eliminated or made benign, by the careful intervention of a competent, caring physician, given current social constraints.

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

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

Voluntary Active Euthanasia

DAN W. BROCK

Brock argues that the same two basic moral principles that support a patient's right to make choices about life-sustaining treatment also support the permissibility of voluntary active euthanasia. The first principle is individual self-determination; the second is individual well-being. Individual self-determination applies to the manner, circumstances, and timing of one's death and dying. A concern for individual well-being may justify euthanasia when a suffering patient determines that life is no longer a benefit.

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

supported by self-determination; it cannot justifiably be administered, for example, in cases of serious dementia or treatable clinical depression.

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

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

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

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

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

Euthanasia Is the Deliberate Killing of an Innocent Person

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

In the context of medicine, the ethical prohibition against deliberately killing the innocent derives some of its plausibility from the belief that nothing in the currently accepted practice of medicine is deliberate killing. Thus, in commenting on the "It's Over, Debbie" case, four prominent physicians and bioethicists could entitle their paper "Doctors Must Not Kill."[1] 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.[2] Both the physician and the greedy son act in a manner intended to cause death, do cause death, and so both kill. One reason this conclusion is resisted is that on a different understanding of the distinction between killing and allowing to die, what the physician does is allow to die. In this account, the mother's ALS is a lethal disease whose normal progression is being held back or blocked by the life-sustaining respirator treatment. Removing this artificial intervention is then viewed as standing aside and allowing the patient to die of her

underlying disease. I have argued elsewhere that this alternative account is deeply problematic, in part because it commits us to accepting that what the greedy son does is to allow to die, not kill.[3] Here, I want to note two other reasons why the conclusion that stopping life support is killing is resisted.

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

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

Many who accept the difference between killing and allowing to die as the distinction between acts and omissions resulting in death have gone on to argue that killing is not in itself morally different from allowing to die.[4] 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.[5] 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.[6] 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.[7]

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.[8] For a variety of reasons, including some physicians' fear of hastening the patient's death, as well as the lack of a publicly accessible means for assessing the amount of the patient's pain, many patients suffer pain that could be, but is not, relieved.

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

Dying patients often undergo substantial psychological suffering that is not fully or even principally the result of physical pain.[9] 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.[10]

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

Might Gaylin and his colleagues nevertheless be correct in their claim that the moral center of medicine would collapse if physicians were to become killers? This question raises what at the deepest level should be the guiding aims of medicine, a question that obviously cannot be fully explored here. But I do want to say enough to indicate the direction that I believe an appropriate response to this challenge should take. In spelling out above what I called the positive argument for voluntary active euthanasia, I suggested that two principal values—respecting patients' self-determination and promoting their well-being—underlie the consensus that competent patients, or the surrogates of

incompetent patients, are entitled to refuse any life-sustaining treatment and to choose from among available alternative treatments. It is the commitment to these two values in guiding physicians' actions as healers, comforters, and protectors of their patients' lives that should be at the "moral center" of medicine, and these two values support physicians' administering euthanasia when their patients make competent requests for it. . . .

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

This second worry is difficult to assess because there is little firm evidence about the likelihood of the feared erosion in the care of dying patients. There are at least two reasons, however, for skepticism about this argument. The first is that the same worry could have been directed at recognizing patients' or surrogates' rights to forgo life-sustaining treatment, yet there is no persuasive evidence that recognizing the right to refuse treatment has caused a serious erosion in the quality of care of dying patients. The second reason for skepticism about this worry is that only a very small proportion of deaths would occur from euthanasia if it were permitted. In the Netherlands, where euthanasia under specified circumstances is permitted by the courts, though not authorized by statute, the best estimate of the proportion of overall deaths that result from it is about 2 percent.[11] 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.[12] This progress has been made against the backdrop of a clear and firm legal prohibition of euthanasia, which has provided a relatively bright line limiting the dominion of others over patients' lives. It has therefore been an important reassurance to concerns about how the authority to take steps ending life might be misused, abused, or wrongly extended.

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

As with the second potential bad consequence of permitting euthanasia, this third consideration too is speculative and difficult to assess. The feared erosion of patients' or surrogates' rights to decide about life-sustaining treatment, together with greater court involvement in those decisions, are both possible. However, I believe there is reason to discount this general worry. The legal rights of competent patients and, to a lesser degree, surrogates of incompetent patients to decide about treatment are very firmly embedded in a long line of informed consent and life-sustaining treatment cases, and are not likely to be eroded by a debate over, or even acceptance of, euthanasia. It will not be accepted

without safeguards that reassure the public about abuse, and if that debate shows the need for similar safeguards for some life-sustaining treatment decisions they should be adopted there as well. In neither case are the only possible safeguards greater court involvement, as the recent growth of institutional ethics committees shows.

The fourth potential bad consequence of permitting euthanasia has been developed by David Velleman and turns on the subtle point that making a new option or choice available to people can sometimes make them worse off, even if once they have the choice they go on to choose what is best for them.[13] Ordinarily, people's continued existence is viewed by them as given, a fixed condition with which they must cope. Making euthanasia available to people as an option denies them the alternative of staying alive by default. If people are offered the option of euthanasia, their continued existence is now a choice for which they can be held responsible and which they can be asked by others to justify. We care, and are right to care, about being able to justify ourselves to others. To the extent that our society is unsympathetic to justifying a severely dependent or impaired existence, a heavy psychological burden of proof may be placed on patients who think their terminal illness or chronic infirmity is not a sufficient reason for dying. Even if they otherwise view their life as worth living, the opinion of others around them that it is not can threaten their reason for living and make euthanasia a rational choice. Thus the existence of the option becomes a subtle pressure to request it.

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

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

Legal permission for physicians or others to perform euthanasia could not be grounded in patients' rights to decide about medical treatment. Permitting euthanasia would require qualifying, at least in effect, the legal prohibition against homicide, a prohibition that in general does not allow the consent of the victim to justify or excuse the act. Nevertheless, the very same fundamental basis of the right to decide about life-sustaining treatment—respecting a person's self-determination—does support euthanasia as well. Individual self-determination has long been a well-entrenched and fundamental value in the law, and so extending it to euthanasia would not

require appeal to novel legal values or principles. That suicide or attempted suicide is no longer a criminal offense in virtually all states indicates an acceptance of individual self-determination in the taking of one's own life analogous to that required for voluntary active euthanasia. The legal prohibition (in most states) of assisting in suicide and the refusal in the law to accept the consent of the victim as a possible justification of homicide are both arguably a result of difficulties in the legal process of establishing the consent of the victim after the fact. If procedures can be designed that clearly establish the voluntariness of the person's request for euthanasia it would under those procedures represent a carefully circumscribed qualification on the legal prohibition of homicide. Nevertheless, some remaining worries about this weakening can be captured in the final potential bad consequence, to which I will now turn.

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

Slippery slope arguments of this form are problematic and difficult to evaluate.[14] From one perspective, they are the last refuge of conservative defenders of the status quo. When all the opponent's objections to the wrongness of euthanasia itself have been met, the opponent then shifts ground and acknowledges both that it is not in itself wrong and that a legal policy which resulted only in its being performed would not be bad. Nevertheless, the opponent maintains, it should still not be permitted because doing so would result in its being performed in other cases in which it is not voluntary and would be wrong. In this argument's most extreme form, permitting euthanasia is the first and fateful step down the slippery slope to Nazism. Once on the slope we will be unable to get off.

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

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

1. The patient should be provided with all relevant information about his or her medical condition, current prognosis, available alternative treatments, and the prognosis of each.
2. Procedures should ensure that the patient's request for euthanasia is stable or enduring (a brief waiting period could be required) and fully voluntary (an advocate for the patient might be appointed to ensure this).
3. All reasonable alternatives must have been explored for improving the patient's quality of life and relieving any pain or suffering.
4. A psychiatric evaluation should ensure that the patient's request is not the result of a treatable psychological impairment such as depression.[15]

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

These examples of procedural safeguards make clear that it is possible to substantially reduce, though not to eliminate, the potential for abuse of a policy permitting voluntary active euthanasia. Any legalization of the practice should be accompanied by a well-considered set of procedural safeguards together with an ongoing evaluation of its use. Introducing euthanasia into only a few states could be a form of carefully limited and controlled social experiment that would give us evidence about the benefits and harms of the practice. Even then firm and uncontroversial data may remain elusive, as the continuing controversy over what has taken place in the Netherlands in recent years indicates.[16]

The Slip into Nonvoluntary Active Euthanasia

While I believe slippery slope worries can largely be limited by making necessary distinctions both in principle and in practice, one slippery slope concern is legitimate. There is reason to expect that legalization of voluntary active euthanasia might soon be followed by strong pressure to legalize some nonvoluntary euthanasia of incompetent patients unable to express their own wishes. Respecting a person's self-determination and recognizing that continued life is not always of value to a person can support not only voluntary active euthanasia, but some nonvoluntary euthanasia as well. These are the same values that ground competent patients' right to refuse life-sustaining treatment. Recent history here is instructive. In the medical ethics literature, in the courts since Quinlan, and in norms of medical practice, that right has been extended to incompetent patients and exercised by a surrogate who is to decide as the patient would have decided in the circumstances if competent.[17] It has been held unreasonable to continue life-sustaining treatment that the patient would not have wanted just because the patient now lacks the capacity to tell us that. Life-sustaining treatment for incompetent patients is today frequently forgone on the basis of a surrogate's decision, or less frequently on the basis of an advance directive executed by the patient while still competent. The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient (acting with or without a formal advance directive from the patient) may well extend the scope of active euthanasia. The argument will be, Why continue to force unwanted life on patients just because they have now lost the capacity to request euthanasia from us?

A related phenomenon may reinforce this slippery slope concern. In the Netherlands, what the courts have sanctioned has been clearly restricted to voluntary euthanasia. In itself, this serves as some evidence that permitting it need not lead to permitting the nonvoluntary variety. There is some indication, however, that for many Dutch physicians euthanasia is no longer viewed as a special action, set apart from their usual practice and restricted only to competent persons.[18] Instead, it is seen as one end of a spectrum of caring for dying patients. When viewed in this way it will be difficult to deny euthanasia to a patient for whom it is seen as the best or most appropriate form of care simply because that patient is now incompetent and cannot request it.

Even if voluntary active euthanasia should slip into nonvoluntary active euthanasia, with surrogates acting for incompetent patients, the ethical evaluation is more complex than many opponents of euthanasia allow. Just as in the case of surrogates' decisions to forgo life-sustaining treatment for incompetent patients, so also surrogates' decisions to request euthanasia for incompetent persons would often accurately reflect what the incompetent person would have wanted and would deny the person nothing that he or she would have considered worth having. Making nonvoluntary active

euthanasia legally permissible, however, would greatly enlarge the number of patients on whom it might be performed and substantially enlarge the potential for misuse and abuse. As noted above, frail and debilitated elderly people, often demented or otherwise incompetent and thereby unable to defend and assert their own interests, may be especially vulnerable to unwanted euthanasia.

For some people, this risk is more than sufficient reason to oppose the legalization of voluntary euthanasia. But while we should in general be cautious about inferring much from the experience in the Netherlands to what our own experience in the United States might be, there may be one important lesson that we can learn from them. One commentator has noted that in the Netherlands families of incompetent patients have less authority than do families in the United States to act as surrogates for incompetent patients in making decisions to forgo life-sustaining treatment.[19] 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 decision-making authority by surrogates for incompetent persons in all decisions at the end of life. This may be the correct response to slippery slope worries about euthanasia.

I have cited both good and bad consequences that have been thought likely from a policy change permitting voluntary active euthanasia, and have tried to evaluate their likelihood and relative importance. Nevertheless, as I noted earlier, reasonable disagreement remains both about the consequences of permitting euthanasia and about which of these consequences are more important. The depth and strength of public and professional debate about whether, all things considered, permitting euthanasia would be desirable or undesirable reflects these disagreements. While my own view is that the balance of considerations supports permitting the practice, my principal purpose here has been to clarify the main issues.

NOTES

1. Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, "Doctors Must Not Kill," *JAMA* 259 (1988): 2139–40.
2. Bonnie Steinbock, ed., *Killing and Allowing to Die* (Englewood Cliffs, N.J.: Prentice-Hall, 1980).
3. Dan W. Brock, "Forgoing Food and Water: Is It Killing?" in *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water*, ed. Joanne Lynn (Bloomington: Indiana University Press, 1986), pp. 117–31.
4. James Rachels, "Active and Passive Euthanasia," *NEJM* 292 (1975): 78–80; Michael Tooley, *Abortion and Infanticide* (Oxford: Oxford University Press, 1983). In my paper, "Taking Human Life," *Ethics* 95 (1985): 851–65, I argue in more detail that killing in itself is not morally different from allowing to die and defend the strategy of argument employed in this and the succeeding two paragraphs in the text.
5. Dan W. Brock, "Moral Rights and Permissible Killing," in *Ethical Issues Relating to Life and Death*, ed. John Ladd (New York: Oxford University Press, 1979), pp. 94–117.
6. P. Painton and E. Taylor, "Love or Let Die," *Time*, 19 March 1990, pp. 62–71; *Boston Globe*/Harvard University Poll, *Boston Globe*, 3 November 1991.
7. James Rachels, *The End of Life* (Oxford: Oxford University Press, 1986).
8. Marcia Angell, "The Quality of Mercy," *NEJM* 306 (1982): 98–99; M. Donovan, P. Dillon, and L. McGuire, "Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients," *Pain* 30 (1987): 69–78.
9. Eric Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991).
10. Gaylin et al., "Doctors Must Not Kill."
11. Paul J. Van der Maas et al., "Euthanasia and Other Medical Decisions Concerning the End of Life," *Lancet* 338 (1991): 669–74.
12. Susan M. Wolf, "Holding the Line on Euthanasia," Special Supplement, *Hastings Center Report* 19, no. 1 (1989): 13–15.
13. My formulation of this argument derives from David Velleman's statement of it in his commentary on an earlier version of this paper delivered at the American Philosophical Association Central Division meetings; a similar point was made to me by Elisha Milgram in discussion on another occasion. For more general

development of the point see Thomas Schelling, *The Strategy of Conflict* (Cambridge, Mass.: Harvard University Press, 1960); and Gerald Dworkin, "Is More Choice Better Than Less?" in *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988).

14. Frederick Schauer, "Slippery Slopes," *Harvard Law Review* 99 (1985): 361–83; Wibren van der Burg, "The Slippery Slope Argument," *Ethics* 102 (October 1991): 42–65.

15. There is evidence that physicians commonly fail to diagnose depression. See Robert I. Misbin, "Physicians Aid in Dying," *NEJM* 325 (1991): 1304–7.

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

17. Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decisionmaking* (Cambridge: Cambridge University Press, 1989).

18. Van der Maas et al., "Euthanasia and Other Medical Decisions."

19. Margaret P. Battin, "Seven Caveats Concerning the Discussion of Euthanasia in Holland," *American Philosophical Association Newsletter on Philosophy and Medicine* 89, no. 2 (1990).

When Self-Determination Runs Amok

DANIEL CALLAHAN

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

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

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

The third turning point is to be found in the claim being made upon medicine: it should be prepared to make its skills available to individuals to help them achieve their private vision of the good life. This puts medicine in the business of

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