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Short Essays are expected to be about 800 words.

Essays should be formatted as follows:

Font: Georgia, 12 pt.

Margins: 1" on all sides

Spacing: 1.5

Paragraphs start with a standard indentation of the first line. There should be no extra lines between paragraphs.

## Euthanasia and Physician-Assisted Suicide

No one escapes death—or the ethical issues that come with it. Advances in medicine now raise the old life-and-death questions anew, force new ones more unsettling, and provoke answers that are disturbing even when plausible. In euthanasia and physician-assisted suicide, the bioethical heart of the matter is the moral rightness of killing or letting die for the good of the patient. The countless disputes on this terrain are often fierce and elemental, for they are the visible signs of deep conflicts among fundamental moral principles and perspectives. Doctors and nurses have sworn to preserve life and relieve suffering—but how to do this when the only way to end suffering is to end life? They understand the need to respect patient autonomy, the right of self-determination—but what should

they do when the patient freely chooses to forgo all their best efforts and to embrace extinction? Or if the terminal patient, inching in agony toward destruction, asks them to cut short her torment by killing her with a lethal injection? Or if she begs only for some help in dying by her own hand? Or if she has never expressed a choice about such matters and has slipped into permanent unconsciousness, withering in pain to the inevitable? In such cases, what does beneficence or mercy or respect for autonomy or regard for the sanctity of life demand?

More so than most other issues in bioethics, the morality of euthanasia and physician-assisted suicide is tangled with legal and policy debates. The ethical questions are, of course, logically distinct from these concerns. You are not necessarily guilty of inconsistency if you think some instances of physician-assisted suicide are morally permissible but believe the practice should

never be legalized because legalization might lead to abuses. Or you may, without contradicting yourself, favor legalization to protect patient autonomy but argue that suicide in any form is almost never morally acceptable. In the heat of controversy, these distinctions often get blurred, and a major task of good moral reasoning is to keep the focus sharp.

Nowhere was moral reasoning and conceptual clarity needed more and used less than in the recent case of Terri Schiavo. In 1990, when she was 26, Schiavo's heart stopped suddenly for reasons that are still unclear; by the time she was resuscitated, she had suffered catastrophic and irreversible brain damage. She was left in what doctors call a persistent vegetative state—wakeful but without consciousness or intentional behavior and almost no chance of significant improvement. In this condition she was sustained for years by food and water injected into her body through tubes. The question arose: Would Terri have wanted to be kept alive like this? Would she have chosen death over this perpetual darkness? She could not answer and had left no written record of her preferences. Her husband, Michael Schiavo, became her legal guardian and claimed that Terri had once told him that she would rather die than be artificially sustained as she eventually was. He said he wanted to have Terri's feeding tube removed so she could die with dignity. Terri's parents would have none of this and insisted that efforts to keep her alive should continue because she could eventually regain consciousness. Across the country people debated the moral questions. Would removing Terri's feeding tube be murder? Would allowing her to die be a permissible act of mercy?

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All the while, the legal war between Michael Schiavo and Terri's parents dragged on, with the former seeking permission to disconnect the feeding tube and the latter trying to thwart him. The essential legal issue was who had the legal right to decide Terri Schiavo's fate. The list of people who weighed in on both the legal and moral questions is long and diverse—President George W. Bush, state legislators, members of the U.S. Congress, bioethicists, religious leaders, pro-life groups, the governor of Florida, disability rights organizations, and a vast assortment of media commentators. Time after time, state and federal courts sided with Michael Schiavo, and in the end a judge gave permission to remove Terri's feeding tube. Thirteen days after its removal, on March 31, 2005, Terri Schiavo was dead.

In some ways the Schiavo case is unique, but several of its more disturbing features are not. Many compelling end-of-life dramas are being played out right now behind closed hospital doors, away from

news cameras, the posturing of politicians, and the gaze of unaffected people. The need for informed moral reasoning to come to terms with the heart-breaking realities is acute—and likely to grow.

## deciding life and death

Almost all of the terms used to discuss the morality of killing and letting die are controversial to some degree. Even the meaning of *death*—a seemingly straightforward concept to most people—has been a point of dispute. Nevertheless, some helpful distinctions are possible. For the sake of clarity (and neutrality), **euthanasia** can be characterized as directly or indirectly bringing about the death of another person for that person's sake.<sup>1</sup> The term derives from the Greek words meaning “good death” and evokes the idea that causing or contributing to someone's end may bestow on that person a good. Death is usually considered an evil, perhaps the greatest evil, but many think it can be a blessing if it spares someone from a slow, horrific dying or a hopeless, vegetative sleep.

Many philosophers maintain that there are two forms of euthanasia. **Active euthanasia** is said to involve performing an action that directly causes someone to die—what most people think of as “mercy killing.” Giving a patient a lethal injection to end his suffering, then, is a case of active euthanasia. **Passive euthanasia** is allowing someone to die by *not* doing something that would prolong life. It includes removing a patient's feeding tube or ventilator, failing to perform necessary surgery, and refraining from giving life-saving antibiotics. The distinction between the two is thought to be essentially this: Active euthanasia is *killing*, but passive euthanasia is *letting die*.

To some people, this conceptual border between active and passive euthanasia is crucial for assessing the morality of euthanasia. They point out that whereas letting a patient die is sometimes morally permissible, deliberately and directly killing a patient is always wrong. The former practice is legal and officially endorsed by the medical profession; the latter is illegal and officially condemned. The American Medical Association sanctioned this dichotomy in a 1973 policy statement:

The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

... The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or immediate family.<sup>2</sup>

For many (including most physicians), passive euthanasia may be moral, but active euthanasia is not.

But not everyone thinks this active-passive distinction makes sense. Some argue that there is no morally significant difference between mercifully killing a patient and mercifully letting the patient die. In both situations the doctor causes the patient's death—by either intentionally doing

something in the one instance or intentionally refraining from doing something in the other. Thus an act of euthanasia may be morally right or wrong, but the rightness or wrongness does not depend purely on this active-passive divide. Moreover in practice, distinguishing examples of active and passive euthanasia may not be as easy as some think. The usual view is that passive euthanasia can sometimes be performed by disconnecting a dying patient's feeding tube and ventilator. But this event can also be seen as an instance of performing an action that directly causes someone to die—that is, active euthanasia.

If euthanasia in some form is morally permissible, its permissibility must be linked to the patient's consent. Thus bioethicists talk about euthanasia that is voluntary, nonvoluntary, or involuntary.

**Voluntary euthanasia** refers to situations in which competent patients voluntarily request or agree to euthanasia, communicating their wishes either while competent or through instructions to be followed if they become incompetent (if they fall into a persistent vegetative state, for example). Patients can indicate what is to be done in incompetence by formulating an advance directive—usually a living will or a document designating a surrogate, or proxy, to act on their behalf. **Nonvoluntary euthanasia** is performed when patients are not competent to choose death for themselves and have not previously disclosed their preferences. (Incompetent patients include not only incapacitated adults but infants and small children as well.) In these circumstances, the patient's family, physician, or other officially designated persons decide for the patient. **Involuntary euthanasia** is bringing about someone's death against her will or without asking for her consent while she is competent to decide. It is illegal and considered morally impermissible by both those who approve and disapprove of euthanasia. It is therefore generally left out of moral debates, except perhaps in slippery-slope arguments warning that voluntary or nonvoluntary euthanasia will inevitably become involuntary.

Combining the terms *active*, *passive*, *voluntary*, and *nonvoluntary*, we can identify four kinds of

Chapter 10: Euthanasia and Physician-Assisted Suicide 627 euthanasia that have been the main focus in

bioethics:

1. **Active voluntary**—Directly causing death (mercy killing) with the consent of the patient
2. **Active nonvoluntary**—Directly causing death (mercy killing) without the consent of the patient
3. **Passive voluntary**—Withholding or withdrawing life-sustaining measures with the consent of the patient
4. **Passive nonvoluntary**—Withholding or withdrawing life-sustaining measures without the consent of the patient

Legally and ethically, the starkest contrast among these is between active and passive euthanasia. Active euthanasia (whether voluntary or nonvoluntary) is unlawful, while passive euthanasia (both voluntary and nonvoluntary) is legal provided certain conditions are met. Judicial rulings have firmly established a right of patients to refuse treatment—and thus to have life-sustaining treatment withheld or withdrawn—even though the patient dies as a result. Withdrawing or withholding treatment from an incompetent patient is generally legal if the patient has left instructions or if an appropriate person can be chosen to make the necessary decisions. Contemporary moral debate centers more on active than on passive euthanasia. There is considerable agreement about the moral rightness of allowing a patient to die but intense controversy about the permissibility of deliberately causing a patient's death (by administering a lethal injection, for example), whether the act is considered voluntary or nonvoluntary.

Recently, disputes over euthanasia have raged alongside arguments about **physician-assisted suicide**, in which a patient takes his own life with the aid of a physician. In a typical scenario, a patient asks the physician for help in committing suicide, the physician assists the patient by prescribing lethal doses of

drugs or explaining a method of suicide, and the patient—not the physician—performs the final act that causes

#### LEGAL BRIEF

### Euthanasia and Assisted Suicide: Major Developments

**1990** In *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court recognizes the right of patients to refuse treatment (essentially a “right to die”) and finds constitutional justification for living wills and surrogates who make medical decisions for incompetent patients.

**1994** Oregon passes the Death With Dignity Act, legalizing the use of physician-assisted suicide under specific conditions. It permits doctors to prescribe drugs that terminally ill patients can use to commit suicide.

**1997** In separate cases—*Washington v. Glucksberg* and *Vacco v. Quill*—the Supreme Court rules that there is no constitutional right to physician-assisted suicide but notes that each state may establish its own policy on the issue. It explicitly acknowledges a distinction between assisted suicide and the withdrawal of life-sustaining treatment.

**2001** U.S. Attorney General John Ashcroft tries to thwart the Oregon right-to-die law by authorizing the Drug Enforcement Agency to act against physicians prescribing drugs for assisted suicide.

death. In contrast, in active euthanasia the physician performs the final act. Many argue that this difference in the ultimate cause of death implies a difference in moral responsibility. In physician-assisted suicide, the patient is thought to bear ultimate moral responsibility for the taking of life. Others doubt that any distinction in ultimate causes can amount to a moral difference. Thus they contend that physician-assisted suicide and active voluntary euthanasia are morally equivalent. What is the moral difference, they ask, between a physician helping a patient die by (1) administering a lethal injection upon

**2006** The Supreme Court rules that the Justice Department (headed by Ashcroft and later Alberto Gonzales) had no authority to interfere with physicians acting under the Oregon law.

**2008** Through a referendum vote, Washington becomes the second state to legalize physician-assisted suicide.

**2008** A district court ruling in the case of *Baxter v. State of Montana* asserts that Montana residents have a right to physician-assisted suicide, thereby legalizing the practice in a third state. In 2009 the Montana Supreme Court affirmed the earlier court ruling.

**2013** Vermont becomes the fourth state to legalize physician-assisted suicide. The Vermont legislature passed the “End of Life Choices” bill, and the governor signed it into law.

**2015** The New Mexico Court of Appeals invalidates a lower-court ruling that had legalized physician-assisted suicide. The Court asserted that “aid in dying is not a fundamental liberty interest under the New Mexico Constitution.”

**2015** California becomes the fifth state to legalize physician-assisted suicide. Governor Jerry Brown signed into law a bill permitting physicians to prescribe fatal doses of drugs to help terminally ill patients end their lives.

request or (2) prescribing a lethal dose of medications upon request?

The American Medical Association has denounced physician-assisted suicide as unethical and inconsistent with physicians' duty to promote healing and preserve life. Surveys suggest, however, that many doctors support the use of physician-assisted suicide, and up to half of adults believe it should be legal in cases of terminal illness or incurable disease with severe pain. To date, it is legal only in Oregon, Washington, Montana, Vermont, and California. The U.S. Supreme Court has ruled that states may legalize or prohibit it as they see fit.

## IN DEPTH

In 2008 a survey of 2,000 practicing physicians (members of the American Medical Association) revealed that:

### PHYSICIAN-ASSISTED SUICIDE

- **69%** objected to physician-assisted suicide
- **42%** had both a "religious and nonreligious objection" to physician-assisted suicide
- **31%** had no objection to physician-assisted suicide
- **21%** had a "nonreligious objection" to physician-assisted suicide
- **5%** had a "religious objection" to physician-assisted suicide
- **TERMINAL SEDATION**
  - **18%** objected to terminal sedation
  - **82%** had no objection to terminal sedation
- Part of the difficulty of making everyday moral decisions about end-of-life situations is that death itself is not so easy to define. Traditionally death was understood to occur when breathing and heartbeat ceased. A person who wasn't breathing and had no heartbeat was dead. But thanks to modern medicine, machines can maintain someone's breathing and heartbeat indefinitely—even though there is permanent loss of all brain function. Heart and lungs keep going, but the individual is irreversibly brain-dead and can remain that way for decades. By the traditional standard, the individual is alive, but this seems counterintuitive.
- We seem to need a new concept of death— an important consideration since any notion we adopt would dramatically influence our
  - **9%** had both a "religious and nonreligious objection" to terminal sedation
  - **7%** had a "nonreligious objection" to terminal sedation
  - **2%** had a "religious objection" to terminal sedation

- **WITHDRAWAL OF LIFE SUPPORT**
  - 5% objected to withdrawal of life support
  - 95% had “no objection” to withdrawal of life
- support
  - 3% had both a “religious and nonreligious
- objection” to withdrawal of life support • 1% had a “nonreligious objection” to
- withdrawal of life support
  - 1% had a “religious objection” to withdrawal
- of life support
- From Farr A. Curlin, Chinyere Nwodin, et al., “To Die, to Sleep: US Physicians’ Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support,” *American Journal of Hospice and Palliative Medicine*, Apr./May 2008.
- judgments about morally permissible behavior toward the living and the dead. If we judge an individual to be dead, then we would presumably think her no longer a person. If she is no longer a person, then it would seem to be permissible to disconnect all life support, harvest organs from the body for transplant, or prepare the body for burial. But if, despite appearances, she is still a person, wouldn’t doing any of these things be murder? If so, those who perform these acts would be morally and legally culpable.
- In 1968 a committee at Harvard Medical School formulated a new way of conceiving death, a perspective that has since become the standard in legal and medical matters. According to this *whole brain* view of death, an individual should be judged dead when all brain

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functions permanently cease. Brain death means genuine death. But several experts take issue with this view. They point out that some physiological processes such as respiration are partly independent of brain functions, and individuals that many would regard as dead (those in persistent vegetative states, for example) may have some residual brain activity. By the whole brain standard, Terri Schiavo, being wakeful but lacking consciousness, was alive until all brain activity stopped. To some, this consequence makes sense; to others, it seems odd. A better notion of death, some argue, is the *higher brain* view, which says that an individual should be considered dead when the higher brain operations responsible for consciousness permanently shut down. The thought behind this standard is that individuals are dead when they are no longer persons, regardless of what physiological activity persists, and individuals are no longer persons when consciousness permanently terminates. By the higher brain criterion, Terri Schiavo died when her higher brain functions permanently stopped, even though other brain activity continued for years. Again, some would find this judgment plausible; others, bizarre.

### autonomy, mercy, and harm

Let us examine the two main flashpoints in end-of-life bioethics: active voluntary euthanasia and physician-assisted suicide. We can focus mostly on the former since arguments for and against it are largely relevant to the latter.

What arguments might be offered to support active voluntary euthanasia? The strongest one derives from the principle of autonomy—a person's inherent right of self-determination. Proponents say that respecting autonomous persons means respecting their autonomous choices, including the choice to end their lives in their own way. Their right is preeminent, its only limit marking the point where their choices bring harm to others. As one philosopher explains it,

People have an interest in making important decisions about their lives in accordance with

their own conception of how they want their lives to go. In exercising autonomy or self-determination, people take responsibility for their lives; since dying is a part of life, choices about the manner of their dying and the timing of their death are, for many people, part of what is involved in taking responsibility for their lives. Many people are concerned about what the last phase of their lives will be like, not merely because of fears that their dying might involve them in great suffering, but also because of the desire to retain dignity and as much control over their lives as possible during this phase. . . . There is no single, objectively correct answer as to when, if at all, life becomes a burden and unwanted. But that simply points up the importance of individuals being able to decide autonomously for themselves whether their own lives retain sufficient quality and dignity to make life worth living.<sup>3</sup>

Proponents believe that this right to die, though strong, does not necessarily compel others. Almost no one who seriously urges the autonomy argument thinks that having a right to die forces a duty on others (physicians, for example) to help in the dying.

Another major argument for active euthanasia appeals to the principle of beneficence, or mercy: If we are in a position to relieve the severe suffering of another without excessive cost to ourselves, we have a duty to do so. To refuse would be cruel, inhumane, and wrong. The argument would run something like this: If a competent, hopelessly ill patient in unrelieved agony requests help to be put out of his misery, we may have a duty to bring about his death. As bioethicist Dan W. Brock says,

When there is a life-sustaining treatment that, if forgone, will lead relatively quickly to death [passive euthanasia], then doing so can bring an end to these patients' suffering without recourse to [active] euthanasia. For patients receiving no such treatment, however, [active] 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.<sup>4</sup>

By these lights, active euthanasia is sometimes better than passive, for withholding or withdrawing treatment from a dying patient in unspeakable pain may only draw out his agony.

The argument from beneficence taps into very deep intuitions about the point of mercy killing. Consider this variation of a twice-told tale in bioethics: A truck overturns on the highway, pinning the screaming driver under the cabin as the wreckage bursts into flames. He is burning alive, and there is no hope of pulling him out of the fire. To avoid slow incineration, he begs the lone onlooker to smash him in the head with a rock to kill him immediately. Should the onlooker oblige him?

A common response to such horrific suffering, at least in cases of medical euthanasia, is to insist that the torment can almost always be relieved without resort to lethal means. It is likely that most patients who request euthanasia because of unrelenting pain and deep depression can get relief through improved pain treatment and enlightened psychiatric care. Therefore euthanasia or physician-assisted suicide is unnecessary. But many bioethicists are not convinced. They argue that there will always be some patients whose pain cannot be eased by any means short of death, or who have no access to adequate palliative care, or whose suffering is neither physical nor psychiatric but social, philosophical, or

spiritual. The main cause of the suffering may be loss of dignity or independence or concern for loved ones who will be left behind.

Those who oppose active voluntary euthanasia give moral weight to autonomy and beneficence but argue that other considerations undermine the pro-euthanasia arguments. One such matter is the supposed moral difference between killing and letting die, or between active and passive euthanasia. The thought is that killing a person is morally worse than letting that person die. Killing is wrong; letting die is permissible. Thus giving a patient a lethal injection is wrong, but unplugging his feeding tube or ventilator may be morally acceptable. Some think that killing is morally worse because it involves a person caus- ing the death of another person (murder), while

letting die is a matter of allowing nature to do its work. In the first, a person kills; in the second, a disease kills.

But critics deny that there is a morally signifi- cant difference between killing and letting die. If there is no difference, they can argue that since passive euthanasia is permissible, and it is mor- ally equivalent to active euthanasia, active eutha- nasia must be permissible as well. James Rachels tries to demonstrate this no-difference thesis in a famous thought experiment about parallel cases:

In the first case, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bath- room, drowns the child, and arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in, planning to drown the child in his bath. However, as he enters the bathroom Jones sees the child slip, hit his head and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "acciden- tally," as Jones watches and does nothing.

Now Smith killed the child, while Jones merely let the child die. That is the only differ- ence between them. Did either man behave better, from a moral point of view?<sup>5</sup>

Rachels concludes that any dissimilarity be- tween killing and letting die does not make a moral difference.

Winston Nesbitt rejects Rachels' no-difference view, arguing that the real reason Smith and Jones seem equally reprehensible is that they are both *prepared to kill*. If we assumed that Jones is ready to let his cousin die but is not prepared to kill him, we would judge Jones less harshly than Smith. If this is correct, Nesbitt says, then Rachels fails to make his case.<sup>6</sup>

Some argue against active voluntary euthana- sia by advancing another kind of distinction— between *intending* someone's death and *not*

Under Oregon's Death With Dignity Act (DWDA), terminally ill adults may get prescriptions from their physicians for lethal drugs and self-administer them. In 2006, Oregon doctors wrote 65 such prescriptions, and 35 patients used the medications. From 1997 to 2006, 292 patients died under the law. The law specifies requirements for both doctor and patient.

To request a prescription for lethal medications, the DWDA requires that a patient must be:

- An adult (18 years of age or older)
- A resident of Oregon
- Capable (defined as able to make and communicate health care decisions)
- Diagnosed with a terminal illness that will lead to death within six months
- Patients meeting these requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician. To receive a prescription
- *intending but foreseeing* it. This difference is emphasized in the doctrine of double effect, an essential feature of Roman Catholic ethics (see Chapter 2). Applying the distinction to euthanasia, we get this principle: It is wrong to intentionally harm someone (cause her death) to produce a good result (release from suffering, for example), but it is permissible to do something intended to produce a good result (release from suffering), even if the action leads to unintended but foreseen harm (her death). The difference is that in the former, a bad thing is directly intended; in the latter, a bad thing is not intended, only foreseen. By this formula, it would be wrong for a physician to try to relieve the chronic misery of a terminally ill patient by deliberately giving her high doses of morphine to hasten her death. But it would be morally acceptable for that physician to give the

for lethal medication, the following steps must be fulfilled:

- The patient must make two oral requests to his physician, separated by at least 15 days.
- The patient must provide a written request

to his or her physician, signed in the presence

of two witnesses.

- The prescribing physician and a consulting physi-

cian must confirm the diagnosis and prognosis. • The prescribing physician and a consulting

physician must determine whether the

patient is capable.

- If either physician believes the patient's

judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.

- The prescribing physician must inform the patient of feasible alternatives to DWDA, including comfort care, hospice care, and pain control.
- The prescribing physician must request, but may not require, the patient to notify his or her next-of-kin of the prescription request.

From Oregon Department of Human Services, "Death With Dignity Act," *Oregon.gov*, March 2007, <http://www.oregon.gov/DHS/ph/pas> (2 February 2008).

patient the same amount of morphine with the sole intention of easing her pain, even though the physician foresees that she will die as a result. (Giving a dying, suffering patient extremely high doses of analgesics to the point of unconsciousness and accelerated death is known as terminal sedation; provided the patient consents, it is legal and generally considered morally permissible in medical practice.)

Many question whether in practice this intended/unintended distinction can always be drawn as clearly as proponents assume. For example:

In the case of euthanasia, just as in pain and symptom control, critics maintain, the physician's end may be the good one of relieving the patient's suffering. In neither case would death

be wanted by the patient or the physician if the suffering could be avoided without it, but both patient and physician may be prepared to accept the patient's earlier death in order to relieve his or her suffering. Although the patient's death in the case of euthanasia may be the necessary means taken in the causal path to relief of suffering, it is the unavoidable side-effect following upon the relief of the patient's suffering in the causal path taken to achieve pain and symptom control.<sup>7</sup>

Others are skeptical of the intended/unintended principle itself. Their view is that even if it is wrong to intentionally do harm to bring about good, directly intending a patient's death may still be permissible because to her, *death may not be a harm*. If her pain is unbearable and untreatable, and she makes an autonomous request to die, then active euthanasia may be a blessing—and therefore within ethical bounds.

Probably the most straightforward arguments against active euthanasia and physician-assisted suicide are appeals to bad consequences. They make their case at the policy level, asking us to consider the ramifications of legalizing or widely accepting these practices. Often their logical shape is the slippery slope: Allowing active euthanasia or physician-assisted suicide will inevitably lead to heinous extensions or perversions of the original practices. The usual worries are that legalization will lead quickly from active voluntary euthanasia to active non-voluntary euthanasia to outright involuntary forms of killing. Or that physicians or families will start pushing unwilling or unsure patients toward assisted suicide or voluntary euthanasia. Or that physicians and nurses will become increasingly willing to give lethal injections to people who are elderly, mentally ill, chronically ill, uninsured, and disabled. As one philosopher explains it,

[E]uthanasia as a policy is a slippery slope. A person apparently hopelessly ill may be allowed to take his own life. Then he may be permitted to deputize others to do it for him

should he no longer be able to act. The judgment of others then becomes the ruling factor. Already at this point euthanasia is not personal and voluntary, for others are acting "on behalf of" the patient as they see fit. This may

well incline them to act on behalf of other patients who have not authorized them to exercise their judgment. It is only a short step, then, from voluntary euthanasia (self-inflicted or authorized), to directed euthanasia administered to a patient who has given no authorization, to involuntary euthanasia conducted as part of a social policy.<sup>8</sup>

The key premise in most slippery-slope arguments, then, is an empirical claim that a policy permitting active voluntary euthanasia or assisted-suicide will lead to unjustified killing (involuntary euthanasia, for example). Much of the debate therefore has centered on whether any good empirical evidence supports such a premise. Unfortunately, scientific research on the issue has been scant, with most of it focused on the Netherlands, where physician-assisted suicide and active voluntary euthanasia have been legal since 2002. (There is even less data on Oregon, where a law permitting physician-assisted suicide was passed by Oregon voters in 1994 but not green-lighted until the Supreme Court decision of 2006.) Thus both those who favor and those who oppose euthanasia and assisted suicide have tried to make their case with data from the Dutch experience. One question they want the research to answer is whether legalization of voluntary euthanasia has expanded the use of nonvoluntary euthanasia, for a significant expansion would seem to support slippery-slope arguments. Opponents of legalization point to all the instances of Dutch physicians performing active euthanasia without the patient's consent (approximately 1000 per year, or about 0.8 percent of all deaths nationwide). Proponents reply that most of those patients were already near death or had become incompetent after initially asking for euthanasia or that the euthanasia was passive, consisting of withholding or withdrawing treatment. Most of all, they emphasize

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that the few studies done so far do not demonstrate that legalization has significantly multiplied the cases of nonvoluntary euthanasia. Dutch authorities have reported that data gathered so far indicate that physician misconduct in euthanasia cases is extremely rare, despite rumors in the United States about rampant involuntary euthanasia committed by Dutch doctors.

The best minds on all sides of these debates recognize the need for better evidence to assess the slipperiness of the slippery slope. But they also know that the *mere possibility* of abuses arising from allowing euthanasia or assisted suicide is not in itself a good reason to ban the practices. If merely possible dangers or abuses justified prohibiting a practice, then we would have good reason to disallow advance directives, surrogate decision-making, and any kind of voluntary passive euthanasia. For a slippery-slope argument to work, there must be good evidence that the bad consequences of taking the first step are probable and serious.

Utilitarians can consistently adopt different views on active euthanasia and assisted suicide depending on how they define the good to be maximized, whether their moral focus is acts or rules, and how much importance they give to self-determination. Classic utilitarianism defines the good as happiness and would therefore judge the issues by how much happiness various actions might produce for everyone involved. From this perspective, euthanasia or assisted suicide for someone suffering horrible, inescapable pain might be permissible because ending life would bring about the most net happiness. Of course, the calculations would have to include other factors such as the psychological, social, and

financial impact on the patient's family, friends, and caregivers. With everything factored in, the utilitarian answer could easily come out against euthanasia.

On the other hand, many utilitarians (following John Stuart Mill) think that there's more to consider in making moral judgments than just net happiness. As utilitarian philosopher Peter Singer says,

Many people prefer to live a life with less happiness or pleasure in it, and perhaps even more pain and suffering, if they can thereby fulfill other important preferences. For example, they may choose to strive for excellence in art, or literature, or sport, even though they know that they are unlikely to achieve it, and may experience pain and suffering in the attempt.<sup>9</sup>

Those in utilitarianism's camp who take this view are known as *preference utilitarians*, holding that right actions are those that satisfy more of a person's preferences overall. To them, killing is bad when it prevents someone from satisfying his own preferences; it can be good (as in euthanasia) when more of the person's future preferences will be frustrated than satisfied. According to Singer,

[I]f the goods that life holds are, in general, reasons against killing, those reasons lose all their force when it is clear that those killed will not have such goods, or that the goods they have will be outweighed by bad things that will happen to them. When we apply this reasoning to the case of someone who is capable of judging the matter, and we add Mill's view that individuals are the best judges of their own interests, we can conclude that this reason against killing does not apply to a person who, with unimpaired capacities for judgment, comes to the conclusion that his or her future is so clouded that it would be better to die than to continue to live. Indeed, the reason against killing is turned into its opposite, a reason for acceding to that person's request.<sup>10</sup>

Rule-utilitarian approaches can lead to positions both favoring and opposing euthanasia and assisted suicide. Most slippery-slope arguments are essentially rule-utilitarian, asserting that a general policy of authorized killing will, step by step, take society down a path to awful consequences. The outcomes to be avoided are many, including increases in nonvoluntary or

## IN DEPTH

When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?

Should    Should Not    68%    28%

Regardless of whether or not you think it should be legal, please tell me whether you personally believe that in general doctor-assisted suicide is morally acceptable or morally wrong.

Chapter 10: Euthanasia and Physician-Assisted Suicide 635 Do you think a person has a moral right to suicide in

any of the following circumstances?

When this person is suffering great pain and has no hope of improvement?

Yes 62%

When this person has an incurable disease?

Yes 56%

When this person is ready to die because living has become a burden?

Yes 38%

When this person is an extremely heavy burden on his or her family?

Yes 32%

Pew Research Center nationwide survey of 1,944 adults,

March 21–April 8, 2013; margin of error 62.9.

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.<sup>11</sup>

What is clear in Kant's theory is that suicide is prohibited because it treats persons as mere things and obliterates personhood. Kant asserts that "the rule of morality does not admit of [suicide] under any condition because it degrades human nature below the level of animal nature and so destroys it." It is also apparent on Kant's view that competent persons must not be killed or permitted to die. But it is not obvious what Kant's opinion would be of individuals no longer regarded as persons because they have lapsed into a persistent vegetative state. Would

Morally Acceptable 56%

Morally Wrong 37%

Gallup Poll, May 6–10, 2015; 1,024 adults nationwide; margin of error 64.

involuntary euthanasia, erosion of respect for the medical profession, and a weakening of society's abhorrence of homicide. Some also argue on rule-utilitarian grounds for a general policy, citing relief of suffering as the most obvious benefit.

The natural law view in Roman Catholicism condemns active and passive euthanasia, though the condemnation comes with qualifications. Directly intending to bring about a person's death to end suffering is prohibited, but the doctrine of double effect permits actions that have unintended but fatal results. As discussed earlier, the doctrine would not allow doctors to give high-dose analgesics to put patients out of their misery, but it would sanction their doing the same thing with the intention of easing pain though death is foreseen. In addition, under Catholic principles there is no obligation to use every means possible to prolong a person's life in every case. The Vatican declares:

## Nancy Cruzan

In the 1990 case of *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court issued its first momentous ruling involving an individual's

wanted. At one time she had mentioned to a friend that she would not want to be kept alive like a "vegetable," but she had left no living will or other ex-

"right to die." The question was whether a feeding tube could be removed from a young woman named Nancy Cruzan, who had been left in a persistent vegetative state after a terrible car crash.

On January 11, 1983, Nancy Cruzan's car overturned on an icy road in Missouri, flinging her into a ditch and stopping her heart. By the time paramedics restarted it, her brain had been oxygen-deprived for at least 15 minutes. The resulting brain damage was profound and permanent. So at age 25 she fell into a persistent vegetative state, a benighted condition of minimal brain activity without consciousness or purposeful behavior. "The vegetative state," says an expert panel, "is a clinical condition of complete unawareness of the self and the environment. . . . Recovery from a nontraumatic persistent vegetative state after three months is exceedingly rare."<sup>12</sup> Nancy lingered in that state for years, her body coiled into a rigid fetal position, nourished only by a surgically implanted feeding tube.

After three years of hoping that Nancy would somehow recover, her parents finally asked that the feeding tube be removed so she could die in peace. "You try your damndest as long as there's hope," said Nancy's father, "and then when there is none anymore, you must let her go."

But authorities in the state of Missouri saw things differently. They sought to block the removal of Nancy's feeding tube. The Missouri Supreme Court said that the state has an extremely strong interest in preserving life and that the Cruzans may not disconnect their daughter's feeding tube without "clear and convincing evidence" of what Nancy would have

explicit instructions.

The Cruzans appealed to the U.S. Supreme

Court, and in June 1990 the Court delivered its far-reaching decision in its first right-to-die case. The Court held that Missouri had a legitimate interest in demanding "clear and convincing evidence" of an incompetent individual's preferences. By sanctioning this strict standard of evidence, the Court effectively ruled against the Cruzans. But in making its decision, it also laid out some weighty principles pertaining to a person's end-of-life choices.

The Court found that competent individuals have a constitutionally guaranteed "liberty interest" in refusing medical treatment, even when refusing could bring about their death. And for the first time, it acknowledged that if a person became incompetent, this right could be exercised through a living will or by a designated surrogate. States could still restrict this liberty interest, however, if a person's refusal of treatment was not stated clearly or strongly enough.

As part of its case, the state argued that there was a difference between withdrawing medical treatment and withdrawing food and fluids. But the Supreme Court recognized no such distinction.

A few months after the Court's ruling, Missouri said it would stop opposing the Cruzans' efforts, and a Missouri judge declared that the evidence of Nancy's intent was sufficiently convincing. In December 1990 he ordered her feeding tube removed.

On December 26, 1990, at the age of 33 and nearly eight years after her accident, Nancy Cruzan died peacefully.

respect for persons demand that they be kept alive at all costs—or that we perform nonvoluntary euthanasia to allow them to die with dignity?

## **key terms**

active euthanasia euthanasia

involuntary euthanasia nonvoluntary euthanasia passive euthanasia physician-assisted suicide voluntary euthanasia

## **summary**

Euthanasia is directly or indirectly bringing about the death of another person for that person's sake. A common distinction is that active euthanasia involves performing an action that directly causes someone's death, while passive euthanasia is allowing someone to die by not doing something to prolong life. Voluntary euthanasia is performed when competent patients request or agree to it; nonvoluntary euthanasia, when patients are not competent to choose for themselves and have not previously disclosed their preferences. Involuntary euthanasia, both illegal and morally impermissible, is bringing about someone's death against her will or without asking for her consent. In physician-assisted suicide a patient takes his own life with the help of a physician.

Death traditionally has been understood as the cessation of breathing and heartbeat, but medical advances have rendered this notion problematic. The whole brain view is now the standard in legal and medical matters. It says that an individual should be judged dead when all brain functions permanently stop. Many experts object to this definition because some physiological processes such as respiration are partly independent of brain functions, a fact that would suggest on the whole brain view that individuals in persistent vegetative states with

some brain activity must be considered alive. An alternative notion is the higher brain standard, which asserts that individuals are dead when the higher brain functions responsible for consciousness permanently close down. This view implies that those in persistent vegetative states whose higher brain functions have irreversibly ceased are dead.

The main argument for the moral permissibility of active voluntary euthanasia is an appeal to autonomy. It contends that respecting people's inherent right of self-determination means respecting their autonomous choices about ending their lives. Another major argument appeals to the principle of beneficence, or mercy: If we are in a position to relieve the severe suffering of another without excessive cost to ourselves, we have an obligation to do so.

An important argument against active voluntary euthanasia appeals to the supposed moral difference between killing and letting die. Killing is thought to be worse than letting die, so giving a patient a lethal injection to effect an easy death is wrong, but disconnecting his feeding tube may be permissible. Critics argue that there is no morally significant difference between these two. Those opposed to voluntary euthanasia make a related distinction between intending someone's death and not intending but foreseeing it. The former is said to be wrong; the latter, permissible. Many are skeptical of this distinction as well.

Very often cases against active euthanasia and physician-assisted suicide are built on slippery-slope arguments, which contend that allowing these practices would inevitably lead to abuses, most notably unjustified killing. Typically, both those who make these arguments and those who criticize them appeal to empirical data on the legalized use of euthanasia or physician-assisted suicide in Oregon or the Netherlands. But the data are sparse and subject to much debate, leaving the key premise in most slippery-slope arguments weak.

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## 638 PART 3: LIFE AND DEATH Cases for Evaluation

### CASE 1

## Doctor-Aided Suicide and “Vulnerable Groups”

(*ScienceDaily*)—Contrary to arguments by critics, a University of Utah–led study found that legalizing physician-assisted suicide in Oregon and the Netherlands did not result in a disproportionate number of deaths among the elderly, poor, women, minorities, uninsured, minors, chronically ill, less educated, or psychiatric patients.

Of 10 “vulnerable groups” examined in the study, only AIDS patients used doctor-assisted suicide at elevated rates.

“Fears about the impact on vulnerable people have dominated debate about physician-assisted suicide. We find no evidence to support those fears where this practice already is legal,” says the study’s lead author, bioethicist Margaret Battin, a University of Utah distinguished professor of philosophy and adjunct professor of internal medicine.

The study will be published in the October 2007 issue of the *Journal of Medical Ethics*. Battin conducted the research with public health physician Agnes van der Heide, of Erasmus Medical Center, Rotterdam; psychiatrist Linda Ganzini at Oregon Health & Science University, Portland; and physician Gerrit van der Wal and health scientist Bregje Onwuteaka-Philipsen, of the VU University Medical Center, Amsterdam. Van der Wal currently is inspector general of the Netherlands Health Care Inspectorate, which advises that nation’s health minister.

The research deals with the so-called “slippery-slope” argument that has been made by critics of doctor-assisted suicide and has raised concern even among proponents. The argument is that by making it legal for medical doctors to help certain patients end their lives, vulnerable people will die in disproportionately large numbers.

“Would these patients be pressured, manipulated or forced to request or accept physician-assisted dying by overburdened family members, callous

physicians, or institutions or insurers concerned about their own profits,” the researchers asked.

The American College of Physicians said in 2005 that it was “concerned with the risks that legalization [of physician-assisted suicide] posed to vulnerable populations, including poor persons, patients with dementia, disabled persons, those from minority groups that have experienced discrimination, those confronting costly chronic illnesses, or very young children.” . . .

Battin’s team analyzed data on assisted suicide and voluntary active euthanasia in the Netherlands during 1985–2005—data taken from four government studies and several smaller ones. They analyzed Oregon Department of Human Services annual reports for 1998–2006, and surveys of physicians and hospice professionals.

The findings fell into three categories, based on the strength of the data. The researchers found:

- Direct evidence that elderly people, women, and uninsured people do not die in disproportionate numbers where physician-assisted death is legal, but AIDS patients do. (The insurance data is from Oregon only; everyone is insured in the Netherlands.)
- Evidence that is partly direct and partly inferred showing that physician-assisted death does not kill disproportionate numbers of people who are poor, uneducated, racial and ethnic minorities, minors, or people with chronic physical or mental disabilities or chronic but not terminal illnesses.
- Evidence that is based on inference or that is partly contested showing that people with psychiatric illness—including depression and Alzheimer’s disease—are not likely to die in lopsided numbers.
- “Those who received physician-assisted dying . . . appeared to enjoy comparative social, economic, educational, professional and other privileges,” the researchers write.
- The researchers noted that in both Oregon and the Netherlands, people who received a doctor’s help in dying averaged 70 years old, and 80 percent were cancer patients.\*

*Suppose the data of this study are accurate. Would they show that all slippery-slope arguments against physician-assisted suicide are unsuccessful? Suppose the study proved that legalization did harm vulnerable populations. Would that finding support the conclusion that physician-assisted suicide should not be legalized under any circumstances? What might someone who is opposed to legalization say about this study? Or someone who favors legalization? How does the news of this study affect your own views on legalization? Give reasons for your answer.*

\*“Doctor-Aided Suicide: No Slippery Slope, Study Finds,” *Science Daily*, 29 September 2007, <http://www.sciencedaily.com/releases/2007/09/070926191348.htm> (10 February 2008).

## CASE 2

### Suicide Pacts Among Friends

(*London Telegraph*)—Jenni Murray, the presenter of BBC Radio 4’s *Woman’s Hour*, has made plans to end her life if she becomes a burden to her family.

She said: “When my time comes I want to be able to decide about my destiny.”

The last thing she wanted, she said, was for her children to suffer from her being desperately ill.

She is sealing a pact with two friends that they will assist each other to die if any of them is diagnosed with a debilitating and incurable illness. Methods they might use include injections or smothering with a pillow.

This is despite a law outlawing assisted suicide, which Murray says is sustained by a religious minority.

She speaks of the pact tomorrow night on a Channel 5 documentary, *Don’t Get Me Started!*, that produces statistics to back the theory that many people in the country share her views on euthanasia.

Her appearance is part of a “personal rant” series in which noted people are given the chance to sound off about a subject they feel strongly about.

Publicity material for the show says that Murray “does not want to look after her sick and aging mother, and plans to end her own life when she becomes a burden to those around her.”

The network said: “Jenni is angry that, having fought so hard to become liberated and independent, women are now being trapped into caring for dependent parents.”

Murray, 56, from Barnsley, South Yorks, has been presenting *Woman's Hour* since 1987. In 1999 she was awarded an OBE for radio broadcasting.

Her pact is with Sally Feldman, a former editor of *Woman's Hour*, and Jane Wilton, another friend. They plan to sign a written agreement.

Murray is the vice-president of a society that concerns itself with Parkinson's disease, which her mother suffers from. Her father is a carer.

In the programme she emphasises that, while she supports her friends helping her to die, she would find it hard to do the same if her mother told her "Let me go."\*

*Do you agree with Murray's decision? Does she have a right to take her life for any reason? Is not wanting to be a burden to one's family a good reason? Should assisted-suicide pacts be legalized? Is it just as moral (or immoral) to assist in a friend's suicide as it is to directly kill her? Explain your answers.*

\*Hugh Davies, "Jenni Murray Makes a Suicide Pact," *Telegraph.co.uk*, 14 August 2006, <http://www.telegraph.co.uk/news/main.jhtml?xml;eq/news/2006/08/14/nmurray14.xml> (10 February 2008).

### CASE 3

## "Baby Euthanasia"

(*TimesOnline*)—When Frank and Anita's daughter Chanou was born with an extremely rare, incurable illness in August 2000, they knew that her life would be short and battled against the odds to make it happy.

They struggled around the clock against their baby's pain. "We tried all sorts of things," said Anita, a 37-year-old local government worker. "She cried all the time. Every time I touched her it hurt."

Chanou was suffering from a metabolic disorder that had resulted in abnormal bone development. Doctors gave her no more than 30 months to live.

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"We felt terrible watching her suffer," said Anita at their home near Amsterdam. "We felt we were letting her down."

Frank and Anita began to believe that their daughter would be better off dead. "She kept throwing up milk that was fed through a tube in her nose," said Anita. "She seemed to be saying, 'Mummy, I don't want to live any more. Let me go.'"

Eventually, doctors agreed to help the baby die at seven months. The feeding was stopped. Chanou was given morphine. "We were with her at that last moment," said Anita. "She was exhausted. She took a very deep last breath. It was so peaceful. It made me feel at peace inside to know that she wasn't suffering any more."

Even so, they felt that the suffering had gone on too long. Child euthanasia is illegal in Holland and doctors were afraid of being prosecuted. "It was a long road to find the humane solution that we reluctantly decided we wanted," said Frank, a bank worker.

Each year in Holland at least 15 seriously ill babies, most of them with severe spina bifida or chromosomal abnormalities, are helped to die by doctors acting with the parents' consent. But only a fraction of those cases are reported to the authorities because of the doctors' fears of being charged with murder.

Things are about to change, however, making it much easier for parents and doctors to end the suffering of an infant.

A committee set up to regulate the practice will begin operating in the next few weeks, effectively making Holland, where adult euthanasia is legal, the first country in the world to allow “baby euthanasia” as well.

The development has angered opponents of euthanasia who warn of a “slippery slope” leading to abuses by doctors and parents, who will be making decisions for individuals incapable of expressing a will.

Others welcome more openness about a practice that, according to doctors, goes on secretly anyway— even in Britain—regardless of the law. “It is a giant step forward and we are very happy about it,” said Eduard Verhagen, clinical director of paediatrics at the University Medical Centre in Groningen, northern Holland.

Anti-euthanasia campaigners have been addressing hate mail to “Dr. Death,” as they call him, ever since he admitted having personally overseen four “assisted neonatal terminations.” He then began drawing up guidelines for doctors carrying out euthanasia on babies.

It forced the government to confront the issue and Verhagen’s so-called “Groningen protocol” has been adopted as the standard to be upheld by the regulatory committee.

It emphasises that life can be ended only in cases involving “unbearable suffering,” with parental consent and after consultation with other physicians.

“If a child is untreatably ill,” Verhagen explained, “there can be horrendous suffering that makes the last few days or weeks of this child’s life unbearable. Now the question is: Are you going to leave the child like that or are you going to prevent that suffering?” He went on: “Does the child have to sit it out until the end? We think that the answer is no. There can be circumstances where, under very strict conditions, if all the requirements are fulfilled, active ending of life can be an option—but only in cases of untreatable disease and unbearable suffering.”\*

*How would you respond to Verhagen’s questions in the last paragraph? Do you believe that neonatal euthanasia performed under the strict conditions described by Verhagen is morally permissible? Why or why not? Should it be legalized?*

\*“Holland to Allow ‘Baby Euthanasia,’” *TimesOnline*, 5 March 2006, <http://www.timesonline.co.uk/article/0,2089-2069963,00.html> (10 February 2008).

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Diane was feeling tired and had a rash. A common scenario, though there was something subliminally worrisome that prompted me to check her blood count. Her hematocrit was 22, and the white-cell count was 4.3 with some metamyelocytes and unusual white cells. I wanted it to be viral, trying to deny what was staring me in the face. Perhaps in a repeated count it would disappear. I called Diane and told her it might be more serious than I had initially thought—that the test needed to be repeated and that if she felt worse, we might have to move quickly. When she pressed for the possibilities, I reluctantly opened the door to leukemia. Hearing the word seemed to make it exist. "Oh, shit!" she said. "Don't tell me that." Oh, shit! I thought, I wish I didn't have to.

Diane was no ordinary person (although no one I have ever come to know has been really ordinary). She was raised in an alcoholic family and had felt alone for much of her life. She had vaginal cancer as a young woman. Through much of her adult life, she had struggled with depression and her own alcoholism. I had come to know, respect, and admire her over the previous eight years as she confronted these problems and gradually overcame them. She was an incredibly clear, at times brutally honest,

From Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision Making," *New England Journal of Medicine*, 324, no. 10 (March 7, 1991): 691–694.

thinker and communicator. As she took control of her life, she developed a strong sense of independence and confidence. In the previous 31/2 years, her hard work had paid off. She was completely abstinent from alcohol, she had established much deeper connections with her husband, college-age son, and several friends, and her business and her artistic work were blossoming. She felt she was really living fully for the first time.

Not surprisingly, the repeated blood count was abnormal, and detailed examination of the peripheral blood smear showed myelocytes. I advised her to come into the hospital, explaining that we needed to do a bone marrow biopsy and make some decisions relatively rapidly. She came to the hospital knowing what we would find. She was terrified, angry, and sad. Although we knew the odds, we both clung to the thread of possibility that it might be something else.

The bone marrow confirmed the worst: acute myelomonocytic leukemia. In the face of this tragedy, we looked for signs of hope. This is an area of medicine in which technological intervention has been successful, with cures 25 percent of the time—long-term cures. As I probed the costs of these cures, I heard about induction chemotherapy (three weeks in the hospital, prolonged neutropenia, probable infectious complications, and hair loss; 75 percent of patients respond, 25 percent do not). For the survivors, this is followed by consolidation chemotherapy (with similar side effects; another 25 percent die, for a

net survival of 50 percent). Those still alive, to have a reasonable chance of long-term survival, then need bone marrow transplantation (hospitalization for two months and whole-body irradiation, with complete killing of the bone marrow, infectious complications, and the possibility for graft-versus-host disease—with a survival of approximately 50 percent, or 25 percent of the original group). Though hematologists may argue over the exact

percentages, they don't argue about the outcome of no treatment—certain death in days, weeks, or at most a few months.

Believing that delay was dangerous, our oncologist broke the news to Diane and began making plans to insert a Hickman catheter and begin induction chemotherapy that afternoon. When I saw her shortly thereafter, she was enraged at his presumption that she would want treatment, and devastated by the finality of the diagnosis. All she wanted to do was go home and be with her family. She had no further questions about treatment and in fact had decided that she wanted none. Together we lamented her tragedy and the unfairness of life. Before she left, I felt the need to be sure that she and her husband understood that there was some risk in delay, that the problem was not going to go away, and that we needed to keep considering the options over the next several days. We agreed to meet in two days.

She returned in two days with her husband and son. They had talked extensively about the problem and the options. She remained very clear about her wish not to undergo chemotherapy and to live whatever time she had left outside the hospital. As we explored her thinking further, it became clear that she was convinced she would die during the period of treatment and would suffer unspeakably in the process (from hospitalization, from lack of control over her body, from the side effects of chemotherapy, and from pain and anguish). Although I could offer support and my best effort to minimize her suffering if she chose treatment, there was no way I could say any of this would not occur. In fact, the last four patients with acute leukemia at our hospital had died very painful deaths in the hospital during various stages of treatment (a fact I did not share with her). Her family wished

she would choose treatment but sadly accepted her decision. She articulated very clearly that it was she who would be experiencing all the side effects of treatment and that odds of 25 percent were not good enough for her to undergo so toxic a course of therapy, given her expectations of chemotherapy and hospitalization and the absence of a closely matched bone marrow donor. I had her repeat her understanding of the treatment, the odds, and what to expect if there were no treatment. I clarified a few misunderstandings, but she had a remarkable grasp of the options and implications.

I have been a longtime advocate of active, informed patient choice of treatment or nontreatment, and of a patient's right to die with as much control and dignity as possible. Yet there was something about her giving up a 25 percent chance of long-term survival in favor of almost certain death that disturbed me. I had seen Diane fight and use her considerable inner resources to overcome alcoholism and depression, and I half expected her to change her mind over the next week. Since the window of time in which effective treatment can be initiated is rather narrow, we met several times that week. We obtained a second hematology consultation and talked at length about the meaning and implications of treatment and nontreatment. She talked to a psychologist she had seen in the past. I gradually understood the decision from her perspective and became convinced that it was the right decision for her. We arranged for home hospice care (although at that time Diane felt reasonably well, was active, and looked healthy), left the door open for her to change her mind, and tried to anticipate how to keep her comfortable in the time she had left.

Just as I was adjusting to her decision, she opened up another area that would stretch me profoundly. It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die. As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort,

and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense. I acknowledged and explored this wish but also thought that it was out of the realm of currently accepted medical practice and that it was more than I could offer or promise. In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left until she found a safe way to ensure her death. I feared the effects of a violent death on her family, the consequences of an ineffective suicide that would leave her lingering in precisely the state she dreaded so much, and the possibility that a family member would be forced to assist her, with all the legal and personal repercussions that would follow. She discussed this at length with her family. They believed that they should respect her choice. With this in mind, I told Diane that information was available from the Hemlock Society that might be helpful to her.

A week later she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries

I was exploring—spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

The next several months were very intense and important for Diane. Her son stayed home from college, and they were able to be with one another and say much that had not been said earlier. Her husband did his work at home so that he and Diane could spend more time together. She spent time with her closest friends. I had her come into the hospital for a conference with our residents, at which she illustrated in a most profound and personal way the importance of informed decision making, the right to refuse treatment, and the extraordinarily personal effects of illness and interaction with the medical system. There were emotional and physical hardships as well. She had periods of intense sadness and anger. Several times she became very weak, but she received transfusions as an outpatient and responded with marked improvement of symptoms. She had two serious infections that responded surprisingly well to empirical courses of oral antibiotics. After three tumultuous months, there were two weeks of relative calm and well-being, and fantasies of a miracle began to surface.

Unfortunately, we had no miracle. Bone pain, weakness, fatigue, and fevers began to dominate her life. Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to

her husband and son that morning, and asked them to leave her alone for an hour. After an hour, which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace. They called me for advice about how to proceed. When I arrived at their house, Diane indeed seemed peaceful. Her husband and son were quiet. We talked about what a remarkable person she had been. They seemed to have no doubts about the course she had chosen or about their cooperation, although the unfairness of her illness and the finality of her death were overwhelming to us all.

I called the medical examiner to inform him that a hospice patient had died. When asked about the cause of death, I said, “acute leukemia.” He said that was fine and that we should call a funeral director. Although acute leukemia was the truth, it was not the whole story. Yet any mention of suicide would have given rise to a police investigation and probably brought the arrival of an ambulance crew for resuscitation. Diane would have become a “coroner’s case,” and the decision to perform an autopsy would have been made at the discretion of the medical examiner. The family or I could have been subject to criminal prosecution, and I to professional review, for our roles in support of Diane’s choices. Although I truly believe that the family and I gave her the best care possible, allowing her to define her limits and directions as much as possible, I am not sure the law, society, or the medical profession would agree. So I said “acute leukemia” to protect all of us, to protect Diane from an invasion into her past and her body, and to continue to shield society from the knowledge of the degree of

suffering that people often undergo in the process of dying. Suffering can be lessened to some extent, but in no way eliminated or made benign, by the careful intervention of a competent, caring physician, given current social constraints.

Diane taught me about the range of help I can provide if I know people well and if I allow them to say what they really want. She taught me about life, death, and honesty and about taking charge and facing tragedy squarely when it strikes. She taught me that I can take small risks for people that I really know and care about. Although I did not assist in her suicide directly, I helped indirectly to make it possible, successful, and relatively painless. Although I know we have measures to help control pain and lessen suffering, to think that people do not suffer in the process of dying is an illusion. Prolonged dying can occasionally be peaceful, but more often the role of the physician and family is limited to lessening but not eliminating severe suffering.

I wonder how many families and physicians secretly help patients over the edge into death in the face of such severe suffering. I wonder how many severely ill or dying patients secretly take their lives, dying alone in despair. I wonder whether the image of Diane’s final aloneness will persist in the minds of her family, or if they will remember more the intense, meaningful months they had together before she died. I wonder whether Diane struggled in that last hour, and whether the Hemlock Society’s way of death by suicide is the most benign. I wonder why Diane, who gave so much to so many of us, had to be alone for the last hour of her life. I wonder whether I will see Diane again, on the shore of Lake Geneva at sunset, with dragons swimming on the horizon.

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## Voluntary Active Euthanasia

DAN W. BROCK

Brock argues that the same two basic moral principles that support a patient’s right to make choices about life-sustaining treatment also support the permissibility of voluntary active euthanasia. The first principle is individual self-determination; the second is individual well-being. Individual self-determination applies to the manner, circumstances, and timing of one’s death

and dying. A concern for individual well-being may justify euthanasia when a suffering patient determines that life is no longer a benefit.

... 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

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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.

### **Euthanasia Is the Deliberate Killing of an Innocent Person**

**The claim that any individual instance of euthanasia is a case of deliberate killing of an innocent person is, with only minor qualifications, correct. Unlike forgoing life-sustaining treatment, commonly understood as allowing to die, euthanasia is clearly killing, defined as depriving of life or causing the death of a living being. While providing morphine for pain relief at doses where the risk of respiratory depression and an earlier death may be a foreseen but unintended side effect of treating the patient's pain, in a case of euthanasia the patient's death is deliberate or intended even if in both the physician's ultimate end may be respecting the patient's wishes. If the deliberate killing of an innocent person is wrong, euthanasia would be nearly always impermissible.**

In the context of medicine, the ethical prohibition against deliberately killing the innocent derives some of its plausibility from the belief that nothing in the currently accepted practice of medicine is deliberate killing. Thus, in commenting on the "It's Over, Debbie" case, four prominent physicians and bioethicists could entitle their paper "Doctors Must Not Kill."<sup>1</sup> The belief that doctors do not in fact kill requires the corollary belief that forgoing life-sustaining treatment, whether by not starting or by stopping treatment, is allowing to die, not killing. Common though this view is, I shall argue that it is confused and mistaken.

Why is the common view mistaken? Consider the case of a patient terminally ill with ALS disease. She is completely respirator dependent with no hope of ever being weaned. She is unquestionably competent but finds her condition intolerable and persistently requests to be removed from the respirator and allowed to die. Most people and physicians would agree that the patient's physician should respect the patient's wishes and remove her from the respirator, though this will certainly cause the patient's death. The common understanding is that the

physician thereby allows the patient to die. But is that correct?

Suppose the patient has a greedy and hostile son who mistakenly believes that his mother will never decide to stop her life-sustaining treatment and that even if she did her physician would not remove her from the respirator. Afraid that his inheritance will be dissipated by a long and expensive hospitalization, he enters his mother's room while she is sedated, extubates her, and she dies. Shortly thereafter the medical staff discovers what he has done and confronts the son. He replies, "I didn't kill her, I merely allowed her to die. It was her ALS disease that caused her death." I think this would rightly be dismissed as transparent sophistry—the son went into his mother's room and deliberately killed her. But, of course, the son performed just the same physical actions, did just the same thing, that the physician would have done. If that is so, then doesn't the physician also kill the patient when he extubates her?

I underline immediately that there are important ethical differences between what the physician and the greedy son do. First, the physician acts with the patient's consent whereas the son does not. Second, the physician acts with a good motive—to respect the patient's wishes and self-determination—whereas the son acts with a bad motive—to protect his own inheritance. Third, the physician acts in a social role through which he is legally authorized to carry out the patient's wishes regarding treatment whereas the son has no such authorization. These and perhaps other ethically important differences show that what the physician did was morally justified whereas what the son did was morally wrong. What they do not show, however, is that the son killed while the physician allowed to die. One can either kill or allow to die with or without consent, with a good or bad motive, within or outside of a social role that authorizes one to do so.

The difference between killing and allowing to die that I have been implicitly appealing to here is roughly that between acts and omissions resulting in death.<sup>2</sup> Both the physician and the greedy son act in a manner intended to cause death, do cause death, and so both kill. One reason this conclusion is resisted is that on a different understanding of the

distinction between killing and allowing to die, what the physician does is allow to die. In this account, the mother's ALS is a lethal disease whose normal progression is being held back or blocked by the life-sustaining respirator treatment. Removing this artificial intervention is then viewed as standing aside and allowing the patient to die of her underlying disease. I have argued elsewhere that this alternative account is deeply problematic, in part because it commits us to accepting that what the greedy son does is to allow to die, not kill.<sup>3</sup> Here, I want to note two other reasons why the conclusion that stopping life support is killing is resisted.

The first reason is that killing is often understood, especially within medicine, as unjustified causing of death; in medicine it is thought to be done only accidentally or negligently. It is also increasingly widely accepted that a physician is ethically justified in stopping life support in a case like that of the ALS patient. But if these two beliefs are correct, then what the physician does cannot be killing, and so must be allowing to die. Killing patients is not, to put it flippantly, understood to be part of physicians' job description. What is mistaken in this line of reasoning is the assumption that all killings are unjustified causings of death. Instead, some killings are ethically justified, including many instances of stopping life support.

Another reason for resisting the conclusion that stopping life support is often killing is that it is psychologically uncomfortable. Suppose the physician had stopped the ALS patient's respirator and had made the son's claim, "I didn't kill her, I merely allowed her to die. It was her ALS disease that caused her death." The clue to the psychological role here is how naturally the "merely" modifies "allowed her to die." The characterization as allowing to die is meant to shift felt responsibility away from the agent—the physician—and to the lethal disease process. Other language common in death and dying contexts plays a similar role; "letting nature take its course" or "stopping prolonging the dying process" both seem to shift responsibility from the physician who stops life support to the fatal disease process. However psychologically helpful these conceptualizations may be in making the difficult responsibility of a physician's role in the patient's death bearable,

they nevertheless are confusions. Both physicians and family members can instead be helped to understand that it is the patient's decision and consent to stopping treatment that limits their responsibility for the patient's death and that shifts that responsibility to the patient.

Many who accept the difference between killing and allowing to die as the distinction between acts and omissions resulting in death have gone on to argue that killing is not in itself morally different from allowing to die.<sup>4</sup> In this account, very roughly, one kills when one performs an action that causes the death of a person (we are in a boat, you cannot swim, I push you overboard, and you drown), and one allows to die when one has the ability and opportunity to prevent the death of another, knows this, and omits doing so, with the result that the person dies (we are in a boat, you cannot swim, you fall overboard, I don't throw you an available life ring, and you drown). Those who see no moral difference between killing and allowing to die typically employ the strategy of comparing cases that differ in these and no other potentially morally important respects. This will allow people to consider whether the mere difference that one is a case of killing and the other of allowing to die matters morally, or whether instead it is other features that make most cases of killing worse than most instances of allowing to die. Here is such a pair of cases:

#### Case 1

A very gravely ill patient is brought to a hospital emergency room and sent up to the ICU. The patient begins to develop respiratory failure that is likely to require intubation very soon. At that point the patient's family members and long-standing physician arrive at the ICU and inform the ICU staff that there had been extensive discussion about future care with the patient when he was unquestionably competent. Given his grave and terminal illness, as well as his state of debilitation, the patient had firmly rejected being placed on a respirator under any circumstances, and the family and physician produce the patient's advance directive to that effect. The ICU staff do not intubate the patient, who dies of respiratory failure.

#### Case 2

The same as Case 1 except that the family and physician are slightly delayed in traffic and arrive shortly after the patient has been intubated and placed on the respirator. The ICU staff extubate the patient, who dies of respiratory failure.

In Case 1 the patient is allowed to die, in Case 2 he is killed, but it is hard to see why what is done in Case 2 is significantly different morally than what is done in Case 1. It must be other factors that make most killings worse than most allowings to die, and if so, euthanasia cannot be wrong simply because it is killing instead of allowing to die.

Suppose both my arguments are mistaken. Suppose that killing is worse than allowing to die and that withdrawing life support is not killing, although euthanasia is. Euthanasia still need not for that reason be morally wrong. To see this, we need to determine the basic principle for the moral evaluation of killing persons. What is it that makes paradigm cases of wrongful killing wrongful? One very plausible answer is that killing denies the victim something that he or she values greatly—continued life or a future. Moreover, since continued life is necessary for pursuing any of a person's plans and purposes, killing brings the frustration of all of these plans and desires as well. In a nutshell, wrongful killing deprives a person of a valued future, and of all the person wanted and planned to do in that future.

A natural expression of this account of the wrongness of killing is that people have a moral right not to be killed.<sup>5</sup> But in this account of the wrongness of killing, the right not to be killed, like other rights, should be waivable when the person makes a competent decision that continued life is no longer wanted or a good, but is instead worse than no further life at all. In this view, euthanasia is properly understood as a case of a person having waived his or her right not to be killed.

This rights view of the wrongness of killing is not, of course, universally shared. Many people's moral views about killing have their origins in religious views that human life comes from God and cannot be justifiably destroyed or taken away, either by the person whose life it is or by another. But in a pluralistic society like our own with a strong commitment

to freedom of religion, public policy should not be grounded in religious beliefs which many in that society reject. I turn now to the general evaluation of public policy on euthanasia.

### **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 it.<sup>6</sup> 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.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup> 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.**

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#### **652 PART 3: LIFE AND DEATH**

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, therefore, 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.<sup>10</sup>

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.

Might Gaylin and his colleagues nevertheless be correct in their claim that the moral center of medicine would collapse if physicians were to become killers? This question raises what at the deepest level should be the guiding aims of medicine, a question that obviously cannot be fully explored here. But I do want to say enough to indicate the direction that I believe an appropriate response to this challenge should take. In spelling out above

what I called the positive argument for voluntary active euthanasia, I suggested that two principal values—respecting 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. . . .

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.<sup>11</sup> 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.<sup>12</sup> 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 general 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 has been developed by David Velleman and 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.<sup>13</sup> 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. 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," 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.<sup>14</sup> 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 likely 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.<sup>15</sup>

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.<sup>16</sup>

### The Slip into Nonvoluntary

#### Active Euthanasia

**While I believe slippery slope worries can largely be limited by making necessary distinctions both in principle and in practice, one slippery slope concern is legitimate. There is reason to expect that legalization of voluntary active euthanasia might soon be followed by strong pressure to legalize some nonvoluntary euthanasia of incompetent patients unable to express their own wishes. Respecting a person's self-determination and recognizing that continued life is not always of value to a person can support not only voluntary active euthanasia, but some nonvoluntary euthanasia as well. These are**

the same values that ground competent patients' right to refuse life-sustaining treatment. Recent history here is instructive. In the medical ethics literature, in the courts since *Quinlan*, and in norms of medical practice, that right has been extended to incompetent patients and exercised by a surrogate who is to decide as the patient would have decided in the circumstances if competent.<sup>17</sup> It has been held unreasonable to continue life-sustaining treatment that the patient would not have wanted just because the patient now lacks the capacity to tell us that. Life-sustaining treatment for incompetent patients is today frequently forgone on the basis of a surrogate's decision, or less frequently on the basis of an advance directive executed by the patient while still competent. The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient (acting with or without a formal advance directive from the patient) may well extend the scope of active euthanasia. The argument will be, Why continue to force unwanted life on patients just because they have now lost the capacity to request euthanasia from us?

A related phenomenon may reinforce this slippery slope concern. In the Netherlands, what the courts have sanctioned has been clearly restricted to voluntary euthanasia. In itself, this serves as some evidence that

permitting it need not lead to permitting the nonvoluntary variety. There is some indication, however, that for many Dutch physicians euthanasia is no longer viewed as a special action, set apart from their usual practice and restricted only to competent persons.<sup>18</sup> Instead, it is seen as one end of a spectrum of caring for dying patients. When viewed in this way it will be difficult to deny euthanasia to a patient for whom it is seen as the best or most appropriate form of care simply because that patient is now incompetent and cannot request it.

Even if voluntary active euthanasia should slip into nonvoluntary active euthanasia, with surrogates acting for incompetent patients, the ethical evaluation is more complex than many opponents of euthanasia allow. Just as in the case of surrogates' decisions to forgo life-sustaining treatment for incompetent patients, so also surrogates' decisions to

request euthanasia for incompetent persons would often accurately reflect what the incompetent person would have wanted and would deny the person nothing that he or she would have considered worth having. Making nonvoluntary active euthanasia legally permissible, however, would greatly enlarge the number of patients on whom it might be performed and substantially enlarge the potential for misuse and abuse. As noted above, frail and debilitated elderly people, often demented or otherwise incompetent and thereby unable to defend and assert their own interests, may be especially vulnerable to unwanted euthanasia.

For some people, this risk is more than sufficient reason to oppose the legalization of voluntary euthanasia. But while we should in general be cautious about inferring much from the experience in the Netherlands to what our own experience in the United States might be, there may be one important lesson that we can learn from them. One commentator has noted that in the Netherlands families of incompetent patients have less authority than do families in the United States to act as surrogates for incompetent patients in making decisions to forgo life-sustaining treatment.<sup>19</sup> From the Dutch perspective, it may be we in the United States who are already on the slippery slope in having given surrogates broad authority to forgo life-sustaining treatment for incompetent persons. In this view, the more important moral divide, and the more important with regard to potential for abuse, is not between forgoing life-sustaining treatment and euthanasia, but instead between voluntary and nonvoluntary performance of either. If this is correct, then the more important issue is ensuring the appropriate principles and procedural safeguards for the exercise of decisionmaking authority by surrogates for incompetent persons in all decisions at the end of life. This may be the correct response to slippery slope worries about euthanasia.

I have cited both good and bad consequences that have been thought likely from a policy change permitting voluntary active euthanasia, and have tried to evaluate their likelihood and relative importance. Nevertheless, as I noted earlier, reasonable disagreement remains both about the consequences of

permitting euthanasia and about which of these consequences are more important. The depth and strength of public and professional debate about whether, all things considered, permitting euthanasia would be desirable or undesirable reflects these disagreements. While my own view is that the balance of considerations supports permitting the practice, my principal purpose here has been to clarify the main issues.

#### notes

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4. James Rachels, "Active and Passive Euthanasia," *NEJM* 292 (1975): 78–80; Michael Tooley, *Abortion and Infanticide* (Oxford: Oxford University Press, 1983). In my paper, "Taking Human Life," *Ethics* 95 (1985): 851–65, I argue in more detail that killing in itself is not morally different from allowing to die and defend the strategy of

argument employed in this and the succeeding two paragraphs in the text.

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14. Frederick Schauer, "Slippery Slopes," *Harvard Law Review* 99 (1985): 361–83; Wibren van der Burg, "The Slippery Slope Argument," *Ethics* 102 (October 1991): 42–65. 15. There is evidence that physicians commonly fail to diagnose depression. See Robert I. Misbin, "Physicians Aid in Dying," *NEJM* 325 (1991): 1304–7.

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## When Self-Determination Runs Amok

DANIEL CALLAHAN

Callahan is opposed to the use of voluntary euthanasia and assisted suicide. He argues that a person's right of self-determination does not morally justify someone else killing that person, even for mercy's sake. He contends that, contrary to common opinion, there is indeed a moral difference between killing and letting die. A policy that lets physicians practice euthanasia will lead to dire consequences and pervert the profession of medicine.

The euthanasia debate is not just another moral debate, one in a long list of arguments in our pluralistic society. It is profoundly emblematic of three important turning points in Western thought. The first is that of the legitimate conditions under which one person can kill another. The acceptance of voluntary active euthanasia would morally sanction what can only be called "consenting adult killing." By the term I mean the killing of one person by another in the name of their mutual right to be killer and killed if they freely agree to play those roles. This turn flies in the face of a long-standing effort to limit the circumstances under which one person can take the life of another, from efforts to control the free flow of guns and arms, to abolish capital punishment, and to more tightly control warfare. Euthanasia would add a whole new category of killing to a society that already has too many excuses to indulge itself in that way.

The second turning point lies in the meaning and limits of self-determination. The acceptance of eu- thanasia would sanction a view of autonomy holding that individuals may, in the name of their own pri- vate, idiosyncratic view of the good life, call upon others, including such institutions as medicine, to help them pursue that life, even at the risk of harm to the common good. This works against the idea that the meaning and scope of our own right to lead our own lives must be conditioned by, and be compatible with, the good of the community,

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which is more than an aggregate of self-directing individuals.

The third turning point is to be found in the claim being made upon medicine: it should be pre- pared to make its skills available to individuals to help them achieve their private vision of the good life. This puts medicine in the business of promoting the individualistic pursuit of general human hap- piness and well-being. It would overturn the tradi- tional belief that medicine should limit its domain to promoting and preserving human health, redi- recting it instead to the relief of that suffering which stems from life itself, not merely from a sick body.

I believe that, at each of these three turning points, proponents of euthanasia push us in the wrong direction. Arguments in favor of euthanasia fall into four general categories, which I will take up in turn: (1) the moral claim of individual self- determination and well-being; (2) the moral irrele- vance of the difference between killing and allowing to die; (3) the supposed paucity of evidence to show likely harmful consequences of legalized euthanasia; and (4) the compatibility of euthanasia and medical practice.

### **Self-Determination**

Central to most arguments for euthanasia is the principle of self-determination. People are pre- sumed to have an interest in deciding for them- selves, according to their own beliefs about what makes life good, how they will conduct their lives. That is an important value, but the question in the euthanasia context is, What does it mean and how far should it extend? If it were a question of suicide,

where a person takes their own life without assis- tance from another, that principle might be perti- nent, at least for debate. But euthanasia is not that limited a matter. The self-determination in that case can only be effected by the moral and physical assistance of another. Euthanasia is thus no longer a matter only of self-determination, but of a mutual, social decision between two people, the one to be killed and the other to do the killing.

How are we to make the moral move from my right of self-determination to some doctor's right to kill me—from *my* right to *his* right? Where does the doctor's moral warrant to kill come from? Ought doctors to be able to kill anyone they want as long as permission is given by competent persons? Is our right to life just like a piece of property, to be given away or alienated if the price (happiness, relief of suffering) is right? And then to be destroyed with our permission once alienated?

In answer to all those questions, I will say this: I have yet to hear a plausible argument why it should be permissible for us to put this kind of power in the hands of another, whether a doctor or anyone else. The idea that we can waive our right to life, and then give to another the power to take that life, requires a justification yet to be provided by anyone.

Slavery was long ago outlawed on the ground that one person should not have the right to own another, even with the other's permission. Why? Because it is a fundamental moral wrong for one person to give over his life and fate to another, whatever the good consequences, and no less a wrong for another person to have that kind of total, final power. Like slavery, dueling was long ago banned on similar grounds: even free, compe- tent individuals should not have the power to kill each other, whatever their motives, whatever the circumstances. Consenting adult killing, like con- senting adult slavery or degradation, is a strange route to human dignity.

There is another problem as well. If doctors, once sanctioned to carry out euthanasia, are to be themselves responsible moral agents—not simply hired hands with lethal injections at the ready—then they must have their own *independent* moral grounds to kill those who request such services. What do I mean?

As those who favor euthanasia are quick to point out, some people want it because their life has become so burdensome it no longer seems worth living.

The doctor will have a difficulty at this point. The degree and intensity to which people suffer from their diseases and their dying, and whether they find life more of a burden than a benefit, has very little directly to do with the nature or extent of their actual physical condition. Three people can have the same condition, but only one will find the suffering unbearable. People suffer, but suffering is as much a function of the values of individuals as it is of the physical causes of that suffering. Inevitably in that circumstance, the doctor will in effect be treating the patient's values. To be responsible, the doctor would have to share those values. The doctor would have to decide, on her own, whether the patient's life was "no longer worth living."

But how could a doctor possibly know that or make such a judgment? Just because the patient said so? I raise this question because, while in Holland at the euthanasia conference reported by Maurice de Wachter . . . , the doctors present agreed that there is no objective way of measuring or judging the claims of patients that their suffering is unbearable. And if it is difficult to measure suffering, how much more difficult to determine the value of a patient's statement that her life is not worth living?

However one might want to answer such questions, the very need to ask them, to inquire into the physician's responsibility and grounds for medical and moral judgment, points out the social nature of the decision. Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable.

### **Killing and Allowing to Die**

Against common opinion, the argument is sometimes made that there is no moral difference between stopping life-sustaining treatment and more active forms of killing, such as lethal injection. Instead I would contend that the notion that there is no morally significant difference between omission and commission is just wrong. Consider in its broad implications what the eradication of the distinction implies: that death from disease has been banished,

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leaving only the actions of physicians in terminating treatment as the cause of death. Biology, which used to bring about death, has apparently been displaced by human agency. Doctors have finally, I suppose, thus genuinely become gods, now doing what nature and the deities once did.

What is the mistake here? It lies in confusing causality and culpability, and in failing to note the way in which human societies have overlaid natural causes with moral rules and interpretations. Causality (by which I mean the direct physical causes of death) and culpability (by which I mean our attribution of moral responsibility to human actions) are confused under three circumstances.

They are confused, first, when the action of a physician in stopping treatment of a patient with an underlying lethal disease is construed as *causing* death. On the contrary, the physician's omission can only bring about death on the condition that the patient's disease will kill him in the absence of treatment. We may hold the physician morally responsible for the death, if we have morally judged such actions wrongful omissions. But it confuses reality and moral judgment to see an omitted action as having the same causal status as one that directly kills. A lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a

healthy person. Turn off the machine on me, a healthy person, and nothing will happen. It will only, in contrast, bring the life of a sick person to an end because of an underlying fatal disease.

Causality and culpability are confused, second, when we fail to note that judgments of moral responsibility and culpability are human constructs. By that I mean that we human beings, after moral reflection, have decided to call some actions right or wrong, and to devise moral rules to deal with them. When physicians could do nothing to stop death, they were not held responsible for it. When, with medical progress, they began to have some power over death—but only its timing and circumstances, not its ultimate inevitability—moral rules were devised to set forth their obligations. Natural causes of death were not thereby banished. They were, instead, overlaid with a medical ethics designed to determine moral culpability in deploying medical power.

To confuse the judgments of this ethics with the physical causes of death—which is the connotation of the word *kill*—is to confuse nature and human action. People will, one way or another, die of some disease; death will have dominion over all of us. To say that a doctor “kills” a patient by allowing this to happen should only be understood as a moral judgment about the licitness of his omission, nothing more. We can, as a fashion of speech only, talk about a doctor *killing* a patient by omitting treatment he should have provided. It is a fashion of speech precisely because it is the underlying disease that brings death when treatment is omitted; that is its cause, not the physician’s omission. It is a misuse of the word *killing* to use it when a doctor stops a treatment he believes will no longer benefit the patient—when, that is, he steps aside to allow an eventually inevitable death to occur now rather than later. The only deaths that human beings invent are those that come from direct killing—when, with a lethal injection, we both cause death and are morally responsible for it. In the case of omissions, we do not cause death even if we may be judged morally responsible for it.

This difference between causality and culpability also helps us see why a doctor who has omitted a treatment he should have provided has “killed” that patient while another doctor—performing precisely the same act of omission on another patient in different circumstances—does not kill her, but only allows her to die. The difference is that we have come, by moral convention and conviction, to classify unauthorized or illegitimate omissions as acts of “killing.” We call them “killing” in the expanded sense of the term: a culpable action that permits the real cause of death, the underlying disease, to proceed to its lethal conclusion. By contrast, the doctor who, at the patient’s request, omits or terminates unwanted treatment does not kill at all. Her underlying disease, not his action, is the physical cause of death; and we have agreed to consider actions of that kind to be morally licit. He thus can truly be said to have “allowed” her to die.

If we fail to maintain the distinction between killing and allowing to die, moreover, there are some disturbing possibilities. The first would be to confirm many physicians in their already too-powerful belief that, when patients die or when physicians

stop treatment because of the futility of continuing it, they are somehow both morally and physically responsible for the deaths that follow. That notion needs to be abolished, not strengthened. It needlessly and wrongly burdens the physician, to whom should not be attributed the powers of the gods. The second possibility would be that, in every case where a doctor judges medical treatment no longer effective in prolonging life, a quick and direct killing of the patient would be seen as the next, most reasonable step, on grounds of both humaneness and economics. I do not see how that logic could easily be rejected.

### **Calculating the Consequences**

When concerns about the adverse social consequences of permitting euthanasia are raised, its advocates tend to dismiss them as unfounded and overly speculative. On the contrary, recent data about the Dutch experience suggests that such concerns are right on target. From my own discussions in Holland, and from the articles on

that subject in this issue and elsewhere, I believe we can now fully see most of the *likely* consequences of legal euthanasia.

Three consequences seem almost certain, in this or any other country: the inevitability of some abuse of the law; the difficulty of precisely writing, and then enforcing, the law; and the inherent slipperiness of the moral reasons for legalizing euthanasia in the first place.

Why is abuse inevitable? One reason is that almost all laws on delicate, controversial matters are to some extent abused. This happens because not everyone will agree with the law as written and will bend it, or ignore it, if they can get away with it. From explicit admissions to me by Dutch proponents of euthanasia, and from the corroborating information provided by the Rummelink Report and the outside studies of Carlos Gomez and John Keown, I am convinced that in the Netherlands there are a substantial number of cases of nonvoluntary euthanasia, that is, euthanasia undertaken without the explicit permission of the person being killed. The other reason abuse is inevitable is that the law is likely to have a low enforcement priority in the criminal justice system. Like other laws of similar status, unless there is an unrelenting and harsh

willingness to pursue abuse, violations will ordinarily be tolerated. The worst thing to me about my experience in Holland was the casual, seemingly indifferent attitude toward abuse. I think that would happen everywhere.

Why would it be hard to precisely write, and then enforce, the law? The Dutch speak about the requirement of “unbearable” suffering, but admit that such a term is just about indefinable, a highly subjective matter admitting of no objective standards. A requirement for outside opinion is nice, but it is easy to find complaisant colleagues. A requirement that a medical condition be “terminal” will run aground on the notorious difficulties of knowing when an illness is actually terminal.

Apart from those technical problems there is a more profound worry. I see no way, even in principle, to write or enforce a meaningful law that can guarantee effective procedural safeguards. The reason is obvious yet almost always overlooked. The euthanasia transaction will ordinarily take place within the boundaries of the private and confidential doctor-patient relationship. No one can possibly know what takes place in that context unless the doctor chooses to reveal it. In Holland, less than 10 percent of the physicians report their acts of euthanasia and do so with almost complete legal impunity. There is no reason why the situation should be any better elsewhere. Doctors will have their own reasons for keeping euthanasia secret, and some patients will have no less a motive for wanting it concealed.

I would mention, finally, that the moral logic of the motives for euthanasia contain within them the ingredients of abuse. The two standard motives for euthanasia and assisted suicide are said to be our right of self-determination, and our claim upon the mercy of others, especially doctors, to relieve our suffering. These two motives are typically spliced together and presented as a single justification. Yet if they are considered independently—and there is no inherent reason why they must be linked—they reveal serious problems. It is said that a competent, adult person should have a right to euthanasia for the relief of suffering. But why must the person be suffering? Does not that stipulation already compromise the principle of self-determination? How can self-determination have any limits? Whatever the person’s motives may be, why are they not sufficient?

Consider next the person who is suffering but not competent, who is perhaps demented or mentally retarded. The standard argument would deny euthanasia to that person. But why? If a person is suffering but not competent, then it would seem grossly unfair to deny relief solely on the grounds of incompetence. Are the incompetent less entitled to relief from suffering than the competent? Will it only be affluent, middle-class people,

mentally fit and savvy about working the medical system, who can qualify? Do the incompetent suffer less because of their incompetence?

Considered from these angles, there are no good moral reasons to limit euthanasia once the principle of taking life for that purpose has been legitimated. If we really believe in self-determination, then any competent person should have a right to be killed by a doctor for any reason that suits him. If we believe in the relief of suffering, then it seems cruel and capricious to deny it to the incompetent. There is, in short, no reasonable or logical stopping point once the turn has been made down the road to euthanasia, which could soon turn into a convenient and commodious expressway.

### **Euthanasia and Medical Practice**

A fourth kind of argument one often hears both in the Netherlands and in this country is that euthanasia and assisted suicide are perfectly compatible with the aims of medicine. I would note at the very outset that a physician who participates in another person's suicide already abuses medicine. Apart from depression (the main statistical cause of suicide), people commit suicide because they find life empty, oppressive, or meaningless. Their judgment is a judgment about the value of continued life, not only about health (even if they are sick). Are doctors now to be given the right to make judgments about the kinds of life worth living and to give their blessing to suicide for those they judge wanting? What conceivable competence, technical or moral, could doctors claim to play such a role? Are we to medicalize suicide, turning judgments about its worth and value into one more clinical issue? Yes, those are rhetorical questions.

Yet they bring us to the core of the problem of euthanasia and medicine. The great temptation of modern medicine, not always resisted, is to move

beyond the promotion and preservation of health into the boundless realm of general human happiness and well-being. The root problem of illness and mortality is both medical and philosophical or religious. "Why must I die?" can be asked as a technical, biological question or as a question about the meaning of life. When medicine tries to respond to the latter, which it is always under pressure to do, it moves beyond its proper role.

It is not medicine's place to lift from us the burden of that suffering which turns on the meaning we assign to the decay of the body and its eventual death. It is not medicine's place to determine when lives are not worth living or when the burden of life is too great to be borne. Doctors have no conceivable way of evaluating such claims on the part of patients, and they should have no right to act in response to them. Medicine should try to relieve human suffering, but only that suffering which is brought on by illness and dying as biological phenomena, not that suffering which comes from anguish or despair at the human condition.

Doctors ought to relieve those forms of suffering that medically accompany serious illness and the threat of death. They should relieve pain, do what they can to allay anxiety and uncertainty, and be a comforting presence. As sensitive human beings, doctors should be prepared to respond to patients who ask why they must die, or die in pain. But here the doctor and the patient are at the same level. The doctor may have no better an answer to those old questions than anyone else; and certainly no special insight from his training as a physician. It would be terrible for physicians to forget this, and to think that in a swift, lethal injection, medicine has found its own answer to the riddle of life. It would be a false answer, given by the wrong people. It would be no less a false answer for patients. They should neither ask medicine to put its own vocation at risk to serve their private interests, nor think that the answer to suffering is to be killed by another. The problem is precisely that, too often in human history, killing has seemed the quick, efficient way to put aside that which burdens us. It rarely helps, and too often simply adds to one evil still another. That is what I believe euthanasia would accomplish. It is self-determination run amok.

## Physician-Assisted Suicide: A Tragic View

JOHN D. ARRAS

Arras is a firm believer in autonomy and finds himself “deeply sympathetic to the central values motivating the case for [physician-assisted suicide] and euthanasia.” Nevertheless, he argues that legalizing the practices poses “too great a threat to the rights and welfare of too many people.”

For many decades now, the calls for PAS and euthanasia have been perennial lost causes in American society. Each generation has thrown up an assortment of earnest reformers and cranks who, after attracting their fifteen minutes of fame, inevitably have been defeated by the combined weight of traditional law and morality. Incredibly, two recent federal appellate court decisions suddenly changed the legal landscape in this area, making the various states within their respective jurisdictions the first governments in world history, excepting perhaps the Nazi regime in Germany, to officially sanction PAS. Within the space of a month, both an eight- to-three majority of the United States Court of Appeals for the Ninth Circuit<sup>1</sup> on the West Coast, and a three-judge panel in the United States Court of Appeals for the Second Circuit,<sup>2</sup> in the Northeast, struck down long-standing state laws forbidding physicians to aid or abet their patients in acts of suicide. Within a virtual blink of an eye, the unthinkable had come to pass: PAS and euthanasia had emerged from their exile beyond the pale of law to occupy center stage in a dramatic public debate that eventually culminated in the United States Supreme Court’s unanimous reversal of both lower court decisions in June 1997.<sup>3</sup>

Judge Reinhardt, writing for a majority of an *en banc* decision of the Ninth Circuit,<sup>4</sup> held that competent, terminally ill patients have a powerful “liberty interest,” what used to be called a Constitutional right, to enlist the aid of their physicians in hastening death via prescriptions for lethal drugs.<sup>5</sup>

From *Physician Assisted Suicide: Expanding the Debate* by Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York and London: Routledge 1998, pp. 279–300. Reprinted with permission.

He argued that, just as the right to privacy guarantees women the right to choose an abortion, this liberty interest protects a right to choose the time and manner of one’s death.<sup>6</sup>

In response to warnings against the expansion of this right to broader categories of patients (e.g., to the mentally incapacitated) and against the great likelihood of mistake and abuse, Judge Reinhardt permitted the regulation of PAS in order to avoid such evils; however, he pointedly ruled out any and all blanket prohibitions.<sup>7</sup> In response to the traditional objections that allowing PAS would subvert the state’s interests in preventing suicide and maintaining the integrity of the medical profession, Judge Reinhardt contended that our society already has effectively erased the distinction between merely allowing patients to die and killing them.<sup>8</sup> Reinhardt claimed that by allowing patients or their surrogates to forgo life-sustaining medical treatments, including artificially administered nutrition and hydration, and by sanctioning the administration of pain-killing drugs that might also hasten death, our society already permits a variety of “death inducing” practices. Thus, the social risks of allowing PAS are only different in degree, not in kind, from risks that we already countenance.

Writing for the Second Circuit in striking down a similar New York statute, Judge Miner explicitly rejected the claim of the Second Circuit majority that a “substantive due process” right of PAS exists in the Constitution. While presciently conceding that the Supreme Court was unlikely to extend the boundaries of the so-called right to privacy, Judge Miner found nevertheless that the statute violated the equal protection clause of the Constitution.<sup>9</sup> Echoing Judge Reinhardt’s assertion that only a difference of degree separates PAS from the foregoing

of life-sustaining treatments—claiming in effect that the administration of potentially death hastening analgesics constitutes a kind of suicide—Judge Miner observed that New York’s law allowed some people relief from the ravages of terminal illness (i.e., those connected to some form of removable life-support) while denying relief to those not so connected, for whom PAS was the only remaining exit.<sup>10</sup> Concurring with Judge Reinhardt that the social risks of PAS are identical to those of our more socially approved “death inducing” practices, Judge Miner concluded that this kind of differential treatment serves no legitimate state purpose. Thus, he held that the law was unconstitutional even in the absence of a new fundamental right to PAS.<sup>11</sup>

What to think of these startling decisions? Were they harbingers of a new world brave enough to overcome centuries of religious censure and fear-mongering, a world that will no longer permit human beings to suffer unwillingly the torments of terminal illness? Or were they dangerous aberrations, decisions that simultaneously affirmed the autonomy of some, while endangering the lives of society’s most vulnerable citizens?

The Supreme Court has finally left little doubt about where it stands on these questions. In a set of majority and concurring opinions remarkable for their ideological restraint, compassion, and thoughtfulness, the various Justices have concluded that extant state laws barring PAS and euthanasia violate neither the Fourteenth Amendment protection of liberty nor the Fifth Amendment’s due process provision.<sup>12</sup> While thus issuing a painful rebuke to the partisans of liberalization, each of the Justices tempered his or her final judgment with the recognition that their collective decision would by no means end public debate, but would rather displace it onto the agendas of the fifty state legislatures.

As a firm believer in patient autonomy, I find myself to be deeply sympathetic to the central values motivating the case for PAS and euthanasia; I have concluded, however, that these practices pose too great a threat to the rights and welfare of too many people to be legalized in this country at the present time. Central to my argument in this essay will be the claim that the recently overturned decisions of the circuit courts employ a form of case-based

reasoning that is ill-suited to the development of sound social policy in this area. I shall argue that in order to do justice to the very real threats posed by the widespread social practices of PAS and euthanasia, we need to adopt precisely the kind of policy perspective that the circuit courts rejected on principle. Thus, this essay presents the case for a forward-looking, legislative approach to PAS and euthanasia, as opposed to an essentially backward-looking, judicial or constitutional approach.<sup>13</sup> Although I suggest below that the soundest legislative policy at the present time would be to extend the legal prohibition of PAS into the near future, I remain open to the possibility that a given legislature, presented with sufficient evidence of the reliability of various safeguards, might come to a different conclusion.

### **Arguments and Motivations in Favor of PAS/Euthanasia**

**Let us begin, then, with the philosophical case for PAS and euthanasia, which consists of two distinct prongs, both of which speak simply, directly, and powerfully to our commonsensical intuitions. First, there is the claim of autonomy, that all of us possess a right to self-determination in matters profoundly touching on such religious themes as life, death, and the meaning of suffering. Just as we should each be free to make important choices bearing on how we shall live our own lives, so we should be equally free in choosing the time and manner of our deaths. For some, more life will always be welcome as a gift or perhaps even as a test of faith, but for others, continued life signifies only disfiguring suffering and the unrelenting loss of everything that invested their lives with meaning and dignity. As philosopher Ronald Dworkin has eloquently argued, it is a form of *tyranny* to force someone to endure terrible suffering at the end-of-life merely for the sake of someone else’s values.<sup>14</sup> Each of us should be free to live or die as we see fit according to our own conceptions of the meaning of life and death.**

Second, PAS and/or euthanasia are merciful acts that deliver terminally ill patients from a painful and protracted death. According to the utilitarian, acts are morally right insofar as they promote happiness and alleviate unhappiness, and wrong insofar as they

cause or allow others to suffer needlessly. Even according to the traditional ethic of the medical profession, physicians have a solemn duty not merely to extend life whenever possible (and desirable), but also to alleviate pain and suffering whenever possible. For patients suffering from the final ravages of end-stage AIDS or cancer, a doctor's lethal prescription or injection can be, and often is, welcomed as a blessed relief. Accordingly, we should treat human beings at least as well as we treat grievously ill or injured animals by putting them, at their own request, out of their misery.

These philosophical reflections can be supplemented with a more clinical perspective addressed to the motivational factors lying behind many requests to die. Many people advocate legalization because they fear a loss of control at the end-of-life. They fear falling victim to the technological imperative; they fear dying in chronic and uncontrolled pain; they fear the psychological suffering attendant upon the relentless disintegration of the self; they fear, in short, a bad death. All of these fears, it so happens, are eminently justified. Physicians routinely ignore the documented wishes of patients and all too often allow patients to die with uncontrolled pain.<sup>15</sup> Studies of cancer patients have shown that over 50 percent suffer from unrelieved pain,<sup>16</sup> and many researchers have found that uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide and suicidal ideation.<sup>17</sup>

Clinical depression is another major factor influencing patients' choice of suicide.<sup>18</sup> Depression, accompanied by feelings of hopelessness, is the strongest predictor of suicide for both individuals who are terminally ill and those who are not.<sup>19</sup> Yet most doctors are not trained to notice depression, especially in complex cases such as the elderly suffering from terminal illnesses. Even when doctors succeed in diagnosing depression, they often do not successfully treat it with sufficient amounts of readily available medications.<sup>20</sup>

Significantly, the New York State Task Force on Life and Law found that the vast majority of patients who request PAS or euthanasia can be treated successfully both for their depression and their pain,

and that when they receive adequate psychiatric and palliative care, their requests to die usually are withdrawn.<sup>21</sup> In other words, patients given the requisite control over their lives and relief from depression and pain usually lose interest in PAS and euthanasia.<sup>22</sup>

With all due respect for the power of modern methods of pain control, it must be acknowledged that a small percentage of patients suffer from conditions, both physical and psychological, that currently lie beyond the reach of the best medical and humane care. Some pain cannot be alleviated short of inducing a permanent state of unconsciousness in the patient, and some depression is unconquerable. For such unfortunate patients, the present law on PAS/euthanasia can represent an insuperable barrier to a dignified and decent death.<sup>23</sup>

### **Objections to PAS/Euthanasia**

Opponents of PAS and euthanasia can be grouped into three main factions. One strongly condemns both practices as inherently immoral, as violations of the moral rule against killing the innocent. Most members of this group tend to harbor distinctly religious objections to suicide and euthanasia, viewing them as violations of God's dominion over human life.<sup>24</sup> They argue that killing is simply wrong in itself, whether or not it is done out of respect for the patient's autonomy or out of concern for her suffering. Whether or not this position ultimately is justifiable from a theological point of view, its imposition on believers and nonbelievers alike is incompatible with the basic premises of a secular, pluralistic political order.<sup>25</sup>

A second faction primarily objects to the fact that physicians are being called upon to do the killing. While conceding that killing the terminally ill or assisting in their suicides might not always be morally wrong for others to do, this group maintains that the participation of physicians in such practices undermines their role as healers and fatally compromises the physician-patient relationship.<sup>26</sup>

Finally, a third faction<sup>27</sup> readily grants that neither PAS nor active euthanasia, practiced by ordinary citizens or by physicians, are always morally wrong. On the contrary, this faction believes that in certain rare instances early release from a painful

or intolerably degrading existence might constitute both a positive good and an important exercise of personal autonomy for the individual. Indeed, many members of this faction concede that should such a terrible fate befall them, they would hope to find a thoughtful, compassionate, and courageous physician to release them from their misery. But in spite of these important concessions, the members of this faction shrink from endorsing or regulating PAS and active euthanasia due to fears bearing on the social consequences of liberalization. This view is based on two distinct kinds of so-called “slippery slope” arguments. One bears on the inability to cabin PAS/euthanasia within the confines envisioned by its proponents; the other focuses on the likelihood of abuse, neglect, and mistake.

### An Option Without Limits

The first version of the slippery slope argument contends that a socially sanctioned practice of PAS would in all likelihood prove difficult, if not impossible, to cabin within its originally anticipated boundaries. Proponents of legalization usually begin with a wholesomely modest policy agenda, limiting their suggested reforms to a narrow and highly specified range of potential candidates and practices.<sup>28</sup> “Give us PAS,” they ask, “not the more controversial practice of active euthanasia, for presently competent patients who are terminally ill and suffering unbearable pain.” But the logic of the case for PAS, based as it is upon the twin pillars of patient autonomy and mercy, makes it highly unlikely that society could stop with this modest proposal once it had ventured out on the slope. As numerous other critics have pointed out, if autonomy is the prime consideration, then additional constraints based upon terminal illness or unbearable pain, or both, would appear hard to justify.<sup>29</sup> Indeed, if autonomy is crucial, the requirement of unbearable suffering would appear to be entirely subjective. Who is to say, other than the patient herself, how much suffering is too much? Likewise, the requirement of terminal illness seems an arbitrary standard against which to judge patients’ own subjective evaluation of their quality of life. If my life is no longer worth living, why should a terminally ill cancer patient be granted PAS but not me, merely because my

suffering is due to my “nonterminal” arterio-lateral sclerosis (“ALS”) or intractable psychiatric disorder?<sup>30</sup>

Alternatively, if pain and suffering are deemed crucial to the justification of legalization, it is hard to see how the proposed barrier of contemporaneous consent of competent patients could withstand serious erosion. If the logic of PAS is at all similar to that of forgoing life-sustaining treatments, and we have every reason to think it so, then it would seem almost inevitable that a case soon would be made to permit PAS for incompetent patients who had left advance directives. That would then be followed by a “substituted judgment” test for patients who “would have wanted” PAS, and finally an “objective” test would be developed for patients (including newborns) whose best interests would be served by PAS or active euthanasia even in the absence of

any subjective intent.<sup>31</sup>

In the same way, the joint justifications of au-

tonomy and mercy combine to undermine the plausibility of a line drawn between PAS and active euthanasia. As the authors of one highly publicized proposal have come to see, the logic of justification for active euthanasia is identical to that of PAS.<sup>32</sup> Legalizing PAS, while continuing to ban active euthanasia, would serve only to discriminate unfairly against patients who are suffering and wish to end their lives, but cannot do so because of some physical impairment. Surely these patients, it will be said, are “the worst off group,” and therefore they are the most in need of the assistance of others who will do for them what they can no longer accomplish on their own.

None of these initial slippery slope considerations amount to knock-down objections to further liberalization of our laws and practices. After all, it is not obvious that each of these highly predictable shifts (e.g., from terminal to “merely” incurable, from contemporaneous consent to best interests, and from PAS to active euthanasia), are patently immoral and unjustifiable. Still, in pointing out this likely slippage, the consequentialist opponents of PAS/euthanasia are calling on society to think about the likely consequences of taking the first tentative step onto the slope. If all of the extended practices predicted above pose substantially greater risks for vulnerable patients than the more highly

circumscribed initial liberalization proposals, then we need to factor in these additional risks even as we ponder the more modest proposals.<sup>33</sup>