that we should not overlook. We may legitimately seek for others and for ourselves an easeful death, as Arthur Dyck has pointed out.[1] Euthanasia, however, is not just an easeful death. It is a wrongful death. Euthanasia is not just dying. It is killing.

NOTE

1. Arthur Dyck, "Beneficent Euthanasia and Benemortasia," in *Beneficent Euthanasia,* ed. Marvin Kohl (Buffalo, NY: Prometheus Books, 1975), 117–29.

From *Voluntary Active Euthanasia*

DAN W. BROCK

* * *

THE CENTRAL ETHICAL ARGUMENT FOR VOLUNTARY ACTIVE EUTHANASIA

The central ethical argument for euthanasia is familiar. It is that the very same two fundamental ethical values supporting the consensus on patient's rights to decide about life-sustaining treatment also support the ethical permissibility of euthanasia. These values are individual self-determination or autonomy and individual well-being. By self-determination as it bears on euthanasia, I mean people's interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life, and in being left free to act on those decisions. Self-determination is valuable because it permits people to form and live in accordance with their own conception of a good life, at least within the bounds of justice and consistent with others doing so as well. In exercising self-determination people take responsibility for their lives and for the kinds of persons they become. A central aspect of human dignity lies in people's capacity to direct their lives in this way. The value of exercising self-determination presupposes some minimum of decision making capacities or competence, which thus limits the scope of euthanasia supported by self-determination; it cannot justifiably be administered, for example, in cases of serious dementia or treatable clinical depression.

Does the value of individual self-determination extend to the time and manner of one's death? Most people are very concerned about the nature of the last stage of their lives. This reflects not just a fear of experiencing substantial suffering when dying, but also a desire to retain dignity and control during this last period of life. Death is today increasingly preceded by a long period of significant physical and mental decline, due in part to the technological interventions of modern medicine. Many people adjust to these disabilities and find meaning and value in new activities and ways. Others find the impairments and burdens in the last stage of their lives at some point sufficiently great to make life no longer worth living. For many patients near death, maintaining the quality of one's life, avoiding great suffering, maintaining one's dignity, and insuring that others remember us as we wish them to become of paramount importance and outweigh merely extending one's life. But there is no single, objectively correct answer for everyone as to when, if at all, one's life becomes all things considered a burden and unwanted. If self-determination is a fundamental value, then the great variability among people on this question makes it especially important that individuals control the manner, circumstances, and timing of their dying and death.

The other main value that supports euthanasia is individual well-being. It might seem that individual well-being conflicts with a person's self-determination when the person requests euthanasia. Life itself is

commonly taken to be a central good for persons, often valued for its own sake, as well as necessary for pursuit of all other goods within a life. But when a competent patient decides to forgo all further life-sustaining treatment then the patient, either explicitly or implicitly, commonly decides that the best life possible for him or her with treatment is of sufficiently poor quality that it is worse than no further life at all. Life is no longer considered a benefit by the patient, but has now become a burden. The same judgment underlies a request for euthanasia: continued life is seen by the patient as no longer a benefit, but now a burden. Especially in the often severely compromised and debilitated states of many critically ill or dying patients, there is no objective standard, but only the competent patient's judgment of whether continued life is no longer a benefit.

Of course, sometimes there are conditions, such as clinical depression, that call into question whether the patient has made a competent choice, either to forgo life-sustaining treatment or to seek euthanasia, and then the patient's choice need not be evidence that continued life is no longer a benefit for him or her. Just as with decisions about treatment, a determination of incompetence can warrant not honoring the patient's choice: in the case of treatment, we then transfer decisional authority to a surrogate, though in the case of voluntary active euthanasia a determination that the patient is incompetent means that choice is not possible.

The value or right of self-determination does not entitle patients to compel physicians to act contrary to their own moral or professional values. Physicians are moral and professional agents whose own self-determination or integrity should be respected as well. If performing euthanasia became legally permissible, but conflicted with a particular physician's reasonable understanding of his or her moral or professional responsibilities, the care of a patient who requested euthanasia should be transferred to another.

Most opponents do not deny that there are some cases in which the values of patient self-determination and well-being support euthanasia. Instead, they commonly offer two kinds of arguments against it that on their view outweigh or override this support. The first kind of argument is that in any individual case where considerations of the patient's self-determination and well-being do support euthanasia, it is nevertheless always ethically wrong or impermissible. The second kind of argument grants that in some individual cases euthanasia may not be ethically wrong, but maintains nonetheless that public and legal policy should never permit it. The first kind of argument focuses on features of any individual case of euthanasia, while the second kind focuses on social or legal policy. In the next section I consider the first kind of argument.

* * *

WOULD THE BAD CONSEQUENCES OF EUTHANASIA OUTWEIGH THE GOOD?

The argument against euthanasia at the policy level is stronger than at the level of individual cases, though even here I believe the case is ultimately unpersuasive, or at best indecisive. The policy level is the place where the main issues lie, however, and where moral considerations that might override arguments in favor of euthanasia will be found, if they are found anywhere. It is important to note two kinds of disagreement about the consequences for public policy of permitting euthanasia. First, there is empirical or factual disagreement about what the consequences would be. This disagreement is greatly exacerbated by the lack of firm data on the issue. Second, since on any reasonable assessment there would be both good and bad consequences, there are moral disagreements about the relative importance of different effects. In addition to these two sources of disagreement, there is also no single, well-specified policy proposal for legalizing euthanasia on which policy assessments can focus. But without such specification, and especially without explicit procedures for protecting against well-intentioned misuse and ill-intentioned abuse, the consequences for policy are largely speculative. Despite these difficulties, a preliminary account of the main likely good and bad consequences is possible. This should help clarify where better data or more moral analysis and

argument are needed, as well as where policy safeguards must be developed.

Potential Good Consequences of Permitting Euthanasia

What are the likely good consequences? First, if euthanasia were permitted it would be possible to respect the self-determination of competent patients who want it, but now cannot get it because of its illegality. We simply do not know how many such patients and people there are. In the Netherlands, with a population of about 14.5 million (in 1987), estimates in a recent study were that about 1,900 cases of voluntary active euthanasia or physician-assisted suicide occur annually. No straightforward extrapolation to the United States is possible for many reasons, among them, that we do not know how many people here who want euthanasia now get it, despite its illegality. Even with better data on the number of persons who want euthanasia but cannot get it, significant moral disagreement would remain about how much weight should be given to any instance of failure to respect a person's self-determination in this way.

One important factor substantially affecting the number of persons who would seek euthanasia is the extent to which an alternative is available. The widespread acceptance in the law, social policy, and medical practice of the right of a competent patient to forgo life-sustaining treatment suggests that the number of competent persons in the United States who would want euthanasia if it were permitted is probably relatively small.

A second good consequence of making euthanasia legally permissible benefits a much larger group. Polls have shown that a majority of the American public believes that people should have a right to obtain euthanasia if they want.[1] No doubt the vast majority of those who support this right to euthanasia will never in fact come to want euthanasia for themselves. Nevertheless, making it legally permissible would reassure many people that if they ever do want euthanasia they would be able to obtain it. This reassurance would supplement the broader control over the process of dying given by the right to decide about life-sustaining treatment. Having fire insurance on one's house benefits all who have it, not just those whose houses actually burn down, by reassuring them that in the unlikely event of their house burning down, they will receive the money needed to rebuild it. Likewise, the legalization of euthanasia can be thought of as a kind of insurance policy against being forced to endure a protracted dying process that one has come to find burdensome and unwanted, especially when there is no life-sustaining treatment to forgo. The strong concern about losing control of their care expressed by many people who face serious illness likely to end in death suggests that they give substantial importance to the legalization of euthanasia as a means of maintaining this control.

A third good consequence of the legalization of euthanasia concerns patients whose dying is filled with severe and unrelievable pain or suffering. When there is a life-sustaining treatment that, if forgone, will lead relatively quickly to death, then doing so can bring an end to these patients' suffering without recourse to euthanasia. For patients receiving no such treatment, however, euthanasia may be the only release from their otherwise prolonged suffering and agony. This argument from mercy has always been the strongest argument for euthanasia in those cases to which it applies.

The importance of relieving pain and suffering is less controversial than is the frequency with which patients are forced to undergo untreatable agony that only euthanasia could relieve. If we focus first on suffering caused by physical pain, it is crucial to distinguish pain that could be adequately relieved with modern methods of pain control, though it in fact is not, from pain that is relievable only by death. For a variety of reasons, including some physicians' fear of hastening the patient's death, as well as the lack of a publicly accessible means for assessing the amount of the patient's pain, many patients suffer pain that could be, but is not, relieved.

Specialists in pain control, as for example the pain of terminally ill cancer patients, argue that there are very few patients whose pain could not be adequately controlled, though sometimes at the cost of so sedating them that they are effectively unable to interact with other people or their environment. Thus, the argument from mercy in cases of physical

pain can probably be met in a large majority of cases by providing adequate measures of pain relief. This should be a high priority, whatever our legal policy on euthanasia—the relief of pain and suffering has long been, quite properly, one of the central goals of medicine. Those cases in which pain could be effectively relieved, but in fact is not, should only count significantly in favor of legalizing euthanasia if all reasonable efforts to change pain management techniques have been tried and have failed.

Dying patients often undergo substantial psychological suffering that is not fully or even principally the result of physical pain. The knowledge about how to relieve this suffering is much more limited than in the case of relieving pain, and efforts to do so are probably more often unsuccessful. If the argument from mercy is extended to patients experiencing great and unrelievable psychological suffering, the numbers of patients to which it applies are much greater.

One last good consequence of legalizing euthanasia is that once death has been accepted, it is often more humane to end life quickly and peacefully, when that is what the patient wants. Such a death will often be seen as better than a more prolonged one. People who suffer a sudden and unexpected death, for example by dying quickly or in their sleep from a heart attack or stroke, are often considered lucky to have died in this way. We care about how we die in part because we care about how others remember us, and we hope they will remember us as we were in "good times" with them and not as we might be when disease has robbed us of our dignity as human beings. As with much in the treatment and care of the dying, people's concerns differ in this respect, but for at least some people, euthanasia will be a more humane death than what they have often experienced with other loved ones and might otherwise expect for themselves.

Some opponents of euthanasia challenge how much importance should be given to any of these good consequences of permitting it, or even whether some would be good consequences at all. But more frequently, opponents cite a number of bad consequences that permitting euthanasia would or could produce, and it is to their assessment that I now turn.

Potential Bad Consequences of Permitting Euthanasia

Some of the arguments against permitting euthanasia are aimed specifically against physicians, while others are aimed against anyone being permitted to perform it. I shall first consider one argument of the former sort. Permitting physicians to perform euthanasia, it is said, would be incompatible with their fundamental moral and professional commitment as healers to care for patients and to protect life. Moreover, if euthanasia by physicians became common, patients would come to fear that a medication was intended not to treat or care, but instead to kill, and would thus lose trust in their physicians. This position was forcefully stated in a paper by Willard Gaylin and his colleagues:

> The very soul of medicine is on trial. . . . This issue touches medicine at its moral center; if this moral center collapses, if physicians become killers or are even licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty.

These authors go on to make clear that, while they oppose permitting anyone to perform euthanasia, their special concern is with physicians doing so:

> We call on fellow physicians to say that they will not deliberately kill. We must also say to each of our fellow physicians that we will not tolerate killing of patients and that we shall take disciplinary action against doctors who kill. And we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing.[2]

If permitting physicians to kill would undermine the very "moral center" of medicine, then almost certainly physicians should not be permitted to perform euthanasia. But how persuasive is this claim? Patients should not fear, as a consequence of permitting voluntary active euthanasia, that their physicians will substitute a lethal injection for what patients want and believe is part of their care. If active euthanasia is restricted to cases in which it is truly voluntary, then no patient should fear getting it unless she or he has voluntarily requested it. (The fear that we might in time also come to accept nonvoluntary, or even involuntary, active euthanasia is a slippery slope worry

I address below.) Patients' trust of their physicians could be increased, not eroded, by knowledge that physicians will provide aid in dying when patients seek it.

. . . In spelling out above what I called the positive argument for voluntary active euthanasia, I suggested that two principal values—respective patients' self-determination and promoting their well-being—underlie the consensus that competent patients, or the surrogates of incompetent patients, are entitled to refuse any life-sustaining treatment and to choose from among available alternative treatments. It is the commitment to these two values in guiding physicians' actions as healers, comforters, and protectors of their patients' lives that should be at the "moral center" of medicine, and these two values support physicians' administering euthanasia when their patients make competent requests for it.

What should not be at that moral center is a commitment to preserving patients' lives as such, without regard to whether those patients want their lives preserved or judge their preservation a benefit to them. . . .

A second bad consequence that some foresee is that permitting euthanasia would weaken society's commitment to provide optimal care for dying patients. We live at a time in which the control of health care costs has become, and is likely to continue to be, the dominant focus of health care policy. If euthanasia is seen as a cheaper alternative to adequate care and treatment, then we might become less scrupulous about providing sometimes costly support and other services to dying patients. Particularly if our society comes to embrace deeper and more explicit rationing of health care, frail, elderly, and dying patients will need to be strong and effective advocates for their own health care and other needs, although they are hardly in a position to do this. We should do nothing to weaken their ability to obtain adequate care and services.

This second worry is difficult to assess because there is little firm evidence about the likelihood of the feared erosion in the care of dying patients. There are at least two reasons, however, for skepticism about this argument. The first is that the same worry could have been directed at recognizing patients' or surrogates' rights to forgo life-sustaining treatment, yet there is no persuasive evidence that recognizing the right to refuse treatment has caused a serious erosion in the quality of care of dying patients. The second reason for skepticism about this worry is that only a very small proportion of deaths would occur from euthanasia if it were permitted. In the Netherlands, where euthanasia under specified circumstances is permitted by the courts, though not authorized by statute, the best estimate of the proportion of overall deaths that result from it is about 2 percent.[3] Thus, the vast majority of critically ill and dying patients will not request it, and so will still have to be cared for by physicians, families, and others. Permitting euthanasia should not diminish people's commitment and concern to maintain and improve the care of these patients.

A third possible bad consequence of permitting euthanasia (or even a public discourse in which strong support for euthanasia is evident) is to threaten the progress made in securing the rights of patients or their surrogates to decide about and to refuse life-sustaining treatment. This progress has been made against the backdrop of a clear and firm legal prohibition of euthanasia, which has provided a relatively bright line limiting the dominion of others over patients' lives. It has therefore been an important reassurance to concerns about how the authority to take steps ending life might be misused, abused, or wrongly extended.

Many supporters of the right of patients or their surrogates to refuse treatment strongly oppose euthanasia, and if forced to choose might well withdraw their support of the right to refuse treatment rather than accept euthanasia. Public policy in the last fifteen years has generally let life-sustaining treatment decisions be made in health care settings between physicians and patients or their surrogates, and without the involvement of the courts. However, if euthanasia is made legally permissible greater involvement of the courts is likely, which could in turn extend to a greater court involvement in life-sustaining treatment decisions. Most agree, however, that increased involvement of the courts in these decisions would be undesirable, as it would make sound decisionmaking more cumbersome and difficult without sufficient compensating benefits.

As with the second potential bad consequence of permitting euthanasia, this third consideration too is speculative and difficult to assess. The feared erosion of patients' or surrogates' rights to decide about life-sustaining treatment, together with greater court involvement in those decisions, are both possible. However, I believe there is reason to discount this generally worry. The legal rights of competent patients and, to a lesser degree, surrogates of incompetent patients to decide about treatment are very firmly embedded in a long line of informed consent and life-sustaining treatment cases, and are not likely to be eroded by a debate over, or even acceptance of, euthanasia. It will not be accepted without safeguards that reassure the public about abuse, and if that debate shows the need for similar safeguards for some life-sustaining treatment decisions they should be adopted there as well. In neither case are the only possible safeguards greater court involvement, as the recent growth of institutional ethics committees shows.

The fourth potential bad consequence of permitting euthanasia . . . turns on the subtle point that making a new option or choice available to people can sometimes make them worse off, even if once they have the choice they go on to choose what is best for them. Ordinarily, people's continued existence is viewed by them as given, a fixed condition with which they must cope. Making euthanasia available to people as an option denies them the alternative of staying alive by default. If people are offered the option of euthanasia, their continued existence is now a choice for which they can be held responsible and which they can be asked by others to justify. We care, and are right to care, about being able to justify ourselves to others. To the extent that our society is unsympathetic to justifying a severely dependent or impaired existence, a heavy psychological burden of proof may be placed on patients who think their terminal illness or chronic infirmity is not a sufficient reason for dying. Even if they otherwise view their life as worth living, the opinion of others around them that it is not can threaten their reason for living and make euthanasia a rational choice. Thus the existence of the option becomes a subtle pressure to request it.

This argument correctly identifies the reason why offering some patients the option of euthanasia would not benefit them. [David] Velleman takes it not as a reason for opposing all euthanasia, but for restricting it to circumstances where there are "unmistakable and overpowering reasons for persons to want the option of euthanasia,"[4] and for denying the option in all other cases. But there are at least three reasons why such restriction may not be warranted. First, polls and other evidence support that most Americans believe euthanasia should be permitted (though the recent defeat of the referendum to permit it in the state of Washington raises some doubt about this support). Thus, many more people seem to want the choice than would be made worse off by getting it. Second, if giving people the option of ending their life really makes them worse off, then we should not only prohibit euthanasia, but also take back from people the right they now have to decide about life-sustaining treatment. The feared harmful effect should already have occurred from securing people's right to refuse life-sustaining treatment, yet there is no evidence of any such widespread harm or any broad public desire to rescind that right. Third, since there is a wide range of conditions in which reasonable people can and do disagree about whether they would want continued life, it is not possible to restrict the permissibility of euthanasia as narrowly as Velleman suggests without thereby denying it to most persons who would want it; to permit it only in cases in which virtually everyone would want it would be to deny it to most who would want it.

A fifth potential bad consequence of making euthanasia legally permissible is that it might weaken the general legal prohibition of homicide. This prohibition is so fundamental to civilized society, it is argued, that we should do nothing that erodes it. If most cases of stopping life support are killing, as I have already argued, then the court cases permitting such killing have already in effect weakened this prohibition. However, neither the courts nor most people have seen these cases as killing and so as challenging the prohibition of homicide. The courts have usually grounded patients' or their surrogates' rights to refuse life-sustaining treatment in rights to privacy, liberty,

self-determination, or bodily integrity, not in exceptions to homicide laws.

Legal permission for physicians or others to perform euthanasia could not be grounded in patients' rights to decide about medical treatment. Permitting euthanasia would require qualifying, at least in effect, the legal prohibition against homicide, a prohibition that in general does not allow the consent of the victim to justify or excuse the act. Nevertheless, the very same fundamental basis of the right to decide about life-sustaining treatment—respecting a person's self-determination—does support euthanasia as well. Individual self-determination has long been a well-entrenched and fundamental value in the law, and so extending it to euthanasia would not require appeal to novel legal values or principles. That suicide or attempted suicide is no longer a criminal offense in virtually all states indicates an acceptance of individual self-determination in the taking of one's own life analogous to that required for voluntary active euthanasia. The legal prohibition (in most states) of assisting in suicide and the refusal in the law to accept the consent of the victim as a possible justification of homicide are both arguably a result of difficulties in the legal process of establishing the consent of the victim after the fact. If procedures can be designed that clearly establish the voluntariness of the person's request for euthanasia it would under those procedures represent a carefully circumscribed qualification on the legal prohibition of homicide. Nevertheless, some remaining worries about this weakening can be captured in the final potential bad consequence, to which I will now turn.

This final potential bad consequence is the central concern of many opponents of euthanasia and, I believe, is the most serious objection to a legal policy permitting it. According to this "slippery slope" worry, although active euthanasia may be morally permissible in cases in which it is unequivocally voluntary and the patient finds his or her condition unbearable, a legal policy permitting euthanasia would inevitably lead to active euthanasia being performed in many other cases in which it would be morally wrong. To prevent those other wrongful cases of euthanasia we should not permit even morally justified performance of it.

Slippery slope arguments of this form are problematic and difficult to evaluate. From one perspective, they are the last refuge of conservative defenders of the status quo. When all the opponent's objections to the wrongness of euthanasia itself have been met, the opponent then shifts ground and acknowledges both that it is not in itself wrong and that a legal policy which resulted only in its being performed would not be bad. Nevertheless, the opponent maintains, it should still not be permitted because doing so would result in its being performed in other cases in which it is not voluntary and would be wrong. In this argument's most extreme form, permitting euthanasia is the first and fateful step down the slippery slope to Nazism. Once on the slope we will be unable to get off.

Now it cannot be denied that it is *possible* that permitting euthanasia could have these fateful consequences, but that cannot be enough to warrant prohibiting it if it is otherwise justified. A similar *possible* slippery slope worry could have been raised to securing competent patients' rights to decide about life support, but recent history shows such a worry would have been unfounded. It must be relevant how likely it is that we will end with horrendous consequences and an unjustified practice of euthanasia. How *like*, and *widespread* would the abuses and unwarranted extensions of permitting it be? By abuses, I mean the performance of euthanasia that fails to satisfy the conditions required for voluntary active euthanasia, for example, if the patient has been subtly pressured to accept it. By unwarranted extensions of policy, I mean later changes in legal policy to permit not just voluntary euthanasia, but also euthanasia in cases in which, for example, it need not be fully voluntary. Opponents of voluntary euthanasia on slippery slope grounds have not provided the data or evidence necessary to turn their speculative concerns into well-grounded likelihoods.

It is at least clear, however, that both the character and likelihood of abuses of a legal policy permitting euthanasia depend in significant part on the procedures put in place to protect against them. I will

not try to detail fully what such procedures might be, but will just give some examples of what they might include:

1. The patient should be provided with all relevant information about his or her medical condition, current prognosis, available alternative treatments, and the prognosis of each.
2. Procedures should ensure that the patient's request for euthanasia is stable or enduring (a brief waiting period could be required) and fully voluntary (an advocate for the patient might be appointed to ensure this).
3. All reasonable alternatives must have been explored for improving the patient's quality of life and relieving any pain or suffering.
4. A psychiatric evaluation should ensure that the patient's request is not the result of a treatable psychological impairment such as depression.

These examples of procedural safeguards are all designed to ensure that the patient's choice is fully informed, voluntary, and competent, and so a true exercise of self-determination. Other proposals for euthanasia would restrict its permissibility further—for example, to the terminally ill—a restriction that cannot be supported by self-determination. Such additional restrictions might, however, be justified by concern for limiting potential harms from abuse. At the same time, it is important not to impose procedural or substantive safeguards so restrictive as to make euthanasia impermissible or practically infeasible in a wide range of justified cases.

These examples of procedural safeguards make clear that it is possible to substantially reduce, though not to eliminate, the potential for abuse of a policy permitting voluntary active euthanasia. Any legalization of the practice should be accompanied by a well-considered set of procedural safeguards together with an ongoing evaluation of its use. Introducing euthanasia into only a few states could be a form of carefully limited and controlled social experiment that would give us evidence about the benefits and harms of the practice. Even then firm and uncontroversial data may remain elusive, as the continuing controversy over what has taken place in the Netherlands in recent years indicates.[5]

* * *

THE ROLE OF PHYSICIANS

If euthanasia is made legally permissible, should physicians take part in it? Should only physicians be permitted to perform it, as is the case in the Netherlands? In discussing whether euthanasia is incompatible with medicine's commitment to curing, caring for, and comforting patients, I argued that it is not at odds with a proper understanding of the aims of medicine, and so need not undermine patients' trust in their physicians. If that argument is correct, then physicians probably should not be prohibited, either by law or by professional norms, from taking part in a legally permissible practice of euthanasia (nor, of course, should they be compelled to do so if their personal or professional scruples forbid it). Most physicians in the Netherlands appear not to understand euthanasia to be incompatible with their professional commitments.

Sometimes patients who would be able to end their lives on their own nevertheless seek the assistance of physicians. Physician involvement in such cases may have important benefits to patients and others beyond simply assuring the use of effective means. Historically, in the United States suicide has carried a strong negative stigma that many today believe unwarranted. Seeking a physician's assistance, or what can almost seem a physician's blessing, may be a way of trying to remove that stigma and show others that the decision for suicide was made with due seriousness and was justified under the circumstances. The physician's involvement provides a kind of social approval, or more accurately helps counter what would otherwise be unwarranted social disapproval.

There are also at least two reasons for restricting the practice of euthanasia to physicians only. First, physicians would inevitably be involved in some of the important procedural safeguards necessary to a defensible practice, such as seeing to it that the patient is well-informed about his or her condition, prognosis, and possible treatments, and ensuring that all reasonable means have been taken to improve the quality of the patient's life. Second, and probably more important, one necessary protection against abuse of the practice is to limit the persons given authority to perform it, so that they can be held accountable for their

exercise of that authority. Physicians, whose training and professional norms give some assurance that they would perform euthanasia responsibly, are an appropriate group of persons to whom the practice may be restricted.

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NOTES

1. P. Painton and E. Taylor, "Love or Let Die," *Time,* 19 March 1990, 62–71; Boston Globe/Harvard University Poll, *Boston Globe,* 3 November 1991.

2. Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, "Doctors Must Not Kill," *Journal of the American Medical Association* 259 (1988): 2139–40.

3. Paul J. Van der Maas et al., "Euthanasia and Other Medical Decisions Concerning the End of Life," *Lancet* 338 (1991): 669–74.

4. David Velleman commented on an earlier version of the paper delivered at the American Philosophical Association Central Division meetings.

5. Richard Fenigsen, "A Case against Dutch Euthanasia," *Special Supplement, Hastings Center Report* 19, no. 1 (1989): 22–30.

Euthanasia

PHILIPPA FOOT

The widely used *Shorter Oxford English Dictionary* gives three meanings for the word "euthanasia": the first, "a quiet and easy death"; the second, "the means of procuring this"; and the third, "the action of inducing a quiet and easy death." It is a curious fact that no one of the three gives an adequate definition of the word as it is usually understood. For "euthanasia" means much more than a quiet and easy death, or the means of procuring it, or the action of inducing it. The definition species only the manner of the death, and if this were all that was implied a murderer, careful to drug his victim, could claim that his act was an act of euthanasia. We find this ridiculous because we take it for granted that in euthanasia it is death itself, not just the manner of death, that must be kind to the one who dies.

To see how important it is that "euthanasia" should not be used as the dictionary definition allows it to be used, merely to signify that a death was quiet and easy, one has only to remember that Hitler's "euthanasia" program traded on this ambiguity. Under this program, planned before the War but brought into full operation by a decree of 1 September 1939, some 275,000 people were gassed in centers which were to be a model for those in which Jews were later exterminated. Anyone in a state institution could be sent to the gas chambers if it was considered that he could not be "rehabilitated" for useful work. As Dr. Leo Alexander reports, relying on the testimony of a neuropathologist who received 500 brains from one of the killing centers,

> In Germany the exterminations included the mentally defective, psychotics (particularly schizophrenics), epileptics and patients suffering from infirmities of old age and from various organic neurological disorders such as infantile paralysis, Parkinsonism, multiple sclerosis and brain tumors. . . . In truth, all those unable to work and considered nonrehabilitable were killed.[1]

These people were killed because they were "useless" and "a burden on society"; only the manner of their deaths could be thought of as relatively easy and quiet.

Let us insist, then, that when we talk about euthanasia we are talking about a death understood as a good or happy event for the one who dies. This stipulation follows etymology, but is itself not exactly in line with