] practitioner is

perfectly justified in pushing such treatment to an extreme degree, if that is the only way of affording freedom from acute suffering . . . If the risks be explained to the friends we are of opinion that even should death result the medical man has done the best he can for his patient" (97).

As editors of *The Lancet* suggested, opponents of euthanasia frequently emphasized the ethical distinction between active and passive or indirect euthanasia, between intentionally using medications to kill a patient and using morphine for pain relief.

I should not hesitate to use morphia, or even chloroform, freely, with the intent to relieve pain; but surely it should not be beyond the power of a capable physician to so grade the dosage as to keep the patient free from pain but short of killing him. And should he accidentally or unintentionally in such a case as this administer an overdose, this is a very different thing from willingly and knowingly poisoning the patient (62) [1906].

Past arguments against euthanasia culminated in the enumeration of five deleterious consequences that would result from legalizing euthanasia; these are also frequently voiced today. First, it was claimed that legalizing euthanasia would result in abuse: "[Euthanasia] would put into the hands of unscrupulous parties a certain and easy method of being rid of an objectionable relative" [1885] (38, 46). Second, medicine was not an exact science, "apparently hopeless cases sometimes terminate in recovery and that the predictions of the most skilled and competent physicians are sometimes not fulfilled" [1914] (98). Permitting euthanasia could have the "most terrible result" of putting to death a person who would otherwise go on to live a full life.

Third, legalizing euthanasia would place tremendous pressure on patients to request it in order to relieve their families of distress.

The patient knows that he is being a burden to his loved ones, who are certainly sharing his agony. If the agonized patient knows that he alone can cut short their mental suffering by consenting to, or perhaps suggesting euthanasia, he will find himself faced with a hideous dilemma: he must either be so selfish as to discard euthanasia and let his dear ones suffer, or, by being generous, he must bid farewell to those last sweetest, still hopeful, moments of life [1936] (99).

Fourth, legalizing euthanasia would undermine patients' trust and thereby destroy the medical profession. "Once an alteration was made in that conception of a physician's duty [by legalizing euthanasia] the whole public confidence in the medical profession would go" (61).

The doctor is eagerly awaited with the hope, not that he will put the man out of pain, but that he will put the pain out of the man. This new society aims at putting the man out of existence. Let us make no mistake about this; the change is so fundamental that it will reach much further than even we contemplate, and the whole status of the profession will be altered in the minds of the people . . . [E]very doctor knows that there are already enough shadows in the sick-room without adding that of the lethal chamber [1936] (84).

Fifth, opponents of euthanasia argued that legalizing voluntary euthanasia for terminally ill patients is "only the thin end of a very big wedge" [1936] (81). Initially, the

terminally ill could voluntarily request euthanasia, then the aged could, and then involuntary euthanasia for “absolute idiots, incurably demented persons, and convicted murderers” [1906] would be justified and tolerated (62).

Euthanasia and Advances in Medical Technology

Whereas current advocates of euthanasia claim that advances in life-sustaining technology create interest in this practice, this historical review suggests that there is no inherent or causal link between actual advances in biomedical technology and interest in euthanasia (100). Physicians’ capability to use life-sustaining interventions and to prolong patients’ dying postdates by centuries both the debates in ancient Greece and the interest in euthanasia expressed by More and Bacon. More importantly, the late 19th and early 20th century British and U.S. campaigns for the legalization of euthanasia occurred before medicine had recourse to life-sustaining interventions. Medicine in the late 19th century was becoming scientific through events such as the recognition of the importance of the biological sciences, the identification of the role of microorganisms in disease, and the implementation of the first diagnostic laboratory tests. Yet, the therapeutic interventions available to physicians were meager and ineffective. It was not until the turn of the 20th century that anesthesia and aseptic techniques combined to enable surgery to be a safe, curative intervention (101). And life-sustaining *medical* interventions lagged even further. Sulfonamides were introduced in 1932; penicillin was discovered in 1928 and became widely available in 1941; Drinker and Shaw developed the first respirator (the “iron lung”) in 1927 (102). The speeches by Williams, Bach, and Baldwin, and the proposed legislation in Ohio all predate the development of effective life-sustaining medical technology. In addition, when effective life-sustaining medical technology did become widely available after World War II, no immediate resurgence of public interest in euthanasia occurred. During the 1950s and 1960s, medicine could sustain the lives of brain-damaged patients. As Pope Pius XII’s comments on this issue make clear, concern about keeping patients alive existed, but popular interest in euthanasia did not.

If any technologic development stimulated the 19th century interest in euthanasia, it was not that of life-sustaining technologies but of anesthetics, especially of hypodermic morphine, ether, and chloroform, which make death easier and medicalize it. Although fear of being kept alive by medical technology may be a necessary factor in motivating interest in euthanasia, this historical review suggests that it is not the only one. Indeed, almost all of the arguments made today to justify euthanasia were made before modern medical technology existed and could prolong life. What other factors—social, economic, and cultural—might motivate interest in euthanasia and make society receptive to it?

Social Darwinism, Individualism, and Euthanasia

These periods of widespread interest in euthanasia in Britain and the United States contained many complex interactions between leading individuals and social, political, economic, and cultural forces. At this time, it is

important to look beyond the differences to find generalizations, “see the patterns they compose,” and identify threads of connection (103). I put forth three speculative connections between the past and today. First, interest by the medical profession and the public in euthanasia erupts when economic depression coincides with the acceptance of social Darwinism for the justification of social policies. Second, interest in euthanasia increases during intense struggles over physician authority, especially over physician control of the dying process and death. Third, interest in euthanasia arises when easing the dying process, through pain medications or the withdrawal of unnecessary treatments, becomes an established medical practice.

In the United States and Britain, the worst economic recessions over the last 120 years occurred in the mid-1870s, mid-1890s, the 1930s, and the current time period (104). Some of these periods were characterized by public acceptance of individualism and social Darwinism. These have been periods of rationalist, economic conservatism, which celebrates individual self-assertion and accumulation rather than communal attachments and bonds; it accepts the circumstances of the less fortunate as of their own making rather than as a failure of the social order; and it directs the government to promote economic competition rather than social welfare. In these periods, the language of Darwinism becomes the idiom of public discourse. And with strain on government budgets, it legitimates resentment of the dependent and justifies cuts in “safety net” programs.

This Darwinian public philosophy also changes the individual’s own perceptions. It legitimates the adoption of the utilitarian logic of business—contracts, calculations of costs and benefits, success and profit—rather than traditional bonds and respect for authority, as the proper guide for individual action. When self-sufficiency is viewed as the highest virtue, dependence as a vice, acceptance of governmental aid as a drain, and rationalist calculations of life as proper, the old and sick are categorized with the “unfit.” Finally, with a shrinking safety net, individuals come to fear sickness, especially chronic and terminal illness, as a threat to their family’s well-being and their own self-esteem and social standing.

As we have noted, in the last third of the 19th century, economic recessions occurred simultaneously with the affirmation of individualism and social Darwinism. Often, advocates of euthanasia appealed to Darwinian ideas for legitimation. Williams’s speech was suffused with references to Darwin and the “universal struggle . . . of the strong over the weak” (25). Similarly, Baldwin in 1899 invoked the “one great all-dominating lesson which the nineteenth century has taught, the law of evolution” in support of a calm passage to death through euthanasia (45). Advocates frequently attacked the belief in the “sacredness of life [as] still tinged with ancient superstition and with metaphysical haziness” (64). They also mocked “the greater sensibility and the greater power of sympathy which [the euthanasia opponent] implies are worth preserving, even at the cost of the poor old parent who is forcibly maintained in a world which has become a torment to him” (30). Conversely, 19th century opponents frequently attacked euthanasia by attacking Darwinian ideas. For instance, they attacked the “purely utilitarian

[calculations in which] old people past their productive periods could be easily disposed of [by euthanasia] as a long step backward toward savagery" (50, 105).

The 1980s are reminiscent of the 1880s. Deep recessions occurred just when the economic and social policies of Ronald Reagan in the United States and Margaret Thatcher in Britain revived raw individualism, unfettered capitalistic competition for survival, anti-union sentiments, wholesale governmental deregulation, and curtailment of social "safety net" programs for the poor, old, and sick. As historian Eric Foner and others have suggested, there has been a "resurrection in the 1980s of . . . the social Darwinism mentality, if not the name itself" (106, 107). Although it is not respectable now to appeal openly to social Darwinism, contemporary advocates of euthanasia do justify euthanasia by appealing to individualism and individual rights; opponents explicitly worry that discrimination against vulnerable groups and cost containment focused on the elderly and terminally ill do influence support for euthanasia (108, 109). Consistent with this public philosophy, Americans are worried about their future and have indicated that the single most important reason for endorsing euthanasia is to avoid being a burden on the family (110).

None of this is to say that the leading advocates of euthanasia are overt or covert social Darwinists. Rather, it suggests that society may be more receptive to appeals for legalizing euthanasia because of the long economic recession, the acceptance of survival of the fittest, the laissez faire policies, and the affirmation of individual rights that accompanies the "social Darwinism mentality." This idea may be supported by the fact that states with a long tradition of individualism and laissez faire policies—such as some Western states and New Hampshire—have been at the forefront of current popular campaigns for legalizing euthanasia.

Physician Authority and Euthanasia

In addition to these general factors that might inspire interest in euthanasia, other factors impinge more directly on medical practice. There have been continuous social, cultural, and legal processes delineating the extent of physician authority. It appears that the periods in which physician authority is powerfully challenged are precisely the periods of interest in euthanasia.

In the late 19th century, medicine was being transformed from a suspect and divided profession into one with authority (42). Americans became willing to "surrender [their] private judgments" in matters of health to physicians (101). Allopathic physicians were overcoming the challenges posed by Sectarians, Christian Scientists, and others. During this period, advocates of euthanasia frequently couched their appeals in attacks on the "pride of many in the medical profession" (45). They justified euthanasia by arguing that patients, not physicians, had the right to decide when patients' lives should end. Concomitantly, many physicians viewed euthanasia as another way to undermine the very "foundations of the existence of the profession" (105). As Abraham Jacobi, president of the American Medical Association, put it: If you legalize euthanasia then "you would make true what Plato said of

the practice of medicine: It was no respectable calling" (63).

There is a striking similarity between the past and the present. In the early 1970s, the widely accepted authority of the medical profession came under concerted attack in the name of patient autonomy. This challenge has been embodied in the progressive enumeration of patient rights, especially the right to refuse medical care, even life-sustaining care. The goals have been to remove physicians from decision making and to let individual patients weigh the benefits and burdens of continued life (111). In the view of many, the general acceptance of the patient's right to refuse medical care and the concomitant restriction of physician authority have set the stage for acceptance of euthanasia; the arguments that justify refusal of life-sustaining treatment logically extend to euthanasia (112). The interest in euthanasia may be a public condemnation of physician control over patients' deaths. As leading proponents of Washington State's Proposition 119 argued:

My sense is that people do feel in many aspects of their lives as if they are out of control. I suspect in this one area [of death and euthanasia] people are saying "Dammit, this is the one thing that I ought to be able to control for myself" (110).

Thus, the current interest in euthanasia may be the culmination of the 20-year effort to curtail physician authority over end-of-life decisions. Technology, and physicians' control over technologic interventions, may be an easily characterized but inaccurate surrogate for this struggle to limit physician authority.

Expanding the Boundaries of Appropriate Practices

There seems to be a tendency within medicine to develop a new treatment or technology for a core, well-defined condition and then, once the treatment or technology is well accepted, to expand the range of its uses. For instance, dialysis was developed for patients with acute renal failure, then applied to young patients with chronic renal failure who had no comorbid diseases, and then to older patients with many comorbidities such as diabetes. A similar tendency may be found with regard to euthanasia in the 19th century and today.

The 19th century witnessed a marked development in anesthesia. In the latter half of the century, a fierce debate took place about whether it was better to relieve suffering at some risk or whether "immunity of pain merely should never be purchased at the risk of life" (21). "By the 1870s, some use of anesthetics has been accepted by all" physicians for surgery, childbirth, the relief of the agonies of dying, and other conditions (16, 21, 24, 41). Just when 19th century physicians became comfortable with the use of anesthetics, there was an effort, initiated by Williams, to expand their use to include euthanasia.

A similar pattern can be observed in the current U.S. interest in euthanasia. Since the *Quinlan* decision and the passage of the California Natural Death Act (the first living-will law) in 1976, there has been growing acceptance of the practice of withdrawing life-sustaining treatment. First, physicians accepted withdrawal of respirators from patients in persistent vegetative states; now it has

become acceptable to stop any kind of medical intervention, including artificial nutrition and hydration, from patients in any condition. Just when contemporary physicians became willing to regularly terminate life-sustaining treatments, the effort to legalize euthanasia emerged (113). Physicians' acceptance of easing the dying process or withholding life-sustaining treatments seems to have induced interest in extending established practices to include euthanasia.

Conclusion

We are in the midst of a deep battle over the legalization of euthanasia, a battle that has profound implications for the care of the terminally ill and aged and the social understanding of medicine. This is not the first time that this battle has been waged in Britain and the United States; we have largely forgotten the exuberant euthanasia debates that occurred between 1870 and 1936 in both countries. Remembering those debates and trying to identify common threads among them may help us gain a more enlightened perspective on our current concern with euthanasia.

It seems clear that the arguments for and against euthanasia have changed neither in form nor substance in almost 120 years. They predate by many decades those arguments made in Nazi Germany, and they appeal to various philosophical traditions. This history suggests that factors other than technology play a critical role in making people receptive to euthanasia. In trying to identify general patterns that might explain public interest in euthanasia in the United States and Britain, the resurgence of individualistic conservatism, characteristic of both the Gilded Age and the Reagan-Thatcher years, is striking, as is the waning of interest in euthanasia in the early 20th century when this individualistic public philosophy was repudiated by Progressivism. It is also striking that British and U.S. interest in euthanasia flourished at the two times in the last century when the struggle over physician authority was most pronounced. Such connections raise important questions about what forces are driving our current interest in euthanasia and whether there are alternative ways to achieve a compassionate and painless death.

Acknowledgments: The author thanks Drs. Linda Emanuel, Lee Goldman, Robert Mayer, Jane Weeks, and David Weinberg for their continuing support and critical comments on the manuscript; Professors Barbara Rosenkrantz, Allan Brandt, and Jeffrey Williamson for their helpful discussions on the medical and economic history of the time; Ms. Ruth Bartels of the State Historical Society of Iowa and Ms. Linda Robertson of the Iowa State Legislature Law Library for their efforts to locate information on Dr. Ross Gregory and whether he submitted an euthanasia bill in Iowa; and Ms. Elizabeth Daniels for her review of the manuscript and her heroic efforts to track down pictures and old articles in magazines and newspapers.

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