CHAPTER 10

Euthanasia and Physician-Assisted Suicide

No one escapes death—or the ethical issues that come with it. Advances in medicine now raise the old life-and-death questions anew, force new ones more unsettling, and provoke answers that are disturbing even when plausible. In euthanasia and physician-assisted suicide, the bioethical heart of the matter is the moral rightness of killing or letting die for the good of the patient. The countless disputes on this terrain are often fierce and elemental, for they are the visible signs of deep conflicts among fundamental moral principles and perspectives. Doctors and nurses have sworn to preserve life and relieve suffering—but how to do this when the only way to end suffering is to end life? They understand the need to respect patient autonomy, the right of self-determination—but what should they do when the patient freely chooses to forgo all their best efforts and to embrace extinction? Or if the terminal patient, inching in agony toward destruction, asks them to cut short her torment by killing her with a lethal injection? Or if she begs only for some help in dying by her own hand? Or if she has never expressed a choice about such matters and has slipped into permanent unconsciousness, withering in pain to the inevitable? In such cases, what does beneficence or mercy or respect for autonomy or regard for the sanctity of life demand?

More so than most other issues in bioethics, the morality of euthanasia and physician-assisted suicide is tangled with legal and policy debates. The ethical questions are, of course, logically distinct from these concerns. You are not necessarily guilty of inconsistency if you think some instances of physician-assisted suicide are morally permissible but believe the practice should never be legalized because legalization might lead to abuses. Or you may, without contradicting yourself, favor legalization to protect patient autonomy but argue that suicide in any form is almost never morally acceptable. In the heat of controversy, these distinctions often get blurred, and a major task of good moral reasoning is to keep the focus sharp.

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

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

In some ways the Schiavo case is unique, but several of its more disturbing features are not. Many compelling end-of-life dramas are being played out right now behind closed hospital doors, away from news cameras, the posturing of politicians, and the gaze of unaffected people. The need for informed moral reasoning to come to terms with the heartbreaking realities is acute—and likely to grow.

DECIDING LIFE AND DEATH

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

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

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

> The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. . . . The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or immediate family.[2]

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

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

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

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

Combining the terms *active*, *passive*, *voluntary*, and *nonvoluntary*, we can identify four kinds of euthanasia that have been the main focus in bioethics:

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

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

Recently, disputes over euthanasia have raged alongside arguments about **physician-assisted suicide**, in which a patient takes his own life with the aid of a physician. In a typical scenario, a patient asks the physician for help in committing suicide, the physician assists the patient by prescribing lethal doses of drugs or explaining a method of suicide, and the patient—not the physician—performs the final

LEGAL BRIEF

Euthanasia and Assisted Suicide: Major Developments

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

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

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

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

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

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

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

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

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

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

2016 Colorado passes the "End of Life Options Act," and the "Death with Dignity Act of 2016" becomes law in Washington, DC. Both laws legalize physician-assisted suicide.

2018 Hawaii becomes the seventh state to enact an assisted dying law.

2019 New Jersey becomes the eighth state to enact an assisted dying law, and Maine becomes the ninth.

2021 New Mexico becomes the tenth state to enact an assisted dying law.

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

IN DEPTH
ASSISTED SUICIDE: WHAT DO DOCTORS THINK?

Results from a 2014 survey of 21,000 physicians (17,000 U.S. and 4,000 European):

Should physician-assisted suicide be allowed (U.S. physicians)?

Yes	No	It depends
54%	31%	15%

Should physician-assisted suicide be allowed (European physicians)?

Yes	No	It depends
41%	41%	18%

Would you give life-sustaining therapy if you considered it futile (U.S. and European)?

Yes	No	It depends
19%	35%	46%

Would you go against a family's wishes and continue treating a patient whom you felt had a chance to recover (U.S. and European)?

Yes	No	It depends
22%	28%	50%

Leslie Kane, *Medscape Ethics Report 2014*, December 16, 2014, https://www.medscape.com/features/slide show/public/ethics2014-part1#21. Sample size: 21,531 physicians across 25+ specialties, September 18 through November 12, 2014; margin of error: +0.72 (U.S. sample), +1.55 (European sample); 95% confidence level.

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

The American Medical Association has denounced physician-assisted suicide as unethical and inconsistent with physicians' duty to promote healing and preserve life. Surveys suggest, however, that many doctors support the use of physician-assisted suicide, and over 70 percent of adults believe it should be legal in cases of terminal illness or incurable disease with severe pain. To date, it is legal in Washington, DC, and ten states: California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington. The U.S. Supreme Court has ruled that states may legalize or prohibit it as they see fit.

Part of the difficulty of making everyday moral decisions about end-of-life situations is that death itself is not so easy to define. Traditionally death was understood to occur when breathing and heartbeat ceased. A person who wasn't breathing and had no heartbeat was dead. But thanks to modern medicine, machines can maintain someone's breathing and heartbeat indefinitely—even though there is permanent loss of all brain function. Heart and lungs keep going, but the individual is irreversibly brain-dead and can remain that way for decades. By the traditional standard, the individual is alive, but this seems counterintuitive.

We seem to need a new concept of death—an important consideration since any notion we adopt would dramatically influence our judgments about morally permissible behavior toward the living and the dead. If we judge an individual to be dead, then we would presumably think her no longer a person. If she is no longer a person, then it would seem to be permissible to disconnect all life support, harvest organs from the body for transplant, or prepare the body for burial. But if, despite appearances, she is still a person, wouldn't doing any of these things be murder? If so, those who perform these acts would be morally and legally culpable.

In 1968 a committee at Harvard Medical School formulated a new way of conceiving death, a perspective that has since become the

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

AUTONOMY, MERCY, AND HARM

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

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

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

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

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

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

> treatment, however, [active] euthanasia may be the only release from their otherwise prolonged suffering and agony. This argument from mercy has always been the strongest argument for euthanasia in those cases to which it applies.[4]

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

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

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

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

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

> In the first case, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom, drowns the child, and arranges things so that it will look like an accident.
>
> In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in, planning to drown the child in his bath. However, as he enters the bathroom Jones sees the child slip, hit his head and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.
>
> Now Smith killed the child, while Jones merely let the child die. That is the only difference between them. Did either man behave better, from a moral point of view?[5]

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

Winston Nesbitt rejects Rachels's no-difference view, arguing that the real reason Smith

and Jones seem equally reprehensible is that they are both *prepared to kill*. If we assumed that Jones is ready to let his cousin die but is not prepared to kill him, we would judge Jones less harshly than Smith. If this is correct, Nesbitt says, then Rachels fails to make his case.[6]

Some argue against active voluntary euthanasia by advancing another kind of distinction—between *intending* someone's death and *not intending but foreseeing* it. This difference is emphasized in the doctrine of double effect, an essential feature of Roman Catholic ethics (see Chapter 2). Applying the distinction to euthanasia, we get this principle: It is wrong to intentionally harm someone (cause her death) to produce a good result (release from suffering, for example), but it is permissible to do something intended to produce a good result (release from suffering), even if the action leads to unintended but foreseen harm (her death). The difference is that in the former, a bad thing is directly intended; in the latter, a bad thing is not intended, only foreseen. By this formula, it would be wrong for a physician to try to relieve the chronic misery of a terminally ill patient by deliberately giving her high doses of morphine to hasten her death. But it would be morally acceptable for that physician to give the patient the same amount of morphine with the sole intention of easing her pain, even though the physician foresees that she will die as a result. (Giving a dying, suffering patient extremely high doses of analgesics to the point of unconsciousness and accelerated death is known as terminal sedation; provided the patient consents, it is legal and generally considered morally permissible in medical practice.)

IN DEPTH
OREGON'S DEATH WITH DIGNITY ACT

On March 6, 2020, the Oregon Health Authority released the annual report for the 22nd year of implementation of the Oregon Death with Dignity Act, the world's first assisted dying statute.

In 2019, 112 Oregon physicians wrote 290 prescriptions to dying Oregonians who qualified for the Act; 188 people died using the medications obtained under the law.

Similar to previous years, most patients

- were 65 years or over (75 percent), with the median age of 74;
- had cancer (68 percent);
- were on hospice at the time of death (90 percent);
- died at home (90 percent);
- had some form of health insurance (99 percent).

Consistent with past reports, the most frequently reported end-of-life concerns were loss of autonomy (87%), decreasing ability to participate in activities that made life enjoyable (90%), and loss of dignity (72%).

During 2019, the estimated rate of deaths under the law was 51.9 per 10,000 total deaths in the state.

Since the first Oregonian took medication under the law in 1998, a total of 2,518 people have received prescriptions under the Act, of whom 1,657, or 66 percent, have died from ingesting the medications.

These figures continue to underscore not only that only a small number of people use the law but also that more than one-third of those who received the medication took it, finding great comfort in merely knowing it was available to them.

From Death with Dignity, "Latest Report on Oregon Death with Dignity Act Shows Law Continues to Work as Intended," March 11, 2020, https://deathwithdignity.org/news/2020/03/2019-report-on-oregon-death-with-dignity-act/.

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

> In the case of euthanasia, just as in pain and symptom control, critics maintain, the physician's end may be the good one of relieving the patient's suffering. In neither case would death be wanted by the patient or the physician if the suffering could be avoided without it, but both patient and physician may be prepared to accept the patient's earlier death in order to relieve his or her suffering. Although the patient's death in the case of euthanasia may be the necessary means taken in the causal path to relief of suffering, it is the unavoidable side-effect following upon the relief of the patient's suffering in the causal path taken to achieve pain and symptom control.[7]

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

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

> [E]uthanasia as a policy is a slippery slope. A person apparently hopelessly ill may be allowed to take his own life. Then he may be permitted to deputize others to do it for him should he no longer be able to act. The judgment of others then becomes the ruling factor. Already at this point euthanasia is not personal and voluntary, for others are acting "on behalf of" the patient as they see fit. This may well incline them to act on behalf of other patients who have not authorized them to exercise their judgment. It is only a short step, then, from voluntary euthanasia (self-inflicted or authorized), to directed euthanasia administered to a patient who has given no authorization, to involuntary euthanasia conducted as part of a social policy.[8]

The key premise in most slippery-slope arguments, then, is an empirical claim that a policy permitting active voluntary euthanasia or assisted-suicide will lead to unjustified killing (involuntary euthanasia, for example). Much of the debate therefore has centered on whether any good empirical evidence supports such a premise. Unfortunately, scientific research on the issue has been limited, with most of it focused on the Netherlands (where physician-assisted suicide and active voluntary euthanasia have been legal since 2002) and on Oregon (where a law permitting physician-assisted suicide was passed by Oregon voters in 1994 but was not green-lighted until the Supreme Court decision of 2006). One question of particular interest has been whether vulnerable groups—the elderly, the poor, uninsured people, racial and ethnic minorities, people with psychiatric illness, women, people with little education, and others—have been at greater risk of physician-assisted death. Research in both Oregon and the Netherlands has found little or no evidence that this is the case. Opponents of legalization point to all the instances of Dutch physicians performing active euthanasia without the patient's consent (approximately 1,000 per year, or about

IN DEPTH
END-OF-LIFE DECISIONS IN THE NETHERLANDS

In the Netherlands, physician-assisted suicide and euthanasia (where a physician administers lethal medication explicitly requested by the patient) has been legal since 2002. This help in dying is permitted only for patients who are "suffering unbearably" without hope of relief. Physicians who investigated end-of-life decision-making from 1990 to 2015 reported the following:

- The number of patients involved rose from 5,197 in 1990 to 7,761 in 2015.
- In 1990, 1.7 percent of all deaths were the result of euthanasia; in 2015, 4.5 percent.
- In 2015, physician help in dying was requested by 8.3 percent of all deceased persons.
- The ending of life without an explicit request from patients in this 25-year-period decreased from 0.8 percent to 0.3 percent.
- The use of morphine as "terminal sedation" increased from 19 percent to 36 percent.
- A 2015 survey of physicians showed that "92% of the patients who received physician assistance in dying had a serious somatic disease; 14% had an accumulation of health problems related to old age, and a small minority had early-stage dementia (3%) or psychiatric problems (3%)."
- "About half of all requests for physician assistance in dying were granted in 2015. Such assistance is provided predominantly to patients with severe disease but increasingly involves older patients and those with a life expectancy of more than a month."

From Agnes van der Heide, Johannes J. M. van Delden, and Bregje D. Onwuteaka-Philipsen, "End-of-Life Decisions in the Netherlands over 25 Years," *New England Journal of Medicine* 377 (August 3, 2017): 492–94.

0.8 percent of all deaths nationwide). Proponents reply that most of those patients were already near death or had become incompetent after initially asking for euthanasia or that the euthanasia was passive, consisting of withholding or withdrawing treatment. Most of all, they emphasize that the few studies done so far do not demonstrate that legalization has significantly multiplied the cases of nonvoluntary euthanasia. Dutch authorities have reported that data gathered so far indicate that physician misconduct in euthanasia cases is extremely rare, despite rumors in the United States about rampant involuntary euthanasia committed by Dutch doctors.

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

APPLYING MAJOR THEORIES

Utilitarians can consistently adopt different views on active euthanasia and assisted suicide depending on how they define the good to be maximized, whether their moral focus is acts or rules, and how much importance they give to self-determination. Classic utilitarianism defines the good as happiness and would therefore judge the issues by how much happiness various actions might produce for everyone involved. From this perspective, euthanasia or assisted

IN DEPTH
PHYSICIAN-ASSISTED SUICIDE AND PUBLIC OPINION

When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?

	Yes, should	No, should not
All Adults	72%	27%
Gender		
Men	79%	20%
Women	65%	34%
Age		
18–29	85%	15%
30–49	72%	28%
65 and older	65%	34%
Church Attendance		
Attend church weekly	37%	60%
Attend church seldom/never	86%	14%

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

Morally acceptable	Morally wrong
54%	42%

Gallup Poll, "America's Strong Support for Euthanasia Persists," Megan Brenan. Results are based on telephone interviews conducted May 1–10, 2018, with a random sample of 1,024 adults aged 18 and older, living in all 50 U.S. states and the District of Columbia.

suicide for someone suffering horrible, inescapable pain might be permissible because ending life would bring about the most net happiness. Of course, the calculations would have to include other factors such as the psychological, social, and financial impact on the patient's family, friends, and caregivers. With everything factored in, the utilitarian answer could easily come out against euthanasia.

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

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

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

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

CLASSIC CASE FILE

Nancy Cruzan

In the 1990 case of *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court issued its first momentous ruling involving an individual's "right to die." The question was whether a feeding tube could be removed from a young woman named Nancy Cruzan, who had been left in a persistent vegetative state after a terrible car crash.

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

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

But authorities in the state of Missouri saw things differently. They sought to block the removal of Nancy's feeding tube. The Missouri Supreme Court said that the state has an extremely strong interest in preserving life and that the Cruzans may not disconnect their daughter's feeding tube without "clear and convincing evidence" of what Nancy would have wanted. At one time she had mentioned to a friend that she would not want to be kept alive like a "vegetable," but she had left no living will or other explicit instructions.

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

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

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

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

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

Rule-utilitarian approaches can lead to positions both favoring and opposing euthanasia and assisted suicide. Most slippery-slope arguments are essentially rule-utilitarian, asserting that a general policy of authorized killing will, step by step, take society down a path to awful consequences. The outcomes to be avoided are many, including increases in nonvoluntary or involuntary euthanasia, erosion of respect for the medical profession, and a weakening of society's abhorrence of homicide. Some also argue on rule-utilitarian grounds *for* a general policy, citing relief of suffering as the most obvious benefit.

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

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

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

KEY TERMS

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

SUMMARY

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

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

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

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

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

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

Cases for Evaluation

CASE 1

Doctor-Aided Suicide and "Vulnerable Groups"

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

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

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

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

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

"Would these patients be pressured, manipulated or forced to request or accept physician-assisted