

THE ETHICAL DEBATE

The ethics of assisted suicide and euthanasia are squarely before the public eye. A steady drumbeat of media attention and mounting concern about control at life's end have generated serious consideration of legalizing the practices. Public discussion has centered on the desire for control over the timing and manner of death, amidst warnings about the potential abuse or harm of overriding society's long-standing prohibitions against assisting suicide or directly causing another person's death.

Concurrent with this public debate, but in many ways separate from it, has been the discussion of assisted suicide and euthanasia in the medical and ethical literature. In this debate, some assert that both assisted suicide and euthanasia are morally wrong and should not be provided, regardless of the circumstances of the particular case. Others hold that assisted suicide or euthanasia are ethically legitimate in rare and exceptional cases, but that professional standards and the law should not be changed to authorize either practice. Finally, some advocate that assisted suicide, or both assisted suicide and euthanasia, should be recognized as legally and morally acceptable options in the care of dying or severely ill patients.¹

An Historical Perspective

For thousands of years, philosophers and religious thinkers have addressed the ethics of suicide. These debates have rested on broad principles about duties to self and to society as well as fundamental questions of the value of human life. Many great thinkers of Western intellectual history have contributed to this debate, ranging from Plato and Aristotle in ancient Greece to Augustine and Thomas Aquinas in the Middle Ages, and Locke, Hume, and Kant in more modern times.²

Some views and practices surrounding suicide were rooted in particular cultures and beliefs that have little relevance for contemporary society. For example, in the warrior society of the Vikings, only those who died violently could enter paradise, or Valhalla. The greatest honor was death in battle; suicide was the second best alternative.³ Likewise, the ancient Scythians believed that suicide was a great honor when individuals became too old for their nomadic way of life, thereby sparing the younger members of

¹ Through most of this chapter, arguments are schematically presented as those of "proponents" of legalizing assisted suicide and euthanasia and "opponents" of legalizing these practices. Each category groups together diverse views in order to provide an overview of a debate marked by complex and nuanced positions.

² It is notable that the current debate about assisted suicide, even among academic commentators, has drawn so little from this rich history. For an excellent discussion of the intellectual history of suicide, see B. A. Brody, "Introduction," in *Suicide and Euthanasia: Historical and Contemporary Themes*, ed. B. A. Brody (Dordrecht: Kluwer Academic Publishers, 1989), 1. For an engaging literary history of suicide, see A. Alvarez, *The Savage God* (New York: Random House, 1971).

³ Those who died peacefully in their beds of old age or illness were eternally excluded from Valhalla, Alvarez, 54.

the tribe the burden of carrying or killing them. In other eras and civilizations, the debate about suicide touched on values that influenced the course of Western thought and still resonate to contemporary perspectives on suicide.

The word "euthanasia" derives from Greek, although as used in ancient Greece, the term meant simply "good death," not the practice of killing a person for benevolent motives.⁴ In ancient Greece, euthanasia was not practiced, and suicide itself was generally disfavored.⁵ Some Greek philosophers, however, argued that suicide would be acceptable under exceptional circumstances. Plato, for example, believed that suicide was generally cowardly and unjust but that it could be an ethically acceptable act if an individual had an immoral and incorrigible character, had committed a disgraceful action, or had lost control over his or her actions due to grief or suffering.⁶

Unlike contemporary proponents of assisted suicide and euthanasia, who regard individual self-determination as central, Plato considered the individual's desire to live or die largely irrelevant to determining whether suicide might be an appropriate act. An objective evaluation of the individual's moral worthiness, not the individual's decision about the value of continued life, was critical.⁷

In contrast to Plato, the Stoics of the later Hellenistic and Roman eras focused more strongly on the welfare of the individual than on the community. They believed that, while life in general should be lived fully, suicide could be appropriate in certain rare circumstances when deprivation or illness no longer allowed for a "natural" life.⁸ The Stoics did not, however, maintain that suicide would be justified whenever an individual loses the desire to live. Unlike contemporary proponents of a right to suicide

⁴ According to one author, no Greek philosopher "ever discusses euthanasia in our contemporary sense of the word." J. M. Cooper, "Greek Philosophers on Euthanasia and Suicide," in *Suicide and Euthanasia*, ed. Brody, 14. See also P. Carrick, *Medical Ethics in Antiquity* (Dordrecht: D. Reidel, YJuw, 1985), 127-31.

⁵ A. Alvarez suggests that although suicide was taboo, the Greeks tolerated suicide in some circumstances. Noting the Greek practice of burying the corpse of a suicide outside the city limits with its hand cut off, Alvarez argues that this practice was "linked with the more profound Greek horror of killing one's own kin. By inference, suicide was an extreme case of this, and the language barely distinguishes between self-murder and murder of kindred." Alvarez points out that many suicides in Greek literature reflect acceptance and even admiration of the act. Alvarez, 58.

⁶ Plato, *Laws*, chap. 9, 854, 873; see Cooper, 17-19. Plato also argued that, in most cases, suicide would represent abandonment of one's duty and would violate divinely mandated responsibilities. Plato, *Phaedo*, 62. In contrast to Plato, Aristotle believed that suicide was unjust under all circumstances, because it deprived the community of a citizen. Aristotle, *Nicomachean Ethics*, chap. 5, 1138a; Cooper, 19-23.

⁷ Plato's suggestion that medical treatment should not be provided to severely ill and disabled patients reflects a similar objective view. In the *Republic* (chap. 3, 406-7), Plato argues that no treatment should be provided to prolong the life of severely ill or disabled individuals, because they represent a burden to themselves and others. As with suicide, the individual's subjective feelings about the merits of continued life had no bearing on the appropriateness of continued medical treatment. Interestingly, Plato did not apply this analysis to the severely ill and disabled elderly, who, he argued, should be permitted to live regardless of their ability to contribute to the community. See Cooper, 13.

⁸ Cooper, 24-29, 36n.

assistance, the Stoics believed that suicide was appropriate only when the individual loses the ability to pursue the life that nature intended.⁹

Since ancient times, Jewish and Christian thinkers have opposed suicide as inconsistent with the human good and with responsibilities to God. In the thirteenth century, Thomas Aquinas espoused Catholic teaching about suicide in arguments that would shape Christian thought about suicide for centuries.

Aquinas condemned suicide as wrong because it contravenes one's duty to oneself and the natural inclination of self-perpetuation; because it injures other people and the community of which the individual is a part; and because it violates God's authority over life, which is God's gift.¹⁰) This position exemplified attitudes about suicide that prevailed from the Middle Ages through the Renaissance and Reformation.¹¹⁾

By the sixteenth century, philosophers began to challenge the generally accepted religious condemnation of suicide. Michel de Montaigne, a sixteenth-century philosopher, argued that suicide was not a question of Christian belief but a matter of personal choice. In an essay presenting arguments on both sides of the issue, he concluded that suicide was an acceptable moral choice in some circumstances, noting that "pain and the fear of a worse death seem to me the most excusable incitements."¹² Other writers employed more theological arguments to challenge the religious prohibition on suicide. In the early seventeenth century, for example, John Donne asserted that while suicide is morally wrong in many cases, it can be acceptable if performed with the intention of glorifying God, not serving self-interest. Donne acknowledged the merit of laws against suicide that discouraged the practice, but he argued that civil and common laws ordinarily admit of some exceptions, suggesting that suicide could be morally acceptable in certain cases.¹³

⁹ Some Roman Stoics such as Seneca, however, argued that the individual should have broad discretion to end his or her own life. He criticized those who "maintain that one should not offer violence to one's own life, and hold it accursed for a man to be the means of his own destruction; we should wait, say they, for the end decreed by nature. But one who says this does not see that he is shutting off the path of freedom. The best thing which eternal law ever ordained was that it allowed to us one entrance into life, but many exits." In Carrick, 145.

¹⁰ Thomas Aquinas, *Summa Theologiae*, II-II, 64; D. W. Amundsen, "Suicide and Early Christian Values," in *Suicide and Euthanasia*, ed. Brody, 142-44; T. L. Beauchamp, "Suicide in the Age of Reason," in *Suicide and Euthanasia*, ed. Brody, 190-93.

¹¹ These principles continue to influence contemporary religious and secular views about suicide. See the discussion below in this chapter.

¹² G. B. Ferngren, "The Ethics of Suicide in the Renaissance and Reformation," in *Suicide and Euthanasia*, ed. Brody, 159-61. As Ferngren notes, suicide and euthanasia were discussed a generation earlier in satirical works by Erasmus and Thomas More, but it is unclear whether the authors intended to advocate these practices. Ferngren, 157-59.

¹³ Donne articulated these views in an essay entitled *Biathanalos*, which was published only after his death. He did not want it published during his lifetime, perhaps reflecting his discomfort with views that challenged the prevailing Christian ethics of his time. In *Biathanatos*, Donne acknowledges that he battled his own urge to commit suicide. "Whenever any affliction assails me, me thinks I have the keys of my prison in mine own hand, and no remedy presents itself so soon to my heart as mine own sword." In Ferngren, 169.

In the eighteenth century, David Hume made the first unapologetic defense of the moral permissibility of suicide on grounds of individual autonomy and social benefit. He asserted that even if a person's death would weaken the community, suicide would be morally permissible if the good it afforded the individual outweighed the loss to society. Moreover, suicide would be laudatory if the person's death would benefit the group and the individual. Hume did not advocate that all suicides are justified, but argued that when life is most plagued by suffering, suicide is most acceptable.¹⁴

Other philosophers of the Age of Reason, such as John Locke and Immanuel Kant, opposed suicide. Locke argued that life, like liberty, represents an inalienable right, which cannot be taken from, or given away by, an individual.¹⁵ For Kant, suicide was a paradigmatic example of an action that violates moral responsibility. Kant believed that the proper end of rational beings requires self-preservation, and that suicide would therefore be inconsistent with the fundamental value of human life.¹⁶ Like some contemporary opponents of assisted suicide and euthanasia, Kant argued that taking one's own life was inconsistent with the notion of autonomy, properly understood. Autonomy, in Kant's view, does not mean the freedom to do whatever one wants, but instead depends on the knowing subjugation of one's desires and inclinations to one's rational understanding of universally valid moral rules.¹⁷

Essays advocating active euthanasia in the context of modern medicine first appeared in the United States and England in the 1870s. In an 1870 work, schoolmaster and essayist Samuel D. Williams argued that "in all cases of hopeless and painful illness it should be the recognized duty of the medical attendant, whenever so desired by the patient, to administer chloroform, or such other anaesthetics as may by and by supersede chloroform, so as to destroy

consciousness at once, and put the sufferer at once to a quick and painless end."¹⁸ Support for euthanasia at this time was animated in part by the philosophy of social Darwinism and concerns with eugenics -- improving the biological stock of the community. In 1873, essayist Lionel A. Tollemache asserted that euthanasia could serve

¹⁴ D. Hume, "On Suicide," in *Ethical Issues in Death and Dying*, ed. T. L. Beauchamp and S. Perlin (Englewood Cliffs, N.J.: Prentice-Hall, 1978), 105-10; T. L. Beauchamp, "An Analysis of Hume and Aquinas on Suicide," in *Ethical Issues in Death and Dying*, ed. Beauchamp and Perlin, 111-21; Beauchamp, "Age of Reason," 199-205.

¹⁵ Ferngren, 173-75.

¹⁶ See Immanuel Kant, *Grounding for the Metaphysics of Morals*, 3d ed., trans. J. W. Ellington (Indianapolis: Hackett, 1993); and the discussion in Beauchamp, "Age of Reason," 206-15.

¹⁷ For Kant, the fundamental moral law was expressed in the "categorical imperative": "Act only according to that maxim whereby you can at the same time will that it should become a universal law," or, in another formulation, "Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means." Ellington translation, pp. 30, 36-1 Ak. 421, 429.

¹⁸ "Euthanasia," in W. B. Fye, "Active Euthanasia: An Historical Survey of Its Origins and Introduction into Medical Thought," *Bulletin of the History of Medicine* 52 (1978): 498. Similar arguments were advanced in the 1936 debate on a bill to legalize euthanasia in the British House of Lords; see S. J. Reiser, A. J. Dyck, and W. J. Curran, *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Cambridge: MIT Press, 1977), 498.

the patient's interests and benefit society in appropriate cases by removing an individual who was "unhealthy, unhappy, and useless."¹⁹

Over the course of the following decades, essays discussing euthanasia continued to appear in medical and popular journals. The British Parliament debated a bill to legalize euthanasia in 1936. In the United States, similar proposals were introduced in state legislatures during the first half of the twentieth century, including New York State in 1947. The Euthanasia Society of America, an organization advocating such proposals, was founded in 1938.²⁰ Following World War II, however, the term "euthanasia" became disfavored due to sensitivity about Nazi practices.

Distinguishing Assisted Suicide and Euthanasia

Contemporary discussion has not focused primarily on the ethics of suicide itself, but on assistance to commit suicide and the direct killing of another person for benevolent motives. Actions that intentionally cause death are often referred to as active euthanasia, or simply as euthanasia. Euthanasia performed at the explicit request of a patient is referred to as "voluntary" euthanasia. Euthanasia of a child or an adult who lacks the capacity to consent or refuse is often termed "nonvoluntary."²¹

In addition, the terms "euthanasia" and "passive euthanasia" are sometimes used to describe withholding or withdrawal of life-sustaining treatment. For example, Roman Catholic authorities often use the word "euthanasia" to refer to inappropriate decisions to withhold or to stop treatment.²² This report uses the term "euthanasia" to refer only to active steps, such as a lethal injection, to end a patient's life.

¹⁹ "The New Cure for Incurables," in Fye, 499.

²⁰ J. Fletcher, *Morals and Medicine* (Princeton: Princeton University Press, 1954); J. Fletcher, "The Courts and Euthanasia," *Law, Medicine and Health Care* 15 (1987/98): 223-30.

²¹ Involuntary euthanasia, performed over a patient's explicit objection, has not been endorsed by anyone in the current debate.

²² The Vatican's 1980 "Declaration on Euthanasia" describes euthanasia as "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated." In President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (Washington: U.S. Government Printing Office, 1993), 303. Appropriate decisions to forgo extraordinary or disproportionately burdensome treatment would not be considered euthanasia, however. *Ibid.* This report does not discuss the criteria that characterize appropriate decisions to forgo life-sustaining treatment. The Task Force has addressed this issue in previous reports. See *New York State Task Force on Life and the Law, When Others Must Choose: Deciding for Patients Without Capacity* (New York: New York State Task Force on Life and the Law, 1992) and *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (New York: New York State Task Force on Life and the Law, 1987).

In assisted suicide, one person contributes to the death of another, but the person who dies directly takes his or her own life. Many individuals hold similar positions on assisted suicide and euthanasia. Others find assisted suicide more acceptable, either because of the nature of the actions or because of differences they see in the societal impact and potential harm of the two practices.

For some, assisted suicide and euthanasia differ intrinsically. A physician who writes a prescription for a lethal dose of medication, for example, is less directly involved in the patient's death than a physician who actually administers medication that causes death. With assisted suicide, the patient takes his or her own life, usually when the physician is not present. Accordingly, factors such as the physician's intentions may be more complex. In some cases, a physician may intend to make it possible for a patient to commit suicide so that the patient feels a greater sense of control, but may hope that the patient does not take this final step. In addition, because the patient's own actions intervene between the physician's actions and the patient's death, the physician's causal responsibility may be less clear.²³

Some regard physician-assisted suicide as less subject to abuse than euthanasia. When assisted suicide occurs, the final act is solely the patient's. It would therefore be more difficult to pressure or convince a patient to commit suicide than to secure agreement to euthanasia.²⁴ Further, a patient who requests assistance in suicide but then becomes ambivalent could simply put off the final step. By contrast, some patients would be too embarrassed or intimidated to express uncertainty to a physician on the verge of giving a lethal injection, or would be concerned that the doctor might be hesitant to administer the injection at a later time.²⁵

Some note that the potential for intimidation or influence stems not only from the doctor's actions in euthanasia, but also from his or her presence at the time of death. Some individuals therefore distinguish cases when a physician assists a suicide by providing information or a prescription, which they believe should be permitted, from instances when the physician is present at the time of the suicide and directly aids or

²³ See R. F. Weir, "The Morality of Physician-Assisted Suicide," *Law, Medicine and Health Care* 20 (1992): 116-26.

²⁴ D. E. Meier, "Physician-Assisted Dying: Theory and Reality," *Journal of Clinical Ethics* 3 (1992): 35.

²⁵ J. Glover, *Causing Death and Saving Life* (Harmondsworth, England: Penguin Books, 1977), 184. Howard Brody writes: "There are psychological reasons to prefer patient control over physician-assisted lethal injection whenever possible. The normal human response to facing the last moment before death, when one has control over the choice, ought to be ambivalence. The bottle of pills allows full recognition and expression of that ambivalence: I, the patient, can sleep on it, and the pills will still be there in the morning; I do not lose my means of escape through the delay. But if I am terminally ill of cancer in the Netherlands and summon my family physician to my house to administer the fatal dose, I am powerfully motivated to deny any ambivalence I may feel." H. Brody, "Assisted Death - A Compassionate Response to Medical Failure," *New England Journal of Medicine* 327 (1992):1384-88.

supervises the act, posing a greater risk.²⁶ Others are not troubled by this risk, and believe that the physician's presence could express caring and a desire to accompany the patient in the final moments of life.²⁷

For others, no decisive distinction can be drawn between assisted suicide and voluntary euthanasia. Whatever differences may exist do not justify a policy of accepting one practice while forbidding the other. This view is shared by some who support both practices and by others who oppose both.²⁸ Proponents of the practices believe that the risks of error and abuse are similar in both practices, and can be minimized with appropriate safeguards.²⁹ Many who oppose both assisted suicide and euthanasia agree that the practices pose similar risks, but reject these risks as unacceptable.³⁰

Most of those who emphasize the basic similarities between assisted suicide and voluntary active euthanasia nevertheless acknowledge some difference in degree between the two practices. Some claim that while both should be allowed, assisted suicide would be a preferable option in any particular case, in order to minimize the possibility of error.³¹ Others oppose both practices but view active euthanasia as more problematic.³² As discussed above, American law draws a clear distinction between the two types of action, treating euthanasia as a far more serious offense. In New York and many other states, while both practices are felonies, assisting suicide is generally classified as manslaughter, while euthanasia constitutes second-degree murder.³³

²⁶ D. T. Watts and T. Howell, "Assisted Suicide Is Not Euthanasia," *Journal of the American Geriatrics Society* 40 (1992): 1043.

²⁷ T. E. Quill, C. K. Cassel, and D. E. Meier, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327 (1992): 1383.

²⁸ Among supporters of the practices, see E. H. Loewy, "Healing and Killing, Harming and Not Harming," *Journal of Clinical Ethics* 3(1992):30; G. C. Graber and J. Chassman, "Assisted Suicide Is Not Voluntary Active Euthanasia, but It's Awfully Close," *Journal of the American Geriatrics Society* 41 (1993):88-89. An opponent of both practices likewise argues: "If the right to control the time and manner of one's death - the right to shape one's death in the most humane and dignified manner one chooses - is well founded, how can it be denied to someone simply because she is unable to perform the final act by herself?" Y. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" *Hastings Center Report* 23, no.3(1993):35.

²⁹ D. Brock, "Voluntary Active Euthanasia," *Hastings Center Report* 22, no.2(1992):10; Graber and Chassman, 88.

³⁰ Kamisar, 35.

³¹ E.g., Glover, 184; 1-1. Brody, 1384-88. As Dr. Aadri Heiner of the Netherlands describes his practice, "I will bring a small glass bottle, and I will hand it over and say, 'This is for you.' he has [to] drink it by [him]self. ... And that makes me very sure that it is his own wish." "Choosing Death," *Health Quarterly*, broadcast March 23, 1993.

³² See American Medical Association, Council on Ethical and Judicial Affairs, "Decisions Near the End of Life," *Journal of the American Medical Association* 267 (1992):2233.

³³ See chapter 4, p. 63.

The Appeal to Autonomy

American society has long embraced individual liberty and the freedom to make personal choices as fundamental values. These values have always been pursued within a social context, accompanied by commitments to promote the overall good of society and protect vulnerable individuals from harm. For some, the exercise of autonomy must also be balanced against other fundamental values embraced by society, including our reverence for human life. The current debate about assisted suicide and euthanasia also presents questions about the way autonomy can best be realized, and the manner in which the tension between autonomy and other ethical and societal values should be resolved.

One strand of the debate about assisted suicide and euthanasia has focused on whether the value of self-determination, which undergirds the right to refuse treatment, provides the basis for a right to assisted suicide or euthanasia as well. Would the self-determination of severely ill patients actually be promoted in practice if assisted suicide and euthanasia were legalized? Does contributing to another person's death manifest respect for that person's autonomy? Questions have also been posed about the impact of legalizing assisted suicide and euthanasia on the self-determination and well-being of individuals who do not seek out these options.

Proponents

Proponents of assisted suicide and euthanasia maintain that respect for individual self-determination mandates the legalization of these practices. Individuals have a fundamental right to direct the course of their lives, a right that should encompass control over the timing and circumstances of their death. While few if any advocates argue for an absolute right to commit suicide, most believe that in appropriate cases suicide can minimize suffering or enhance human dignity, and that people in these circumstances should have the right to take their own lives.³⁴

Proponents suggest that a physician's participation in assisted suicide or euthanasia can support a choice embraced by the patient, consistent with his or her own value system. Individual beliefs about the meaning of life and the significance of death vary greatly. For proponents, establishing assisted suicide and euthanasia as accepted alternatives would respect this diversity. As stated by one commentator:

³⁴ M. Battin, "Voluntary Euthanasia and the Risks of Abuse," *Law, Medicine and Health Care* 20 (1992): 134; M. P. Battin, "Suicide: A Fundamental Human Right?" in *Suicide: The Philosophical Issues*, ed. M. P. Battin and D. J. Mayo (New York: St. Martin's Press, 1980), 267-85. See also J. Arras, "The Right to Die on the Slippery Slope," *Social Theory and Practice* 8 (1982): 285-328, noting arguments on both sides of this issue.

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 death and dying.³⁵

Some proponents promote legalizing assisted suicide and voluntary euthanasia as an affirmative step to grant individuals further control over their dying process.³⁶ For others, the decisive principle is the right to be free of state interference when individuals voluntarily choose to end their lives.³⁷ When differences on basic issues such as life and death go deep and involve profound values, a tolerant, pluralistic society must allow each individual to decide. Many believe that, even if pain can be alleviated, the individual's right to control his or her death should prevail.³⁸

"I wouldn't want to be kept alive that way" has become a modern motto in American society. Pain management and hospice care are better than ever before. But for some people they are simply the trees. The forest is that they no longer want to live, and they believe the decision to die belongs to them alone.³⁹

Opponents

Some believe that assisted suicide and euthanasia can promote autonomy, at least in some cases, but that the dangers of the practices are overriding. For others, the value of human life outweighs the claim to autonomy, and argues decisively against permitting suicide assistance or direct killing, even with benevolent motives. Still others assert that seeking to end one's life intrinsically contradicts the value of autonomy. Like the "freedom" to sell oneself into slavery, the freedom to end one's life should be limited for the sake of freedom.

Many reject euthanasia because it violates the fundamental prohibition against killing. They understand this prohibition, except in defense of self or others, to be a basic

³⁵ Brock, 11. See similarly R. Dworkin, *Life's Dominion* (New York: Knopf, 1993), 208-11; C. K. Cassel and D. E. Meier, "Morals and Moralism in the Debate over Euthanasia and Assisted Suicide," *New England Journal of Medicine* 323 (1990): 751.

³⁶ Weir, 124. Dick Lehr reports that in every case of assisted suicide that health care professionals discussed in interviews, "patients were middle- to-upper class, accustomed to being in charge." An oncologist who had assisted suicide stated that "these are usually very intelligent people, in control of their life - white, executive, rich, always leaders of the pack, can't be dependent on people a lot." D. Lehr, "Death and the Doctor's Hand," *Boston Globe*, April 26, 1993.

³⁷ As stated by one philosopher, "One will need to live with individuals' deciding with consenting others when to end their lives, not because such is good, but because one does not have the authority coercively to stop individuals from acting together in such ways." H. T. Engelhardt, Jr., "Fashioning an Ethics for Life and Death in a Post-Modern Society," *listings Center Report* 19, no. 1 (1989): S9. See also J. Rachels, *The End of Life* (New York: Oxford University Press, 1986), 181-82.

³⁸ Dworkin, 217.

³⁹ A. Quindlen, "Death: The Best Seller," *New York Times*, August 14, 1991, A19.

moral and social principle. This view is expressed within the context of diverse religious, philosophical, and personal perspectives.⁴⁰ Rooted in religious beliefs about the value and meaning of human life, it also resonates to and informs secular values and attitudes, including our laws proscribing murder.

Assisted suicide is opposed by many for similar reasons; although it does not violate the ban against killing directly, it renders human life dispensable and implicates physicians or others in participating in the death of the patient. Some emphasize that assisted suicide and euthanasia are not simply nonintervention in the private choice of another person. The participation of a second person makes assisted suicide and euthanasia social and communal acts, ones in which social, moral, and legal principles must be considered.⁴¹ A physician who assists a patient's death affirms, or at least accepts, the patient's choice, actively contributing to the outcome.⁴² Some believe that one person should never be granted this power over the life and death of another, even a consenting other; it is intrinsically offensive to human dignity, in the way that consensual slavery would be.⁴³ Others are more pragmatically concerned about the influence physicians would exercise in the decision-making process.⁴⁴

⁴⁰ See, e.g., R. M. Veatch, *Death, Dying, and the Biological Revolution*, rev. ed. (New Haven: Yale University Press, 1989), 69-72. Among the Biblical statements of this prohibition are Exodus 20:13, Deuteronomy 5:17, and Genesis 9:5-6. Many religious traditions understand these statements as prohibiting suicide and assisted suicide as well as direct killing. For an overview of the attitudes of diverse religious traditions, see R. Hamel, ed., *Active Euthanasia, Religion, and the Public Debate* (Chicago: Park Ridge Center, 1991)- and C. S. Campbell, "Religious Ethics and Active Euthanasia in a Pluralistic Society," *Kennedy Institute of Ethics Journal* 2 (1992): 253-77. On the significance of religiously influenced views for public policy deliberations, see, e.g., S. Hauerwas, *Suffering Presence* (Notre Dame: University of Notre Dame Press, 1986), 105; Joseph Cardinal Bernadin, "Euthanasia: Ethical and Legal Challenge," *Origins* 18 (1988): 52-1 J. Stout, *Ethics After Babel* (Boston: Beacon Press, 1988); D. Callahan and C. S. Campbell, eds., "Theology, Religious Traditions, and Bioethics," *Hastings Center Report* 20, no. 4 suppl. (1990); S. L. Carter, *The Culture of Disbelief* (New York: Basic Books, 1993).

⁴¹ See, e.g., Callahan, 52-53; T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989), 227. Many religious traditions, including Roman Catholicism, challenge the notion of an autonomous right to end one's life, appealing to the social nature of human life and the mutual dependence of individuals in society. See, e.g., Bernadin, 55. This point is also advocated in secular terms.

⁴² Opponents argue that the patient's request for suicide assistance is not just a way to obtain drugs: The request might represent a desire for companionship in pursuing a difficult course of action; a wish for confirmation of a decision about which the patient is unsure; inquiry of the physician's opinion on an issue about which the patient is ambivalent; an appeal for the physician's reassurance that he or she is committed to the patient and believes that the patient's life is worthwhile; or simply an expression of desperation and a cry for help. See, e.g., E. D. Caine and Y. C. Conwell, "Self-Determined Death, the Physician, and Medical Priorities: Is There Time to Talk," *Journal of the American Medical Association* 270 (1993): 875-76. See also Glover, 183.

⁴³ As stated by Daniel Callahan, "No human being, whatever the motives, should have that kind of ultimate power over the fate of another. It is to create the wrong kind of relationship between people, a community that sanctions private killings between and among its members in pursuit of their individual goals and values." 1). Callahan, "Can We Return Death to Disease?" *Hastings Center Report* 19, no. 1 (1989): S5.

⁴⁴ Edmund D. Pellegrino argues that while the doctor appears to place the initiative in the patient's hands and be merely "open" to suicide under the right circumstances, the physician actually retains control:

For some, assisted suicide and euthanasia are not inherently incompatible with self-determination, but they believe that the practices as applied in the daily routines of medical practice and family life would undermine the autonomy of many individuals. In many cases, a patient who requests euthanasia or assisted suicide may have undiagnosed major clinical depression or another psychiatric disorder that prevents him or her from formulating a rational, independent choice. Other patients may feel compelled to end their lives because they lack real alternatives, due to inadequate medical treatment or personal support.⁴⁵ Offering suicide assistance, but not good medical care, could be especially troubling for some segments of the population. As expressed by one doctor who manages a Latino health clinic, legalizing assisted suicide would pose special dangers for members of minority populations whose primary concern is access to needed care, not assistance to die more quickly.

In the abstract, it sounds like a wonderful idea, but in a practical sense it would be a disaster. My concern is for Latinos and other minority groups that might get disproportionately counseled to opt for physician-assisted suicide.⁴⁶

Diverse religious traditions oppose assisted suicide and euthanasia because the practices violate the basic value of human life, seen as God's gift. From the perspective of many religions, suicide itself is not an ethically sanctioned choice. Many religious traditions reject assisted suicide and euthanasia based on their understanding of general values, including appreciation for the life and value of each individual, the individual's responsibility to the community, and society's obligations towards all of its members, especially the poor and vulnerable. Many religions understand life itself as something that is entrusted to persons by God, entailing a sense of individual responsibility that is often expressed in terms of "stewardship." Differing religious perspectives also share a commitment to compassion for patients and others who are suffering.⁴⁷ They believe that

"Ultimately, the determination of the right circumstances is in the physician's hands. The physician controls the availability and timing of the means whereby the patient kills himself. Physicians also judge whether patients are clinically depressed, their suffering really unbearable, and their psychological and spiritual crises resolvable. Finally, the physician's assessment determines whether the patient is in the 'extreme' category that, per se, justifies suicide assistance." "Compassion Needs Reason Too," *Journal of the American Medical Association* 270 (1993): 874.

⁴⁵ See, e.g., Arras, 311-13; J. Teno and J. Lynn, "Voluntary Active Euthanasia: Individual Case and Public Policy," *Journal of the American Geriatrics Society* 39 (1991): 827-30; H. Hendin and G. Klerman, "Physician-Assisted Suicide: The Dangers of Legalization," *American Journal of Psychiatry* 150 (1993): 143-45; D. W. McKinney, "Euthanasia as Public Policy: Rights and Risks," *The Berry Street Essay*, delivered in New Haven, Conn., June 22, 1989, Unitarian Universalist General Assembly, 9. See also the sections discussing suicide and depression in chapter 1.

⁴⁶ Dr. Nicolas Parkhurst Carballeira, Director of the Boston-based Latino Health Institute, in Lehr, April 26, 1993. A recent study found that patients treated at centers that serve predominantly minority patients were three times more likely than those treated elsewhere to receive inadequate pain treatment. Elderly individuals and women were also more likely than others to receive poor pain treatment. C. S. Cleeland et al., "Pain and Its Treatment in Outpatients With Metastatic Cancer," *New England Journal of Medicine* 330 (1994): 592-96.

⁴⁷ See, e.g., H. Arkes et al., "Always to Care, Never to Kill," *First Things* no. 18 (1992): 45-77.

this compassion should be expressed by offering care and companionship, not assisted death or medical killing, to the severely ill.

As articulated in the 1980 Vatican Declaration on Euthanasia, and affirmed in recent speeches by Pope John Paul II, the Catholic Church firmly rejects assisted suicide and euthanasia.⁴⁸

Similar views are expressed by representatives of all branches of Judaism.⁴⁹ Many Protestant denominations, such as the American Lutheran Church and the Episcopal Church, also oppose the practices as ethically unacceptable.⁵⁰ The Unitarian-Universalist Association, however, has expressed support for legalizing the practices.⁵¹

Benefiting the Patient

Individuals suffer from diverse causes. They may experience pain, physical discomfort, and psychological distress.⁵² Relieving suffering is widely recognized as a basic moral value and a goal of medicine in particular.⁵³ The debate about euthanasia and

⁴⁸ Speaking in the United States in 1993, the Pope condemned euthanasia, stating: "In the modern metropolis, life - God's first gift, and the fundamental right of every individual, on which all other rights are based - is often treated as just one more commodity" "The Prayer Vigil," *Origins* 23 (1993): 184. See also "Contributors to the Formation of Society: Ad Limina Address," *Origins* 23 (1993): 486-87; "Veritatis Splendor," *Origins* 23 (1993): 321, par. 80.

⁴⁹ For further discussion of Jewish views on assisted suicide and euthanasia, see, e.g., I. Bettan et al., "Euthanasia," in *American Reform Response*, ed. W. Jacob (New York: Central Conference of American Rabbis, 1983), 261-71; J. D. Bleich "Life as an Intrinsic Rather Than Instrumental Good: The 'Spiritual' Case Against Euthanasia," *Issues in Law and Medicine* 9 (1993): 139-49; B. A. Brody, "A Historical Introduction to Jewish Casuistry on Suicide and Euthanasia," in *Suicide and Euthanasia*, ed. Brody, 39-75; E. N. Dorff, "Rabbi, I Want to Die: Euthanasia and the Jewish Tradition," in *Choosing Death in America* (Philadelphia: Westminster/John Knox, forthcoming); D. M. Feldman and F. Rosner, ed., *Compendium on Medical Ethics*, 6th ed. (New York: Federation of Jewish Philanthropies of New York, 1984), 101-2; I. Jakobovits, *Jewish Medical Ethics*, 2d ed. (New York: Bloch, 1975).

⁵⁰ As stated in a report of the American Lutheran Church: "Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering." "Death and Dying," 1982, in Hamel, ed., 63. See also Hamel, ed., 52-71.

⁵¹ The 1988 Unitarian Universalist General Assembly issued a statement resolving "That Unitarian Universalists advocate the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths." In Hamel, ed., 68-69. This resolution has been criticized by some within the Unitarian Universalist Association, including Donald McKinney. McKinney.

⁵² See chapter 3 for discussion of current approaches in pain and palliative care. See also K. M. Foley, "The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide," *Journal of Pain and Symptom Management* 6 (1991): 289-97.

⁵³ See, e.g., R. S. Smith, "Ethical Issues Surrounding Cancer Pain," in *Current and Emerging Issues in Cancer Pain: Research and Practice*, ed. C. R. Chapman and K. M. Foley (New York: Raven Press, 1993), 385-92.

assisted suicide turns in part on a judgment about how to help suffering individuals most effectively while protecting them and others from harm.

In the debate about assisted suicide and euthanasia, compassion for patients in pain or with unrelieved suffering is a common moral and social ground. Disagreement centers on how society can best care for these patients, and the consequences for others if the practices are permitted. The debate hinges in part on assumptions about the number of patients affected, the availability of pain relief, and the effect of legalizing assisted suicide and euthanasia on the provision of palliative care. At the core are basic differences about what compassion demands for suffering individuals. Disagreement exists too about whether the availability of assisted suicide or euthanasia would reassure or threaten ill and disabled patients.

Proponents

Those who support euthanasia and/or physician-assisted suicide believe that such actions are the most effective way to help some patients experiencing intractable pain or intolerable psychological distress. They regard these actions as essential to fulfill a commitment to relieve suffering. Indeed, many feel that, in appropriate circumstances, a physician's desire to act compassionately towards his or her patient provides the strongest rationale for the practices.

Contemporary advocates argue that, despite advances in palliative medicine and hospice care, a small number of patients continue to suffer from severe pain and other physical symptoms that available medical therapies cannot reduce to a tolerable level.⁵⁴ Studies have shown that large numbers of patients receive poor palliative care; while state-of-the-art treatment could manage their pain and discomfort, they are not receiving and are unlikely to receive this care. In these cases, euthanasia or assisted suicide would directly end the patient's suffering.⁵⁵

In addition to physical pain and discomfort, patients experience psychological and personal suffering, which is less amenable to medical treatment. As articulated by several doctors, "The most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, un[a]esthetic, absurd, and existentially unacceptable condition."⁵⁶ Some patients suffer because of losses that have already occurred or because of anticipated losses and decline. Others may experience anxiety, loneliness, helplessness, anger, and despair. Proponents

⁵⁴ At least short of anesthetizing the patient to a sleep-like state; see p. 93, n. 60.

⁵⁵ G. A. Kasting, "The Nonnecessity of Euthanasia," in *Physician-Assisted Death*, ed. J. M. Humber, R. F. Almeder, and G. A. Kasting (Totowa, N.J.: Humana Press, 1993), 2545; Weir, 123-24; Rachels, 152-54.

⁵⁶ Quill, Cassel, and Meier, 1383.

of assisted suicide and euthanasia assert that only the patient can determine when suffering renders continued life intolerable.⁵⁷

The number of patients who would receive assistance to commit suicide or euthanasia is unknown. Most advocates assert that these actions would be appropriate only in rare cases, and that relatively few patients would be directly affected. They argue, however, that many individuals who never use the practices would benefit. Some patients would feel better cared for and more secure if they knew that their physician would provide a lethal injection or supply of pills if they requested these means to escape suffering.⁵⁸ Knowing that assisted suicide or euthanasia is available would also reassure members of society in general, including those who are not severely ill. "While relatively few might be likely to seek assistance with suicide if stricken with a debilitating illness, a substantial number might take solace knowing they could request such assistance."⁵⁹

Opponents

Those who oppose legalizing assisted suicide and euthanasia are also deeply concerned about the needs of terminally and severely ill patients. They believe that society all too often abandons these patients, adding to their suffering and sense of despair. However, they reject assisted suicide and euthanasia as unacceptable or harmful responses to these patients in need. They also believe that the likely harm to many patients far exceeds the benefits that would be conferred. Advances in pain control have rendered cases of intolerable and untreatable pain extremely rare. In exceptional cases in which symptoms cannot be controlled adequately while the patient is alert, sedation to a sleep-like state would remain an option.⁶⁰ Allowing assisted suicide or euthanasia, especially given the current state of palliative care, would deny patients the treatment and

⁵⁷ Brock, 11; Weir, 123; Kasting.

⁵⁸ F. G. Miller and J. C. Fletcher, "The Case for Legalized Euthanasia Perspectives in Biology and Medicine 36 (1993):163-64; Quill, Cassel, and Meier, 1382.

⁵⁹ Watts and Howell, 1044-45.

⁶⁰ N. Coyle et al., "Character of Terminal Illness in the Advanced Cancer Patient: Pain and Other Symptoms During the Last Four Weeks of Life," *Journal of Pain and Symptom Management* 5 (1990): 83-93; Foley; Teno and Lynn. Watts and Howell (1045), in advocating assisted suicide, write: "We concede that there is another alternative: terminally ill patients who cannot avoid pain while awake may be given continuous anesthetic levels of medication. But this is exactly the sort of dying process we believe many in our society want to avoid." In contrast, Leon R. Kass states: "It will be pointed out [that] full analgesia induces drowsiness and blunts or distorts awareness. How can that be a desired outcome of treatment? Fair enough. But then the rationale for requesting death begins to shift from relieving experienced suffering to ending a life no longer valued by its bearer or, let us be frank, by the onlookers." "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (1989): 33. Palliative care experts report that while sedation seems objectionable to many healthy individuals contemplating it in the abstract, most terminally ill patients and families find it acceptable. Nessa M. Coyle, R. N., Director, Supportive Care Program, Pain Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, oral communication, March 11, 1993. While continual sedation can be an important option for patients in severe and intractable physical pain, it is a less practical option for patients whose suffering is primarily psychological and who may have years to live. Quill, Cassel, and Meier.

support that should be a routine part of medical practice. It also would lead to the death of some patients whose pain could be alleviated.⁶¹

Health care professionals can do much to help relieve psychological suffering by providing humane care and personal support.⁶² Opponents believe that assisting a patient's suicide or performing euthanasia in an attempt to relieve psychological anguish or despair will rarely serve the patient's interests. For some, this is an evident contradiction; causing death can never constitute a benefit.⁶³ Others maintain that assisted suicide and euthanasia could alleviate psychological suffering in rare cases, but believe that the advantages of allowing the practices are outweighed by the potential harm to many other patients.⁶⁴

Significant too is the concern that suicide should not be pursued as a means to care for, or "treat," patients who suffer because of psychological reasons. Society has long discouraged suicide as a remedy for psychological suffering, even though many individuals who consider suicide are anguished and find relief in the prospect of death.⁶⁵ Even for patients who are suffering and seek assistance in ending life, complying with the request may provide the wrong kind of "assistance," causing some patients to end their lives prematurely. Two physicians report that, while many hospice patients at times express a desire for death, almost none make serious and persistent requests for active euthanasia. They write:

New patients to hospice often state they want to "get it over with." At face value, this may seem a request for active euthanasia. However, these requests are often an expression of the patient's concerns regarding pain, suffering, and isolation, and their fears about whether their dying will be prolonged by technology. Furthermore, these requests may be attempts by the patient to see if anyone really cares whether he or she lives. Meeting such a request with ready

⁶¹ Reflecting on this danger in the United States, Alexander M. Capron writes: "The difficulties in developing caring and creative means of responding to suffering discourage society as well as health care providers from greater efforts. A policy of active euthanasia can become another means of such avoidance... I could not rid my mind of the images of care provided in our hard-pressed public hospitals and in many nursing homes, where compassionate professionals could easily regard a swift and painless death as the best alternative for a large number of patients." "Euthanasia in the Netherlands: American Observations," *Hastings Center Report* 22, no. 2 (1992): 32.

⁶² See, e.g., N. Coyle, "The Euthanasia and Physician-Assisted Suicide Debate: Issues for Nursing," *Oncolog Nursing Forum* 19, no. 7 suppl. (1992): 4445; and discussion above, chapter 3. Most proponents of assisted suicide and euthanasia would agree with this statement but still believe that the practices should be available at the patient's option.

⁶³ As argued by Leon Kass: "To intend and to act for someone's good requires his continued existence to receive the benefit." Kass, 40.

⁶⁴ P. A. Singer and M. Siegler, "Euthanasia - A Critique," *New England Journal of Medicine* 322 (1990): 1881-83.

⁶⁵ As explained by one sociologist who studied suicide: "It is undeniable that all persons - 100 percent - who commit suicide are perturbed and experiencing unbearable psychological pain." E. S. Shneidman, "Rational Suicide and Psychiatric Disorders," *New England Journal of Medicine* 326 (1992): 889. Two psychiatrists offer a similar opinion; see Hendin and Klerman, 144.

acceptance could be disastrous for the patient who interprets the response as confirmation of his or her worthlessness.⁶⁶

Others note that even if all patients are assumed to make rational and beneficial choices for themselves, giving patients the option of choosing to end life would change the way they and those around them perceive their lives. Specifically, a patient could no longer stay alive by default, without needing to justify his or her continued existence. The patient will be seen (by others and himself or herself) as responsible for the choice to stay alive, and as needing to justify that choice. Given societal attitudes about handicaps and dependence, "the burden of proof will lie heavily on the patient who thinks that his terminal illness or chronic disability is not a sufficient reason for dying."⁶⁷

Severely ill patients depend on others not only for physical care, but for conversation, respect, and meaningful human interaction. In some cases, family members may encourage patients to "choose" the option of dying.⁶⁸ More commonly, even without such pressure, a patient may assume that friends and family regard the choice to remain alive as irrational or selfish. As expressed by one commentator, "The patient may rationally judge that he's better off taking the option of euthanasia, even though he would have been best off not having the option at all. ... To offer the option of dying may be to give people new reasons for dying."⁶⁹

Many opponents believe that establishing an option of assisted suicide or euthanasia would have negative consequences not only for patients who receive assisted dying, but for many others who would not use either practice. The option of assisted suicide or euthanasia could distract attention from the care that some patients might otherwise be offered. Especially if a patient's symptoms persist despite initial attempts to alleviate them, the effort and expense of more aggressive treatment and support may seem less compelling.⁷⁰ Officially sanctioning these practices might also provide an excuse for those wanting to spend less money and effort to treat severely and terminally ill patients, such as patients with acquired immunodeficiency syndrome (AIDS).⁷¹

Societal Consequences

⁶⁶ Teno and Lynn, 828.

⁶⁷ This argument is well developed by J. David Velleman, "Against the Right to Die," *Journal of Medicine and Philosophy* 17 (1992): 665-81. While Velleman argues against establishing a law or policy permitting euthanasia, he believes that some patients would benefit from death and welcome euthanasia and that in such cases rules against euthanasia should not be enforced.

⁶⁸ See Kamisar, 37; and also the concerns noted in M. P. Battin, "Manipulated Suicide," in *Suicide: The Philosophical Issues*, ed. Battin and Mayo, 169-82.

⁶⁹ Velleman, 675-76.

⁷⁰ A. J. Dyck, "Physician-Assisted Suicide - Is It Ethical?" *Harvard Divinity Bulletin* 21, no. 4 (1992): 16.

⁷¹ Donald McKinney argues that even if relatively few patients avail themselves of the choice, officially sanctioning the option may alter public perceptions, making improvement in palliative care and increased social support for suffering patients seem less urgent. McKinney, 7-8.

Decisions about euthanasia and assisted suicide touch upon fundamental societal values and standards. They entail questions about why we value human life, when life may be taken, and what obligations we owe to others. Legalizing assisted suicide or euthanasia would represent a dramatic change, and is likely to cause both intended and unintended consequences.

Those who favor or oppose legalizing assisted suicide and euthanasia differ both in their prediction of societal consequences and in the way that they evaluate possible outcomes.⁷² They disagree, for example, about the effect of the practices on society's respect for the value of the lives of others, especially those who are most frail and ill. They also differ about whether expansion of a policy of voluntary euthanasia to include nonvoluntary euthanasia would benefit or threaten vulnerable members of society, and whether mistakes or abuses in a relatively small number of cases would constitute a moral outrage or the unfortunate but unavoidable imperfections of any human activity. Finally, proponents and opponents disagree about how the burden of proof should fall in deciding public policy. If the societal consequences of authorizing assisted suicide or euthanasia are uncertain, should society allow these practices until such time as harmful effects can be proven, or should the practices remain prohibited unless society can assure itself that they would not cause unacceptable social harm?⁷³

Proponents

Proponents believe that legalizing assisted suicide and euthanasia would not produce harmful consequences for society as a whole, and that potential dangers can be minimized by appropriate safeguards. For example, some argue that, despite current prohibitions, assisted suicide now occurs. Openly permitting assisted suicide in accord with required safeguards might therefore encourage physicians to communicate more freely with their patients and to consult with professional colleagues. Mandated consultation with a licensed psychiatrist would improve the diagnosis and treatment of many patients who are depressed.⁷⁴ As a result, allowing the practice in carefully defined circumstances would lead to greater professional accountability and fewer cases of abuse.⁷⁵

⁷² See Brock, 14.

⁷³ Similar arguments about potential consequences and the "burden of proof" in the absence of unproven but probable risks have been raised in the debate on Surrogate motherhood. See New York State Task Force on Life and the Law, *Surrogate Parenting.- Analysis and Recommendations for Public Policy* (New York: New York State Task Force on Life and the Law, 1988) 73-74, 116-17.

⁷⁴ Some opponents, though, emphasize the difficulty of diagnosing depression among severely ill patients, and argue that mandated psychiatric consultation would fail to identify some cases of depression. See chapters 1 and 8.

⁷⁵ Cassel and Meier, 751. Data on the number of cases of assisted suicide and euthanasia currently occurring are difficult to obtain, especially because the practices are illegal. Information about cases of assisted suicide and euthanasia has largely been presented in anecdotal reports. See Lehr.

Many who favor legalizing physician-assisted suicide see little distinction between assisted suicide and euthanasia. Both practices rest on commitments to respect autonomy and prevent suffering. Some acknowledge that a practice of euthanasia with the patient's consent is likely to lead to euthanasia for patients incapable of expressing consent or refusal. They believe that nonvoluntary euthanasia would be appropriate when it reflects some information about the patient's own wishes or when it relieves the patient's suffering.⁷⁶ Others accept euthanasia for patients too ill or too young to decide for themselves because they see no value in continued life for severely disabled individuals who irreversibly lack the ability to experience life consciously or to relate to others. Essentially, some believe that these individuals do not "have a life" in the sense in which life is treasured.⁷⁷

Advocates of legalizing assisted suicide and/or euthanasia maintain that although some abuses will occur, the number of inappropriate deaths would be small, and the opportunity to alleviate suffering in other cases outweighs this cost. The potential for abuse suggests the need for safeguards, but should not preclude legalizing assisted suicide and euthanasia. For them, claims about negative consequences for the medical profession or the broader society seem uncertain and speculative.⁷⁸

Some advocates of legalizing assisted suicide or euthanasia favor prospective guidelines: for example, requiring that the attending physician consult with colleagues and that the patient voluntarily and repeatedly request assisted suicide or euthanasia, receive psychological evaluation and counseling, and experience intolerable suffering with no hope for relief.⁷⁹ Proposals also stipulate requirements for the patient's medical condition: for example, that assisted suicide or euthanasia would be allowed only if a patient is terminally ill or has an incurable disease. Others recommend that a panel or

⁷⁶ Brock, 20.

⁷⁷ See, e.g., Rachels, 24-33, 64-67, 178-80; P. Singer, *Practical Ethics* (Cambridge: Cambridge University Press, 1979), 138-39.

⁷⁸ Concerns about the potential consequences of a change in policy are often discussed in terms of "slippery slope" arguments: allowing a given practice will tend to lead to acceptance of other actions that are objectionable. A logical or conceptual version of a slippery-slope argument would claim that there is no distinction in principle between two actions; for example, that if voluntary euthanasia is allowed, there would be no principled basis for not allowing nonvoluntary euthanasia. Causal or empirical versions of the argument maintain that allowing a certain type of action would tend to lead in practice to another, objectionable action; for example, that if voluntary euthanasia is allowed, society would be more likely to accept nonvoluntary euthanasia. The empirical version of the argument can rarely prove that a given result (e.g., nonvoluntary euthanasia) is certain to follow. Those utilizing such arguments maintain that they may nevertheless establish that allowing one type of action poses a significant or unacceptable risk that the problematic result will occur. See Arras; Beauchamp and Childress, 139-41; W. van der Burg, "The Slippery-Slope Argument," *Ethics* 102 (1991): 42-65; B. Freedman, "The Slippery-Slope Argument Reconstructed," *Journal of Clinical Ethics* 3 (1992): 293-97; B. Williams, "Which Slopes Are Slippery?" in *Moral Dilemmas in Modern Medicine*, ed. M. Lockwood (New York: Oxford University Press, 1985), 126-37.

⁷⁹ Various safeguards are suggested in Hemlock Society U.S.A., "Model Aid-in-Dying Act," 1993; M. Battin, "Voluntary Euthanasia and the Risks of Abuse;" Weir, "Morality," 124-25; H. Rigter, "Euthanasia and the Netherlands," *Hastings Center Report* 19, no. 1 (1989): S31-32; Quill, Cassel, and Meier, 1381-82. For a discussion and critique of guidelines proposed by Quill, Meier and Cassel, see chapter 6, pp. 142-45.

committee review the patient's request before assisted suicide or euthanasia is performed.⁸⁰

Under some proposals, assisting suicide or performing euthanasia would remain a violation of criminal law, but guidelines would specify types of cases that would not subject physicians to any penalty. Physicians would be able to avoid punishment by proving that they acted appropriately in exceptional circumstances; a showing that the physician responded compassionately and competently to a voluntary request by a competent patient would constitute a defense to criminal prosecution.⁸¹ Finally, some advocates have suggested a trial period of voluntary active euthanasia or measures to legalize the practice in a few states, in order to gain data on the consequences of the practice.⁸²

Opponents

For many, the potential for error and abuse in particular cases, the risks to vulnerable individuals, and the profound effect on society's values present the most compelling reasons against allowing assisted suicide and euthanasia. Most immediately, the practices create enormous potential for abuse in particular cases. Some decisions to contribute to a patient's death may be well-intentioned but hasty and possibly mistaken. In other cases, patients may be pressured to consent to euthanasia when their care is expensive or burdensome to others. As one commentator has argued, "Advocating legal sanction of euthanasia at a time and in a society where access to care is so limited and its cost so critical, the so-called 'right to die' all too easily becomes a duty to die."⁸³

Some warn that individuals who are disadvantaged or members of minority groups would be especially susceptible to such pressures. Others note the widely recognized failure of our health care system to provide minimally acceptable health care to the poor and disadvantaged. Especially in overburdened facilities serving the rural and urban poor, the lack of available options may effectively pressure patients into assisted suicide or euthanasia.⁸⁴ For some opponents, cases of abuse, even if relatively infrequent, would count decisively against a policy authorizing assisted suicide and euthanasia.⁸⁵

⁸⁰ See, e.g., Brody, 1387.

⁸¹ This is the way the law is structured in the Netherlands, although most agree that physicians are not reporting many cases of euthanasia despite the legal requirement to do so.

⁸² See, e.g., Brock, 20; Glover.

⁸³ McKinney, 9. Similarly, David Velleman asserts that some patients will choose to die out of concern for the resources of family members or society, and that to accept such a "gift" can be problematic. "Establishing the right to die is tantamount to saying, to those who might contemplate dying for the social good, that such favors all never be refused." Velleman, 678-79.

⁸⁴ As argued by John Arras, "Insofar as we sustain unjust conditions, including profoundly inequitable systems of terminal health care, we thereby heighten the impoverished person's sense of being truly a 'dead end case.' By failing to alleviate or eliminate those social conditions that would make a quick death look relatively attractive, we become deeply implicated in this choice for death." Arras, 312.

⁸⁵ Singer and Siegler maintain, "Even one case of involuntary euthanasia would represent a great harm." Singer and Siegler, 1883.

Opponents also believe that the practice would expand, presenting even more profound dangers. A policy of allowing assisted suicide or euthanasia only when a patient voluntarily requests an assisted death, and a physician also judges that assisted suicide or euthanasia are appropriate to relieve suffering, is inherently unstable. The reasons for allowing these practices when supported by both a patient's request and a physician's judgment would lead to allowing the practices when either condition is met.⁸⁶ The value of self-determination supports compliance with any voluntary request by a patient with decision-making capacity. Moreover, any serious request would reflect psychological suffering that the patient considers unbearable. Suggested restrictions on the practices, such as requiring that patients have a terminal or degenerative illness, would be seen as arbitrary limits on patients' autonomy.⁸⁷ In particular cases, and more broadly over time, assisted suicide and euthanasia would be provided based on any serious voluntary request by a competent patient, regardless of his or her medical condition.⁸⁸

Opponents similarly argue that restrictions requiring the patient's informed choice would be difficult to maintain. If intentionally contributing to or causing death is an appropriate course of treatment for suffering patients, then physicians should be able to provide this treatment to patients unable to make the request themselves.⁸⁹ The resulting policy of euthanasia for children and incompetent adults is regarded as intrinsically wrong, or as an option that poses an extraordinarily high risk of abuse.

Some believe that legalizing assisted suicide and euthanasia would have a subtle but widespread impact on society. They fear a general reduction of respect for human

⁸⁶ See Dyck; Kamisar.

⁸⁷ As argued by Benjamin Freedman (293), societal acceptance of decisions to forgo life-sustaining treatment began with decisions made directly by terminally ill patients; over time the courts and policymakers concluded that it is inappropriate or infeasible to make such criteria decisive for purposes of public policy. Daniel Callahan adds that it would be difficult to enforce restrictions on euthanasia because of the privacy of the interaction between doctor and patient. Callahan, "When Self-Determination Runs Amok," 54. Some express concern that legalizing assisted suicide and euthanasia would render it more difficult to forgo life-sustaining treatment. Restrictions on euthanasia might be applied to decisions to forgo treatment, and all decisions at life's end might become subject to overly intrusive review. S. M. Wolf, "Holding the Line on Euthanasia," *Hastings Center Report* 19, no. 1 (1989): S13-15; McKinney, 4-6.

⁸⁸ Among others, Yale Kamisar asserts that, if assisted suicide is allowed for patients with a terminal or degenerative illness, it would seem unfair to exclude others, such as a quadriplegic or severely injured accident victim. He continues: "Why stop there? If a competent person comes to the unhappy conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not 'qualify' under somebody else's standards?" Kamisar, 36-37. In a recent case in the Netherlands, a court approved a psychiatrist's assistance of suicide for a patient who was depressed and experiencing psychological suffering, but had no other medical illness. W. Drozdak, "Dutch Seek Freer Mercy Killing; Court Case Could Ease Limits on Assisted Suicide, Euthanasia," *Washington Post*, October 29, 1993, A29.

⁸⁹ Callahan, "When Self-Determination Runs Amok," 54; Dyck, 17; Capron, 31. Some point to the Dutch experience as evidence that the practice would expand. See the discussion in chapter 6, pp. 132-34.

life if official barriers to killing are removed.⁹⁰ Others are especially fearful of the effect on the disabled and other vulnerable persons in society at large.

Instead of the message a humane society sends to its members -- "Everybody has the right to be around, we want to keep you with us, every one of you" -- the society that embraces euthanasia, even the "mildest" and most "voluntary" forms of it, tells people: "We wouldn't mind getting rid of you." This message reaches not only the elderly and the sick, but all the weak and dependent.⁹¹

Some who oppose legalizing euthanasia believe that acts of voluntary euthanasia are morally acceptable in exceptional cases, such as when a terminally ill patient suffering from intolerable and untreatable pain makes an informed request. On balance, however, they conclude that conscientious objection and leniency in the judicial process would be appropriate in these cases, but such exceptional cases cannot justify explicit changes in the law or moral rules that bar active and intentional killing. However strong our compassion for patients in these rare circumstances, it cannot support fundamental changes to society's moral code, with potentially disastrous and irreversible consequences.⁹²

Similarly, some argue that even if actions of assisting suicide in particular cases are morally justified or excusable, it would be difficult or impossible to craft a policy that resulted in assisted suicide only in those cases. A policy that allowed sensitive physicians to assist suicide indirectly in exceptional cases, after lengthy discussions with a patient, would also allow less thoughtful physicians to aid suicides after perfunctory conversations. Accordingly, a former president of Concern for Dying, an advocacy organization for patients' rights, suggests:

A deliberate act to assist someone in taking her/his life -- however merciful the intent -- should not be sanctioned by law. Rather it should be left a private act, with society able to be called in to judgment when and if the motive

⁹⁰ See, e.g., Beauchamp and Childress, 141; Dyck, 17. -102-

⁹¹ R. Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Center Report* 19, no. 1 (1989): S26. Richard Doerflinger similarly argues: "Elderly and disabled patients are often invited by our achievement-oriented society to see themselves as useless burdens. ... In this climate, simply offering the option of 'self-deliverance' shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it." "Assisted Suicide: Pro-Choice or Anti-Life?" *Hastings Center Report* 19, no. 1 (1989): S16-19. Hendin and Klerman assert that for society to authorize assisted suicide would in effect endorse "the view of those who are depressed and suicidal that death is the preferred solution to the problems of illness, age, and depression." Hendin and Klerman, 145.

⁹² See Veatch, 73-75; J. F. Childress, "Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: A Framework for the Analysis and Assessment of Illegal Actions in Health Care," *Journal of Medical Philosophy* 10 (1985): 73-77.

should be impugned. This is not a neat and precise system of justice to be sure, but one that continues to afford the least possibility of abuse.⁹³

The Role and Responsibilities of Physicians

While any person can aid suicide or cause death, the current debate about assisted suicide and euthanasia generally centers on the actions of physicians. Long-standing medical tradition, exemplified by the Hippocratic Oath, enjoins physicians not to harm patients, and in particular not to "give a deadly drug to anybody if asked for it, nor ... make a suggestion to this effect."⁹⁴ The oath also commits the physician to employ therapeutic measures to benefit the patient.⁹⁵

The issues of assisted suicide and euthanasia confront some physicians in a dramatic and deeply personal way, as they consider how best to respond to a patient's suffering, or to an explicit request for assistance in ending life. In these as in other cases, some physicians feel a conflict between their personal commitments and conscientious judgment in a particular case, and policies designed to prevent harm or abuse for patients generally.

The debate about assisted suicide and euthanasia raises complex questions about the duties of physicians and the goals of the medical profession. What is a physician's obligation when a patient requests assisted suicide or euthanasia? How does this obligation relate to the overall goals of medicine? What impact would the practices have on the social role of physicians and on the physician-patient relationship? In response to the growing public debate, the organized medical community has focused on the special questions posed for its profession.

Proponents

Physicians and others who advocate assisted suicide and euthanasia believe that the practices are consistent with the professional role and responsibilities of physicians. They assert that the physician's responsibility to care for patients should be understood broadly in terms of promoting patients' self-determination and enhancing their well-

⁹³ McKinney, 7.

⁹⁴ In T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 2d ed. (New York: Oxford University Press, 1983), 330. The Hippocratic Oath dates back to approximately the fourth century B.C. Although doctors no longer swear by the god Apollo, the oath has been regarded as a central statement about the ethical responsibilities of physicians throughout the history of Western medicine. Nonetheless, not all aspects of the oath are universally honored as prescriptions in contemporary medical practice. For example, many physicians reject the oath's proscription against abortion.

⁹⁵ *Ibid.* The oath specifies, "I will apply dietetic measures for the benefit of the sick according to my ability and judgment."

being. Accordingly, it would be appropriate for a physician to assist suicide or perform euthanasia when these actions are chosen by and would benefit a patient.⁹⁶ Others believe that "alleviating suffering, curing disease, and not causing death are important and simultaneous obligations."⁹⁷ If suffering can be eliminated only by causing death, a physician would face conflicting obligations, requiring a personal choice about which obligation is most compelling under the circumstances.

Some proponents regard assisted suicide as less threatening to professional integrity than euthanasia.⁹⁸ They believe that removing rules against physician-assisted suicide would offer physicians an important option in responding to the personal experiences and values of each patient. In appropriate cases, a physician's willingness to discuss this alternative and assist suicide would demonstrate commitment to the patient throughout the course of life, including the moment of death.

Some proponents maintain that physicians should have a special role in contributing to patients' deaths because they have access to drugs and the expertise to cause death quickly and painlessly.⁹⁹ Other individuals, such as family members and friends, may be reluctant to cause or contribute to a patient's death. In addition, the moral authority of physicians enables them to aid patients seeking to end their lives in less tangible ways.

Historically, in the United States suicide has carried a strong negative stigma that many today believe unwarranted. Seeking a physician's assistance, or what can almost seem a physician's blessing, may be a way of trying to remove that stigma and show others that the decision for suicide was made with due seriousness and was justified under the circumstances. The physician's involvement provides a kind of social approval, or more accurately helps counter what would otherwise be unwarranted social disapproval.¹⁰⁰

Some urge that only physicians should be authorized to assist suicide or perform euthanasia. Physicians can discuss the patient's medical condition, explore alternative means for alleviating pain and suffering, and determine whether the patient's judgment is significantly impaired by psychiatric conditions. Physicians can also use their technical skills to provide or administer a lethal dose that leads to a rapid and painless death. Finally, limiting the number of people authorized to assist suicide or perform euthanasia would enhance accountability and protect against abuse.¹⁰¹

Others frame the argument for assisted suicide and euthanasia more broadly. Another person, such as a family member, might be best able to help the patient achieve relief through death. The patient may not have an established relationship with a

⁹⁶ Brock, 16-17.

⁹⁷ Loewy, 31.

⁹⁸ Diane E. Meier argues that euthanasia and assisted suicide "would likely have a substantially different impact on the ethos of the medical profession." Meier, 35.

⁹⁹ See, e.g., Brock, 21.

¹⁰⁰ Ibid.

¹⁰¹ See, e.g., Weir, 125.

physician, or the patient's physician may be unwilling to comply with the patient's request. In several prominent cases, family members or friends, motivated by compassion, have assisted suicide or caused death. According to some advocates, "mercy-killing" should be established in general as an acceptable defense to criminal prosecution.¹⁰²

Opponents Many physicians and others who oppose assisted suicide and euthanasia believe that the practices undermine the integrity of medicine and the patient-physician relationship. Medicine is devoted to healing and the promotion of human wholeness; to use medical techniques in order to achieve death violates its fundamental values. Even in the absence of widespread abuse, some argue that allowing physicians to act as "beneficent executioners" would undermine patients' trust, and change the way that both the public and physicians view medicine.¹⁰³

Some believe that, while physicians may be motivated by compassion in some cases, a physician abandons the patient in a profound sense when he or she deliberately causes the patient's death.¹⁰⁴ Others note that professionals such as physicians have great power and enjoy significant discretion to use that power prudently. Strict boundaries to prevent the misuse of power are therefore necessary. General professional limits may in some cases impinge on an individual physician's personal sense of vocation, but are needed to maintain public confidence in the profession and guard against abuse.¹⁰⁵

Some object that assisted suicide and euthanasia would be used as a "quick fix" of the kind that is too prevalent in contemporary medical practice.

Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked ... provide a final technical solution for the evil of human finitude and for their own technical failure: If you cannot cure me, kill me.¹⁰⁶

Others note that relying on medical practices to assist suicide removes a natural psychological barrier to the act, leading some individuals to end their lives without facing

¹⁰² Rachels, 2-6, 28-33, 168-70.

¹⁰³ As expressed by a group of four physicians: "If physicians become killers or are even merely licensed to kill, the profession - and, therewith, each individual physician - will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty." W. Gaylin et al., "Doctors Must Not Kill," *Journal of American Medical Association* 259 (1988): 2139-40. See also McKinney, 6-8; D. Orentlicher, "Physician Participation in Assisted Suicide," *Journal of the American Medical Association* 262 (1989): 1844-45. Some physicians writing near the beginning of the century expressed similar concerns. If part of the doctor's role was to cause death in specified cases, "his very presence would necessarily be associated the idea of death. He would enter the sick room, into which he should bring life and hope, with the dark shadow of death behind him." "The Right to Die," in Reiser, Dyck and Curran, 491.

¹⁰⁴ See P. Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970).

¹⁰⁵ Kass, 35.

¹⁰⁶ *Ibid.*

the full implications of the act.¹⁰⁷ Some believe that a judgment about whether to assist suicide or perform euthanasia is not essentially a medical judgment, and falls outside the parameters of the patient-physician relationship.¹⁰⁸ They object to the notion that physicians would be granted special authority to assist suicide or perform euthanasia.

Some believe that assisted suicide or euthanasia performed by physicians would be more problematic than similar actions by other individuals. Because of the risks of abuse and threats to the integrity of the medical profession, it would be particularly objectionable for physicians to participate in these actions. A group of four physicians writes: "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."¹⁰⁹

Finally, some object in particular to the concept of killing as a form of healing or death as cure, arguing that such views resonate with periods in history when the medical profession was used to end human life. While the practice of mass murder in Nazi Germany differs from contemporary proposals for euthanasia, it began with the active killing of the severely ill, and built on earlier proposals advanced by leading German physicians and academics in the 1920s, before the Nazis took power. Like policies currently advocated in the United States, these proposals were limited to the incurably ill, and mandated safeguards such as review panels.¹¹⁰

The Views of Medical Organizations

¹⁰⁷ A. Alvarez writes that "Modern drugs not only have made suicide more or less painless, they have also made it seem magical. A man who takes a knife and slices deliberately across his throat is murdering himself. But when someone lies down in front of an unlit gas oven or swallows sleeping pills, he seems not so much to be dying as merely seeking oblivion for a while." Alvarez, 137. Writing about ancient Greece, Paul Carrick notes that the development of hemlock contributed to a change in the conception of suicide, and to an increase in the suicide rate. Carrick, 130.

¹⁰⁸ "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?" Callahan, "When Self-Determination Runs Amok," 55.

¹⁰⁹ Gaylin et al., 2140. For some, physician participation in assisted suicide and euthanasia raises similar concerns to physician participation in capital punishment: whatever an individual physician's personal beliefs about the practice, to act as a physician in a way that contributes to a person's death would violate one's professional responsibilities. For a recent statement on participation in capital punishment, see American Medical Association, Council on Ethical and Judicial Affairs, "Physician Participation in Capital Punishment," *Journal of the American Medical Association* 270 (1993): 365-68. An argument for distinguishing between physician involvement in capital punishment and physician involvement in euthanasia may be found in Loewy, 29-34.

¹¹⁰ Capron, 32-33; R. J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986), 45-50-1 Veatch, 66-67. Lifton, while distinguishing Nazi "euthanasia" from euthanasia in the Anglo-American context, traces the significance of concepts such as "life unworthy of life" and "killing as a therapeutic imperative" in removing social and psychological barriers against killing and advancing the Nazi program of genocide. "The medicalization of killing - the imagery of killing in the name of healing - was crucial to that terrible step." Lifton, 14-15, 46. See also the recent translation of Karl Binding and Alfred Roche's 1920 work, "Permitting the Destruction of Unworthy Life: Its Extent and Form," trans. W. E. Wright, P. G. Derr, and R. Salomon, *Issues in Law and Medicine* 8 (1992): 231-65.

In recent years, professional organizations -- including the American Medical Association, the American College of Physicians, and the American Geriatrics Society -- have joined the public debate about assisted suicide and euthanasia. The positions embraced by these organizations share several elements. The organizations consistently distinguish assisted suicide and euthanasia from the withdrawing or withholding of treatment, and from the provision of palliative treatments or other medical care that risk fatal side effects.¹¹¹

Professional organizations report that most pain and suffering can be alleviated, but that some patients find their situation so intolerable that they request assisted suicide or euthanasia. Physicians should respond to these patients by exploring their concerns, investigating whether the patient is suffering from depression, and improving palliative care when needed. The organizations generally recognize that assisted suicide or euthanasia might be beneficial to a small number of patients. They note, however, that such actions are illegal, and they express concern that allowing these practices could damage the physician-patient relationship and pose serious risks to vulnerable members of society.¹¹²

Within the framework of this consensus, medical societies have offered somewhat differing views. While not supporting assisted suicide and euthanasia, the American College of Physicians Ethics Manual does not explicitly reject all such actions. The manual recommends that physicians respond to patient requests for euthanasia or assisted suicide by seeking to ascertain and respond to the patient's concerns.¹¹³ In contrast, the American Geriatrics

Society strongly urges physicians not to provide interventions that directly and intentionally cause the patient's death. It also recommends that the current legal prohibition of physician assistance to commit suicide and euthanasia should not be changed.¹¹⁴

¹¹¹ American Medical Association; American College of Physicians, "American College of Physicians Ethics Manual," 3d ed., *Annals of Internal Medicine* 117 (1992): 953-54; American Geriatrics Society, Public Policy Committee, "Voluntary Active Euthanasia," *Journal of the American Geriatrics Society* 39 (1991): 826.

¹¹² *Ibid.*

¹¹³ As stated in the ACP manual: "In most cases, the patient will withdraw the request when pain management, depression, and other concerns have been addressed, but occasionally the issue of physician-assisted suicide needs to be explored in depth. However, our society has not yet arrived at a consensus on assisted suicide and most jurisdictions have specific laws prohibiting such action. Physicians and patients must continue to search together for answers to these problems without violating the physician's personal and professional values and without abandoning the patient to struggle alone." American College of Physicians, 955.

¹¹⁴ As set forth in the organization's policy statement, "Active euthanasia might reasonably be preferred by a few patients with intractable pain or other overwhelming symptoms; however, the benefit of allowing this choice must be weighed against possible abuse of euthanasia on the frail, disabled, and economically disadvantaged members of society. The American Geriatrics Society also expressed its concern that

The Council on Ethical and Judicial Affairs of the American Medical Association similarly states that "physicians must not perform euthanasia or participate in assisted suicide." While these actions may seem beneficial for patients in some sympathetic cases, authorizing physicians to perform them would pose unacceptable risks of allowing mistaken or coerced deaths. It could also gradually distort both public perceptions of medical practice and the practice of medicine itself.¹¹⁵

Killing and Allowing to Die

The debate about euthanasia and assisted suicide takes place against the backdrop of changes in medical practice. Medical developments have increased the number and range of treatment decisions that must be made near the end of life. Decisions to withhold and withdraw life-sustaining treatment in accord with the patient's wishes and interests have become widely accepted in principle, and to an increasing extent in practice. As a result, many physicians have participated in decisions and actions to end life-sustaining treatment, giving them a sense of control over the timing and manner of a patient's death.

Some believe that such actions are essentially similar to assisted suicide and euthanasia. They challenge the commonly accepted distinction between intentional killing, which is viewed as always wrong, and allowing to die, which is accepted in many cases. Many of those who reject this distinction support policies authorizing assisted suicide and euthanasia.¹¹⁶ The current debate about assisted suicide and euthanasia poses questions about whether killing and allowing to die are intrinsically different on ethical grounds, and whether the practices should be distinguished for purposes of social policy.

allowing euthanasia could also lessen patients' trust in physicians, and further weaken society's commitment to provide adequate resources for supportive care. American Geriatrics Society, 826.

¹¹⁵ American Medical Association. The Committee on Bioethical Issues of the Medical Society of the State of New York articulates a similar position in "Physician-Assisted Suicide," *New York State Journal of Medicine* 92 (1992): 391. The National Hospice Organization has adopted a resolution rejecting the practice of euthanasia and assisted suicide. The resolution "reaffirms the hospice philosophy that hospice care neither hastens nor postpones death," and advocates hospice care as an alternative to euthanasia and assisted suicide. Resolution approved by the delegates of the National Hospice Organization, Annual Meeting, November 8, 1990, Detroit, Michigan. The American Nurses Association has not issued a formal position statement on assisted suicide and euthanasia. Some nurses have argued that ANA position papers would suggest a position opposing euthanasia. N. Coyle, 44.

¹¹⁶ Others who reject the distinction oppose decisions to forgo life-sustaining treatment, as well as assisted suicide and euthanasia. Discussion about distinguishing between killing and allowing to die may be found in R. F. Weir, *Abating Treatment with Critically Ill Patients: Ethical and Legal Limits to the Medical Prolongation of Life* (New York: Oxford University Press, 1989), 228-32, 261-68; J. McMahan, "Killing, Letting Die, and Withdrawing Aid," *Ethics* 103 (1993): 250-79; J. Feinberg, *Harm to Others* (New York: Oxford University Press, 1984), 159-63, 171-86, 257-59n; P. Foot, "Morality, Action and Outcome," in *Morality and Objectivity: A Tribute to J. L. Mackie*, ed. T. Honore (London: Routledge and Kegan Paul, 1985), 23-25.

Against the Distinction

Some claim that forgoing treatment cannot be distinguished in principle from taking affirmative steps to end a patient's life because the intentions, motives, and outcomes are identical in both cases. They argue that in each instance, the decision maker seeks the patient's death and is motivated by compassion, and the same result occurs.¹¹⁷ Some supporters of assisted suicide and euthanasia assert that society currently accepts decisions to forgo life-sustaining treatment that effectively constitute killing; for example, withdrawing a respirator or failing to provide artificial nutrition and hydration.

Even if this characterization of current practice is rejected, they argue, killing (or more generally, contributing to a person's death) should not be seen as intrinsically immoral. Ending a person's life is wrong in most cases because it deprives a person of the benefit of continued life, and violates the individual's rights. However, in appropriate cases of assisted suicide or voluntary euthanasia, the patient believes that continued life would not provide a benefit (and, with euthanasia, waives his or her right not to be killed).¹¹⁸ Some patients decide to stop or withhold life-sustaining treatment because they perceive life as a burden and wish to die. In these cases, assisted suicide or euthanasia would end the patient's life and suffering more quickly and effectively than withdrawing or withholding treatment. As one philosopher argues:

If one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made, active euthanasia is actually preferable to passive euthanasia, rather than the reverse.¹¹⁹

Finally, proponents of assisted suicide and euthanasia point out that the potential for mistake or abuse exists for withdrawing and withholding treatment as well. They argue that society has addressed this problem with appropriate safeguards, and could do the same for assisted suicide and euthanasia.

¹¹⁷ Rachels, 106-28, 139-43; Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine*, 78-80. See also J. Fletcher, *Humanhood: Essays in Biomedical Ethics* (Buffalo: Prometheus Press, 1979), 149-58. Rachels describes two cases: Smith, who kills his 6-year-old cousin, and Jones, who intentionally lets his cousin die, both in order to gain an inheritance. He argues that as both acts are equally reprehensible, the "bare difference" between killing and letting die is morally insignificant. Others have criticized such arguments as inconclusive at best. Even if the two cases in the example are equally objectionable, the difference between killing and letting die is significant in other cases. For instance, a person is not morally obligated to endanger his or her own health or spend a large sum of money to save another person, but it would be morally wrong for a person to kill someone actively in order to safeguard his or her health or save that sum of money. Beauchamp and Childress, 136-38; Feinberg, 167-68, citing H. Maim, "Good Samaritan Laws and the Concept of Personal Sovereignty," typescript, University of Arizona (1983), 11.

¹¹⁸ Rachels, *End of Life*, 39-59.

¹¹⁹ Rachels, "Active and Passive Euthanasia," 78-80.

For the Distinction

Despite such claims, the distinction between killing and letting die, in general and in the context of medical decisions, is widely accepted and supported. Many insist that the nature of the action in each case is different. Decisions to withhold or withdraw treatment allow the natural course of the disease to continue. The decision maker determines that certain treatments are not medically appropriate or morally obligatory, and the physician refrains from imposing interventions that legally would constitute battery. Moreover, forgoing treatment does not always result in a patient's immediate death; the patient may continue to live, as in cases of an inaccurate prognosis.¹²⁰

This distinction in the nature of the acts of killing and allowing to die is accompanied by a difference in causation. In one case, the decision maker seeks to cause death and employs direct means to achieve this result. In the other, the decision maker accepts but does not cause the person's death, which is caused by the underlying illness or condition. Paul Ramsey, for example, argues that forgoing treatment is not simply an indirect means of killing. "In omission no human agent causes the patient's death, directly or indirectly. He dies his own death from causes that it is no longer merciful or reasonable to fight by means of possible medical interventions."¹²¹

For many, the prohibition against actively and intentionally killing innocent persons represents a basic moral and social norm. Diverse philosophical and religious perspectives affirm this view.¹²² Some also contend that the psychological effect on professionals and family are different in cases of killing and allowing to die.¹²³

For others, the crucial distinction lies in the different consequences of policies of killing and of allowing to die. A practice of accepted killing is more vulnerable to abuse in particular cases, and poses a greater risk of harm to others in society. Some focus on the role of the distinction in the context of law and public policy. As articulated by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the prohibition of active killing is part of "an accommodation that adequately protects human life while not resulting in officious overtreatment of

¹²⁰ Beauchamp and Childress, 144; Weir, Abating Treatment, 316-18; Ramsey, 153. See also G. R. Scofield "Privacy (or Liberty) and Assisted Suicide," *Journal of Pain and Symptom Management* 6 (1991): 283.

¹²¹ Ramsey, 151. See also Callahan, "When Self-Determination Runs Amok," 53-54; McMahan, 263, 271. The two types of cases also tend to be characterized by different intentions. See Weir, Abating Treatment, 310-11; G. Meilaender, "The Distinction Between Killing and Allowing to Die," *Theological Studies* 37 (1976): 468-69.

¹²² see pp. 9-10.

¹²³ This argument was put forward as early as 1884 in an editorial in the *Boston Medical and Surgical Journal*: "Perhaps logically it is difficult to justify a passive more than an active attempt at euthanasia; but certainly it is less abhorrent to our feelings. To surrender to superior forces is not the same thing as to lead the attack of the enemy upon one's friends. May there not come a time when it is a duty in the interest of the survivors to stop a fight which is only prolonging a useless and hopeless struggle?" "Permissive Euthanasia," in Fye, 501-2.

dying patients," and "helps to produce the correct decision in the great majority of cases."¹²⁴

Some argue that the negative effects of active killing on those involved and on society are stronger, and the potential scope of abuse wider, than with allowing patients to die.¹²⁵ Additionally, patients have a strong moral and legal right to refuse treatment. Respecting decisions to forgo treatment recognizes this right to be let alone and the moral obligation not to impose treatment coercively. In contrast, people do not have the same basic right to active participation by others in achieving their death. Society's refusal to allow another person to assist suicide or to cause death directly does not impose the same burden on the patient that would result from forced medical interventions.¹²⁶

¹²⁴ President's Commission, 70-73.

¹²⁵ See the discussion of risks posed by euthanasia throughout this chapter and in chapter 6.

¹²⁶ See, e.g., Veatch, 67.