

Why Physicians Should Aid the Dying

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Background

Dying today is usually neither private nor easy to accomplish with dignity and without pain. For the typical person, dying today is a long, slow process of deterioration and dependence on others. It is exactly this dependence on others – on family, on physicians, and on nurses – that makes physician-assisted dying a moral issue.

What makes one issue a “moral issue” and not another? Actions that affect no one else are *personal*. Actions that may harm or help others, raise *moral* issues. Whether or not a physician helps a person die is a moral issue because it affects a very important interest of people: how and when they die.

Generally, physicians and patients see physician-assisted dying in different ways. Surveys of physicians repeatedly show that most *oppose* legalization of physician-assisted dying, while surveys of patients repeatedly show that most *endorse* legalization of physician-assisted dying (see *New York Times*, October 29, 1993, p. A7). This asymmetry creates the tension surrounding this moral issue.

Two Cases: Janet Adkins and “Diane”

In June of 1990, Jack Kevorkian, a retired pathologist, helped Janet Adkins, a 54-year-old Oregonian, kill herself. Janet had had an active life: she loved playing the piano, hiking, and playing tennis. When she developed Alzheimer’s disease, the life she loved evaporated before her eyes. When she could no longer read sheet music or remember when she was supposed to play tennis, she decided her brain was being destroyed too quickly.

No treatment cures Alzheimer’s and the experimental drug Tacrine did not help. So Mrs Adkins faced a “Catch 22” situation: kill herself while still in control of her declining life, or let her disease progress to the point where she would be incompetent and hence, incapable of deciding to die.

Because assisting in suicide was not illegal at the time in Michigan, Mrs Adkins's decision was honored by Dr Kevorkian. A year or so later, Dr Kevorkian was first successfully prosecuted for assisting in the death of his seventeenth patient, Thomas Hyde, a 30-year-old man in the last stages of Lou Gehrig's disease (amyotrophic lateral sclerosis). Medical experts testified that without Kevorkian's assistance in dying, Tom Hyde would have "strangled to death in his own saliva" (*New York Times*, April 28, 1994, p. A8). For a variety of reasons, including the belief that the law had no right to make terminally-ill patients suffer by forbidding physicians to help them die, the jury acquitted Dr Kevorkian (*New York Times*, May 5, 1994, pp. A1, 11).

In 1990, another physician, Timothy Quill, an internist in Rochester, New York, was asked by his patient "Diane" to help her die. As a young woman, Diane had survived vaginal cancer and overcome alcoholism. In 1990 at age 45, she developed acute myelomonocytic leukemia – one of the very worst kinds. Dr Quill explained to Diane that she had a 25 percent chance of long-term survival after treatment by two courses of chemotherapy and a bone-marrow transplant, but only if a well-matched bone-marrow donor could be found. Even with treatment, Diane had a 75 percent chance of being dead in several months, and because a good donor was not found, her chances of being dead in months with treatment were actually much higher. Moreover, the treatment would begin immediately and cause her last months to be marred with infections, hair loss, and nausea. Although the surgeons and oncologists pressured her into starting treatment "that very day," Diane waited and then decided not to undergo treatment.

After her decision, Dr Quill worried that a new "preoccupation with her fear of lingering death would interfere with her getting the most out of the time she had left." Having made sure that she was not irrationally depressed, he wrote her a prescription for barbiturates and told her how to use them for both sleep and suicide.

During the next three "tumultuous months," Diane's family provided constant support: her son stayed home from college and her husband worked at home. Several times she became weak or developed infections but bounced back. Near the end, she had two weeks of "relative calm," followed by rapid decline. Because she was now faced with what she feared most – "increasing discomfort, dependence, and hard choices" – Quill knew that her end had come:

When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.

Dr Quill published an account of Diane's death in the *New England Journal of Medicine* (1991: 691–4) and, soon thereafter, was prosecuted for murder. After hearing the district attorney's arguments, the grand jury refused to indict Dr Quill – in part because some members didn't agree with the law and believed that Diane both wanted to die and had the right to do so.

Between 1990 and 1995, Dr Kevorkian assisted 22 people to die and made physician-assisted dying a prominent, international moral issue. His cases, however, contrasted in several ways with those of Timothy Quill. Dr Quill knew Diane well and had treated her for a long time; he first offered her a course of treatment that might have allowed her to survive; he helped her to die privately and without publicity; he preserved her anonymity; he presented his account in an established medical forum; and he was not a "specialist" in assisted dying.

The point of comparing Dr Kevorkian and Dr Quill is this: some discussions of physician-assisted dying generalize from the eccentric personality and methods of Dr Kevorkian to the actions of average physicians, but Dr Quill is far closer to the average physician who might occasionally accept physician-assisted dying for his patients. Dr Quill was actually practicing medicine with real patients, whereas Dr Kevorkian, a retired pathologist, was not.

This is not necessarily to criticize Dr Kevorkian: he does not have a typical physician-patient relationship with his patients because they come to him after they feel they have been abandoned by all other physicians. But ideally, if such assistance was legal, dying patients would have a long-standing relationship with a personal physician who knew them well – like Dr Quill and Diane, and like physicians in Holland (see below).

When is Assisting in Death Wrong?

Throughout human history, most people have wanted to live as long as possible. That fact is less true today. Why? The answer is that our view of dying is different now because of the recent successes of medicine. Medicine has now largely cured the old, acute diseases that killed swiftly, and left us with chronic diseases that kill slowly, such as cancer and heart disease. In the past, people tried to live as long as possible because they never experienced the disability and dysfunction that came with chronic diseases, but we have now learned that if people live long enough, the quality of life diminishes. For most people, the quality of life is more important than the quantity of days lived.

Now let us specifically consider the morality of physician-assisted dying. When you help me accomplish what I want to do, you do a good thing, and morality encourages you to help me. When you prevent me from doing what I want to do, you hurt me and my interests, and morality regards you as immoral. Whether or not dying assisted by physicians is good or bad depends, not on what has traditionally been judged right or wrong, but on the dying patient and his desires. Similarly, whether physician-assisted dying is moral or immoral does not depend on whether it promotes or hinders mere life or death, but on whether the dying patient accepts it.

Someone might object that helping me do what I want is not a good thing if I want to do something immoral, and it is said, helping dying people die is immoral. But why should we accept the underlying premise that “Helping dying people die is immoral”? This begs the question, it is not an *argument against* a position to assume that it is wrong.

Faced with one who believes physician-assisted dying to be immoral, what do we do? No country advocates forced death, and that was the horror of what some Nazi physicians did. On the other hand, to forbid physicians from assisting dying patients will force many persons to prolong their pain and suffering unduly. From these patients' perspective, being forced to die in a way they do not like is little different from simply being forced to die. Both violate personal autonomy and destroy perhaps the most important choice a person ever makes.

People may disagree about whether they want to have a physician help them die more quickly. However, history has shown that democratic societies that allow citizens to make their own choices about such personal matters fare better than those that attempt to legislate one moral view on everybody.

Unfortunately, the debate over physician-assisted suicide has been defined so that the status quo (forbidding it) is conceived as one (and perhaps the) reasonable option. In fact,

this is an extreme position, with the other extreme being forced death. The reasonable compromise is allowing each person to decide how and when she will die. To this extent the debate over physician-assisted suicide is like the debate over abortion: the real extremes are forced conception and forced abortion. The reasonable compromise is free choice.

Direct Arguments Against Physician-assisted Dying

The most general, direct argument against physician-assisted dying is that it is a kind of killing of innocent humans, conjoined with the claim that it is wrong to kill humans. Any time one human being consciously acts to end the life of another, a terrible evil is committed. Such an action goes, it is said, against the will of God.

This argument is not very good. First, and as argued previously, what is wrong is not "killing humans" but "killing humans who do not want to die." Secondly, it is not clear that God forbids aid-in-dying. After all, God presumably created a world with disease, God willed for each of us to die a mortal death, and God could save us if he chose to do so. Indeed, it is not even clear that God forbids suicide, since God allowed King Saul to fall on his sword, and allowed his own Son, Jesus, to go to Jerusalem when Jesus knew that there he would be crucified.

More important, no one thinks that dying patients commit suicide by not doing everything possible to stay alive – at least, no reasonable person, because dying patients are (and not to put too fine a point on it) *dying*. Moreover, is it reasonable to equate a physician helping a terminally-ill patient die with "killing" a patient? No. Again, to argue that "assisting the dying" is morally equivalent to "killing" is misleading because "killing" refers to taking the life of a person *who does not want to die*.

Let us end with another analogy. Suppose that a surgeon fixes a woman's deviated septum while she is under anesthesia for an operation on her knee, and without asking her permission. When she objects afterwards, he cannot claim that he has done nothing wrong because he has "healed" her nose. (Unknown to the surgeon, she was a promising singer and the operation permanently ruined the sound of her singing. He did not "heal" her; he ruined her.) So whether a particular operation is "healing" or "impairing," whether a particular act of assisted dying is "murder" or "compassion," depends on the desires and decisions of the patient in a particular circumstance.

Direct Arguments For Physician-assisted Dying

The argument from control of one's own life

Perhaps the strongest and simplest direct argument favoring physician-assisted dying is the Argument from Control of One's Own Life. This argument paradigmatically concerns a competent adult afflicted with a terminal illness. A fundamental principle in both moral and political life in civilized countries is that competent adults possess the right to make personal decisions. As John Stuart Mill argued famously in *On Liberty*, "The only part of the conduct of any one, for which [a citizen] is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."

A good law honors the ultimate choices that patients make because, at bottom, that is the point of living in a good society with democracy, the rule of law, and civilized attitudes. The State has no business telling people whether to make such choices, and consequently, telling a physician whether he can help a patient die more easily. Similarly, the government should not be able to prevent me from hiring a physician to help me die as I want.

Unfortunately, it is not so easy to kill oneself. The older one gets, the more difficult this becomes. Many elderly people become *gradually* infirm and weak, especially in their late 80s. When such people get a terminal illness, such as cancer or coronary artery disease, deterioration accelerates, but there rarely is a sudden death. A patient in the final stages of coronary artery disease may be so sick that, bedridden, he cannot even lift up his hand to wave. These patients and their families face more and more difficult tradeoffs as the disease progresses. They lose their physical health, their memory and their friends. So people at the end need a physician's help.

One tradeoff is between living as long as possible with an acceptable quality of life (but possibly losing control of one's own dying), and dying early (but exactly as one wants). The case of Janet Adkins shows this problem: because physicians now do not actively assist patients in dying, terminal patients sometimes die early to control their own fate.

Consider how different dying would be if physicians were to do what patients wanted. A patient could find a physician who would – at some indefinite point in the future – honor his or her request to die before pain became intolerable. Having made that “contract,” the patient could then live as long as possible before intolerable pain began. When, and if, that point came (and an advantage of this approach is that sometimes it would not), the physician would do as the patient wanted. Under this vision of the future, patients would no longer need to guess about when pain “might” become impossible and then die before that happened.

So a related, direct argument for physician-assisted dying here is this: by legalizing it, medicine maximizes life for all those patients who now are forced to die early. Legalizing physician-assisted dying is life-enhancing for those not afraid to take control of their own dying.

The argument from mercy

Sometimes, medication cannot adequately control the pain associated with a disease. When this occurs with a family dog or cat, the veterinarian and owners mercifully do not make the animal suffer. When this occurs with a human, mercy is sometimes absent.

Some physicians deny that anyone need ever die in pain. But such claims must be carefully examined. Yes, it is possible to get someone out of pain if one totally sedates a patient, but most patients want to be conscious during their final weeks. But can dying patients stay conscious and be pain-free?

This is a question widely debated and with great disagreement over the answers. Some physicians deny that dying patients ever need be in intense pain and hence, ever need the “mercy” of physician-assisted death (Teno and Lynn, 1991: 827–30). Yet even they admit that most physicians are not adequately trained in pain relief, a point that champions of physician-assisted dying have been making for years. So most dying patients still have a physician who is not the best at pain control. Because that is so, some patients still die a horrible death in terrible pain. Is this a fact that a civilized society should tolerate? No, and so, some physicians should be legally allowed to heed the request of such patients for a speedier, painless death.

Critics of physician-assisted dying often say at this point, "We need better care of the dying, not physician-assisted dying. To legalize physician-assisted dying is to accept the failure of the present system to care well for the dying." Well, yes, this is not a perfect world, but what does that imply? What about the two million Americans who die each year? *They can't wait* for the system to improve. When the system gets perfect at some grand time in the future, we can reassess physician-assisted dying, but for the foreseeable future . . .

Moreover, it is not clear that the system will ever get very good for dying patients. Many physicians are not that comfortable with the process of dying. To them, it feels like failure on their part. Others don't like to empathize with the dying because it reminds them of their own death. As long as these statements are true, we need the legal option for some physicians to help patients who aren't getting adequate, compassionate care from their assigned physicians. Although it may seem odd, perhaps the idea of physicians who specialize in dying isn't such a bad idea after all.

The Argument from Empirical Precedent

Sometimes people argue moral issues in medicine and wish that there was some "ethics laboratory" where such issues could be tested empirically. Remarkably, there is. Holland is just such an "ethics lab," because Dutch citizens have almost totally legalized physician-assisted dying for over 25 years. In Holland, there are about a thousand assisted deaths each year (van Delden et al., 1993: 6) with this change.

What English-speaking people want is what Dutch patients have had for decades: a physician they have known for many years who makes house calls, not some impersonal specialist in a hospital who is a stranger. What people also want is what dying Dutch patients also have had for 25 years: a physician they trust to carry out their real wishes at the end.

Should we follow the Dutch example and legalize physician-assisted dying? Arguments against such legalization are generally "slippery slope" predictions: if we legalize one kind of dying, others will soon follow; if physicians are desensitized to killing one kind of patient, they will eventually kill others. At the most extreme, opponents claim that legalizing physician-assisted death will start us down a slippery slope to the kind of state-mandated killing of "undesirables" practiced in Nazi Germany.

I discuss examples of such arguments below, but for now, notice one thing: the predicted "descent" down the slope did not occur in Holland (some bad things may have occurred, but they don't qualify as a "descent" – see below). Put differently, terrible things were predicted to occur in Holland on a massive scale with legalization of physician-assisted dying. These terrible things have not occurred after a quarter-century of Dutch medical practice. So physician-assisted dying does not always lead down a slippery slope.

Indirect Arguments Against Physician-assisted Dying

The slippery slope

Most arguments against physician-assisted dying are indirect ones, such as the slippery slope. The phrase "slippery slope" actually covers many more ideas than is customarily

noted in the literature and the use of this argument in practice is often quite sloppy. I discuss some variations below.

Slippery slope #1: Generalization to other kinds of cases

With legalization, the social practice of killing will snowball: once physicians become accustomed to killing competent, terminal patients, they will accept killing semi-competent and incompetent patients. In a famous article, Leo Alexander, a physician who witnessed the Nuremberg trials of Nazi physicians, wrote, "The destructive principle, once unleashed, is bound to engulf the whole personality and to occupy all its relationships. Destructive urges and destructive concepts arising there cannot remain limited or focused upon one subject or several subjects alone, but must inevitably spread and be directed against one's entire surrounding world . . ." (Alexander, 1949: 47).

A Right to Life spokesperson says in this context that if you "accept quality of life as the standard" then, "First you withdraw the respirators, then the food, and then you actively kill people. It's a straight line from one place to the others" (Bopp, as quoted in Specter, 1990). Vienna was shocked to discover in 1989 that a nursing aide had killed at least 49 elderly patients in an Austrian nursing home by lethal injection or by forcing water into their lungs (Protzman, 1989).

The answer to this "slope" argument is that not all change is unstoppable; not all change generalizes to everything. In essence, this slope claim argues that competent patients with terminal diseases are the easy, safe cases, but legalization of physician-assisted dying will inevitably spread to hard, murky, dangerous cases involving formerly-competent patients (e.g., Alzheimer's patients), then never-competent patients (severely retarded adults), and finally, as-yet-to-be competent patients (children with leukemia).

The evidence against this slope claim is impressive. The key slide is from competent to incompetent patients. It is easy for physicians and families to accept the wishes of a competent, adult, dying patient who repeatedly says, "Enough is enough!"

With formerly-competent and never-competent patients, the results are very different. It is one thing to decide for yourself to die because of low quality of life; it is quite another thing to decide that someone else's quality of life is so low that he or she should be "assisted" to find death. Spouses, families, judges, and legislatures are morally uncomfortable with, and hence have resisted, accelerating deaths for incompetent people judged to have a low quality of life. Indeed, surveys of families show that, while individuals want the right to die for themselves, they are very reluctant to force their view on someone else – even a family member they have known for many years.

Legally, different standards of evidence have often been erected to protect these different classes of patients. For example in America, the 1990 *Cruzan* decision by the US Supreme Court held that states may not pass laws restricting the rights of competent patients in any way to decline medical treatment and die. No "evidentiary" standard at all was necessary to prove that a physician here should do what a patient wanted. The same decision, however, said that a state may pass a much higher evidentiary standard to protect *incompetent* patients from overzealous attempts by families to end their lives. So the state of Missouri was permitted to apply the higher "clear and convincing evidence" standard and resist the efforts of Nancy Cruzan's parents to disconnect her feeding tube so her life could be ended (Pence, 1995). Similarly, many scholars and disability advocates believe that an even higher standard should be applied to ending the lives of never-competent patients, namely, the "beyond a reasonable doubt" standard. Only when ending

the life of such a patient ended suffering and produced so much good that killing the person was good "beyond a reasonable doubt," could it be ordered.

Slippery slope #2: Unleashing the dark side of human nature

A second kind of slippery slope is also often predicted to occur with legalization of physician-assisted dying: with legalization, the worst motives of physicians and families will take over, and all decisions will be made for the sake of money or convenience of families, not for the best interests of the dying patient. Some fear that physicians will be pressured by skyrocketing medical costs into urging assisted dying on high-cost, low-benefit patients, mostly old and poor patients. Families can be financially crippled by the cost of supportive services for a dying or vegetative patient. Cost containment has become a driving force in the American health-care system; is it wise to institute "managed care" and physician-assisted dying at the same time?

Much of modern-day medical ethics evolved during times of economic prosperity, and hard times – such as a worldwide depression – might motivate individuals and communities to accept or demand euthanasia in more and more situations. (Was it not a crumbling economy that presaged the rise of the Nazis in Germany?) As medical historian Stanley Reiser says, "A good deal of the debate is about whether we could control all of the steps that might coerce or intimidate a patient" (Reiser, 1992: 13).

This is an important objection, perhaps more important than most citizens realize. American medicine is currently experiencing efforts to control its costs. More and more Americans are being enrolled in insurance plans where the physicians, not the company or the patients, assume the financial risk of keeping costs low.

If such massive change occurs, there is obviously a potential problem with physician-assisted suicide. If the financial momentum for physicians is also reversed, from maintaining life to ending life, what will then happen? No one really knows what will happen. Part of the (usually unspoken) worry here concerns what really motivates American physicians: will conscience hold firm when one's income is reduced by supporting the patient?

Some people say that the answer to this real problem is that some safeguards must be erected. Recognizing that financial gain may motivate some physicians, and that both physicians and families can have conflicts of interest *vis-à-vis* dying patients, devices must be created to prevent physicians from directly profiting on early deaths.

The problem with this discussion is that, at least in America, the current argument assumes that financial gain does not *already* motivate physicians to recommend treatment for patients that might benefit them financially. Where such temptation exists, a physician's ethics and conscience are supposed to prevent him from giving in. It is then bizarre for critics of physician-assisted dying to claim that, when it comes to dying patients, financial gain might be too tempting for physicians. Why isn't it too tempting in all the other areas of medicine *now*? Why isn't it financial gain that motivates physicians to *resist* physician-assisted dying?

Slippery slope #3: Consistency

What justifies one case of assisted death justifies other, similar cases. If it is justifiable to kill a 36-year-old dying leukemic in great misery, is it also justifiable to assist in the death of a 16-year-old? Or a spina bifida child with painful leukemia? In opposing physician-assisted dying, Daniel Callahan says that the logic of the case for assisted suicide will inevitably lead to its extension far beyond the cases of terminally-ill, competent adults. If relief of suffering

is critical, he says, "why should that relief be denied to the demented or the incompetent? (Callahan, as quoted in Steinfels, 1991).

There is some evidence that consistency has pulled Dutch physicians toward generalization of physician-assisted dying from the original class of competent patients, for some cases of incompetent patients. This problem is perhaps inevitable, given the pull of consistency. However, the Dutch people themselves do not think that the occasional abuse is an indictment against the whole system.

Nor is it clear that the pull of consistency is a bad thing. We just may not be ready for a perfectly consistent ethical system about life and death at this time. Practical ethics is not a logically perfect system. Lines must be drawn somewhere, and where the line is drawn is often somewhat arbitrary. The point is to have some cut-off point at all, not one that has some metaphysical anchor or logical perfection. It may be that, for a particular time in American history, we will draw the line about a moral issue at X and not Y. Then, 20 years later when conditions change, we may feel better about moving the line to Y, *even though Y may have been a more logically consistent point at the beginning.*

That is fine. The whole point of "drawing lines" is to stop a mindless run down a slippery slope as soon as some change occurs. We don't want to change everything at once because we need time to evaluate changes to see if they are producing good consequences. If they are not, we can reverse policies, just as Prohibition and the military draft were reversed.

In conclusion, considerations of consistency may tend to expand the cases covered under any criteria for physician-assisted dying. This pull can be resisted in statutes by legislatures that "draw the lines" of the laws of the land. If the passage of time shows that the lines need to be changed, either to permit more cases or to permit fewer, that is something that can be done.

The Role of Physicians

So far, we have been viewing the issue from the patient's side, but now we evaluate arguments frequently heard on the physician's side. Most are "slippery slope" arguments.

The physician-patient relationship

One line of worry about assisted dying is not about money but about the kind of relationship that exists between physician and patient in an assisted suicide. Dr Quill, who helped "Diane" die, argued that because Kevorkian had no long-term physician-patient relationship with those he helped, he had done a bad thing. Quill said of Kevorkian, "Suicide is the sole basis for the relationship he has with his patients, and that is frightening (*Newsweek*, March 8, 1993, p. 46).

Dutch physicians have an answer. Seeing a patient all his life and then doing nothing as he dies is not seen by them as good patient care. Instead it is seen as patient abandonment. Offering a continuity of care across a lifetime in a way unknown in modern America, Dutch physicians see helping patients die as the final step in a lifetime of intimate, personal medical care between physicians and their patients. It is true that coming to a stranger who was a "thanatologist" would be an undesirable way to die, but it need not be that way. Holland has shown us a better option.

The Argument from Medical Tradition

This argument asserts that physicians should not assist patients to die because physicians have not historically done so. This argument in itself carries little weight. Appeals to tradition always buttress such arguments against change, but they are question-begging. People who like tradition don't like change.

Tradition is only as good as its consequences. Western civilization practiced slavery for two thousand years, but the consequences of this practice were not good for most people.

The Argument from Tradition also implies that "tradition" has some collected moral wisdom embedded in it, as Tevye the dairyman implies in *Fiddler on the Roof* (possibly referring to the rabbinic moral teachings). But in medicine, tradition in the twentieth-century ethics does not always carry moral wisdom, especially when it comes to change.

Consider that American medicine in the twentieth century opposed the federal Medicare program for the elderly, which turned old age from terror of disease and resultant impoverishment to one of assured, good medical treatment. During the 1960s, medicine opposed telling cancer patients their true diagnosis, and opposed Elizabeth Kubler-Ross's attempt to identify dying patients as such and help them die comfortably in special hospices. Later, medicine opposed as "active euthanasia" the removal in the 1970s of respirators in comatose patients such as Karen Quinlan. After that and during the 1980s, it opposed removal of indwelling feeding tubes because to do so denied patients humane "food and water."

In all these cases, the public grew wise long before physicians and, as a result, it was the public who dragged medicine along with the new moral consensus. Thus, the argument – that medicine should not accept physician-assisted dying in the 1990s because it violates medical tradition – is not a good argument. Medicine has rarely taken the lead in moral progress for patients' rights.

It should be noted too that medicine has not always resisted helping the dying. Ancient Greek physicians commonly helped the dying finish their days peacefully and with dignity. (Hippocrates was an exception who followed the sanctity-of-life ethic of Pythagoras.) It may be time for modern physicians to emulate the virtues of ancient Greek physicians.

The idea that the role of physicians does not permit killing is sometimes expressed in the saying that, "Physicians should be healers, not killers." This claim is frequently made, and as explained in the historical survey above about what patients want, this claim has been a good directive for most of human history. Today, however, it begs the question against patients by assuming, contrary to much evidence, that all patients do not want their physicians to help them die.

A related argument by opponents of physician-assisted dying concerns the role of physicians: If they are legally allowed to assist the dying, what reason do we have to suppose that they would not soon *recommend* dying? And once physicians began recommending assisted dying, how do we know that they – and others – would not try to make it *mandatory*?

This is a kind of scarey rhetorical argument that one sometimes hears, but it is a bad one. It is of exactly the same form as this: If we allow stores to sell cars to people who want one, soon the stores will make it mandatory to buy one (false). Giving people the choice to have something is not equivalent to, nor does it usually lead to, the same people being required to have that thing.

A related argument about the role of physicians is expressed in the idea that "killing will brutalize the medical profession." Again, this is a bad argument. First, physicians already have many experiences that could brutalize them, and so people who cannot stay

compassionate around sick, dying, or paralyzed people should not be physicians. Whether or not a particular kind of experience brutalizes a physician depends on many things, including the patient's attitude to what is going on. Secondly, the status quo is already very "brutal" for both patients and physicians: to watch Janet Adkins lose her mind and then to maintain her mindless body for another decade is far more brutal on the Adkins family and attending physicians than to give her help in dying.

This point is relevant to the objection that, if we legalize physician-assisted dying, there will be some abuses by some physicians. That is true. No system is perfect. But what is overlooked is this: the slow, painful dying of many patients today, against their will, is just as much a kind of abuse. It is not as if the present system has no abuses.

Finally, some physicians argue that assisting terminal patients to die "doesn't feel right, and I have to go with my gut moral feelings." To this argument, it must be replied that pop psychology about feelings is not always correct. Feelings may be embedded in antiquated moral traditions, such as racist traditions, and so need to be re-evaluated. When incorrect, they need to be overcome by a decision to do what is morally right. If a physician's experience and reason tell her that the patient's best interest is to die quickly, then even if "it doesn't feel right" to assist, it still may be.

Conclusion

Jean-Paul Sartre made famous the idea that, "Not to choose is also a choice." Doing nothing to legalize physician-assisted dying is to choose to let millions upon millions of people pile up in advanced stages of senility, dysfunction, and mental vacuity. Doing nothing chooses to let millions upon millions of bodies continue to eke out an existence while the personalities that once inhabited them disintegrate. Doing nothing takes away the right of people to die who do not want their bodies to continue for decades after their minds are gone, or who do not want to live their final years in pain and misery.

We need not worry too much about slippery slopes and things getting out of control. Not all change is bad. People don't decide to die lightly. Let's face it: no one wants to die. To become so frail, so disoriented, so full of pain that death is preferable to life is to come to a very bad place. We need not fear help by physicians in getting out of that place. Instead of a danger, such help for some will be a blessing.

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