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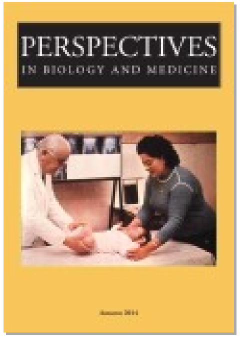

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THE CASE FOR LEGALIZED EUTHANASIA

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The recent referendum to legalize voluntary, active euthanasia in Washington state, which was narrowly defeated, has stimulated increased public discussion of this troubling ethical issue. In this paper we examine two recent statements against euthanasia, which together pose a seemingly formidable array of considerations against legalizing physician assistance of patients who request to die owing to terminal illness and unbearable suffering. One way to test a controversial moral position such as the legalization of euthanasia, which departs from the tradition of social morality and from traditional medical ethics, is to weigh the merit of the arguments against it. We offer a critique of these arguments and a different ethical view of the issues. In the last part of this paper, we recommend guidelines for a public policy framework to minimize abuses in social experiments with beneficent voluntary euthanasia that are approved by referenda or state legislatures. Such a framework was lacking in the Washington initiative and also to an extent in the Netherlands, where the practice of physician-performed euthanasia has become institutionalized but remains technically illegal.

"Always to Care, Never to Kill"

Under the heading "Always to Care, Never to Kill," thirteen[1] Jewish and Christian theologians, philosophers, and legal scholars issued a

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[1] The authors include: Hadley Arkes, Amherst College; Matthew Berke, First Things Magazine; Midge Decter, Institute on Religion and Public Life; Rabbi Marc Gellman, Hebrew Union College; Robert George, Princeton University; Pastor Paul Hinlicky, Lu-

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strong statement against euthanasia, published in *The Wall Street Journal* [1]. The authors' argument condemns the practice of euthanasia by appeals to "religious wisdom," "moral wisdom," "political wisdom," and "institutional wisdom." We consider seven assertions that the authors make in defense of their position.

1. *"Although it may sometimes appear to be an act of compassion, killing is never caring."*—It is widely considered humane treatment of animals "to put them out of their misery" when they sustain incurable, disabling injuries or diseases. Why is compassionate treatment of animals not compassionate when applied to humans? To kill innocent humans against their will or without their consent would be profoundly immoral. Killing incompetent patients who have never expressed a clear wish to be killed is prima facie morally wrong, even if they are terminally ill. But the issue at stake in the Washington referendum was the permissibility of killing competent patients who request to die owing to suffering from an incurable condition. Why is this "never caring"? Admittedly, caring may be misplaced. But to kill another who requests to be relieved of suffering may be an act of compassion or caring, whether or not it is considered morally legitimate. Caring is tacitly defined by the authors as conformity with traditional morality.

2. *There is a profound moral distinction ("deeply embedded in our moral and medical traditions") between killing and allowing to die.*—James Rachels has vigorously attacked the moral significance of this distinction. According to Rachels, "If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons" [2]. Rachels's argument may go too far, and he does not address adequately why some physicians consider physician-performed euthanasia morally objectionable under all circumstances. It seems highly dubious, however, that there is a morally decisive distinction between killing patients and allowing them to die, such that the former is always wrong and the latter is justified when the burdens of treating a terminally ill patient outweigh the benefits to the patient. Indeed, there may be cases when killing is more humane than allowing to die, insofar as it achieves a result *desired by the patient* more swiftly, and consequently with less suffering.

The authors fail to acknowledge the opening to voluntary, active euthanasia stemming from the accepted practice of allowing to die. Decisions by competent patients to forego life-sustaining treatment have become a routine, legally authorized practice in American hospitals. In

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theran Forum; Russell Hittinger, Catholic University of America; The Rev. Robert Jenson, St. Olaf College; Gilbert Meilaender, Oberlin College; Father Richard John Neuhaus, Institute on Religion and Public Life; Rabbi David Novak, University of Virginia; James Nuechterlein, First Things Magazine; and Max Stackhouse, Andover Newton Theological School.

addition, death by decision is also allowed with terminally ill, incompetent patients who have no written advance directives and when state law permits family members or other duly appointed surrogates to make this decision with physicians [3]. If patients (or surrogates for incompetent patients) can legitimately opt for death by deciding to withhold or withdraw treatment, why are patients forbidden to choose to be killed when suffering from an incurable condition, thus producing more swiftly the same desired result?

3. "Once we have transgressed and blurred the line between killing and allowing to die, it will be exceedingly difficult—in logic, law, and practice—to limit the license to kill."—Thus the authors invoke "the slippery slope," which is itself a rather slippery argumentative gambit. The slippery slope argument presumes that once we permit voluntary euthanasia, there is no stopping wholesale murder of those considered unworthy of living. Are we incapable of making morally valid discriminations between acceptable and unacceptable practice? Clearly we make such discriminations all the time in practices that permit research with human beings and animals but within rules designed to constrain abuses. Do we need to adhere slavishly to a questionable absolute moral distinction for fear of making grave moral mistakes?

No doubt, where there is use, there is the prospect of abuse. Though not without abuse, the experience with euthanasia in the Netherlands [4] suggests that the horrors prophesied by proponents of the slippery slope argument do not necessarily materialize. We discuss below the Nazi program of "euthanasia." The key moral issue in deciding whether to experiment with legalizing voluntary, active euthanasia is: can a policy be developed and implemented that maximizes the probable benefits of permitting voluntary, active euthanasia and minimizes the risks of morally objectionable abuses?

4. "Euthanasia, even when requested by the competent, attacks the distinctiveness and limitations of being human."—Obviously, what it means to be human in this context is a normative issue that biology, psychology, or medicine cannot presume to settle. It is worth noting, however, that a diametrically opposite conclusion has been argued forcefully by Joseph Fletcher in his pioneering book, *Morals and Medicine* [5]. For Fletcher, choice and control are distinctively human. Control over dying in the face of incurable suffering manifests human self-determination and dignity. Denying rational persons who are terminally ill the opportunity to receive active help to die in order to relieve unbearable suffering is arguably a violation of human personhood.

5. "If life is a thing that can be renounced or taken at will, the moral structure of human community, understood as a community of persons, is shattered. The result is a brave new world in which killing is defined as caring, life is viewed as the enemy, and death is counted as a benefit to be bestowed."—This brave new world is a figment of the authors' imaginations. No reasonable person would define killing as caring, though she or he might recognize cases in which killing at the request of a suffering person is the caring thing to do. Nor would a reasonable person declare that life is the enemy. Death may be a benefit to be bestowed if it relieves incurable and unbearable suffering. It was in this regard that pneumonia was known as "the old man's best friend." If it is merciful to avoid prolonging death by stopping treatment, why cannot voluntary, active euthanasia in some cases be construed as bestowing a benefit?

6. *The right to life is "unalienable."*—With all due respect to the Founding Fathers, to whom the authors appeal, the concept of inalienable rights is open to question. Baruch Brody argues cogently that all rights are waivable. Against the concept of inalienable rights he remarks, "It turns a right into something you are stuck with, and that is not the proper way of understanding rights" [6]. Even if some rights are considered genuinely inalienable, this does not amount to a valid consideration against voluntary euthanasia. The point of claiming a right to be inalienable is to rule out the legitimacy of arbitrary control over the life and liberty of individuals by other individuals or by institutions (particularly, the state). Thus, it is impermissible for a person to alienate his or her right to liberty by choosing to become a slave. The practice of voluntary euthanasia, however, does not surrender the life or liberty of persons to the arbitrary control of others. Rather, it enables competent patients to request physicians to effect their clearly expressed, considered wishes to be relieved of suffering from an incurable condition, by assisting with suicide or causing death.

7. *Euthanasia "undermines the integrity of the medical profession."*—The integrity of medicine is undermined by practices that violate the ends of the medical profession. There is no single end that medicine serves. The ends of medicine are several, and include preserving life, healing, promoting health and preventing disease, helping patients cope with illness or injury, and relief of suffering. Euthanasia would undermine the integrity of medicine if its practice could not be construed as serving any of these ends of medicine. Active euthanasia at the request of patients is incompatible with the medical ends of preserving life and healing. However, insofar as it is justified, voluntary euthanasia serves the beneficent end of relief of suffering and respects patient autonomy. It no more undermines the integrity of medicine than the practice of allowing to die, which is also incompatible with the ends of preserving life and healing.

Legalizing voluntary, active euthanasia is a complex issue. One cannot be sure that the benefits would outweigh the harms. Reasonable persons may differ on the morality of euthanasia and on the probable consequences of legalizing it in some form. Taking a stand is a matter of judgment, which is inherently fallible. However, the authors' statement against euthanasia evinces an aura of infallibility. They show no signs of recognizing that they may be mistaken in their judgment that physician-performed euthanasia must be prohibited under all circumstances. Nor do they acknowledge that the opposing side may have morally significant considerations in its favor. Instead of careful argument, they offer slogans—"Always to care, never to kill"—and pronouncements. In sum, the authors present dogmatism and absolutism masquerading as wisdom.

AMA Statement on Euthanasia

The American Medical Association's Council on Ethical and Judicial Affairs addressed euthanasia in a 1991 Report entitled "Decisions Near the End of Life" [7]. It is a balanced and temperate statement that strongly endorses the duty of physicians to respect the wishes of competent patients to forego life-sustaining treatment, including artificial nutrition and hydration. The Report also endorses the practice of "providing effective palliative treatment [to relieve pain and suffering] even though it may foreseeably hasten death" [7, p. 15]. The Council draws a line, however, that excludes the permissibility of euthanasia and assisted suicide.

The Report acknowledges that the value of patient autonomy—the ground for decisions to forego life-sustaining treatment—is at stake in requests for euthanasia. Yet it notes that autonomy "does not give patients the right to demand euthanasia" [7, p. 11]. This formulation may be misleading. Patients have a right to demand any treatment they want. The issue is whether physicians have a duty to comply. The Report rightly asserts that physicians have no obligation to offer or provide a lethal dose of medicine to relieve suffering. Autonomy supports the right of patients to refuse treatment offered by physicians; it does not justify a right to treatment considered medically inappropriate. If euthanasia were to be legalized under circumscribed situations, physicians opposed to euthanasia, like those opposed to abortion, would not be obligated to provide it. As the Report asserts, "At issue is whether it is ever ethical for physicians to offer euthanasia in certain circumstances" [7, p. 11].

Consistent with clinical reasoning, the Report considers the potential benefits and risks of euthanasia. The sole potential benefit cited is relief of pain and suffering, which other medical intervention, short of death, cannot accomplish. Although relief of suffering is the primary ethical consideration in favor of euthanasia, it is not the only potential benefit. Patients may also benefit from knowing that the timing of death is under their control; accordingly, they are not constrained to linger indefinitely in a condition of intolerable suffering or indignity. Furthermore, the assurance that a physician stands ready to cause or assist in death when the patient determines that his or her suffering is no longer bearable can provide relief from crippling anxiety and can help the terminally ill patient make the most of the short time remaining in his or her life.

Certainly, euthanasia is not a desirable option for all or most terminally ill patients. Some patients insist that they receive all medical means to preserve their lives until death arrives. Some patients prefer to "let nature take its course," by foregoing life-sustaining treatment and receiving only comfort care. Good clinical care of dying patients, including adequate pain relief, is likely to minimize the number of patients who seek to end their lives. Yet there is no guarantee that the best care is sufficient to relieve suffering and preserve the dignity of patients. Some patients will prefer to end their lives by suicide or active euthanasia when they find them no longer worth living [8]. Should physicians assist competent patients who wish to terminate their lives?

A distinguished group of twelve physicians (with two dissenting members) stated their belief that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person" [9]. However, they disapproved of physician-performed euthanasia: "Many physicians oppose euthanasia because they believe it to be outside the physician's role and some fear that it may be subject to abuse" [9, p. 849]. Assisted suicide and active euthanasia are not identical. In the former, the physician provides the patient with the means to end his or her life; in the latter, the physician directly intervenes to cause the death of the patient. Nevertheless, we are not persuaded that there is a morally significant difference between assisted suicide and active euthanasia—a difference that would justify considering assisted suicide as potentially within the physician's role but would rule out active euthanasia. In both types of conduct, physicians are actively involved in, and thus responsible for, helping the patient to die. Moreover, both forms of ending lives, at the request of competent patients, are directed at relieving patients from unbearable suffering and respect their autonomous preferences. Nor do we see why active, voluntary euthanasia is more subject to abuse than assisted suicide. We argue below for a policy of prior committee review of requests for assisted suicide and active euthanasia to safeguard against potential abuses and promote accountability.

Another potential benefit of physician-performed euthanasia is the prevention of untimely and secretive suicides, which apparently cause more acute bereavement problems in survivors than do other types of deaths [10]. Since 1980, the rate of suicide[2] among the elderly, especially

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[2] Although the psychosocial well-being of the elderly in the United States is significantly different in quality and hope than that of their predecessors in previous generations, the

among elderly white men, has been rising [11]. Geriatric psychiatrists correctly cite lack of treatment for major depression as a primary contributing factor [11, p. 339]. We raise the question as to whether the perception of lack of options in the circumstances of dying also contributes to this high rate of "lonely" suicides among the elderly. We favor a position that, under legally authorized conditions, permits either physician-performed euthanasia or physician-assisted suicide, in addition to the "allowing to die" option. Some patients may prefer to end their own lives, but the assurance of having a physician in attendance would overcome the fear of failure and isolation. If the acts were open and planned, the context and quality of bereavement would also change. Until such options do become legal, axious persons may be tempted to commit secretive suicide or to ask physicians to participate in secretive, assisted suicide. Some of these acts may be ill-considered or premature, and they could be prevented by giving persons, with the help of their physicians, more control over the circumstances of their dying. Thus, the dying process would be relieved of some of its secrecy and made more accountable. In sum, the involvement of physicians in assisted suicide or active euthanasia at the request of competent patients is desirable in order to assure the voluntariness of the request, the incurability of the conditions from which the patient is suffering, a caring presence at the time of death, and a swift and painless death.

Why is it that personal autonomy, so prized in this society, is snatched away at the point of death? One answer is that religious leaders and leading physicians, such as those who endorsed the AMA statement, foresee more probable harm than probable benefits from the practice of euthanasia in this culture.

In this vein, the AMA Report cites three sorts of "serious risks associated with condoning physician-performed euthanasia" [7, p.12]. First, it might "undermine public trust in medicine's dedication to preserving the life and health of patients. If physicians are licensed to kill, even under well-defined conditions, it might arouse fears in patients that they will be subjected to involuntary euthanasia. Patients might feel pressured to comply with recommendations of physicians (or others) that euthanasia is appropriate in their case.

These concerns are certainly serious, since the profession of medicine

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suicide rate is high and has been rising slowly since 1980. In 1986, it was up to 21.6 per 100,000 (a 25 percent increase since 1980), whereas the national rate was 12.8 per 100,000 in 1986. The suicide rate among those over 65 years of age is higher than in younger cohorts, largely due to very high rates among older white men. In 1984, the rate of suicide in the general population was 11.6 per 100,000, and for white men 65 or older, it was nearly four times higher, 41.6 per 100,000. This rate is three times that for older black men, six times that for older white women, and 24 times that for older black women [11, p. 112].

depends on a relationship of trust between physicians and patients. However, if legalized euthanasia is confined to killing at the request of competent patients, then it should not undermine trust. Guidelines for legalized euthanasia must guard against patients being pressured to accept it. It is also arguable that trust in physicians might be enhanced by legalized voluntary euthanasia, at least for some patients, who will have the assurance that a physician will not abandon them to their suffering but will intervene to end a life that the patient believes has become unbearable. Such trust would be especially evident in cases where patients had been "saved" by technology and physicians' skills several times from the brink of death, as often occurs in long-term cancer treatment [12]. Some patients may feel, as we do, that it is morally contradictory and even cruel for the same physicians who have "saved" them from death several times to then abandon them in their request to die swiftly when death is inevitable. There is a time to die and a responsibility to help patients die from which contemporary physicians shrink at the risk of losing more trust and confidence.

Yet another reason to believe that public trust in physicians would not be seriously undermined derives from studies of attitudes among the public, and to some extent among practicing physicians, towards legalized euthanasia. To date, such studies indicate that about one-third to one-half of physicians [13–15] and about sixty percent of the public [16–18] would support legalized euthanasia.[3]

The second risk associated with condoning physician-performed euthanasia is that mounting concern over health care costs, particularly the enormous expense of caring for persons at the end of life, might generate incentives in favor of inappropriate euthanasia. If patients are

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[3] Estimates of physician attitudes are drawn from one national and two state surveys. A 1988 Harris poll [13] of a sample representative of U.S. physicians found that 30 percent favored euthanasia if a terminally ill patient requested it (60 percent believed it was wrong and 4 percent were "not sure"). A 1988 survey of 7,095 Colorado physicians [14], with a 31.3 percent response rate, found that 60.1 percent had attended a patient for whom they believed active euthanasia would be justified if it were legal, and 58.7 percent would "personally have been willing to administer a lethal dose of medication." A 1991 survey [15] of 2,000 randomly selected physician members of the Washington State Medical Society had a 55 percent response rate, and found 51 percent opposed and 49 percent supported Initiative 119 to legalize euthanasia.

Estimates of public attitudes are based on one national, one regional, and one state survey. A 1990 Roper report [16], based on face-to-face interviews with 1,978 adult men and women in their homes, asked this question: "When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?" Sixty-four percent answered that it should be allowed by law. A Roper poll [17] of 1,500 persons in California, Oregon, and Washington posed the same question, and 68 percent said that it should be allowed by law. In 1990, a social research center at the University of Washington [18] completed 56.6 percent of 1,150 telephone interviews with adult respondents. This study found that 54.8 percent agreed with legalizing euthanasia.

certain to die in a short period of time, why not persuade them to get it over with quickly and thus save time, effort, and money? One should not underestimate the distortions of medical care that cost considerations motivate in our system of health care. Guidelines and review procedures would need to be carefully tailored to minimize this risk.

Finally, there is a risk of abuse that stems from the inherent difficulty of determining whether euthanasia is appropriate, e.g., whether the patient has a terminal illness and the request is genuinely voluntary. The Report notes [7, p. 13] that "In the Netherlands, where euthanasia seems to be fairly successful, physicians who provide euthanasia generally have a life-long relationship with the patient." How can abuse be prevented or minimized where physicians typically meet patients as relative strangers? We consider below a proposal for mandatory prior review of euthanasia by an impartial committee as a safeguard against these, and other, risks of abuse.

Under this third category of risks the Report makes [7, p. 13] the following point: "Furthermore, since it will be physicians and the state who would decide which patients are eligible for euthanasia, value judgments about patients' lives will be made by another person or entity than patients." This concern seems misplaced in the case of legalized euthanasia restricted to voluntary requests of patients; for the patient's judgment that his or her life is not worth living is a necessary condition for a determination that euthanasia is appropriate. The value judgments of others concerning patients' lives do not determine eligibility for, or appropriateness of, euthanasia.

It is important to recognize that the three risks cited by the AMA Council's Report are not unique to the practice of euthanasia. The accepted practice of foregoing life-sustaining treatment (allowing to die), endorsed by the Council, poses the same sorts of risks. Pressuring patients to forego life-sustaining treatment may erode some patients' trust in the profession of medicine, particularly those with vitalistic beliefs who are disposed to demand that "everything be done" in the face of terminal illness or persistent vegetative state. This risk is also seen in cases where physicians pressure relatives with vitalistic beliefs to forego treatment when the patient is incapacitated and moribund [19]. Cost constraints can also contribute to recommendations and pressure to withhold or withdraw expensive life-sustaining treatment. Nor is it always easy to draw the line between cases in which foregoing treatment is or is not appropriate. Legalized euthanasia, therefore, would not introduce these risks of abuse into the practice of medicine, though it might pose additional risks. More significantly, if the risks of abuse can be reduced satisfactorily in the practice of foregoing life-sustaining treatment, why would this be impossible under a carefully circumscribed policy of legalized euthanasia?

It is to the credit of the Council that its recommendation against legalized euthanasia does not amount to an absolute moral prohibition. The Report concludes [7, p. 15] that "the societal risks of involving physicians in medical interventions to cause patients' death is [sic] too great in this culture to condone euthanasia and assisted suicide at this time." This is a reasonable opinion. In our view, however, none of the cited considerations against euthanasia, separately or in combination, are sufficiently persuasive to undermine the case for a carefully designed social experiment with legalized, voluntary euthanasia.

The Nazi "Euthanasia" Program

Lurking behind the "Always to Care, Never to Kill" statement, the AMA Report, and other arguments against euthanasia is the Nazi experience. Beginning around 1939, the Nazis instituted a program of "euthanasia" directed against hospitalized children considered unfit and against adult mental patients. In his remarkable book *The Nazi Doctors,* Robert Jay Lifton documents in detail this harrowing story and probes the motivations and beliefs of the perpetrators [20]. Physicians played a central role in planning and executing this program. The methods of "euthanizing" patients included injections administered by physicians and nurses of lethal doses of medication, starvation, and gassing with carbon monoxide. The latter method, pioneered in the "euthanasia" program, was applied systematically against Jewish and other prisoners of the Nazi extermination camps. Lifton sees the "medicalized killing" practiced in the "euthanasia" program as a vital link in the chain leading to the systematic genocide perpetrated at Auschwitz:

> My argument in this study is that the medicalization of killing—the imagery of killing in the name of healing—was crucial to that terrible step. At the heart of the Nazi enterprise, then, is the destruction of the boundary between healing and killing. [20, p. 14]

Any form of legalized active euthanasia necessarily crosses the boundary between healing and killing. Does crossing this boundary lead inevitably to gross abuses? We think not. Surely there is a profound moral difference between the Nazi "euthanasia" program and medicalized killing at the voluntary request of competent patients suffering from an incurable condition. The Nazi program involved systematic involuntary killing. Death certificates were falsified by physicians, who endeavored to choose plausible causes of death for the exterminated patients. The Nazi program, authorized by Hitler, was administered by the state through the intervention of the Health Ministry and was executed in state institutions. A racist biological world-view legitimized the "euthanasia" program in the eyes of the doctors who planned and administered it. By eliminating "life unworthy of life," the Nazi "euthanasia" program was believed to contribute to promoting the health of the Aryan race and thus of humanity in general. Entirely absent from the Nazi program was voluntary request for death on the part of the suffering patients, and patient-centered beneficence on the part of physicians concerned to relieve incurable suffering.

The Voluntariness of Requests for Euthanasia

How can the healer legitimately act to terminate the life of a patient? Only, we believe, if assisted suicide or active euthanasia is undertaken in response to a voluntary request of a competent patient suffering from a terminal illness. It seems cruel and morally inconsistent for a society that so highly values autonomy to deny this choice in appropriate cases to such patients, especially when there is strong public support for choice and when many physicians who share this view are willing to be active in helping patients die [13–18]. To insist on the voluntariness of legitimate euthanasia, however, raises another difficulty. Can decisions to seek death by euthanasia be genuinely voluntary and autonomous? In his case against euthanasia, Carlos Gomez stresses the vulnerability of suffering patients:

> Irrespective of how highly among a hierarchy of values one wishes to elevate patient autonomy, one cannot escape the fact that the patient, by virtue of his or her disease, comes to a physician under particularly unprotected circumstances. Debilitated by illness, weary, almost always anxious or afraid, a patient is necessarily in an unequal position with respect to the physician, by virtue of both his or her illness and the physician's presumed skill and knowledge on matters medical. When a patient is dying, when he or she is racked by pain to the point of "unbearable suffering," that patient, I would contend, is even more vulnerable. [21].

Gomez, however, stops short of denying the possibility of voluntariness and autonomy with respect to euthanasia.

Eric Cassell seems to go further, in an article on the importance for clinical ethics of understanding suffering:

> the purposes of the suffering individual are no longer subsumed under an organized unity. This loss of unity is why suffering persons are not autonomous and not free and cannot clearly articulate what is in their best interests. [22].

Cassell argues that it is the responsibility of the physician to help the suffering patient achieve genuine self-determination, but he does not address whether this might include voluntary, active euthanasia. Nevertheless, the categorical claim that suffering patients are neither autonomous nor free seriously challenges the legitimacy of voluntary euthanasia at the request of suffering patients. Against this claim we cite two cases from the literature.

The first is the death of Sigmund Freud [23], who requested that his personal physician end the suffering he had long endured from cancer of the mouth. Peter Gay, Freud's biographer, remarked of Freud's death by euthanasia, "The old stoic had kept control of his life to the end" [24]. If Gay's account is credible, Freud exercised autonomy in the face of great suffering. The second case is Timothy Quill's recent report of assisted suicide [8]. Quill's patient, Diane, autonomously refused treatment for leukemia and opted for suicide when her condition became unbearable. These cases may not fairly represent the degree of autonomy possessed by many patients who request to die in the face of unbearable suffering. Moreover, it may be true that in all cases severe suffering diminishes, to some extent, a person's autonomy. But it is dubious that suffering invariably or almost always destroys the autonomy that healthy patients enjoy.

If suffering were to negate autonomy, the implications would be momentous. It would undermine informed consent to treatment and participation in research for patients suffering from life-threatening and painful illnesses. In addition, it would call into question the voluntariness of patients' decisions to forego life-sustaining treatment in similar situations to those in which some patients may request euthanasia. If this argument is directed uniquely against euthanasia, it needs to be shown that the suffering behind requests to be killed is a greater threat to voluntariness and autonomy than the suffering experienced by patients who are faced with decisions regarding standard treatment, participation in research, and foregoing treatment. We see no reason to deny the possibility of autonomous decisions to undergo euthanasia. The prospect of diminished autonomy, however, underscores the need for careful consideration of the voluntariness of patients' requests.

Safeguards Against Abuse

What safeguards could be implemented to assure that crossing the boundary between healing and killing (at the request of patients) would not lead to unconscionable abuse? We suggest that there is a fruitful analogy between the regulation of medical research on human subjects and the regulation of legalized voluntary euthanasia. Just as the Nazi "euthanasia" program and genocide lie at the bottom of the slippery slope when the boundary between healing and killing is crossed, so the coercive and brutal Nazi medical experimentation on human subjects lies at the bottom of the slippery slope when the boundary between treatment and research is crossed. The analogy might be contested on the grounds that research, although potentially liable to abuse, serves the humanitarian purpose of promoting health, whereas active euthanasia, since it involves killing of innocent persons, is always morally wrong. But this begs the question with respect to the morality of euthanasia.

The analogy, however, serves to convey three points of similarity between the two activities. First, both euthanasia and research involve physicians in an inherent conflict of responsibilities. The research imperative, concerned with producing general knowledge, potentially conflicts with total dedication to the best interests of the individual patient; likewise, euthanasia to relieve suffering conflicts with the physician's duty to heal and preserve life. Second, the analogy reminds us that patients in each situation are quite vulnerable. Patients in the context of research may be unduly pressured to participate by physician-investigators; terminally ill patients may be vulnerable to (actual or perceived) pressure to end life more quickly if euthanasia were legally permitted. Third, the justification of euthanasia appeals to the same principles as the justification of research on human subjects: respect for persons and beneficence [25].

Prior review and approval by an Institutional Review Board (IRB) is the major means by which the protection of human subjects of research is assured. The conscience of the physician-investigator is the greatest protection after a research project begins. For all institutions receiving federal funding, committee review and approval by an IRB is mandatory before biomedical research involving human subjects can be initiated. The principal tasks of an IRB are to scrutinize the reasonableness of the risk-benefit ratio of research protocols and the procedures for obtaining informed consent of research subjects, including a proposed written explanation of the study to subjects [26]. Mandatory prior committee review is likewise essential to safeguard a practice of legalized euthanasia or physician-assisted suicide.

How might this approach be translated into public policy and legally enforced? Here we offer three general guidelines to promote discussion concerning social experiments with euthanasia by one or more states. To guard against abuse, a considered legal and public policy framework is needed for these experiments.

The premise of a public policy in this arena is that it is in the best interests of persons, families, and their communities to promote choice and control of the circumstances of dying, within the constraints of a publicly supported review process of the competence of patients who make requests and of the voluntariness of their decisions. The policy continues and builds upon the past evolution of morality and law, in terms of respecting the desires of competent adults. In an emergent public policy, dying persons will have more options: (1) to die as a consequence of withholding or withdrawing treatment, by their own choices to refuse treatment or by advance directives in the case of incapacity;

(2) to die by voluntary euthanasia administered by a licensed physician in attendance, after review by a duly appointed committee; or (3) to die by self-administered means, with the assistance of a licensed physician in attendance, after review of a duly appointed committee. State law would protect these options and immunize from prosecution physicians who respected patients' preferences. The law would require that the death certificate completed by the attending physician state that euthanasia or assisted suicide was the cause of death, and that a document certifying committee review and authorization be submitted to the appropriate authorities along with the death certificate. Physicians responsible for killing patients who did not follow the legally stipulated guidelines and procedures would be liable to prosecution, just as physicians who do not respect advance directives are so liable today. Obviously, to institute such a policy, detailed procedures would need to be carefully designed and monitored.

The first guideline for such procedures would be that euthanasia is only permitted on the request of competent, terminally ill patients whose conditions were incurable by proven medical means. Following the guidelines of a Hastings Center task force, we define "terminal illness" as follows:

> an illness in which, on the basis of the best available diagnostic criteria and in the light of available therapies, a reasonable estimation can be made prospectively and with a high probability that a person will die within a relatively short time. [27]

What constitutes a "relatively short time" is a matter of judgment. We recommend that this period be no more than six months, as this would clearly limit permissible euthanasia to patients who are dying or will die shortly. Some competent patients will become terminally ill as a consequence of refusing proven or unproven treatments [8], and if such patients request euthanasia, they would also be subject to the recommended guidelines.

The second guideline would be that prior review by a publicly authorized and supported committee is required before physicians could actively assist to bring about the death of the patient. The third guideline would be a required statement by the attending physician that the means of death was euthanasia or assisted suicide, and proof of prior committee review and concurrence.

The major functions of the committee would be (1) to confirm that a patient requesting assistance in dying is terminally ill, (2) to assure that the patient is capable, and (3) that her or his request for assistance in dying is genuinely voluntary. Physicians receiving a request for euthanasia and the committee would need to probe whether the request is the result of a treatable depression or other psychiatric disorder, or inappropriate influence. As in the case of informed consent to research, patients need to understand the availability of alternatives to euthanasia, such as comfort care in the context of a hospice program.

To discharge the committee's review functions, it would seem necessary for at least one properly qualified committee member to interview the patient to assure decision-making capacity and voluntariness. In addition, two physician members of the committee would need to review the medical facts and determine that the patient's condition is terminal and incurable. Because death is the result of euthanasia, committee review should be mandatory: the seriousness of error is too great to make review merely optional at the initiative of physicians in doubtful or difficult cases. The committee would not approve the act of euthanasia; rather, it would determine whether a patient's request for euthanasia meets the legal criteria of permissibility. The decision to seek death rests with the patient; the decision to comply rests with the physician. In other words, the legitimacy of euthanasia depends on an informed and willing patient and a willing physician, subject to legal guidelines and committee review.

Institutional ethics committees, now mandated by law only in Maryland [28, 29], should not review patient requests for euthanasia. These groups, now institutionally based, tend to be large and to serve diverse purposes, among which are consultation to resolve ethical conflicts. Ethics committee review of cases is not mandatory, and findings of ethics consultants or committees are typically given as recommendations that may have ethical weight but are not legally binding. The law creating more options in the dying process should authorize special review committees that are accountable to the public. In this respect, these committees would be similar to IRBs. Within the National Institutes of Health, an Office of Protection from Research Risks is responsible for overseeing a national process of "assurances," by which institutions demonstrate to the federal government, and thus to the public, that they comply with the principles and practices of protection of human subjects. Using the same analogy within a state framework, one source—perhaps the office of the medical examiner—can be charged with overseeing an assurance process from communities or institutions that want to exercise the options in the dying process granted by referendum or vote of the legislature. The costs of such oversight and support of the activities and records of the committee need to be publicly supported to insure the best process of accountability and public trust.

The committees need to be small and specialized so that their members are qualified to assure that the patient requesting euthanasia is both capable of choice and that the choice is voluntary. Each community needs to have its own committee, the more adequately to respond to requests in a timely and responsible way. We leave open for more discussion the precise legal mechanisms for accountability and appointment of such committees, as well as for their deployment and support. However, mandatory prior review of patient requests for euthanasia or assisted suicide would be a requirement to minimize abuses and maximize benefits of a public policy that approved this practice. Otherwise, we see little chance for change in current practice.

Mandatory committee review would obviate some of the problems associated with the practice of euthanasia in the Netherlands, where active euthanasia remains illegal. Physicians, however, are assured that they will escape prosecution if they follow certain guidelines. In the Netherlands, regulation, in fact, falls to the professional discretion of physicians, since no impartial committee review is mandated and euthanasia is not regularly reported as the cause of death [4, 21]. Decisions to die by euthanasia are too ethically problematic to be left to the privacy of the physician-patient relationship. Furthermore, we oppose the position of leaving the law against euthanasia unchanged while conducting a social experiment. On grounds of respect for law and public accountability, we recommend legalizing voluntary euthanasia subject to prior committee review.

Conclusion: The Path to Legalized Euthanasia

How should a complex, contested ethical issue such as legalization of euthanasia be settled in a liberal, democratic society? Though it concerns the professional ethics of health care providers, it is also an issue of social morality and of interest to all citizens. Therefore, determination of policy on euthanasia should be determined by state referenda or legislatures. There is no better method than the practices and procedures of democratic decision making—the vote of the people (or their representatives) following open, public debate—for determining the norms by which a people will be governed.

One of the virtues of our federal system of government is that we can learn from the policy experiments that individual states institute by the democratic process. We predict that it will not be long before one or more states vote affirmatively to license physicians to perform euthanasia or to assist in suicide at the request of competent patients suffering from incurable illness. Then it will become possible to test whether this moral experiment produces more benefit than harm.

REFERENCES

1. *The Wall Street Journal,* Nov. 27, 1991, p. 1.
2. RACHELS, J. Active and passive euthanasia. In *Euthanasia,* edited by R. BAIRD and S. ROSENBAUM. Buffalo: Prometheus Books, 1989. p. 49.

3. Weir R. F., and Gostin, L. Decisions to abate life-sustaining treatment for nonautonomous patients. *J.A.M.A.* 264:1846–1853, 1990.
4. Van der Maas, P. J.; Van Delden, J. J. M.; and Pijnenborg, L. Euthanasia and other medical decisions concerning the end of life. *Lancet* 338:669–674, 1991.
5. Fletcher, J. F. *Morals and Medicine.* Princeton: Princeton Univ. Press, 1954.
6. Brody, B.A. *Life and Death Decision Making.* New York: Oxford Univ. Press, 1988. p. 22.
7. American Medical Association, Report of the Council on Ethical and Judicial Affairs, Richard J. McMurray, M.D., Chairperson. "Decisions Near the End of Life." 1991 Report: B.
8. Quill, T. E. Death and dignity: A case of individualized decision making. *N. Engl. J. Med.* 324:691–694, 1991.
9. Wanzer, S. H.; Federman, D. D.; and Adelstein, S. J. The physician's response toward hopelessly ill patients: A second look. *N. Engl. J. Med.* 320:844–849, 1989.
10. Frierson, R. L. Suicide attempts by the old and the very old. *Arch. Int. Med.* 151:141–144, 1991.
11. Warheit, G.; Longino, C. F.; and Bradsher, J.E. Sociocultural aspects. In *Comprehensive Review of Geriatric Psychiatry,* edited by J. Sadavoy, L., Lazarus, and L. Jarvik. Washington, DC: American Psychiatric Press, Inc., 1991. p. 112.
12. Benrubi, G. I. Euthanasia—The need for procedural safeguards. *N. Engl. J. Med.* 326:197–199, 1992.
13. Louis Harris Poll. Making difficult health care decisions. For Loran Commission, New York, 1988.
14. Abrams, F. R. Licensed physician questionnaire—anonymous poll. Boulder: Center for Health Ethics and Policy, University of Colorado (unpublished), 1988.
15. Gianelli, D. M. Washington state physicians divided on proposal to legalize euthanasia. *American Medical News,* April 1, 1991. p. 1.
16. The Roper Organization. Terminal illness attitude study. Prepared for National Hemlock Society, P.O. Box 11830, Eugene, OR 97440-3900, 1990.
17. The Roper Organization. The Roper poll of the West Coast. Prepared for National Hemlock Society, P.O. Box 11830, Eugene, OR 97440-3900, 1991.
18. Washington State University Omnibus Survey, Part Three. Data Report #90-45. Social and Economic Sciences Research Center, Pullman, WA 99164-4014, 1980.
19. Miles, S. H. The case of Helga Wanglie. A new kind of "right to die" case. *N. Engl. J. Med.* 325:511–515, 1991.
20. Lifton, R. J. *The Nazi Doctors.* Part I. New York: Basic Books, 1986.
21. Gomez, C. F. *Regulating Death.* New York: Free Press, 1991. p. 134.
22. Cassell, E. J. The importance of understanding suffering for clinical ethics. *J. Clin. Ethics* 2:82, 1991.
23. Miller, F. G. Is active killing of patients always wrong? *J. Clin. Ethics,* 2:130–132, 1991.
24. Gay, P. *Freud.* New York: Norton, 1988. p. 651.
25. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research." Washington, DC: U.S. GPO, GPO 887-809, April 18, 1979.
26. 45 *U.S. Code of Federal Regulations* 46:107–117, Rev. March 8, 1983.

27. Bayer, R.; Callahan, D.; and Fletcher, J. C. The care of the terminally ill: Morality and economics. *N. Engl. J. Med.* 309:1490–1494, 1983.
28. Act of May 27, 1986, ch. 749, 1986 MD. LAWS 2841 (codified as amended at MD. HEALTH-GEN. CODE ANN. 19-370-374, 1990.
29. Symposium on Hospital Ethics Committees and the Law. *Maryland Law Rev.* 50:742–919, 1991.

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