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Voluntary Active Euthanasia

by Dan W. Brock

Since the case of Karen Quinlan first seized public attention fifteen years ago, no issue in biomedical ethics has been more prominent than the debate about forgoing life-sustaining treatment. Controversy continues regarding some aspects of that debate, such as forgoing life-sustaining nutrition and hydration, and relevant law varies some from state to state. Nevertheless, I believe it is possible to identify an emerging consensus that competent patients, or the surrogates of incompetent patients, should be permitted to weigh the benefits and burdens of alternative treatments, including the alternative of no treatment, according to the patient's values, and either to refuse any treatment or to select from among available alternative treatments. This consensus is reflected in bioethics scholarship, in reports of prestigious bodies such as the President's Commission for the Study of Ethical Problems in Medicine, The Hastings Center, and the American Medical Association, in a large body of judicial decisions in courts around the country, and finally in the beliefs and practices of health care professionals who care for dying patients.¹

More recently, significant public and professional attention has shifted from life-sustaining treatment to euthanasia—more specifically, voluntary active euthanasia—and to physician-assisted suicide. Several factors have contributed to the increased interest in euthanasia. In the Netherlands, it has been openly practiced by physicians for several years with the acceptance of the country's highest court.² In 1988 there was an unsuccessful attempt to get the

question of whether it should be made legally permissible on the ballot in California. In November 1991 voters in the state of Washington defeated a widely publicized referendum proposal to legalize both voluntary active euthanasia and physician-assisted suicide. Finally, some cases of this kind, such as "It's Over, Debbie," described in the *Journal of the American Medical Association*, the "suicide machine" of Dr. Jack Kevorkian, and the cancer patient "Diane" of Dr. Timothy Quill, have captured wide public and professional attention.³ Unfortunately, the first two of these cases were sufficiently problematic that even most supporters of euthanasia or assisted suicide did not defend the physicians' actions in them. As a result, the subsequent debate they spawned has often shed more heat than light. My aim is to increase the light, and perhaps as well to reduce the heat, on this important subject by formulating and evaluating the central ethical arguments for and against voluntary active euthanasia and physician-assisted suicide. My evaluation of the arguments leads me, with reservations to be noted, to support permitting both practices. My primary aim, however, is not to argue for euthanasia, but to identify confusions in some common arguments, and problematic assumptions and claims that need more defense or data in others. The issues are considerably more complex than either supporters or opponents often make out; my hope is to advance the debate by focusing attention on what I believe the real issues under discussion should be.

In the recent bioethics literature some have endorsed physician-assisted suicide but not euthanasia.⁴ Are they sufficiently different that the moral arguments for one often do not apply to the other? A paradigm case of physician-assisted suicide is a patient's ending his or her life with a lethal dose of a medication requested of and pro-

vided by a physician for that purpose. A paradigm case of voluntary active euthanasia is a physician's administering the lethal dose, often because the patient is unable to do so. The only difference that need exist between the two is the person who actually administers the lethal dose—the physician or the patient. In each, the physician plays an active and necessary causal role.

In physician-assisted suicide the patient acts last (for example, Janet Adkins herself pushed the button after Dr. Kevorkian hooked her up to his suicide machine), whereas in euthanasia the physician acts last by performing the physical equivalent of pushing the button. In both cases, however, the choice rests fully with the patient. In both the patient acts last in the sense of retaining the right to change his or her mind until the point at which the lethal process becomes irreversible. How could there be a substantial moral difference between the two based only on this small difference in the part played by the physician in the causal process resulting in death? Of course, it might be held that the moral difference is clear and important—in euthanasia the physician kills the patient whereas in physician-assisted suicide the patient kills him- or herself. But this is misleading at best. In assisted suicide the physician and patient together kill the patient. To see this, suppose a physician supplied a lethal dose to a patient with the knowledge and intent that the patient will wrongfully administer it to another. We would have no difficulty in morality or the law recognizing this as a case of joint action to kill for which both are responsible.

If there is no significant, intrinsic moral difference between the two, it is also difficult to see why public or legal policy should permit one but not the other; worries about abuse or about giving anyone dominion over the lives of others apply equally to either. As a result, I will take the arguments evaluated below to apply to both and will focus on euthanasia.

My concern here will be with *voluntary* euthanasia only—that is, with the case in which a clearly competent patient makes a fully voluntary and persistent request for aid in dying. Involuntary euthanasia, in which a competent patient explicitly refuses or opposes receiving euthanasia, and nonvoluntary

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euthanasia, in which a patient is incompetent and unable to express his or her wishes about euthanasia, will be considered here only as potential unwanted side-effects of permitting voluntary euthanasia. I emphasize as well that I am concerned with *active* euthanasia, not withholding or withdrawing life-sustaining treatment, which some commentators characterize as "passive euthanasia." Finally, I will be concerned with euthanasia where the motive of those who perform it is to respect the wishes of the patient and to provide the patient with a "good death," though one important issue is whether a change in legal policy could restrict the performance of euthanasia to only those cases.

A last introductory point is that I will be examining only secular arguments about euthanasia, though of course many people's attitudes to it are inextricable from their religious views. The policy issue is only whether euthanasia should be permissible, and no one who has religious objections to it should be required to take any part in it, though of course this would not fully satisfy some opponents.

The Central Ethical Argument for Voluntary Active Euthanasia

The central ethical argument for euthanasia is familiar. It is that the very same two fundamental ethical values supporting the consensus on patient's rights to decide about life-sustaining treatment also support the ethical permissibility of euthanasia. These values are individual self-determination or autonomy and individual well-being. By self-determination as it bears on euthanasia, I mean people's interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life, and in being left free to act on those decisions. Self-determination is valuable because it permits people to form and live in accordance with their own conception of a good life, at least within the bounds of justice and consistent with others doing so as well. In exercising self-determination people take responsibility for their lives and for the kinds of persons they become. A central aspect of human dignity lies in people's capacity to direct their lives in this way. The value of exercising self-

termination presupposes some minimum of decisionmaking capacities or competence, which thus limits the scope of euthanasia supported by self-determination; it cannot justifiably be administered, for example, in cases of serious dementia or treatable clinical depression.

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

The other main value that supports euthanasia is individual well-being. It might seem that individual well-being conflicts with a person's self-determination when the person requests euthanasia. Life itself is commonly taken to be a central good for persons, often valued for its own sake, as well as necessary for pursuit of all other goods within a life. But when a competent patient decides to forgo all further life-sustaining treatment then the patient, either explicitly or implicitly, commonly decides that the best life possible for him or her with treatment is of sufficiently poor quality that it is worse than no further life at all. Life

is no longer considered a benefit by the patient, but has now become a burden. The same judgment underlies a request for euthanasia: continued life is seen by the patient as no longer a benefit, but now a burden. Especially in the often severely compromised and debilitated states of many critically ill or dying patients, there is no objective standard, but only the competent patient's judgment of whether continued life is no longer a benefit.

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

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

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

'I Gave Him All the Morphine . . . in My Bag. It Wasn't Easy.'

"I've never shared this with anyone," says the retired internist, who looks like the subject of an Andrew Wyeth painting. "Not with the patient's family, not with anyone else. I've never even told my wife about this one. This was probably the toughest one."

The patient was a retired business executive and attorney in his early 70s, whose attention to physical fitness could only be described as a fetish and for whom control was the dominant element in his life. He was used to doing things his way, including leaving home and business for up to two months a year to travel the globe in search of high adventure.

"He developed colon cancer and had some problems with intestinal obstruction and was clearly headed for a kind of miserable end, not just pain, but obstruction and vomiting, a demeaning thing that he just could not think of facing."

Not unexpectedly, having so controlled his life, the patient wanted to control his death. The physician agreed and gave him a hypodermic of morphine to keep in a jar in his bedroom.

But as often happens in such cases, as the cancer spread the patient was given ever increasing doses of morphine with a home IV pump, and he developed a tolerance for the drug. Clearly, the physician thought, the single syringe was not going to do the job.

"I didn't want to go through the scenario I did with another patient, where he'd taken something and not have it work. I knew that the morphine would never do it—on the other hand I never carry anything in my bag that's adequate to resolve the problem. But I had thought that probably two full, 20cc, ampules of morphine would be sufficient. So I went up and talked with him," says the physician, and the patient told him he wanted out.

"He said, 'I don't want to get you in any legal trouble,' and I said, 'No, that's my problem'—he didn't want me to jeopardize myself. I didn't make him sign anything, or make him say . . . [what he wanted] in so many words, but we had a clear understanding that this was it. The family waited in the dining room, the son and the mother. They didn't know what I was doing and they never asked.

"I gave him all the morphine and all the atropine I had in my bag. It wasn't easy. It's the only time I've ever done this, but I felt in his case that it was extraordinary. He never felt anything and it worked all right. I think his wife knows and is very grateful, but I've never discussed it."

The physician is convinced he did the right thing in killing his patient of many years, yet the act does not sit easily. "It's just the uncomfortable feeling that you are the actual mechanism. It's a step that we normally take when we say, 'I'm not going to give antibiotics for this bout of pneumonia in this person who's comatose.'"

"It's the only time I've ever done anything that direct. It's not part of your training, it's not part of the Hippocratic oath, it's not part of anything that's justified. And yet, I felt that there was no other solution to the situation, and when you take on medicine you put yourself through uncomfortable situations, hopefully for the benefit of your patients."

*From "Death on Request" by B. D. Colen.
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permit it. The first kind of argument focuses on features of any individual case of euthanasia, while the second kind focuses on social or legal policy. In the next section I consider the first kind of argument.

Euthanasia Is the Deliberate Killing of an Innocent Person

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

In the context of medicine, the ethical prohibition against deliberately killing the innocent derives some of its plausibility from the belief that nothing in the currently accepted practice of medicine is deliberate killing. Thus, in commenting on the "It's Over, Debbie" case, four prominent physicians and bioethicists could entitle their paper "Doctors Must Not Kill."⁵ The belief that doctors do not in fact kill requires the corollary belief that forgoing life-sustaining treatment, whether by not starting or by stopping treatment, is allowing to die, not killing. Common though this view is, I shall argue that it is confused and mistaken.

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

certainly cause the patient's death. The common understanding is that the physician thereby allows the patient to die. But is that correct?

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

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

The difference between killing and allowing to die that I have been implicitly appealing to here is roughly that between acts and omissions resulting in death.⁶ Both the physician and the greedy son act in a manner intended to cause death, do cause death, and so

both kill. One reason this conclusion is resisted is that on a different understanding of the distinction between killing and allowing to die, what the physician does is allow to die. In this account, the mother's ALS is a lethal disease whose normal progression is being held back or blocked by the life-sustaining respirator treatment. Removing this ar-

The characterization as allowing to die is meant to shift felt responsibility away from the agent—the physician—and to the lethal disease process. Other language common in death and dying contexts plays a similar role; "letting nature take its course" or "stopping prolonging the dying process" both seem to shift responsibility from the physician who

Killing patients is not understood to be part of physicians' job description, but some killings are ethically justified, including many instances of stopping life support.

tificial intervention is then viewed as standing aside and allowing the patient to die of her underlying disease. I have argued elsewhere that this alternative account is deeply problematic, in part because it commits us to accepting that what the greedy son does is to allow to die, not kill.⁷ Here, I want to note two other reasons why the conclusion that stopping life support is killing is resisted.

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

Another reason for resisting the conclusion that stopping life support is often killing is that it is psychologically uncomfortable. Suppose the physician had stopped the ALS patient's respirator and had made the son's claim, "I didn't kill her, I merely allowed her to die. It was her ALS disease that caused her death." The clue to the psychological role here is how naturally the "merely" modifies "allowed her to die."

stops life support to the fatal disease process. However psychologically helpful these conceptualizations may be in making the difficult responsibility of a physician's role in the patient's death bearable, they nevertheless are confusions. Both physicians and family members can instead be helped to understand that it is the patient's decision and consent to stopping treatment that limits their responsibility for the patient's death and that shifts that responsibility to the patient.

Many who accept the difference between killing and allowing to die as the distinction between acts and omissions resulting in death have gone on to argue that killing is not in itself morally different from allowing to die.⁸ In this account, very roughly, one kills when one performs an action that causes the death of a person (we are in a boat, you cannot swim, I push you overboard, and you drown), and one allows to die when one has the ability and opportunity to prevent the death of another, knows this, and omits doing so, with the result that the person dies (we are in a boat, you cannot swim, you fall overboard, I don't throw you an available life ring, and you drown). Those who see no moral difference between killing and allowing to die typically employ the strategy of comparing cases that differ in these and no other potentially morally important respects. This will allow people to consider whether the mere difference that one is a case of killing and the other of allowing to die matters morally, or whether instead it is other features that make most cases of

killing worse than most instances of allowing to die. Here is such a pair of cases:

Case 1. A very gravely ill patient is brought to a hospital emergency room and sent up to the ICU. The patient begins to develop respiratory failure that is likely to require intubation very soon. At that point the patient's family members and long-standing physician arrive at the ICU and inform the ICU staff that there had been extensive discussion about future care with the patient when he was unquestionably competent. Given his grave and terminal illness, as well as his state of debilitation, the patient had firmly rejected being placed on a respirator under any circumstances, and the family and physician produce the patient's advance directive to that effect. The ICU staff do not intubate the patient, who dies of respiratory failure.

Case 2. The same as Case 1 except that the family and physician are slightly delayed in traffic and arrive shortly after the patient has been intubated and placed on the respirator. The ICU staff extubate the patient, who dies of respiratory failure.

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

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

these plans and desires as well. In a nutshell, wrongful killing deprives a person of a valued future, and of all the person wanted and planned to do in that future.

A natural expression of this account of the wrongness of killing is that people have a moral right not to be killed.⁹ But in this account of the wrongness of killing, the right not to be killed, like other rights, should be waivable when the person makes a competent decision that continued life is no longer wanted or a good, but is instead worse than no further life at all. In this view, euthanasia is properly understood as a case of a person having waived his or her right not to be killed.

This rights view of the wrongness of killing is not, of course, universally shared. Many people's moral views about killing have their origins in religious views that human life comes from God and cannot be justifiably destroyed or taken away, either by the person whose life it is or by another. But in a pluralistic society like our own with a strong commitment to freedom of religion, public policy should not be grounded in religious beliefs which many in that society reject. I turn now to the general evaluation of public policy on euthanasia.

Would the Bad Consequences of Euthanasia Outweigh the Good?

The argument against euthanasia at the policy level is stronger than at the level of individual cases, though even here I believe the case is ultimately unpersuasive, or at best indecisive. The policy level is the place where the main issues lie, however, and where moral considerations that might override arguments in favor of euthanasia will be found, if they are found anywhere. It is important to note two kinds of disagreement about the consequences for public policy of permitting euthanasia. First, there is empirical or factual disagreement about what the consequences would be. This disagreement is greatly exacerbated by the lack of firm data on the issue. Second, since on any reasonable assessment there would be both good and bad consequences, there are moral disagreements about the relative importance of different effects. In addition to these two sources of disagreement, there is

also no single, well-specified policy proposal for legalizing euthanasia on which policy assessments can focus. But without such specification, and especially without explicit procedures for protecting against well-intentioned misuse and ill-intentioned abuse, the consequences for policy are largely speculative. Despite these difficulties, a preliminary account of the main likely good and bad consequences is possible. This should help clarify where better data or more moral analysis and argument are needed, as well as where policy safeguards must be developed.

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

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

A second good consequence of making euthanasia legally permissible benefits a much larger group. Polls have shown that a majority of the American public believes that people should have a right to obtain euthanasia if they want it.¹⁰ No doubt the vast majority of

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

A third good consequence of the legalization of euthanasia concerns patients whose dying is filled with severe and unrelievable pain or suffering. When there is a life-sustaining treatment that, if forgone, will lead relatively quickly to death, then doing so can bring an end to these patients' suffering without recourse to euthanasia. For patients receiving no such treatment, however, euthanasia may be the only release from their otherwise prolonged suffering and agony. This argument from mercy has always been the strongest argument for euthanasia in those cases to which it applies.¹¹

The importance of relieving pain and suffering is less controversial than is the frequency with which patients are forced to undergo untreatable agony that only euthanasia could relieve. If we focus first on suffering caused by physical pain, it is crucial to distinguish pain that *could* be adequately relieved with modern methods of pain control, though it in fact is not, from pain that is relievable only by death.¹² For a variety of reasons, including some physicians' fear of hastening the patient's death, as well as the lack of a publicly accessible means for assessing the amount of the

'She Wanted Out Now'

An internist, who three times in twenty-seven years has provided terminally ill patients with the means to kill themselves, recalls when he provided aid-in-dying to a patient he barely knew.

A woman in her fifties, who was dying of breast cancer that had metastasized throughout her body, "somehow or other knew that I was interested in this subject of the dying patient, so she called me up on the phone one day," the physician recalls. "She lived in a neighboring town, five or six miles away, and asked if she could come see me about a very important matter concerning her final illness."

When the woman arrived in the physician's office it turned out that what "she wanted was to have me assist her in dying with a prescription for pills, because her physician would not. She'd been a patient of some physicians at a cancer center and had had beautiful care. They'd done quite well by her. But at this point she had absolutely run out of options and there was nothing more that could be done. And she was miserable. She had a tightly distended abdomen, was highly uncomfortable and in moderately severe pain and just was generally miserable. And she wanted out. She wanted out now.

"After listening to her and talking with her and her husband, I said I was unwilling to do anything for her unless she was my patient," the physician recalls, stressing both that he had to convince himself of the woman's medical need, and protect himself against possible legal repercussions.

The woman and the internist each spoke by phone with the woman's specialist, explaining that she wanted to be cared for by the internist, and her records were transferred to him. The following day, the internist says, "I had her come back and did a complete physical and history and wrote it all down so it was thoroughly documented that this was a patient of mine.

"Then I gave her husband a prescription for sleeping pills in his name and I gave her one. Her husband took them to two different drug stores and within a day or two she took the pills. He called me up early one morning and said she had died overnight. He was aware when she took the pills and helped her with this. Then he went to another part of the house and returned a few hours later and she had died. That was good.

"This was all relatively compressed in time; from the time I first met her until she took the pills and died was a matter of a week," he acknowledges. "In this instance I felt perfectly okay about it because I was so convinced her disease was so far progressed. And her husband was highly supportive, and after this he continued to be my patient and on a number of occasions expressed his gratitude for what I had done.

"I think you draw the line at your own sense of comfort about it," the internist says. "Each of the instances that I've had anything to do with, either withdrawing treatment or assisting in suicide, they've all been instances that I have felt perfectly okay about. The situation has been so bad, clearly so bad, that I didn't have a problem with it in my own mind. Now this sets me up as the judge, and I don't claim to be all knowing. But in the instances where it was really needed, it seemed to me to be so clear cut, and there was no alternative.

"It's not a matter of killing patients. There's a difference between euthanasia and assisted suicide. The physician is involved in helping facilitate, yes, but the patient does the final act, and there is a difference there."

*From "Death on Request" by B. D. Colen
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patient's pain, many patients suffer pain that could be, but is not, relieved.

Specialists in pain control, as for example the pain of terminally ill cancer patients, argue that there are very few patients whose pain could not be adequately controlled, though sometimes at the cost of so sedating them that they are effectively unable to interact with other people or their environment. Thus, the argument from mercy in cases of physical pain can probably be met in a large majority of cases by providing adequate measures of pain relief. This should be a high priority, whatever our legal policy on euthanasia—the relief of pain and suffering has long been, quite properly, one of the central goals of medicine. Those cases in which pain could be effectively relieved, but in fact is not, should only count significantly in favor of legalizing euthanasia if all reasonable efforts to change pain management techniques have been tried and have failed.

Dying patients often undergo substantial psychological suffering that is not fully or even principally the result of physical pain.¹³ The knowledge about how to relieve this suffering is much more limited than in the case of relieving pain, and efforts to do so are probably more often unsuccessful. If the argument from mercy is extended to patients experiencing great and unrelievable psychological suffering, the numbers of patients to which it applies are much greater.

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

loved ones and might otherwise expect for themselves.

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

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

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

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

We call on fellow physicians to say that they will not deliberately kill. We must also say to each of our fellow physicians that we will not tolerate killing of patients and that we shall take disciplinary action against doctors who kill. And we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing.¹⁴

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

Might Gaylin and his colleagues nevertheless be correct in their claim that the moral center of medicine would collapse if physicians were to become killers? This question raises what at the deepest level should be the guiding aims of medicine, a question that obviously cannot be fully explored here. But I do want to say enough to indicate the direction that I believe an appropriate response to this challenge should take. In spelling out above what I called the positive argument for voluntary active euthanasia, I suggested that two principal values—respecting patients' self-determination and promoting their well-being—underlie the consensus that competent patients, or the surrogates of incompetent patients, are entitled to refuse any life-sustaining treatment and to choose from among available alternative treatments. It is the commitment to these two values in guiding physicians' actions as healers, comforters, and protectors of their patients' lives that should be at the “moral center” of medicine, and these two values support physicians' administering euthanasia when their patients make competent requests for it.

What should not be at that moral center is a commitment to preserving patients' lives as such, without regard to whether those patients want their lives preserved or judge their preservation a benefit to them. Vitalism has been rejected by most physicians, and despite some statements that suggest it, is almost certainly not what Gaylin and col-

leagues intended. One of them, Leon Kass, has elaborated elsewhere the view that medicine is a moral profession whose proper aim is "the naturally given end of health," understood as the wholeness and well-working of the human being; "for the physician, at least, human life in living bodies commands respect and reverence—*by its very nature*." Kass continues, "the deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself."¹⁵ I believe Kass is in the end mistaken about the proper account of the aims of medicine and the limits on physicians' power, but this difficult issue will certainly be one of the central themes in the continuing debate about euthanasia.

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

This second worry is difficult to assess because there is little firm evidence about the likelihood of the feared erosion in the care of dying patients. There are at least two reasons, however, for skepticism about this argument. The first is that the same worry could have been directed at recognizing patients' or surrogates' rights to forgo life-sustaining treatment, yet there is no persuasive evidence that recognizing the right to refuse treatment has caused a serious erosion in the quality of care of dying patients. The second reason for skepticism about this worry is that only a very small proportion of deaths would

occur from euthanasia if it were permitted. In the Netherlands, where euthanasia under specified circumstances is permitted by the courts, though not authorized by statute, the best estimate of the proportion of overall deaths that result from it is about 2 percent.¹⁶ Thus, the vast majority of critically ill and dying patients will not request it, and so will still have to be cared for by physicians, families, and others. Permitting euthanasia should not diminish people's commitment and concern to maintain and improve the care of these patients.

A third possible bad consequence of permitting euthanasia (or even a public discourse in which strong support for euthanasia is evident) is to threaten the progress made in securing the rights of patients or their surrogates to decide about and to refuse life-sustaining treatment.¹⁷ This progress has been made against the backdrop of a clear and firm legal prohibition of euthanasia, which has provided a relatively bright line limiting the dominion of others over patients' lives. It has therefore been an important reassurance to concerns about how the authority to take steps ending life might be misused, abused, or wrongly extended.

Most agree, however, that increased involvement of the courts in these decisions would be undesirable, as it would make sound decisionmaking more cumbersome and difficult without sufficient compensating benefits.

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

The legal rights of competent patients to decide about treatment are very firmly embedded in a long line of informed consent and life-sustaining treatment cases, and are not likely to be eroded by a debate over euthanasia.

Many supporters of the right of patients or their surrogates to refuse treatment strongly oppose euthanasia, and if forced to choose might well withdraw their support of the right to refuse treatment rather than accept euthanasia. Public policy in the last fifteen years has generally let life-sustaining treatment decisions be made in health care settings between physicians and patients or their surrogates, and without the involvement of the courts. However, if euthanasia is made legally permissible greater involvement of the courts is likely, which could in turn extend to a greater court involvement in life-sustaining treatment decisions.

of institutional ethics committees shows.

The fourth potential bad consequence of permitting euthanasia has been developed by David Velleman and turns on the subtle point that making a new option or choice available to people can sometimes make them worse off, even if once they have the choice they go on to choose what is best for them.¹⁸ Ordinarily, people's continued existence is viewed by them as given, a fixed condition with which they must cope. Making euthanasia available to people as an option denies them the alternative of staying alive by default. If people are offered the option of eutha-

Death Wish Honored, Despite Doubts

That an action is legal does not necessarily make it any less gut-wrenching, as a physician learned when he participated in what might be termed court-sanctioned euthanasia.

As he vividly recalls the incident, a woman in her forties awoke from a neurosurgical attempt to remove a slow-growing, malignant brain tumor, only to find herself a respirator-dependent quadriplegic. A vital, independent woman used to controlling all aspects of her life, she attempted in her last year to adjust.

"When I saw her I think she'd been on a respirator for about two-and-a-half years," says the physician. "She'd gone through a lot of physical therapy and was seen by a lot of doctors, and after a year began asking much more vigorously for the respirator to be turned off. But she couldn't find anybody who would do it—which kind of surprises me because this was only a couple of years ago."

The woman decided to take her case to court, and the physician, an expert on the care of the dying, was asked to evaluate her. "She was being cared for by a couple of nurses in a hospice program, and they thought I would just come in that day and turn off the respirator. But I did a fairly prolonged evaluation on her that took weeks, and had her seen by other people." Despite that, and despite speaking to the physicians who had cared for her over the two years, the physician says he couldn't understand the woman's reasons for wanting to end her life.

"I'm not sure I ever had a good feeling for why she felt this way, but she just felt life was not worth living if you couldn't be independent, that it was not enough to talk and eat and move around and get out in her van. She lived mostly in a wheelchair, was really independent at home. But there was just a strong sense that life was not worth living."

The judge who heard the woman's case agreed that she had a right to refuse life-sustaining treatment, and he issued an order protecting any medical personnel who turned off the machine.

The physician agreed to help the woman, but had problems. "In the first place, I didn't know how to turn off a respirator and have her comfortable, and I didn't know how to find out about it either—that's not something one learns how to do in medical school. I had to make some phone calls that I felt very uncomfortable about, to people who I thought would know about it, but it wasn't like I could just read about it or pick up a book. One of the problems is even if you're going to do it, how do you do it without harming people?"

He continues: "There were lots of discussions about how to do it, who was going to be in the room, and so on and so forth, and the family decided they wanted to be outside the room—she was in her bedroom and they wanted to be in the living room, although as it turns out, they all came in. And the two nurses who had been caring for her for

many months wanted to be there, so in essence it was done with the whole family there.

"She was lying in her bed. She said her final goodbyes to everybody, kissing them and crying. It wasn't enormously demonstrative at this point, but it had been going on for years and she had been saying goodbye for weeks. I remember one of the nurses was just fed up and wanted to get it over with."

"I'd sort of bitten the bullet at that point," says the physician, to whom dying and death were old companions, "but I was scared. I was worried that something might go wrong with the medicine, I worried that I'd botch it. I'd gotten some advice, and I'd had backups, but . . . I put in an intravenous line and gave her opioids and barbiturates to put her to sleep. She was deeply asleep and unresponsive to pain and we turned off the respirator," he says, pausing and sighing deeply.

"She continued to breathe for another ten, fifteen, minutes and we kind of watched her slowly stop breathing. It was a very painful experience. My head knew . . . felt . . . that this was what she wanted and it was the right thing, and everybody had agreed to it. But it was sort of awful to watch somebody who I basically felt was viable and able to lead a meaningful life from my viewpoint, to see her die. It was pretty ugly and pretty much made me decide not to do that again. I had distasteful feelings and a gut reaction that this was not something I wanted to do."

The physician says that ethical terms and distinctions are useful, but he recognizes that the woman's case blurred them. "You could say that we just withdrew treatment and gave her something to make her comfortable, or you could say that we took her life. But I don't think it matters. What matters to me is this is what she wanted."

"She'd been given everything to lead a happier life. She was not depressed; that was the conclusion reached by three sets of competent psychiatrists. She'd even been medicated with the presumption that she might be depressed and that might help her. She wasn't physically suffering. There was no financial incentive. Her family seemed happy to have her around. This was her choice ultimately, and something that had been her wish for a year, or two years or three years was not going to change, as far as I could see. I guess the other side is she felt like it was a living hell."

However, he adds, while he believes he did the right thing, "it really goes against the grain to kill somebody, to do something of this sort. There's a real potential to tarnish one's image, something that's important . . . if patients think you can turn against them and kill them."

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nasia, their continued existence is now a choice for which they can be held responsible and which they can be asked by others to justify. We care, and are right to care, about being able to justify ourselves to others. To the extent that our society is unsympathetic to justifying a severely dependent or impaired existence, a heavy psychological burden of proof may be placed on patients who think their terminal illness or chronic infirmity is not a sufficient reason for dying. Even if they otherwise view their life as worth living, the opinion of others around them that it is not can threaten their reason for living and make euthanasia a rational choice. Thus the existence of the option becomes a subtle pressure to request it.

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

would be to deny it to most who would want it.

A fifth potential bad consequence of making euthanasia legally permissible is that it might weaken the general legal prohibition of homicide. This prohibition is so fundamental to civilized society, it is argued, that we should do nothing that erodes it. If most cases of stopping life support are killing, as I have already argued, then the court cases permitting such killing have already in effect weakened this prohibition. However, neither the courts nor most people have seen these cases as killing and so as challenging the prohibition of homicide. The courts have usually grounded patients' or their surrogates' rights to refuse life-sustaining treatment in rights to privacy, liberty, self-determination, or bodily integrity, not in exceptions to homicide laws.

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

worries about this weakening can be captured in the final potential bad consequence, to which I will now turn.

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

Slippery slope arguments of this form are problematic and difficult to evaluate.¹⁹ From one perspective, they are the last refuge of conservative defenders of the status quo. When all the opponent's objections to the wrongness of euthanasia itself have been met, the opponent then shifts ground and acknowledges both that it is not in itself wrong and that a legal policy which resulted only in its being performed would not be bad. Nevertheless, the opponent maintains, it should still not be permitted because doing so would result in its being performed in other cases in which it is not voluntary and would be wrong. In this argument's most extreme form, permitting euthanasia is the first and fateful step down the slippery slope to Nazism. Once on the slope we will be unable to get off.

Now it cannot be denied that it is *possible* that permitting euthanasia could have these fateful consequences, but that cannot be enough to warrant prohibiting it if it is otherwise justified. A similar *possible* slippery slope worry could have been raised to securing competent patients' rights to decide about life support, but recent history shows such a worry would have been unfounded. It must be relevant how likely it is that we will end with horrendous consequences and an unjustified practice of euthanasia. How *likely* and *widespread* would the abuses and unwarranted extensions of permitting it be? By abuses, I mean the performance of euthanasia that fails to satisfy the conditions required for vol-

untary active euthanasia, for example, if the patient has been subtly pressured to accept it. By unwarranted extensions of policy, I mean later changes in legal policy to permit not just voluntary euthanasia, but also euthanasia in cases in which, for example, it need not be fully voluntary. Opponents of voluntary euthanasia on slippery slope grounds

determination. Such additional restrictions might, however, be justified by concern for limiting potential harms from abuse. At the same time, it is important not to impose procedural or substantive safeguards so restrictive as to make euthanasia impermissible or practically infeasible in a wide range of justified cases.

ture, in the courts since *Quinlan*, and in norms of medical practice, that right has been extended to incompetent patients and exercised by a surrogate who is to decide as the patient would have decided in the circumstances if competent.²² It has been held unreasonable to continue life-sustaining treatment that the patient would not have wanted just because the patient now lacks the capacity to tell us that. Life-sustaining treatment for incompetent patients is today frequently forgone on the basis of a surrogate's decision, or less frequently on the basis of an advance directive executed by the patient while still competent. The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient (acting with or without a formal advance directive from the patient) may well extend the scope of active euthanasia. The argument will be, Why continue to force unwanted life on patients just because they have now lost the capacity to request euthanasia from us?

A related phenomenon may reinforce this slippery slope concern. In the Netherlands, what the courts have sanctioned has been clearly restricted to voluntary euthanasia. In itself, this serves as some evidence that permitting it need *not* lead to permitting the non-voluntary variety. There is some indication, however, that for many Dutch physicians euthanasia is no longer viewed as a special action, set apart from their usual practice and restricted only to competent persons.²³ Instead, it is seen as one end of a spectrum of caring for dying patients. When viewed in this way it will be difficult to deny euthanasia to a patient for whom it is seen as the best or most appropriate form of care simply because that patient is now incompetent and cannot request it.

Even if voluntary active euthanasia should slip into nonvoluntary active euthanasia, with surrogates acting for incompetent patients, the ethical evaluation is more complex than many opponents of euthanasia allow. Just as in the case of surrogates' decisions to forgo life-sustaining treatment for incompetent patients, so also surrogates' decisions to request euthanasia for incompetent persons would often accurately reflect what the incompetent person would have wanted and would deny

The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient may well extend the scope of active euthanasia.

have not provided the data or evidence necessary to turn their speculative concerns into well-grounded likelihoods.

It is at least clear, however, that both the character and likelihood of abuses of a legal policy permitting euthanasia depend in significant part on the procedures put in place to protect against them. I will not try to detail fully what such procedures might be, but will just give some examples of what they might include:

1. The patient should be provided with all relevant information about his or her medical condition, current prognosis, available alternative treatments, and the prognosis of each.

2. Procedures should ensure that the patient's request for euthanasia is stable or enduring (a brief waiting period could be required) and fully voluntary (an advocate for the patient might be appointed to ensure this).

3. All reasonable alternatives must have been explored for improving the patient's quality of life and relieving any pain or suffering.

4. A psychiatric evaluation should ensure that the patient's request is not the result of a treatable psychological impairment such as depression.²⁰

These examples of procedural safeguards are all designed to ensure that the patient's choice is fully informed, voluntary, and competent, and so a true exercise of self-determination. Other proposals for euthanasia would restrict its permissibility further—for example, to the terminally ill—a restriction that cannot be supported by self-

These examples of procedural safeguards make clear that it is possible to substantially reduce, though not to eliminate, the potential for abuse of a policy permitting voluntary active euthanasia. Any legalization of the practice should be accompanied by a well-considered set of procedural safeguards together with an ongoing evaluation of its use. Introducing euthanasia into only a few states could be a form of carefully limited and controlled social experiment that would give us evidence about the benefits and harms of the practice. Even then firm and uncontroversial data may remain elusive, as the continuing controversy over what has taken place in the Netherlands in recent years indicates.²¹

The Slip into Nonvoluntary Active Euthanasia. While I believe slippery slope worries can largely be limited by making necessary distinctions both in principle and in practice, one slippery slope concern is legitimate. There is reason to expect that legalization of voluntary active euthanasia might soon be followed by strong pressure to legalize some nonvoluntary euthanasia of incompetent patients unable to express their own wishes. Respecting a person's self-determination and recognizing that continued life is not always of value to a person can support not only voluntary active euthanasia, but some nonvoluntary euthanasia as well. These are the same values that ground competent patients' right to refuse life-sustaining treatment. Recent history here is instructive. In the medical ethics litera-

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

For some people, this risk is more than sufficient reason to oppose the legalization of voluntary euthanasia. But while we should in general be cautious about inferring much from the experience in the Netherlands to what our own experience in the United States might be, there may be one important lesson that we can learn from them. One commentator has noted that in the Netherlands families of incompetent patients have less authority than do families in the United States to act as surrogates for incompetent patients in making decisions to forgo life-sustaining treatment.²⁴ From the Dutch perspective, it may be we in the United States who are *already* on the slippery slope in having given surrogates broad authority to forgo life-sustaining treatment for incompetent persons. In this view, the more important moral divide, and the more important with regard to potential for abuse, is not between forgoing life-sustaining treatment and euthanasia, but instead between voluntary and nonvoluntary performance of either. If this is correct, then the more important issue is ensuring the appropriate principles and procedural safeguards for the exercise of decisionmaking authority by surrogates for incompetent persons in *all* decisions at the end of life. This may be the correct response to slippery slope worries about euthanasia.

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

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

The Role of Physicians

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

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

There are also at least two reasons for restricting the practice of euthanasia to physicians only. First, physicians would inevitably be involved in some of the important procedural safeguards nec-

essary to a defensible practice, such as seeing to it that the patient is well-informed about his or her condition, prognosis, and possible treatments, and ensuring that all reasonable means have been taken to improve the quality of the patient's life. Second, and probably more important, one necessary protection against abuse of the practice is to limit the persons given authority to perform it, so that they can be held accountable for their exercise of that authority. Physicians, whose training and professional norms give some assurance that they would perform euthanasia responsibly, are an appropriate group of persons to whom the practice may be restricted.

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