

# Euthanasia and the Changing Ethics of the Deathbed: A Study in Historical Jurisprudence

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*During the course of the nineteenth century, a dramatic change took place in the way Americans die. The deathbed, formerly governed predominantly by religious tradition, gradually was being shaped by medical ethics and state law. By the end of the nineteenth century, not only had the physician replaced the priest as master of ceremonies at the deathbed, but the state, in the form of positive law, had begun to express an interest in regulating the treatment of the dying patient. This interest first emerged in the context of the late nineteenth-century public debate over the legitimacy of medical euthanasia, an issue passionately disputed to this day in America and other Western societies. The history of the deathbed in nineteenth-century America suggests that the intervention of the state in the regulation of dying is a relatively new phenomenon. This paper examines this history, thereby enabling us to explore a world in which the legal regulation of dying was still unthinkable and inviting us to contemplate the historical significance of this development. The paper traces the changes that occurred during the nineteenth century in deathbed ethics, concluding with proposals for regulating dying legally through euthanasia. It focuses on the most significant moments in the history of the nineteenth-century deathbed, outlining a three-stage transformation in deathbed ethics — from the realm of religion, to the jurisdiction of medical ethics, to positive law regulation — a movement that reflects a change not only in specific rules of deathbed conduct, but also a more decisive alteration of*

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*the entire normative system governing the deathbed and the entire experience of dying. The insight to the modus operandi of regulatory law that emerges in the paper can lead to a deeper understanding of the conditions of its possibility. Regulation is only possible if the phenomenon to be regulated undergoes a transformation through which it severs its connections with anything that cannot be regulated. Thus, the paper shows how a radical transformation in the way people die was necessary for regulation by state law to emerge.*

## INTRODUCTION

During the course of the nineteenth century, a dramatic change took place in the way Americans die.<sup>1</sup> The deathbed, once predominantly governed by religious tradition, gradually was being shaped by medical ethics and state law. By the end of the nineteenth century, not only had the physician replaced the priest as master of ceremonies at the deathbed, but the state, in the form of positive law, had begun to express an interest in regulating the treatment of the dying patient. This interest first emerged in the context of the late nineteenth-century public debate over the legitimacy of medical euthanasia.

Over a century later, the question of euthanasia remains a passionately disputed issue in America as in other Western societies. But despite the deep divide between advocates of the right to die and champions of the sanctity of life, there seems to be an overarching consensus that the treatment of the dying must be regulated by law. The growing number of legislative acts, court decisions, and hospital directives in the U.S. concerning the treatment of the dying is testimony to this development.<sup>2</sup> The history of the deathbed in nineteenth-century America, however, suggests that the intervention of the state in the regulation of dying is a relatively new phenomenon. This history

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1 Some important studies of the history of the deathbed in nineteenth-century America include: James J. Farrell, *Inventing the American Way of Death, 1830-1920* (1980); Gary Laderman, *The Sacred Remains: American Attitudes toward Death, 1799-1883* (1996); John McManners, *Death and the Enlightenment: Changing Attitudes to Death among Christians and Unbelievers in Eighteenth-Century France* (1981). For a more general study of the history of the deathbed with specific references to nineteenth-century American history, see Philippe Ariès, *The Hour of Our Death* (1981).

2 For a fascinating study of the growing dominance of law in medicine in the latter half of the twentieth century, see David Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (1991).

enables us to explore a world in which the legal regulation of dying was still unthinkable and invites contemplation of the historical significance of this new development.

Only at the turn of the twentieth century did state law begin to show an interest in the regulation of dying, but this should not imply that no rules previously existed governing deathbed practice. On the contrary, for centuries, dying was governed by cultural norms prescribing the practices, ideations, and emotions at the deathbed. And though varying with time and place, these "deathbed ethics" shared the notion that not all deaths are alike; some deaths are better, more dignified than others. The different ethics of the deathbed all prescribed the proper way to die and embodied — more or less explicitly — a notion of the "good" death.

In what follows, I will trace the changes that occurred during the nineteenth century in deathbed ethics, concluding with proposals to regulate dying legally through the practice of euthanasia. Due to the limited scope of this paper,<sup>3</sup> I will focus on the most significant moments in the history of the nineteenth-century deathbed and will outline a three-stage transformation in deathbed ethics: from the realm of religion, to the jurisdiction of medical ethics, to positive law regulation. What makes this historical movement important is that it reflects a change not only in particular rules of deathbed conduct, but also a more decisive alteration of the entire normative system governing the deathbed and the entire experience of dying.

Three very different ideals with regard to the "good death" prevailed in nineteenth-century America, corresponding to the three different normative realms that governed the deathbed. These ideals are manifested in the changing uses of the term *euthanasia*, and each can be found in a different code of deathbed ethics. The three codes are: the early nineteenth-century *ars moriendi* manuals, which represent the Methodist ethic of dying; the mid-nineteenth-century medical ethics code that prescribed a new role for physicians at the deathbed; and the late nineteenth-century and early twentieth-century legislation that was intended to regulate the practice of medical euthanasia.

The passage of a deeply-embedded cultural practice into the realm of state legislation and regulation is not unique to the matter of dying. Similar developments in other areas have captured the attention of contemporary

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3 This paper is based on a larger project by the author, Shai Lavi *The Modern Art of Dying: The History of Euthanasia in America* (forthcoming 2004). The aim of the present paper is to reflect on the methodological approach to the writing of legal history that guided the larger project, a methodology I refer to here as "historical jurisprudence."

legal historians. In a recent book, William Novak documents the development of a new legal regime in the nineteenth century that was based on legislation and administration rather than on cultural practices and ad-hoc common law adjudication.<sup>4</sup> This new legal regime manifested the emerging aspirations of the state to regulate a growing number of public domains, including public economy, public safety, and public health. In a similar vein, James Scott has shown how during the twentieth century, the modern state became involved in mass regulation of agriculture, urban life, and industry. The objective of the current paper is to contribute to the existing literature by offering both a novel case study and a new conceptual framework through which the movement toward state regulation in general should be understood. This framework will be referred to as "historical jurisprudence."<sup>5</sup> By historical jurisprudence I mean the study of legal history not only for its own sake, but in order to contemplate basic questions of jurisprudence. The jurisprudential question that I raise in what follows concerns the particular nature of modern law as *regulatory*. Law as regulation can be best understood as distinct both from other normative forms, such as religion (Part I) and professional ethics (Part II), as well as from other specific legal forms, such as the common law (Part III). The relationship between regulatory law and other normative orders is dialectic in nature. On the one hand, legal regulation is a unique historical product of the nineteenth century, distinct from the normative regimes that preceded it. On the other hand, regulatory law did not emerge *ex nihilo* and can trace its historical genesis, at least partially, to normative forms that prepared the ground for its appearance. Thus, two jurisprudential questions guide the

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- 4 For a fascinating and rich study of nineteenth-century common law in America and its transformation toward the end of the century, see W.J. Novak, *The People's Welfare: Law and Regulation in Nineteenth-Century America* (1996). A comprehensive account of antebellum legal reform can be found in C.M. Cook, *The American Codification Movement: A Study of Antebellum Legal Reform* (1981). For a discussion of post-civil war developments, see W.E. Nelson, *The Impact of Antislavery Movement Upon Styles of Judicial Reasoning in Nineteenth Century America*, 87 Harv. L. Rev. 513 (1974). For a more specific discussion of a similar development of criminal law in the England, see J. Hostettler, *The Politics of Criminal Law: Reform in the Nineteenth Century* (1992).
- 5 My term "historical jurisprudence" should not be confused with the nineteenth-century German school of legal thought led by Frederick Charles von Savigny. In what follows, the term jurisprudence refers specifically to the philosophical foundations of law and not to law in general. Nevertheless, this paper shares with the old school of historical jurisprudence a strong notion of the study of law as the study of its historical origins. See Friedrich Karl von Savigny, *Of the Vocation of Our Age for Legislation and Jurisprudence* (Abraham Hayward trans., *The Lawbook Exchange* 2002) (1831).

ensuing inquiry: What *is* law as regulation? And what are the *historical conditions of its possibility*?

What, then, makes regulatory law unique as an historical phenomenon? Indeed, every normative system can be thought of as "regulatory" in that it seeks to impose limits on certain human activities and prescribes others. Nevertheless, we think of *regulatory law* in the strict sense as different from other normative forms. Some scholars have sought the uniqueness of regulation in the persona of the regulator, namely, the state. But if we think of regulation as a certain way of ordering human conduct and natural resources, regulation as a technique may be employed by entities other than the state, either supra-national or infra-national. Consequently, we cannot identify regulation by pointing to the state (or any other institution). What is most important about regulation, thus, is *how* it operates, not *whom* it serves.<sup>6</sup>

How, then, does law as regulation operate? Perhaps (and this hypothesis will guide us in what follows) though all normative systems strive to regulate, most aim to order human conduct with the purpose of achieving a particular good (e.g., religious ethics strive for salvation and medical ethics strive for health). Regulatory law, as its name implies, operates differently. In the context of regulatory law, regulation is the end itself, not merely a means to another end (e.g., regulatory law in public health seeks the general regulatory ideals of transparency and accountability).

This insight regarding the *modus operandi* of regulatory law can lead us to a deeper understanding of the conditions of its possibility. Regulation is only possible if the phenomenon to be regulated undergoes a transformation through which it severs its connections with anything that cannot be regulated. Thus, we shall see how a radical transformation in the way people die was necessary for regulation by state law to emerge. Through this transformation, dying, which was traditionally experienced as a moment of transition between this world and the world to come, became a this-worldly event lending itself more easily to regulation. The first stage in this transition took place in the nineteenth-century Methodist art of holy dying and it is during that time that the seeds of state-regulated death were sown.

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6 This notion of law as regulation is closely related to the Foucaultian notion of *governmentality*. Unlike Foucault, however, the aim of this paper is to point out the historical continuity between older notions of law and the new regulatory state. See Michel Foucault, *Governmentality*, in *The Foucault Effect: Studies in Governmentality* 87 (Graham Burchell et al. eds., 1991).

## I. *ARS MORIENDI*: ETHICS OF SALVATION

### A. Dying as an Art of Holy Living

To think of dying in early nineteenth-century America is to think of the Methodist way of death. Not only were the Methodists the largest religious community in America at the time (in 1850, their 20,000 churches made them the preeminent Protestant denomination in America<sup>7</sup>), but they also prepared for death with an intensity unmatched by other religious groups, for Methodists were highly concerned throughout life with forming the proper disposition toward death.<sup>8</sup>

To begin with, the nineteenth-century Methodist did not die alone. Death was a public event, and the dying person chose in advance those who would accompany him or her on this last journey. Death took place in the presence not only of immediate relatives and the local preacher, but also friends and neighbors. Yet an intimate atmosphere was nonetheless maintained, with the event occurring behind closed doors, not in public. The deathbed scene was mainly a spectacle to be seen and studied by those closest to the dying person. Often however, the observers were not merely passive bystanders; they would assist the dying person in his or her last hour. The dying person frequently would cry out, "Help me to rejoice, help me to praise God," at which point all would join in prayer.<sup>9</sup> The last hour of life was a time of great exultation for all evangelical denominations, and it was this form of enthusiastic dying that Cotton Mather, the most celebrated of all New England Puritans, called "euthanasia."<sup>10</sup>

Thus, the Methodist of this period died in the company of friends and

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7 Edwin Scott Gaustad et al., *New Historical Atlas of Religion in America 75-82* (3d ed. 2001). See also Farrell, *supra* note 1, at 36.

8 The following discussion of the Methodist deathbed is based on: Wesley A. Chambers, *John Wesley and Death*, in *John Wesley: Contemporary Perspectives* (John Stacey ed., 1988); E. Brooks Holifield, *Health and Medicine in the Methodist Tradition: Journey toward Wholeness, Health/Medicine and the Faith Traditions* (1986); A. Gregory Schneider, *The Ritual of Happy Dying among Early American Methodists*, 1982 *Early American Methodists* 10; Harold Y. Vanderpool, *The Wesleyan-Methodist Tradition*, in *Caring and Curing: Health and Medicine in the Western Religious Traditions* (D.W. & R.L. Numbers Amundsen eds., 1986).

9 Barnabas Brough, *Some Account for the Life and Death of Sarah Brough*, *Arminian Mag.*, 1780, at 3.

10 See Cotton Mather, *The Angel of Bethesda* at ch. 66 (Gordon W. Jones ed., 1972). See also Cotton Mather, *Euthanasia: A Sudden Death*, *Am. Imp. Micro* 2452 (1723).

family. Nevertheless, at least in one significant way, the Methodist did die alone, and despite the company around the deathbed, Pascal's words "*on mourra seul*" still held. The responsibility of dying a righteous death lay with the individual Methodist, and on her shoulders alone. The prayers of those around the deathbed were not prayers *for* the dying person, but prayers *with* her. While a minister might be present at the deathbed, his role was minimal. He did not offer Absolution, nor did he serve as confessor for the dying. Even sacraments, though not abolished by Methodism, were rarely a part of the deathbed ritual. In fact, strictly speaking, there were no ritual practices at all. This is not to say that there was no structure to the hour of death, but, rather, that recurring patterns paradoxically emerged in a spontaneous way.

Dying posed a particular problem for the Methodist in that period, one he shared with Protestant believers, but not with his Catholic rivals. For the Catholic, dying was a highly ritualized and structured event. The deathbed rituals were not conducted alone by the dying person, but with the aid and accompaniment of the priest, who would provide her with guidance in her final hours. There was much at stake in the death of the Catholic believer. On the one hand, the deathbed presented the dying with the final opportunity for eternal salvation, through repentance for sins and forgiveness. On the other hand, the last article of life was a test and final temptation. The dying man, seeing his entire life passing before his eyes, would be tempted by despair over his sins, by the "vainglory" of his good deeds, or by passionate love for things and persons. During this fleeting moment, either all the sins he had committed in his life would be erased or else all his good deeds would be canceled depending on whether he managed to withstand temptation or gave way to it.<sup>11</sup>

To the nineteenth-century Methodist, however, there were clear ways of overcoming the fear and danger present at the hour of death, in order to achieve a "good" death. The dying person was not expected to face death on his or her own, and the responsibility to die a good death did not rest, at least not entirely, on his or her shoulders. The presence of the priest at the deathbed and the power vested in him to administer the Eucharist and the Extreme Unction structured the deathbed scene and assisted the dying to achieve a good death. These rituals could be practiced even if the dying person was not in full possession of his or her faculties, indicative of the

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11 Philippe Ariès, *Western Attitudes toward Death: From the Middle Ages to the Present* 35-37 (1974).

fact that dying a good death did not require an act of free will on the part of the dying person.

The ritualized death of the Catholic correlated with an understanding of dying as the passage from this world to the world to come. In this respect, the deathbed rituals were a *rite de passage*, preparing the dying person for his or her final journey into a better world. With the intervening role of the priest, who mediated between this world and the world to come, the dying Catholic could maintain the hope that, through the love of God and the power vested in the Church, he or she would achieve eternal salvation.

The Methodist ethic of dying was quite at odds with the traditional Catholic death. For the Methodist, as for other Reform denominations, dying belonged to this world and thus lost the unique transformative power it had under Catholic doctrine. Accordingly, there was no place at the Methodist deathbed either for the traditional rituals conducted by the Catholic, which were considered an expression of superstitious belief, or for a priest to mediate between this world and the world beyond. Unlike the Catholic death, the Methodist way of dying gave no place to ritual and thus created for the believer intense uncertainty as to how to confront his or her death.

It is in the context of this very uncertainty that the emergence of the *ars moriendi* tradition should be understood. The *ars moriendi* consists of manuals detailing exactly how dying should take place. The first printed manuals on the art of dying were published in the late fifteenth-century, and the tradition was revised and revitalized by the Humanists, the Reformers, and Counter-Reformers and became very popular among Methodists during the eighteenth century.<sup>12</sup>

The *ars moriendi* manuals were a compilation of guidelines concerning the proper way to pass the final test of the deathbed. Focusing on the last hours of the dying person, they set out rules for the appropriate conduct and beliefs upon death's approach. In addition, these pamphlets sometimes included suggestions on how to overcome bodily and spiritual pain, as well as rites that should be conducted on corpses. In essence, these were practical manuals designed to assist the dying in preparing for the deathbed and its temptations. In some, advice also was given to bystanders on how to assist the dying patient, and in others, recommendations were made regarding prayers that are especially appropriate at the hour of death.

While the Methodists did not produce an *ars moriendi* guide of their own,

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12 For a more elaborate discussion of the *ars moriendi* tradition, see 5 David William Atkinson, *The English Ars Moriendi, Renaissance and Baroque Studies and Texts* (1992).

their founding fathers, especially John Wesley, were highly influenced by Jeremy Taylor's seventeenth-century *Holy Living and Holy Dying*.<sup>13</sup> In this work, Taylor was writing both within and against the tradition of *ars moriendi*. When he sat down to write his book, he had before him a rich variety of materials to rely upon, and yet he complained, "I was almost forced to walk alone." And while it may be true from a literary perspective that in *Holy Living and Holy Dying*, "[a]ll the distinctive but limited insights of the preceding two and a half centuries are caught up and merged into a single luminous vision of the nature and the meaning of Christian death,"<sup>14</sup> Taylor, in a more fundamental way, was, indeed, walking alone.

Taylor did not break from the *ars moriendi* tradition, but, rather, radicalized it. While *Holy Living and Holy Dying* addresses most, if not all, the issues traditionally addressed in the *ars moriendi* works, it is written from a significantly different perspective, for his advice does not address *the dying* but, rather, *the living*, long before the first signs of their approaching death appear. The practice of *ars moriendi*, according to Taylor, cannot be left for the last moment and, instead, must be exercised throughout one's life.<sup>15</sup> This is the case not only because there is a need for long preparation for death in advance, but also because for Taylor, unlike for the Catholic believer, death is no longer seen primarily as a passage from this world to a world to come. Rather, in Taylor's view, dying is a moment within life and facing death changes from an other-worldly into a this-worldly experience.

Under Taylor's approach, death has a central role in the life of the Christian believer. Death proper, according to Taylor, is *not* the separation of body and soul, nor is it the deliverance from this world into another. Basing his radical interpretation of death on scriptural evidence, Taylor's starting point is the well-accepted belief that death entered the world with Adam's original sin and, moreover, that "man did die the same day in which he sinned."<sup>16</sup> But, Taylor queries, in what sense did Adam "die" that "same

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13 Jeremy Taylor, *Holy Living; and Holy Dying* (Oxford Univ. Press 1989).

14 Nancy Lee Beaty, *The Craft of Dying; a Study in the Literary Tradition of the Ars Moriendi in England 198* (1970).

15 Ariès makes this point more generally with regard to a new variety of *ars moriendi*, which he calls "The New Arts of Dying," arguing that, already in the sixteenth century, "the art of dying was replaced by an art of living." To Ariès, the emergence of these "new arts of dying" is a manifestation of the devaluation of the hour of death, which will ultimately lead to the modern denial of death, Philippe Ariès, *The Hour of Our Death* 300-05 (1981). However, Ariès is mistaken in interpreting this new approach to death as the disappearance of dying rather than as the appearance of a truly new way of dying.

16 Taylor, *supra* note 13, at 68.

day" if he lived hundreds of years after eating the fruit of the Forbidden Tree? It follows that death must be construed not as man's *exiting* this world but the manner in which he is *present* in this world.

"Change or separation of body and soul is but incidental to death. Death may be with, or without either: but the formality, the curse and the sting of death, that is, misery, sorrow, fear, diminution, defect, anguish, dishonor, and whatsoever is miserable and afflictive in nature, that is death: death is not an action, but, a whole state and condition."<sup>17</sup>

Taylor, rather than regarding death as an event occurring at the outer limit of life, conceived it as a condition under which life itself occurs. There is no doubt that this understanding of death embraces the ancient Christian notion of man being inflicted with mortality ever since the commitment of the Original Sin. Yet Taylor diverged from tradition in his application of this belief to the practice of *ars moriendi*. Death is not merely a metaphor for the human condition in a corrupt world, but an actual mode of living: living life in anticipation of coming death.

Taylor's great innovation in reconstructing the relationship between living and dying marks the transformation in the nineteenth-century American deathbed. To Taylor and the Methodists who embraced his approach, living and dying were not two distinct temporalities of human life. Rather, they were two different points along the same continuum and thus equally amenable to the notion of the human desire to master one's destiny.

## B. Dying as Intensified Living

To the nineteenth-century Methodist, dying was a matter of holy living. But though dying had lost its character as a transitional moment between this world and the world to come, it was not merely another event in the life of the Methodist. The hour of death bore special significance because it served as a measure of true faith, an ultimate test for the believer, who was confronting the sincerity of his or her belief for the last time. Dying was the culminating moment at which the entirety of life could be understood. A clear manifestation of this intense understanding of death can be found in the way Methodists memorialized their departed members.

Methodist lore of that period is rife with accounts of deathbed scenes, and these tales were studied as examples of great deaths. The hour of death was also an occasion for others to experience the greatness of a holy death and the power of true belief. The Methodists consistently, and

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<sup>17</sup> *Id.* at 69.

quite remarkably, entitled these accounts (which were published in regional journals) "biographies." In striking contrast to the modern obituary, the Methodist "biography" told very little about the person's life, focusing instead — at times exclusively — on the person's death.<sup>18</sup> Examining these accounts can shed light on how the Methodist theology of death led to the Methodist practice at the deathbed.<sup>19</sup>

Wesley was fond of collecting such accounts and copying them into his journal. He usually chose not accounts of well-known Methodist leaders, but those of ordinary believers who had died a holy death; for a great death, like salvation, was not the sole privilege of an "Elect." When Wesley himself was approaching death, it was quite natural for his physician, Dr. Whitehead, to ask Wesley's close assistant, Elizabeth Ritchie, to document his last days.<sup>20</sup> The carefully documented death was then printed and spread among Methodist preachers, to be rehearsed in public as an "authentic narrative" of Wesley's death.<sup>21</sup> This was in accordance with Wesley's strong belief that "[t]he last scene of life in dying believers is of great use to those who are about them. Here we see the reality of religion and of things eternal; and nothing has a greater tendency to solemnize the soul and make and keep it dead to all below."<sup>22</sup>

There could be no true victory over death without a struggle against it.

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18 See also Gregory Schneider, *The Ritual of Happy Dying among Early American Methodists*, 56 Church Hist. 360 (1987).

19 There is a long-standing debate among Methodist scholars as to the extent to which theology is central to understanding the Methodist way of life in general and that of individual Methodists in particular. The terms of this debate have been quite misleading. It is necessary to distinguish between theology as a meta-reflection on religious experience and theology as the set doctrine, which every devoted Christian should affirm. While Wesley rejected the importance of theology in the latter sense, emphasizing the importance of one's state of heart and soul rather than one's state of mind, he attributed tremendous importance to theology in the former sense. Yet as meta-reflection, theology is only the concern of the few and by no means a necessary part of one's belief. For the scholar, however, the study of theology is central to understanding the grounds of religious practice. For a discussion on Wesleyan theology, see Melvin E. Dieter, *Wesleyan Theology, in John Wesley: Contemporary Perspectives* 162 (John Stacey ed., 1988).

20 The account of Wesley's death and the circumstances under which Miss Ritchie undertook their documentation can be found in 8 John Wesley & Albert Cook Outler, *The Works of John Wesley* 131-44 (Abigdon Press 1988) (*John Wesley's Journal*). Compare to similar accounts of Charles Wesley's death in John Wesley & John R. Tyson, *Charles Wesley: A Reader* 480-81 (1989).

21 Wesley & Tyson, *supra* note 20, at 132.

22 Letter from July 1768, *reprinted in* 25 Wesley & Outler, *supra* note 20, at 96.

Often the opponent was personified in the character of the Devil or Satan, who tempted the dying person. In a letter published in 1797 in the *Arminian Magazine*, the recent death of John Patrick, a Methodist from Yorkshire, is described by his friend.<sup>23</sup> Patrick was a convert to Methodism and, like many, turned to God only when sickness seized him. Through the help of a friend who prayed with him, he sought God's mercy and eventually recovered from his illness. Then, one day, while working at the mine, the damp caught fire and he was wrapped in flames. While "flesh was dropping from him in pieces, his first work was to fall upon his burnt knees, and praise the God of Heaven."<sup>24</sup> His struggle with death is described in great detail. When he arrived home, he cried out, "Glory be thy Name! Thy Will be done! Thy Will be done!" We are told he had one "sore conflict with the Satan" on his deathbed. Satan tempted him to fear that God did not love him because he had permitted this severe affliction. And yet Patrick defied the enemy: "What! give up my Saviour! turn my back on my Saviour! No: I'll praise my Saviour."<sup>25</sup> He is then described as one who "triumphed over the fear of death, having the Love of Christ in his heart, and Heaven in his view." Overcoming the Devil and the fear of death was achieved by casting aside doubt and allowing oneself to be filled with love and joy. On their deathbeds, Methodists demonstrated in words and in action that they did not fear approaching death and that they triumphed over their fears.

The victorious death is often a victory not only over the fear of death but, in a sense, over death itself. A remarkable case of a triumphant death and victory over Satan was that of Caster Garret from Ireland.<sup>26</sup> As he was approaching death, "Satan made his last effort against him. For, all of a sudden he cried out aloud, 'I am undone! undone! I have lost my way! The Lord is departed from me! O, it was all lies I was telling! God has shewed me that I am a great sinner! ...'" But with the help of his friend, who encouraged him not to despair, for it is "the enemy who wants to destroy your confidence,"<sup>27</sup> Garret overcame his fear and called out, "God is faithful and just!" Then, stamping his foot, he exclaimed, "Satan! I stamp thee under my feet!" and, finally, celebrating his victory, "The terror is gone! The sting of Death is gone!

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23 *The Recent Death of John Patrick*, *Arminian Mag.*, 1797, at 20.

24 *Id.* at 204.

25 *Id.* at 205.

26 *A Short Account of the Conversion and Death of Caster Garret: In a Letter to a Friend*, *Arminian Mag.*, 1787, at 10.

27 *Id.* at 20.

O death, where is thy sting! O grave where is thy victory! Blessed be Jesus who hath given me the victory! O I feel his love in my heart."<sup>28</sup>

In order to confront death face-to-face rather than let it sneak up by surprise, one needs to know in advance that death is approaching. The Methodist rejected the old saying that neither the sun nor death can be looked at directly. He sought to stare death in the eye. As Mrs. Beresford's telling behavior was reported by her close friend,

[s]he after asked if I saw no more appearance of death in her face yet. When I told her there was, she begged I would indulge her with a looking-glass; and looking earnestly into it, she said with transport, "I never saw myself with so much pleasure in my life."<sup>29</sup>

To have a victory over death meant, on the one hand, to remain indifferent to it, while, on the other hand, to celebrate its arrival.

Another example of looking death in the eye was the deathbed of the poet John Donne, which was reported in one of the early issues of the *Arminian Magazine*.<sup>30</sup> It was not uncommon for the magazine to publish great experiences and remarkable deaths of non-Methodist Christians, such as John Donne. As death approached, Donne requested that his portrait be drawn, but first ordered a wooden coffin to be built by a carpenter, giving him his exact body measurements. When the coffin was ready, Donne removed his clothes and put on a white winding-sheet. He then climbed into the coffin and placed his hands as was the custom to lay the hands of corpses, fit to be lowered into the grave, eyes shut. When the portrait was finished, he requested that it be set by his bedside and studied it hourly until his death.

### C. From Salvation toward Regulation

The nineteenth-century Methodist contemplated his death throughout life, constantly examining the state of his or her soul, seeking assurance of the love of God in the visible fruits of His love: a fearless death. When the hour of death arrived, the Methodist, conscious of his or her mortality, was prepared to bring life to a close.

Triumphant death was a spectacle for the Methodist community, family, and friends. They came not only to watch how a person lived and died, but

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28 *Id.* at 20-21.

29 Journal entry dated May 5, 1757, in 21 Wesley & Outler, *supra* note 21, at 206-07.

30 The Life of Dr. Donne, *Arminian Mag.*, 1779, at 2. See also a discussion in J.A. Fitch, *Preparation for Death*, 66 *Theology* 445 (1963).

also to partake in the art of dying: interrogating the dying patient as to the state of his or her soul, writing and rewriting the last words of the departed. The Methodist life was completed in death, and the appropriate telling of one's life was as a recital of one's death.

The deathbed was a microcosm of Methodist life, a moment in life that captured its entirety. At the deathbed, the relationship between the Methodist believer, God, and the Methodist people unfolded. Through it, the truth of the Methodist world was brought to life.

It would be anachronistic to ask why turn-of-the-nineteenth-century Methodists did not contemplate medical euthanasia as a way of dying. The Methodist lying on his deathbed was faced with challenges radically different from those faced by the modern patient, and euthanasia could offer no relief to the former. For indeed, a good Methodist death was not a painless one, but rather a death in which pain was overcome. Neither was a good death a hurried departure, for the Methodist took his time to face death and acknowledge its possible terrors. Nor did the Methodist passively await his death. An elaborate set of practices was followed, designed to lead the Methodist to triumphant victory. By medically hastening death, euthanasia would have robbed the dying of the opportunity to face his or her death and overcome it.

Thus, for medical euthanasia to have emerged as a way of dying, the whole context of the deathbed would have had to change to allow the development of a new deathbed ethos and practices. Under such a different ideal of a good death, religion and medicine would have parted ways and priest and physician would have divorced. Death would no longer have been the culmination of life, and pain would have yielded not to a triumphant death but to the powers of medical technique.

Yet already in the Methodist art of dying, there were hints of the future emergence of regulation of the deathbed. Although for the Methodist, dying was not an ordinary moment in life but, rather, an intensified life experience, dying nonetheless became part of life in a way unimaginable to Catholic believers. What is significant about the Methodist death as a precursor of the contemporary way of dying is the attempt to overcome death in *this* world. In other words, underlying the art of holy dying was the Methodist's wish to gain this-worldly mastery over death.

The doubt, hope, and fear of death that characterized the Catholic deathbed, where dying was a bridge between this world and the world to come, had no place in the Methodist believer's experience of death. The Methodist sought an experience of dying with a this-worldly assurance of salvation, a way of dying that was accompanied by a disposition of certainty in the human power to master death. It was on the background of this

new approach to dying that euthanasia, soon understood as the this-worldly medical treatment of dying, became possible.

## II. MEDICAL AID IN DYING: ETHICS OF HEALTH

In a relative short span of time, the course of the nineteenth century, both the sense of euthanasia and the law governing the deathbed changed. The decline of the art of holy dying was captured in an 1861 edition of the *Sick Man's Passing Bell*, an *ars moriendi* book first published in the early seventeenth century. This edition was melancholic in tone, lamenting especially the fact that the physician and lawyer are sent for when a man is dying, but the "physician of the soul stands outside the door."<sup>31</sup> A new way of dying was emerging, and its most visible sign was the increasingly dominant presence of the physician at the deathbed. Whereas in previous centuries, the medical doctor would commonly have left the bedside when it was clear that the patient was hopelessly ill, a new ethic developed in the nineteenth century by which the physician was expected to remain at the deathbed. But the new presence of the physician at the deathbed signified a much deeper change. What allowed for the physician to be present at the deathbed was the transition of the problem of dying into a question of health. Only in the nineteenth century did the treatment of the dying, as such, become a medical concern and, thus, governed by medical practices. The ethics of the deathbed shifted from religion to medicine, and dying further emerged as a matter of regulating life: life was now understood in its biological, rather than biographical, sense.

The sense of the term "euthanasia" changed accordingly. Euthanasia was now understood as the new duty of the medical profession to assist the dying person in his or her last hours, short of hastening death. Euthanasia no longer meant a good death blessed by the Grace of God, but, rather, the actions taken by physicians to achieve such a death.

We shall see how this new role of the medical profession proceeded neither from new scientific knowledge nor from innovations in medical technique. On the contrary, the physician's role at the deathbed was secured long before he had any medical treatment to offer the dying. It is precisely this apparent paradox, that physicians did *not* possess the means for curing dying patients but nevertheless became the new governors of the process of

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31 C.W. Bodemer, *Physicians and the Dying: A Historical Sketch*, 9 *J. Family Practice* 827 (1979).

dying, that must be explained. And it is precisely from this paradox that the final shift in the meaning of euthanasia emanates: from the benign duty of easing death to the troubling practice of hastening death.

### **A. A Changing of the Guard**

Prior to the nineteenth century, reflections on the process of dying were all but absent from medical discourse. Traditionally, physicians had no defined duties at the deathbed. Indeed, it was common medical practice for physicians to withdraw their care from an incurable patient, leaving the dying in the trustworthy hands of the attending family, friends, and clergy.<sup>32</sup> Many physicians held fast to the simple belief that if there was nothing they could do to cure the patient, their place at the bedside was superfluous. Thus, they would willingly step aside to allow the deathbed rites to be performed.

By the early nineteenth century, this widespread medical practice of abandoning the deathbed of the incurable patient was being questioned. A new responsibility on the part of medical practitioners to aid the dying was first mentioned at this time in codes of professional medical ethics. The medical code was a relatively new genre of writing, which had become popular during the late-eighteenth century. Its purpose was to establish the responsibilities of physicians toward their patients in order to secure the good reputation of the medical profession — a reputation that was threatened by the proliferation of quackery.<sup>33</sup> In 1817, one such etiquette read as follows:

Let me here exhort you against the custom of some physicians, who leave their patients when their life is despaired of, and when it is no longer decent to put them to further expense. ... Even in cases where his skill as a physician can be of no further avail, his presence and assistance as a friend may be agreeable and useful both to the patient and to his nearest relations.<sup>34</sup>

Alongside the apparent impotence of medicine to offer cure or treatment

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32 Evidence of this behavior and its implications are presented in what follows.

33 For nineteenth-century medical etiquette, see 2 *The Codification of Medical Morality* (Robert Baker et al. eds., 1993). On its importance in promoting the esteem of orthodox medicine, see Harris L. Coulter, *Divided Legacy: A History of the Schism in Medical Thought* (1973). For later codes, see Kenneth Warren Hamstra, *The American Medical Association Code of Medical Ethics of 1847* (1987).

34 John Gregory, *Lectures on the Duties and Qualifications of a Physician* 37 (1809), *reprinted in* John Gregory's *Writings on Medical Ethics and Philosophy of Medicine* (Laurence B. McCullough ed., 1998).

to the dying patient, a new medical duty emerged calling physicians to action. This new duty was to remain with the dying patient to the very end, despite the fact that nothing of the *materia medica* in their possession was of any avail. While the content of the duty was still unclear, its name quickly spread among physicians in the nineteenth century: it was called "euthanasia."

The first modern discussion of medical euthanasia appeared in a formative article published in 1826 by Karl F.H. Marx.<sup>35</sup> Marx, from Göttingen, was one of the leading German physicians of the mid-nineteenth century, and it is he who gave the new treatment of the dying the old name.<sup>36</sup> Contemplating the goals of "Medical Euthanasia," he asks,

What can be done so the passing from life may be gentle and bearable?  
Why should not man, with his intellect mastering so many problems,  
find and produce some skillfull contrivance for the care of the dying?<sup>37</sup>

Though Marx did not suggest hastening the death of the dying patient,

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35 Carl F.H. Marx, *Medical Euthanasia*, 7 J. Hist. Med. & Allied Sci. 401 (1952). Marx also published exhaustive studies on Herophilus, Blumenbach, Paracelsus, Leibnitz, and Schneider. Fielding H. Garrison, *An Introduction to the History of Medicine* (1929).

36 Admittedly, the use of the term euthanasia to discuss the responsibilities of the physician at the deathbed can already be found in Sir Francis Bacon's writings on the duties of the medical profession. In his work on the "Advancement of Learning," the seventeenth-century scholar proclaimed,

The office of a physician [is] not only to restore health, but also to mitigate the pains and torments of diseases; and not only when such mitigation of pains, as of a dangerous symptom, helps and conduces to recovery; but also when, all hope of recover being gone, it serves only to make a fair and easy passage of from life.

L.T. Cowley et al., *Care of the Dying: An Ethical and Historical Perspective* 1478 (1992). Bacon, however, limited the role of the physician to the treatment of the body. Consequently, he referred to medical euthanasia as "outward euthanasia," or "the easy dying of the body," distinguishing it from euthanasia proper, "which regards the preparation of the soul." Sir Francis Bacon, *The Works of Francis Bacon* 387 (London, Longman 1860). For Bacon, *outward* euthanasia is still subordinate to *inner* euthanasia and, in any event, the former cannot replace the latter. As we shall see, the nineteenth-century resurrection of the division between body and soul bestowed more than the mere care of the body into the hands of the medical profession. The first use of "euthanasia" to signify the medical treatment of the dying patient was made by Paradys in a Latin text from 1794. Paradys, *Oratio De Euthanasia* (1794). However Paradys' text does not give expression to the new sense of euthanasia as it appears in Marx's text and in what follows.

37 Marx, *supra* note 36, at 404-05.

this brief passage contains, in concentrated form, intimations of the new approach to the treatment of dying. First, the duty at the deathbed was not to cure but to care for the dying. Second, this duty can be fulfilled by the skillful — that is, technical — mastery of dying. Third, and as a consequence of both of the above, the responsibility to care for the dying was placed in the hands of the physician.

But what should we make of the medical attempt to solve a problem that was, by definition, unsolvable? What precisely was the new treatment that Marx, along with American physicians of the nineteenth century, had in mind?

One central aspect of Marx's conception of the treatment of the dying patient was the relief of pain. But there were no breakthroughs in the advancement of pain relief medication during the first half of the nineteenth century that could justify the new presence of the physician at the deathbed. With the exception of the replacement of opium with its alkaloid, morphine, in the second half of the century, the capacity of the medical profession to treat dying patients was no different during most of the nineteenth century than it had been during the previous century.<sup>38</sup> Not until far into the twentieth century were there radical changes in medicine's power to treat the dying patient, relieve pain, and prolong life.<sup>39</sup>

Another task included under the new duty of the physician was to protect the patient from any additional discomfort that did not arise directly from his or her medical condition.<sup>40</sup> Thus, the physician would be responsible for preventing the possible development of bedsores and other discomforts that were not related directly to the disease but could increase the suffering of the dying patient. While the relief of suffering was of apparent significance, it did not require any specialized medical knowledge. In fact, any adult attendant at the deathbed, such as a family member or a nurse, could be effective in securing these comforts. Therefore, it is difficult to understand why the physician would be called to the deathbed to attend to such ordinary duties, and it is likewise difficult to understand this deathbed treatment as the emergence of a new type of treatment of the dying.

The physician had no advanced treatment to offer to assuage the dying patient's suffering, nor was he uniquely qualified to play the role he had at the deathbed, and yet, there he was. Despite the hopelessness and the

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38 For a more elaborate discussion of nineteenth-century medical treatment of pain and, specifically the treatment of the suffering of death, see Shai Lavi, *The Problem of Pain and the Right to Die*, in *Death, Pain and the Law* (Austin Sarat ed., 2000).

39 See, e.g., Sherwin B. Nuland, *How We Die* (1996).

40 Marx, *supra* note 36.

inevitable decline associated with dying, and perhaps precisely because of it, the medical profession followed a deeper calling to be present at the deathbed. What the physician had to offer the dying patient was a treatment of a new kind: hope in the face of despair, independent of any cure that could be offered. "For with encouragement and with promise," Marx believed, "he will bring spirit to the dejected, hope to the fearful, confidence to the despairing."<sup>41</sup>

## **B. The Ministry of Intelligent Hope**

Early in the nineteenth century, Thomas Percival, the first to institute a modern code of medical ethics, raised the issue of the physician's duty to care for the patient's spirit as much as for the health of his or her body. Percival based this duty on the belief that the emotional state of the sick patient could have an effect on his or her bodily constitution.

For, the physician should be the minister of hope and comfort to the sick. ... The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.<sup>42</sup>

The new role of the physician at the deathbed was, according to Percival, to minister hope. At times, this ministrations is more important than any particular medicine that the physician can offer the patient. This is especially true at the deathbed, where truly no cure can be offered. Thus, Percival believed that the physician should embody the notion of hope in his persona:

The expression on the physician's countenance should be cheerful; he should greet his patient with smiles, or in more serious maladies, at least with placidity. Even the important questions regarding symptoms and feeling should not seem serious to the sufferer.<sup>43</sup>

This cheerfulness, which Dendy, a leading nineteenth-century physician, identified with hopefulness, is not merely a personality trait required of the physician.<sup>44</sup> Rather, it derives from the certainty and confidence that the

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41 *Id.* at 411.

42 Marx, *supra* note 36, at 410.

43 Thomas Percival, Percival's Medical Ethics 220-21 (1927).

44 W.C. Dendy, *On the Physiology of Death and the Treatment of the Dying*, 1 J. Psychol. Med. & Mental Pathology 121 (1848).

physician, as a physician, can engender in others. Hope, in other words, is not merely a subjective mood, but, rather, is conceived as part of the traits a physician should possess.

To further understand this new identity of the medical profession as a cheerful and hopeful profession, we can contrast it with the role of the clergy at the deathbed. As noted earlier, prior to the nineteenth century, physicians tended to relinquish their responsibilities at the deathbed, leaving the treatment of the dying in the hands of the clergy. Then, early in the nineteenth century, young physicians were reprov'd for such behavior and were reminded that not only were they capable of caring for the dying, but also that they might be more suitable for the task than the clergy. Marx warned his colleagues,

Whoever refuses his part in this duty [administering some kind of higher comfort] and assigns it solely to priests deprives himself of the most noble and rewarding aspect of his work. Where the priest, administering the sacraments, comes to the bedside to soothe the longing soul with the last solace of religion and comfort, who will not see the patient's deep shock when he faces this quasi-harbinger of death?<sup>45</sup>

Not so with the physician. The physician would not raise such terror, for he is associated with hope for a cure, not with the inevitability of death. Of the two, the minister of hope rather than the minister of fate should accompany the dying in his final hour. From the medical viewpoint, the presence of the priest at the deathbed could offer nothing but fear and terror. The possibility of saving the soul that was so intimately related to the *ars moriendi* deathbed was no longer acceptable in principle to the medical profession. Regardless of one's religious belief, the only hope that the clergy could offer was hope in a world to come. In this world, the presence of the clergyman at the deathbed could mean only one thing: imminent death. Therefore, only the physician could offer real hope — i.e., this-worldly hope — founded in the powers available to medical science and technique.

But what were these powers? What possible content could there be to the hope ministered to the dying patient by the physician? And how could the medical physician become the minister of hope, when it was medicine that openly acknowledged that in most cases there was no cure for the dying patient? The answer mid-nineteenth-century physicians came up with was in the form of a new breed of hope, one that did not deny the dying patient's

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45 Marx, *supra* note 36.

incurable condition in the name of the all-powerful capacities of medicine, but that would, at the same time, refrain from undermining the new role of the physician at the deathbed as the minister of hope.

The scientific grounds for such an approach were laid down by Worthington Hooker, one of the leading American physicians of the mid-nineteenth century. Hooker received his education at Harvard Medical School and, after several decades of medical practice, joined the faculty of the Yale Medical School. In 1849, he published the only monograph on the subject of medical ethics written by an American physician in the nineteenth century.<sup>46</sup> In this influential book, Hooker devoted several chapters to the discussion of the natural effect of the mind on disease and, in particular, the role of hope in treatment.

The hope that the physician was to instill in the patient was neither groundless optimism nor a manipulative effort to deceive the patient. Precisely in this way, the hope ministered by the physician differed from that offered by the "quack." This distinction was particularly important at a time when medical orthodoxy was trying to establish its professional boundaries. Physicians of the mid-nineteenth century were forming professional organizations to secure public recognition in their professional capacities. The American Medical Association, established in 1847, launched a war against quackery and excluded from its ranks homeopaths and other non-orthodox practitioners. Similar distinctions were drawn in the realm of day-to-day practice. Specifically with respect to the treatment of the dying, the medical profession sought to offer a scientifically grounded hope that would win the confidence of the dying patient and counter the deceitful practices of non-orthodox medical sects.<sup>47</sup>

But what precisely was modern about the problem of hopelessness in the face of death? Were fear and despair not always part of the temptations of the

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46 Dictionary of American Medical Biography (Martin Kaufman et al. eds., 1988).

47 Some medical historians have ignored the importance of this distinction and, hence, have undermined the central place of the administration of hope in modern medicine. Most explicitly, Rothstein writes,

The therapeutic value of hope and confidence exists solely because of the patient's faith in the physician. Therefore, any practitioner who inspires faith in his patients is the physician's equal in this regard. Indeed, lay healers, faith healers, Indian doctors, nostrum vendors, and the whole range of practitioners who relied largely on their charismatic qualities for their success were probably more successful than most physicians in inspiring hope and confidence in their patients.

William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* 10 (1972).

*ars moriendi* tradition, and was hope not always offered at the deathbed to assuage that fear and despair, or to paraphrase the well-known adage, "Where there is hope there is life"?<sup>48</sup> The new hope offered by modern medicine was a hope that did not promise a cure, but that countered the condition of hopelessness experienced as helplessness. Even if medicine could not offer a solution to the problem of human mortality, it insisted on its power to win small and reliable victories at the deathbed. Medicine's limitations in countering death were regarded by the medical profession not as a weakness, but, rather, as a sign of strength. "The importance and usefulness of the medical profession," a nineteenth-century physician explained, "instead of being diminished will always be elevated exactly in proportion as it understands itself, weighs justly its own powers, and professes simply what it can accomplish."<sup>49</sup>

For the modern physician, in other words, it was not the hopelessness (i.e., terminality) of the condition per se that was the problem, but only hopelessness experienced as helplessness, namely, as the inability to continue medical treatment. The incurable condition of the dying patient would not lead to hopelessness as long as there were some action that could be taken with regard to the patient's condition.

The hope of the physician should be an intelligent hope. It should be based upon just and definite conclusions. It should be discriminating, and should be varied in its degree according to the character of each individual case. ... Hope may thus be indulged in relation to the different stages of a case, without regard to the final event of it, which may be so distant and so clouded in doubt that no calculations can be made in regard to it. ... This in many cases is much better than to come to him every day with the simple expression of the hope that he will at length recover. In the tedium of his confinement, if it be a long one, he soon tires of looking far ahead to the bright fields of convalescence, but finds relief in the time and spots lighted up of hope by the way — the oasis thus made in the desert of sickness.<sup>50</sup>

### C. Euthanasia as a Means of Overcoming Hopelessness

Euthanasia, the hopeful death of the dying patient, should thus be seen as a new way of dying that emerged in the nineteenth century, for in euthanasia,

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48 "As for the patient, as long as there is life, there is hope." 9 Marcus Tullius Cicero, Cicero in Twenty-Eight Volumes 10 (1912).

49 Jacob Bigelow, *On Self-Limited Diseases* 106 (1972).

50 *Id.* at 345-46.

hope becomes a condition for a good death. The dying patient should never be abandoned, and physician and patient alike should always believe in the power of the medical profession to treat the dying. From this benign sense given to euthanasia by mid-nineteenth century physicians soon emerged the more radical form of euthanasia as the medical hastening of death.

In the age of medical therapeutics, which set forth in the nineteenth century the new approach to the physician's duty on the deathbed, hope became a call for action. Simply sitting by and awaiting passively for death was not an appropriate approach for the modern science of dying, which demanded action. Passive waiting was now considered an impossible state of indifference. Oliver W. Holmes, arguably the most notable American physician of the mid-nineteenth century, expressed this notion when he declared, "No human being can rest for any time in a state of equilibrium where the desire to live and that to depart just balance each other."<sup>51</sup> As long as the patient is in good mind and of hopeful spirit, she will be untroubled by any discomforts caused by her condition. But when hope of cure or improvement is gone, "every incommodity stares out at him, each one of them packing up his little bundle of circumstances and calling him to move to his new home, even before the apartment is ready to receive the new bodily tenant."<sup>52</sup>

Though Holmes was by no means advocating euthanasia, his telling metaphor demonstrates how the modern impatience for passively awaiting death gave rise not only to the conception of euthanasia as the medical treatment of the dying patient, but also to euthanasia as the medical hastening of death. The over-ambitious desire to instill hope at the deathbed, despite the incurable condition of the dying patient, was the origin of the medical hastening of death as a last resort. The deathbed became simultaneously the moment when all hope was lost, but also the moment in which a final effort was being made to overcome the sense of helplessness at the deathbed by hastening death.

At times, the dying could have been comforted with the promise of partial or temporary recovery. At other times or for other people, this was not sufficient, and a new call for action emerged at the deathbed, shared by patient and physician alike, despite the apparent hopelessness of the situation. In the same way that dying was defined as a problem of medical mastery (as the apparent incapacity to cure), so the solution to the problem became a task of mastery — i.e., the ability of medicine to prolong life or,

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51 Oliver W. Holmes, cited by E.P. Buffet, *Euthanasia: The Pleasures of Dying*, 55 *New Englander & Yale Rev.* 231, 240-41 (1891).

52 *Id.*

when such attempts fail, to provide a good death. Medicine was summoned to deliver the patient from dying not by curing him, but by hastening his death.

Thus we find that the same logic lies behind prolonging life as behind hastening death.<sup>53</sup> In both, the treatment of the dying becomes a duty; in both, the determination of the time of death shifts from the province of nature to the intercession of technique.<sup>54</sup> Both are grounded in the belief in the power of medicine to secure a good death by technical means; and for both, euthanasia is regarded as medical treatment to assist dying. Finally, common to both is the disposition of hope, i.e. the possibility of medical technique becoming the modern art of dying.

Modern medicine could not offer a great promise of salvation from death. Thus physicians opted for a more tangible and limited promise of hope in the face of death. This hope was not the promise of a world to come, but a this-worldly guarantee that, as long as life persisted, hope could be renewed indefinitely. It is this modest megalomania that characterized the medical practitioner of the latter half of the nineteenth century, and it is the paradoxical nature of the physician's duty that eventually led some to offer euthanasia of a very different kind: medically hastened death. Euthanasia, in this sense, can be understood as the attempt of physicians to take action when really nothing more could be done to save the patient from death. This approach to death and euthanasia demonstrates the extent to which late nineteenth-century physicians sought to master death merely for the sake of proving their mastery. The movement toward legal regulation of the deathbed would become complete only once dying had changed from a limited medical problem to a problem of public policy and positive law.

### III. EUTHANASIA AND PUBLIC POLICY: ETHICS OF REGULATION

Soon after the general conception of euthanasia became one of medical treatment of the dying, the question of its legal status began to emerge.

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53 By the same token, in the contemporary context, the hospital and the hospice, which are seen as two radically different ways of dying, are merely divisions of labor in the modern way of dying. Those same physicians who deny death are those who define it: the very physicians who send their patients to hospice.

54 One could be tempted to say "from nature to the prerogative of man," but this is not the case. The medical practitioner becomes a servant of technique rather than the other way around.

In 1906, the first attempts to legalize euthanasia in the U.S. took place in Ohio and Iowa. In 1938 the first American euthanasia society was founded: the National Society for the Legalization of Euthanasia. This Society, as its name suggests, set as its main objective the legalization of medically hastened death.

The attempts to legalize the medical hastening of death that followed — no more than a handful — all failed. During the first half of the twentieth century, euthanasia remained the unfulfilled dream of a relatively small group of advocates and a preposterous, at times horrifying, possibility for others. For most Americans, euthanasia was simply not an issue, and for all practical purposes, they viewed these early attempts at legalization as altogether insignificant.

True, these legislative attempts may seem at times to be no more than figments of the imagination of one or another advocate of euthanasia. But it is precisely the way in which laws regulating euthanasia were imagined that is of interest for us. The limits of the law here as elsewhere are the limits of its imagination. And while the early draft legislation on euthanasia did not succeed, new ones are currently being formulated daily, sharing with the old drafts if not the letter of the law, its spirit.

What is entailed in the emergence of euthanasia as a legal issue is not only a transition in the ethics of dying from the realm of medicine to the province of law, but also the even more important transformation within law itself from the common law to law as regulation.

### **A. The Problem of Translation**

It quickly became clear to early advocates and opponents of euthanasia that the law was the main obstacle in the way of institutionalizing medical euthanasia. By "law" both sides meant the traditional norms of criminal law, which, in principle, prohibited the taking of life. There were very few exceptions to this rule, and euthanasia did not seem to fall under any of the traditional defenses.<sup>55</sup> In 1879, reviewing the euthanasia debate, a leading medical journal concluded:

The greatest difficulty [more than ethics or religion] was encountered

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55 The obvious defenses would include self-defense, necessity, and duress. See the discussion that follows below in the text. The idea that euthanasia may fall under the defense of duress was introduced only many years later by the British jurist Glanville Williams. See Glanville Williams, *The Sanctity of Life and the Criminal Law* (1957).

in the legal aspects of the subject. According to all codes of civilized men, the law was distinct and clear, "thou shalt not kill." In the present state of society the practice of Euthanasia could only be regarded as the practice of murder. ... Until there was a change in the laws and in society, there would be no possibility of making recommendations upon the practice of euthanasia.<sup>56</sup>

The legal status of euthanasia under the common law is stated in clear and distinct terms in this passage. Euthanasia violates one of the most fundamental principles of the legal system: the sanctity of life, which prohibits the unjustified taking of human life in any form. Since from a legal point of view, euthanasia is intentional and premeditated killing, it is, without any doubt or possible objection, murder. From a medical point of view, however, euthanasia could mean little more than a final act of palliative care. For the physician, the practice of euthanasia could be justified on the following grounds: Since the patient is hopelessly dying, there is nothing the physician can do to prolong life. The physician is, therefore, released from his duty to prolong life. Furthermore, since the patient is suffering from excruciating pain, the physician bears a responsibility to relieve that suffering using all available means. The result is the medical hastening of death.

However, criminal law at common law seemed unequivocal. The common law made no distinction between the life of a dying patient and the life of other person. Shortening life by a few minutes and by a few years were equally considered murder. Moreover, the fact that the patient is suffering from intolerable pain could serve as no justification for the action, since motivation under common law only affects the severity of the punishment, not culpability itself. Thus, under the common law, the medical responsibility to relieve pain could not legally justify shortening the life of a dying patient.<sup>57</sup>

The medical understanding of euthanasia was initially untranslatable into legal terms; the language of euthanasia appeared alien to the legal mind. If euthanasia were to be considered anything other than murder, the law would have to change not only in content but also in form, from a common law tradition based on ancient custom to a modern instrument for regulating medical practice. The simple solution to this problem that early proponents of euthanasia advocated was changing the law. And though to

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<sup>56</sup> *Editorial, Med. & Surgical Rep*, 1879, at 479-80.

<sup>57</sup> Such a medical duty could be legally justified on the basis of the necessity defense. This hypothetical justification of euthanasia was not raised at the time. However, compare with more recent discussions, for example, Williams, *supra* note 55.

contemporary readers this may seem an obvious solution to the problem, it was not as obvious to jurists of the turn of the twentieth century. Nor was the power of state legislation to supersede the common law tradition as clear. True, the power of legislative codes to supersede existing law had long been recognized. But in the nineteenth and early twentieth centuries, a reversal of the balance of power between judge-made common law and statutory law occurred. Whereas judge-made common law had always been the primary source of law, legislation began to overtake it as the main source of law during this period.<sup>58</sup> The unquestioned prerogative of the state to overwrite basic principles of the common law to form new public policies became self-evident only during the Progressive era. The early attempts to legalize and regulate euthanasia were, in this sense, early experiments in the superiority of regulation over tradition. One of the first American jurists to discuss euthanasia in this context was Clark Bell. Though not a supporter of the practice, he pointed out that

[u]nder our civilization, no power is given by the law to end even such a life [stricken with a suspension of all the faculties of consciousness, living on, unconscious of suffering, or of the value of life], but the inherent right of society to regulate its affairs, in its own best interests, must be conceded to be broad enough, to justify any legal enactment ... authorizing the termination of human life in such cases.<sup>59</sup>

Nevertheless, the ban on euthanasia could not simply be removed. After all, euthanasia from the common law perspective was murder, and removing the ban on euthanasia could mean opening the door to unjustified killing. It soon became clear, even to advocates of euthanasia, that medicine could not govern the practice of euthanasia on its own. True, the physician could easily put an end to his or her patient's suffering by hastening death. Yet medical ethics provided no guidelines for how the physician should choose between prolonging life and hastening death. Thus, there was always the danger that the physician might abuse his or her discretion by illicitly bringing life to an end.

For this reason, even advocates of euthanasia believed that the treatment of the dying should be regulated by the law and not simply decriminalized.

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58 William Popkin, *Materials on Legislation* 20 (1993). In America, the New Deal Legislation of the 1930s crowned the ascendancy of law by statute. Frank Grad, *The Ascendancy of Legislation: Legal Problem Solving in Our Time*, 9 *Dalhousie L.J.* 228 (1985).

59 Clark Bell, *Has the Physician Ever the Right to Terminate Life?*, 5 *Medico-Legal Stud.* 78 (1898).

Whereas *decriminalization* is the removal of the legal sanction, *regulation* brings the practice under the domain of law. Proponents of legalized euthanasia viewed the law as an instrument to shape the conditions and safeguards for performing euthanasia. Law was to play a central role in institutionalizing euthanasia, turning it from a discreet medical practice into an established public policy. The power of the law was to be, in other words, constitutive and formative, not only preventive and nay-saying.<sup>60</sup> How advocates of euthanasia faced these challenges is the question before us now.

### B. The 1906 Legislative Attempt

The first attempt to legalize the medical hastening of death was launched in the Winter of 1906.<sup>61</sup> This first piece of euthanasia legislation, like the first euthanasia proposal, was drafted by a layperson, Miss Anne S. Hall of Cincinnati, Ohio. Miss Hall's call to legalize euthanasia was motivated by the experience of her mother's death: Hall regretted the fact that chloroform could not be used to ease the final suffering of her cancer-ridden mother. The importance of this formative experience notwithstanding, Hall's proposal merely put into legal terms notions that were already prevalent in America's public discourse on euthanasia. The draft bill received a great deal of publicity due to the support of the renowned Dr. Charles Norton, a former Harvard Professor and man of letters, who was best known for his highly praised translation of Dante's *Divine Comedy* and John Donne's poetry.

The draft bill was brought before the Ohio Legislature on January 23, 1906, and was entitled "Concerning administration of drugs, etc., to mortally injured or diseased person." This apparently was the first euthanasia bill ever introduced in a legislature in an English-speaking country.

The language of the bill was as follows:

[W]hen a person of legal age and sound mind is fatally hurt, or so ill that recovery is impossible, or is suffering great physical pain without

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60 The constitutive power of law has often been neglected in the analysis of juridical power. At the turn of the twentieth century, the constitutive role of law was especially important with respect to legalization in the context of emerging welfare and public health legislation. See Alan Hunt & Gary Wickham, *Foucault and Law: Toward a Sociology of Law as Governance, Law and Social Theory* (1994).

61 A similar bill was drafted in Iowa a few months later. No trace of the bill can be found in the Iowa Legislature records. E.J. Emanuel, *The History of Euthanasia in the United States and Britain*, 121(10) *Annals Internal Med.* 793 (1994).

hope of relief, his physician, if not a relative or interested in the person's estate, may ask him or her, in the presence of three witnesses, if he or she wants to be killed. If the answer is affirmative three other physicians are to be called in, and if they agree that the case is hopeless, they are to proceed to do the job in a neat and convenient way ...<sup>62</sup>

The bill's language placed the burden of taking the initiative to perform euthanasia on the shoulders of the physician. It authorized the physician to offer the patient death as medical treatment, which the patient may accept or decline. While the consent of the patient was a necessary requirement, the bill emphasized its origins as deriving from the logic of the practice of medicine, not the logic of the will of the patient. Another interesting feature of the bill is that it offered medical euthanasia to three different categories of patients: (1) a person who is fatally hurt (for example, due to an accident); (2) a patient who is irrecoverably ill (from a disease); and (3) any person suffering from pain without hope of recovery. What all three groups share is the notion of an irreversible, fatal state of suffering.

When the bill was introduced before the Ohio Legislature, an opponent of the bill, Hill, brought an immediate motion to reject it. However, the motion was defeated seventy-nine votes to nineteen, and the bill was read for the first time before the Legislature. The following day, it was referred to the Committee on Medical Jurisprudence. But when it was finally voted on, it was defeated by a vote of seventy-nine to twenty-three.<sup>63</sup>

No doubt there were many reasons for the failure of the bill, not the least of which was the objection based on fear of abuse. Several days after the bill's defeat, *The New York Times* published a letter to the editor entitled *Euthanasia in Practice*, which reflected this concern. The letter began with the following lines: "At a recent meeting of our club the Ohio Euthanasia bill was unanimously approved. Next day Smithers, our Secretary, providentially, it would seem, was run over by an automobile and was fatally hurt ... ." The letter, a brilliant parody of the euthanasia bill, continued on to tell how a physician and three bystanders who had gathered around Mr. Smithers had offered to perform on him euthanasia while he was still lying on the ground. After Mr. Smithers had acquiesced, three physicians were summoned: Dr. Dodd (the allopath), Dr. Gusher (the osteopath), and Dr. Winks (the accomplished veterinarian). With the bill's

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62 Journal of the House of Representatives: Seventy-Seventh General Assembly of Ohio 99-100 (Jan. 23, 1906).

63 Olive R. Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia* (1975).

requirements apparently fulfilled, these physicians would have administered euthanasia on the spot if not for the issue of who would pay for the procedure. The letter concluded by reproaching the physicians for not respecting the law and ignoring the fact that Smithers' estate would have been liable for the physicians' fees.<sup>64</sup>

Indeed, one of the strongest and most repeated criticisms directed at the 1906 bill was that it was open to abuse, that the medical procedure it offered was not accompanied by the proper mechanisms for safeguarding it from abuse. Although the bill did require the participation of witnesses and three doctors, it left a wide breach where at least two factors were concerned: the urgency required for performing euthanasia and the identities of the physicians authorized to do so under the bill. Aware of these flaws, all drafters of future pieces of euthanasia legislation took these specific concerns and, more generally, the fear of abuse into account.

The true challenge for the supporters of legalized euthanasia was to draft a bill that would not be open to any risk of abuse. The role of the law was to offer full regulation of the medical procedure. If certainty against abuse of the procedure could be achieved in euthanasia legislation, then nothing could stand in the way of its success. Or so at least its supporters believed.

### **C. The Euthanasia Society of America**

On January 16, 1938, the National Society for the Legalization of Euthanasia was established in New York City. With the establishment of the Society, the efforts to legalize euthanasia entered a new phase. The Society set as its goal to "create public demand for the legalization of voluntary euthanasia, and to secure the enactment of state laws permitting voluntary euthanasia with procedure as simple as is consistent with security against abuse in the state of New York."<sup>65</sup> A year later it changed its name (but not its goal) to the Euthanasia Society of America ("ESA").

The founding of the ESA entailed more than just a change in organizational tactics on the part of euthanasia advocates. It manifested a more radical shift in the understanding of euthanasia and its goals. Both the problem of dying and its solution — euthanasia, which had initially been understood as confined to medical concerns — were now understood more broadly as social concerns. Dying became one among a broad array of public health

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64 N.Y. Times, Jan. 29, 1906.

65 Founding Statement of the National Society for the Legalization of Euthanasia, Jan. 16, 1938, Archive of the Euthanasia Society of America, Baltimore, Md.

issues, such as birth rates and mental health. Similarly, euthanasia became one among several new practices regulating the biological processes of birth and death, such as birth control, abortion, and sterilization. All reflected the belief that human beings can use their knowledge to control events and better their lives.<sup>66</sup> Even more importantly, euthanasia no longer meant merely hastening the death of patients who are already dying. Rather, by the early twentieth century, euthanasia was being advocated as a solution to a broader range of cases, which included the physically handicapped. Thus, for both its supporters and its opponents, euthanasia was no longer confined to the ailing patient on his or her deathbed.

It is of more than anecdotal value to note that the ESA continued its activities even after the general Nazi atrocities and, specifically, the Nazi euthanasia project were revealed. The ESA tried to ward off any attempt to compare its euthanasia proposals with the projects of the Third Reich. One strategy that the ESA chose was to clarify the voluntary character of the American proposals; another and much more striking strategy was to emphasize the fact that American euthanasia, unlike Nazi euthanasia, would be regulated by law:

Misunderstandings of our aim still exists. Some people think we're in favor of the government secretly killing off defectives, as in Nazi Germany; others believe that even now, before the law is amended, the Society can somehow arrange to have euthanasia administered, as we receive piteous appeals from hopeless sufferers.

So during the past year we have taken every opportunity to explain that we are opposed to illegal, surreptitious, compulsory, "mercy killings", that what we are working for is to legalize medically supervised euthanasia for incurable sufferers who ask for it.<sup>67</sup>

#### **D. Law as Regulation**

Early on in the struggle for institutionalization of euthanasia, supporters believed that the law was the greatest obstacle facing them. The law, they rightfully assumed, would not tolerate the taking of human life. From a legal standpoint, euthanasia was nothing less than murder. The problem

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66 *See also* Stephen L. Kuepper, *Euthanasia in America, 1890-1960: The Controversy, the Movement, and the Law* 112-13 (1981).

67 Taken from notes from the ESA Annual Meeting, 1943, Archive of the Euthanasia Society of America, Baltimore, Md.

with legalizing euthanasia was the bridging of the gap between the medical understanding of the practice and its legal status, which were at odds: even assuming that physicians were ready to embrace the practice, the law was not.

The solution to this disparity entailed more than just changing the content of the law, more than passing a bill legalizing euthanasia. For euthanasia to become lawful, a fundamental change in the law and how it related to the medical practice of euthanasia had to occur. In the ESA's attempts to regulate euthanasia, we encounter such a fundamental change in the conceptualization of law. Law, which maintained a stance *vis-à-vis* euthanasia that was staunchly autonomous from that of medicine, now refrained from making judgment as to the validity of the practice and limited its discretion to setting the conditions under which the practice could take place. From being an obstacle standing in the way of euthanasia, law became a necessary component in its practice: law could determine the conditions for practicing euthanasia and safeguard it from possible abuse.

The ESA's move to legalize euthanasia entailed the emergence of law as a means of regulation. Medical euthanasia required the intervention of law to regulate it. Law, from hence on, did not pose a true challenge to euthanasia; on the contrary, it became a necessary condition for its practice. For the ESA and its followers, the practice of euthanasia *without* legal regulation became the greatest threat. Thus, the regulation of euthanasia became more important than the justice of the practice *per se*. Indeed, regulation became the main way to distinguish between the Nazi atrocities and the new American way of dying.

### CONCLUSION: DEATH AND THE LAW

The history of euthanasia began with the *ars moriendi* tradition, when euthanasia bore the benign sense of a good death blessed by the grace of God. It entered a moment of transition when the art of holy dying became a way of holy living and the mastery of dying became a this-worldly affair. The desire to master the hour of death gradually expanded: dying was medicalized and the treatment of the dying became regulated by medical technique. This desire became manifest when the sense in which euthanasia was used changed from "medical aid in dying" to "the medical hastening of death." The will to master dying extended its reach when dying became a concern of public policy and the mastery of dying became just one element in an array of state practices aimed at managing biological processes.

All laws governing the deathbed allow for partial control over the dying

process. But although all ethics entail an ordering of human action, with some ethical forms, mastery has only been a means of achieving a further end. This was the case with the Methodist art of dying, which, in addition to ordering the practices of the deathbed, had the further purpose of achieving Christian perfection. Likewise, medical ethics, which were intended to direct the physician and the dying on how to die, had the further purpose of achieving either cure or a painless death. However, what is unique about modern regulatory law is that the ultimate end of this form of law is mastery for the sake of mastery alone. The history of medical euthanasia suggests precisely this development. The ethical form of regulation became as important and perhaps even more important than the content of regulation.

The case of the dying patient in the mid-nineteenth century is interesting precisely because it demonstrates that even before the emergence of twentieth-century life-prolonging technology, the disposition to master death was at work. Mastery of death, in other words, was not the consequence of the improved abilities of medicine but the contrary. It is this disposition to master death that gave rise to a constant search for treatment, to impatience with regard to what was seen as merely passively waiting for death to come.

In the wondrous *Ode to Man*, the choir in Sophocle's *Antigone* sings of the terrible power of Man to conquer the earth, the skies, and the seas. Nothing seems to escape the will of humanity to control nature, save *thanatos* and *dike*: death and law. It is quite apparent how modern humanity attempts, through euthanasia, to come as close as possible to mastering death. What I have sought to suggest in this article is that in the process, law too transforms and becomes part of the attempt to master the world for the sake of its mastery alone and that perhaps the modern will to overcome death is, in the end, also the will to overcome the law.

