On the Moral and Social Implications of Legalized Euthanasia:
An Argument for the Moral Permissibility of Euthanasia and an Evaluation of the Leading Moral and Social Objections to Legalized Euthanasia in Support of the Continuation of Death with Dignity Initiatives

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I Hereby Reaffirm the Lawrence University Honor Code:

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Part I – Legal and Social Context

Introduction

It is increasingly likely for Americans to die in institutions from chronic illnesses and public concern has become increasingly focused on how society can best protect the dignity and independence of individuals as they reach the end of life. There is a broad movement within the medical community to improve the quality of end of life care, and this trend is most aptly illustrated by the freedom granted to physicians in providing adequate pain control at the end of life; a goal which can be pursued even to the point of hastening death. Yet the process of dying has been extended by the proliferation of medical technologies available to us and many of us will die while experiencing unnecessary pain. Furthermore, studies show that an overwhelming majority of Americans express a desire to die at home, and yet the vast majority of us will die in health care facilities.¹ The current trend in public debate favors the discussion of death and the current level of care provided at the end of life with an emphasis on honesty and openness and this increasing level of discussion is being matched with broad social movements to improve the care provided for the dying.

However, to many, dying “well” involves having a certain amount of control over the place and manner of our deaths. Patients nearing the end of their lives often express concerns about receiving inadequate pain control, receiving too much care, or receiving too little care. To a large extent, these and similar issues can be adequately addressed within the current ethical and legal framework governing medical care. Yet, there are many patients who express a desire to obtain assistance in dying at the place and time of their choosing. The recent passage of the Oregon Death with Dignity Act, which legalizes physician-assisted suicide and regulates the practice, has encouraged both public and scholarly debate on the topic of legalized euthanasia. It this concern, whether or not patients who request assistance in dying ought to be able to legally obtain euthanasia, which I will primarily address. I argue that individual acts of euthanasia can be morally justified and that euthanasia ought to be a legitimate medical option for those patients...
who request assistance in dying. Individuals ought to be free to determine for themselves the manner in which they wish to die. A physician willing to provide euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying ought to be legally permitted to provide the kind of care that the patient desires. Furthermore, legalizing and regulating the practice of euthanasia will serve to increase the quality of care provided at the end of life.

The leading objections against the moral permissibility of euthanasia fail to adequately demonstrate that individual acts of physician-assisted death cannot be morally justified and are incompatible with currently accepted medical practices. While some patients and physicians might understandably wish to avoid hastening death as much as possible, patients experiencing irremediable suffering can legitimately request euthanasia; this is a point on which even those staunchly opposed to legalized euthanasia agree. However, some critics have argued that the potential abuses of poor or otherwise vulnerable patients would outweigh the benefits of legalizing and regulating the practice, regardless of whether or not individual cases of euthanasia can be morally justified. Furthermore, some critics worry that pressing for the legalization of euthanasia will ultimately result in decreasing the level of care provided at the end of life. I argue that an honest and open-minded evaluation of the leading concerns regarding the moral and social implications of legalized euthanasia reveals that these fears are largely unfounded or misguided and do not adequately justify a blanket prohibition against euthanasia.

In Oregon, the legitimate medical option of physician-assisted suicide has not been disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking in end of life care. Furthermore, Oregon physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications to alleviate physical suffering, to improve their ability to recognize psychiatric disorders, and have been referring more patients to hospice care since the passage of the Act. The results of this Death with Dignity initiative in Oregon have thus far demonstrated that the feared abuses are not occurring and that the goals of better health care and legalized euthanasia are not mutually exclusive; rather, they can be pursued in harmony. I argue that Oregon should be allowed to proceed with its self-proclaimed bold experiment, and I support the
continuation of Death with Dignity initiatives as a legitimate movement likely to improve the quality of care provided to patients at the end of life.

**The Legal Landscape**

The euthanasia debate in the United States began, in a sense, with the legal proceedings surrounding the right to withhold or withdraw of life sustaining treatment. The courts have consistently rejected a distinction between withholding and withdrawing life sustaining treatments, as well as a distinction between ordinary and extraordinary treatment. Thus, artificial nutrition and hydration are considered to be medical treatment that competent patients or proxies may refuse, based on the constitutionally protected and deeply personal right of the individual to refuse to consent to invasive bodily intrusion or to refuse to continue life sustaining treatment. However, if there is a constitutionally protected right to assistance in active euthanasia or physician-assisted suicide, it has yet to be recognized and upheld in the United States legal system.

**Karen Quinlan**

The first landmark case of this sort involved Karen Quinlan, a 21 year old woman who suffered irreparable brain damage after she ceased breathing for unknown reasons during a birthday party. Karen was treated aggressively, placed on a respirator, and given artificial nutrition and hydration even though she was eventually diagnosed as being permanently comatose. The cost of maintaining Karen, which was nearly $450 per day, was being covered by the state.

As more and more possible causes of her coma were ruled out, it became clear to her adoptive parents and physicians alike that she was unlikely to recover. However, when her parents requested that the life sustaining treatment be stopped, they met with resistance and were forced to seek legal assistance to allow her to die. In 1976, the New Jersey Supreme Court ruled that Karen’s right to privacy could be extended to her family, allowing them to make decisions regarding her medical care even if those decisions
would result in her death. After 10 years, the life sustaining treatments were ceased and Karen was allowed to die.

The court found that the right to refuse treatment is based on the doctrine of informed consent and holds that physicians have a duty of care that requires disclosure of benefits, risks, and adverse effects of medical treatment. The court has also recognized a “liberty interest” of competent patients to refuse unwanted medical treatment that can be extended to the “dramatic consequences” of refusing life sustaining treatments. Furthermore, a durable power of attorney allows a patient to designate an agent or proxy who may make health care decisions on his or her behalf.⁶

Nancy Cruzan

The second highly influential case involves a patient named Nancy Cruzan. When she was 25, Nancy was involved in a serious automobile accident that left her in a persistent vegetative state. The cost of providing care for Nancy was $130,000 per year, which (like Karen Quinlan) was covered by the state.⁷ Although her parents initially hoped that she would come out of her coma, after eight years of waiting they became convinced that she was unlikely to recover and made the decision to request that treatments keeping her alive be ceased. This decision was not supported by the hospital, and her parents were forced to go to court. Many of her family and friends testified that Nancy would not want to be kept alive in such a condition, and in 1988 the local County Circuit Court ruled in favor of allowing the removal of life sustaining treatments.

However, the Missouri Supreme Court overruled this decision on an appeal, claiming that there was no “clear and convincing” evidence that Nancy would not have wanted to be maintained in a persistent vegetative state. The case was then appealed to the United States Supreme Court, which ruled that the Missouri Supreme Court was right in requiring “clear and convincing” evidence for the decision to be made, but also found a constitutional “liberty interest” that grants proxies the power to make medical decisions on the behalf of others and that there is no rational basis for distinguishing between artificial nutrition and hydration and other forms of medical treatment.⁸ The case was then presented to the County Circuit Court, which ruled that the testimony provided by
Nancy’s family and friends did constitute “clear and convincing” evidence of her wishes, and she was allowed to die in December of 1990.\(^9\)

**Vacco v. Quill**

In 1997, the United States Supreme Court ruled that New York’s prohibition on assisting suicide does not violate the Equal Protection Clause of the Fourteenth Amendment by denying the ability to hasten death to those who cannot do so by refusing life sustaining treatments.\(^10\) The Supreme Court found that the Second Circuit Court judgment which was overturned was based on a faulty interpretation of New York law as creating a “right to hasten death.” Instead, they found that only a right to refuse treatment was supported. The Supreme Court maintained that the distinction between assisting suicide and withdrawing life sustaining treatment is “widely recognized and endorsed in the medical profession and in our legal traditions” and is rational, important, and logical.\(^11\)

In their decision, the Supreme Court held that the distinction between refusing treatment and assisting in suicide rests in the principles of causation and intent. When a patient refuses life sustaining treatment, they are killed by the underlying disease; a physician who withdraws treatment “purposefully intends, or may so intend, only to respect his patient’s wishes.”\(^12\) The same is said to be true with the provision of palliative care that may hasten the time of the patient’s death. On the other hand, they maintained that a physician who assists in suicide must “necessarily and indubitably intend primarily that the patient be made dead.”\(^13\) Furthermore, every competent individual is, regardless of their medical condition, entitled to refuse unwanted life sustaining medical treatment, while no one is permitted to assist in suicide. Thus, they ruled that a law which applies so “evenhandedly” to all individuals cannot be thought to lack compliance with the Equal Protection Clause of the Fourteenth Amendment.\(^14\)

**Washington v. Glucksberg**
In conjunction with the ruling in “Vacco v. Quill,” the Supreme Court upheld a law in Washington specifically prohibiting physician assistance in suicide and stated that there was no need to address the more narrow questions as to whether or not:

[A] mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death… [There is] no need to reach that question in the context of the facial challenges to the New York and Washington laws as issue here… The parties and amici agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death… In this light, even assuming that we would recognize such an interest… the State’s interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide.15

The Supreme Court found that the constitutionally protected “liberty interest” in refusing medical care cannot be “somehow transmuted” into a right to assistance in committing suicide.16 They also hold that there are a number of legitimate interests that may prompt the State in prohibiting assistance in suicide. First, the State has an interest in the preservation of human life and a prohibition against assisted suicide, like homicide laws, would promote this interest. Second, the State has an interest in protecting the integrity and ethics of the medical profession that may involve a prohibition against assisted suicide. Third, the State has an interest in protecting vulnerable groups (which includes the poor, elderly, and disabled persons) from abuse, neglect, and mistakes. Finally, the State may fear that permitting assisted suicide will “start it down the path to voluntary and perhaps even involuntary euthanasia.”17

However, despite these fears, the federal government recognizes that it would be problematic to formulate legislation explicitly regulating or prohibiting the practice of euthanasia because it is unclear what effects such legislation might have. The position which the government has taken, then, is to allow individual states to form their own legislation regarding euthanasia pending information that suggests creating a federal stance. This opinion has been expressed by Supreme Court Justices who maintain that the “challenging task of crafting appropriate procedures for safeguarding… liberty interests is entrusted to the ‘laboratory’ of the states.”18 Thus, states are free to form legislation on either side of the euthanasia debate. Indeed, the rulings of the Supreme Court leave open
“room for vigorous debate” regarding physician-assisted suicide and voluntary active euthanasia, and this is precisely what has been occurring in the last few years.\textsuperscript{19}

Recently, the citizens of Oregon voted to approve an Act that legalizes and regulates the practice of physician-assisted suicide. This legislation has been the subject of substantial political controversy and has served to advance the level of public and scholarly debate on the timely and important topic of legalized euthanasia.

**The Oregon Death with Dignity Act**

**Summary**

The Oregon Death with Dignity Act (ODDA) is a citizens’ initiative that was first passed by the voters of Oregon in November 1994 by a margin of 51 percent in favor and 49 percent opposed.\textsuperscript{20} The Act was delayed due to a legal injunction and multiple legal proceedings, including a petition that was denied by the United States Supreme Court. The Ninth Circuit Court of Appeals lifted the injunction in October 1997, and physician-assisted suicide (PAS) became a legal option for qualified terminally ill patients in Oregon. In November 1997 the voters reaffirmed their support for the ODDA by rejecting Measure 51, which asked them to repeal the Act on a general election ballot, by an increased margin of 60 percent in favor and 40 percent opposed.\textsuperscript{21} The Oregon Health Services (OHS) notes that the term \textit{physician-assisted suicide} is used in the ODDA despite the fact that the Act explicitly states that ending one’s life in accordance with the law does not legally constitute “suicide”; rather, the term is used because it is so widely used by the public and scholars alike to describe the very act that the ODDA allows.\textsuperscript{22}

According to the Oregon Death with Dignity Act, an adult who is capable, who is a resident of Oregon, who has been determined by the attending physician and a consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die may make the informed decision to initiate a request for medication for the purpose of ending his or her life in a humane and dignified manner.\textsuperscript{23}
This concise iteration of the ODDA requires some clarification in accordance with the specifications of the Act. The term adult designates an individual who is 18 years or older and the term resident of Oregon applies (but is not limited) to individuals who have a driver’s license, are registered to vote, own or lease property, or filed their most recent tax return in Oregon. The term terminal disease designates an incurable and irreversible disease that has been medically confirmed by the attending and consulting physicians and is expected to, within reasonable medical judgment, produce death within six months. The term capable means that in the opinion of the court, attending physician, consulting physician, psychiatrist, or psychologist the patient has the ability to make and communicate informed health care decisions to health care providers (or can do so with the assistance of a person of their choosing).

The term informed decision is used to designate a decision made by a qualified patient based on an appreciation of the relevant facts and after being fully informed by the attending physician of the following:

- The medical diagnosis and prognosis;
- The potential risks and probable results of taking the prescription; and
- The feasible alternatives to using the prescription including (but not limited to) comfort care, hospice care, and aggressive pain control.

The term attending physician designates the physician who has primary responsibility for the care of the patient, while the term consulting physician designates a physician who is qualified by specialty or experience for consultation to confirm the diagnosis and prognosis regarding the illness of the patient. The attending physician may sign the patient’s death certificate, notwithstanding other legal restrictions. If either the attending or consulting physician suspects that the patient may be suffering from a psychiatric or psychological disorder or from depression that is causing impaired judgment, the patient must be referred for counseling. If the counselor determines that the patient is not suffering from impaired judgment, then (and only then) may the patient qualify for PAS. The Act specifies that the attending physician must:

- Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
• Ensure that the patient is making an informed decision (see above);
• Refer the patient for counseling if appropriate (see above);
• Refer the patient to a consulting physician for medical confirmation of the
diagnosis and for a determination as to whether or not the patient is capable of
making an informed decision and is acting voluntarily;
• Recommend (but not require) that the patient notify next of kin;
• Counsel the patient about the importance of having another person present when
taking the medication and of not taking the medication in a public place (the
presence of physician at the time of ingestion is recommended, but not required);
• Inform the patient that he or she has an opportunity to rescind the request at any
time and in any manner;
• Verify immediately prior to writing the prescription that the patient is making an
informed and voluntary decision;
• Fulfill the medical record documentation requirements of the Act;
• Ensure that all appropriate steps are carried out in accordance with the Act prior
to writing the prescription; and
• Dispense the prescription directly, provided he or she is qualified to do so; or,
with the patient's written consent, contact and inform a pharmacist of the nature of
the prescription and then deliver the written prescription personally or by mail to
the pharmacist, who will dispense the medications to the patient, the attending
physician, or an expressly identified agent of the patient. (The Act was modified
from its original form in this regard, and now specifically allows pharmacists to
refuse to participate in the ODDA who morally object to PAS).25

Once a qualified patient has made the first oral request to the attending physician, he or
she must then make a written request followed by a second oral request in order to remain
eligible to receive the prescription. The second oral request must take place after the
written request has been completed, and there is a mandatory 15 day waiting period
between the two oral requests. The attending physician cannot write the prescription until
48 hours after the written request has been completed, and must remind patients of their
right to rescind their request at any time upon receiving the second oral request.

The prescription generally consists of a lethal amount of barbiturates and other
medications to help alleviate the nausea or vomiting that can sometimes occur when the
barbiturates are ingested.26 The primary medication used has changed from secobarbital
to pentobarbital because the manufacturer of secobarbital (Eli Lilly) stopped producing
the drug because of a lack of profitability and difficulty in producing the drug due to a
shortage of supplies, not for ethical or publicity reasons.27
The ODDA allows qualified individuals to obtain prescriptions for the purposes of ending their lives, but *specifically prohibits* physicians from directly administering medication for the purposes of ending the life of the patient (active euthanasia). No professional organization or association, or health care provider, or physician may be punished *either* for participating or *or* for refusing to participate in the ODDA. Furthermore, participation in the ODDA does not have an effect upon a life insurance, health insurance, accident insurance, annuity policy, will, contract, or statute.

**The Annual Report**

The Oregon Health Services (OHS) is required to annually review a sample of records maintained with regard to the ODDA and to ensure that all health care providers file a copy of the dispensing record with the OHS *upon writing a prescription* in accordance with the ODDA. Reporting is not required if a patient begins the process but never receives a prescription, and the number of individuals who begin the process but never receive the prescription is unknown. However, one physician who has participated in the ODDA reported that she has begun and not finished the legislative process nearly twice as often as she provided prescriptions, suggesting the possibility that at least twice the number of patients who have participated in the ODDA make an initial inquiry or verbal request for medication which is left undocumented and unreported.28

The OHS is authorized to make rules to facilitate the collection of information regarding the ODDA and (except as otherwise required by law) the information collected shall not be a public record and may not be made available for inspection by the public. The OHS is then required to generate and make available to the public an annual statistical report of information collected in a *neutral* manner in order that informed ethical, legal, and medical decisions can be made based on interpretation of the data.29

**The Statistics**

The Annual Reports provided by the OHS contain all of the statistical information regarding the ODDA that is made available to the public. The Reports were obtained
from physician and pharmacy reporting, physician interviews, and death certificates. The Fourth Annual Report was made available on February 6, 2002, and the other three Reports (plus a preliminary Report issued after the first 10 deaths under the ODDA were reported) can be found on the OHS website. According to the Reports, a total of 140 prescriptions have been written under the ODDA since physician-assisted suicide became legal in Oregon (24 in 1998, 33 in 1999, 39 in 2000, and 44 in 2001). Nineteen of the 33 patients who were prescribed medication under the Act in 2001 died after ingesting the medication; 14 died from their underlying disease; and 11 were alive as of December 31, 2001. Two patients chose not to use prescriptions received in 2000 until 2001, bringing the total number of patients who died after ingesting the medication to 21 in 2001, 27 in 2000, and 27 in 1999, and 16 in 1998. Thus, the total number of patients who have died after ingesting lethal medication prescribed in accordance with the ODDA regulations comes to 91 out of the 140 who have received a lethal prescription.

The 21 patients who died as a result of ingesting lethal medications in 2001 were comparable in many ways to the other 6,265 Oregon residents who died from similar diseases during the year, although they were slightly more likely to be women, to have graduated from college, and to have been divorced. Trends such as these do not seem to have a particular pattern, but have varied from year to year. The most commonly mentioned end of life concerns were losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control. Typically, the median age of participants is around 70, they are likely to have a high school diploma, and they tend to be white. One of the most important findings over the four year period is that it has not been the case in any year that PAS was disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking end of life care.

The majority of patients who have chosen to participate in the ODDA suffer from some form of cancer (86 percent in 2001). It should be stressed that most of the patients utilized hospice care at some point during their illness (76 percent in 2001), while all of the patients who did not utilize hospice care were offered it and declined. Approximately half of the attending physicians were present at the time of ingestion, while other health
care providers were present in almost all of the remaining cases. Approximately one-half of patients become unconscious within 3 minutes and die within 25 minutes, and complications are rare. A small number of patients have lived for longer than 24 hours after ingesting the medication and a small number have vomited shortly after ingestion. Two physicians have been questioned in regard to submitting incomplete written consent forms, but formal charges have not been filed against them. Finally, Oregon physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications, to improve their ability to recognize psychiatric disorders (such as depression), and have been referring more patients to hospice care since the passage of the ODDA.32

Political Controversy

In November 2001, U.S. Attorney General John Ashcroft issued a directive specifying a new interpretation of the Controlled Substances Act (CSA) that was specifically aimed at prohibiting physicians from prescribing medication for use in PAS on a federal level, but not intended to increase scrutiny on physicians who prescribe pain controlling medications.33 According to Ashcroft’s interpretation of the federal law, the dispensing of controlled substances to assist in suicide does not constitute a legitimate medical purpose and, therefore, the ODDA violates federal regulations. This reverses the policy of former U.S. Attorney General Janet Reno, who deferred to state law in the determination of what constitutes a legitimate medical practice.34

In response to these actions, Oregon Attorney General Hardy Myers filed a federal lawsuit claiming that the directive is inconsistent with the intended use of the CSA as created by Congress, and that it is unconstitutional on both Commerce Clause and Tenth Amendment grounds. U.S. District Judge Robert Jones issued a temporary restraining order against Ashcroft’s directive in response to the suit, thereby allowing physicians to continue participating in the ODDA pending legal proceedings which were to be held within the year.35 Timothy Quill, a leading advocate for the ODDA, charged Ashcroft with unjustly attempting to usurp the rights of the state of Oregon and its voters by attempting to circumvent the democratic process.36 He maintains that the ODDA has
been a success, and that the continuation of the Act will provide important information that is vital in making the decision as to whether or not PAS can be regulated without undermining the quality of end of life care.

The legality surrounding the ability of states to govern their practice of medicine is somewhat unclear in this regard, but will likely be clarified to some extent as a result of these recent events. It has been suggested that the increase in support for the ODDA that occurred when the voters were (unsuccessfully) asked to repeal the Act in Measure 51 may have been due to the disapproval of voters who perceived Measure 51 as an attack on the democratic process. It is not unlikely that a similar effect is occurring in Oregon now, caused by the feeling that Oregon’s right to pass legislation regarding the practice of medicine within the state is being challenged. Some recent studies conducted by non-advocacy organizations have demonstrated a strong support throughout the U.S. for legislation based on the ODDA to be passed in additional states (61 percent of those surveyed) and a public disapproval of Ashcroft’s directive (58 percent).

In April 2002, U.S. District Judge Robert Jones ruled that Ashcroft lacks the authority to overturn the ODDA, noting that the legislation was passed after two votes in its favor. According to the Washington Post, Jones “scolded” Ashcroft by saying that he was attempting to “stifle an ongoing, earnest, and profound debate in the various states concerning physician-assisted suicide” and concluded that the Controlled Substance Act did not support Ashcroft’s directive. In closing, Jones remarked that his “task is not to criticize those who oppose the concept of assisted suicide for any reason… many of our citizens, including the highest respected leaders of this country, oppose assisted suicide. But the fact that opposition to assisted suicide may be fully justified, morally, ethically, religiously or otherwise, does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal.” Despite this ruling, an appeal is expected to be filed and the end result of Ashcroft’s directive is unlikely to be known for some time.

As I mentioned above, the Annual Reports issued by the OHS have suggested that many requests for assistance in dying are motivated by one or more of a limited number of concerns. The identification of these concerns offers a rare and valuable insight into some of the more common hopes and fears expressed by persons engaged in the dying process.
In the following section, I expand upon this issue and attempt to better explain the motivating factors which commonly prompt requests for assistance in dying.

**The Leading Motivations for Requesting Physician-Assisted Suicide**

The Fourth Annual Report on Oregon’s Death with Dignity Act found that the most commonly mentioned end of life concerns for those who requested assistance in dying in accordance with the ODDA were: losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control. Discussing the typical factors which have motivated such patients to request assistance in dying is one way in which we can better understand what the notion of a “death with dignity” might really mean to an individual patient nearing the end of life.

**Losing Autonomy**

Autonomy is generally defined in medical ethics indirectly by describing the manner in which one can respect the autonomy of an individual. The term autonomy as it is typically used in medical ethics finds its roots primarily in the Belmont Report, which was produced by a commission that attempted to identify the basic ethical principles that should underlie conduct in the medical and behavioral research of human subjects and to develop guidelines for those conducting research. One of the staff members in this commission, Tom Beauchamp, has defined autonomy as “personal self-governance.” Respecting the capacities and perspectives of individuals and the right of every individual to hold certain views and to act consistently with their vision of “the good life” is one way in which we can respect a person’s autonomy. Someone who fears “losing autonomy” may feel that they are losing the ability to control the way in which they live and desire the ability to make important and deeply personal decisions about the course of their lives without the interference of others, and possibly with their assistance.
Decreasing Ability to Participate in Activities that Make Life Enjoyable

This motivation for participating in the ODDA is closely related to the idea that human life should not be thought of as an end in itself but as a means for obtaining other “goods” such as achieving goals, experiencing pleasure, or engaging in rewarding physical and mental activities. It is not uncommon for individuals to desire to hasten death if they are unable to find a motivation to continue living or if the continuation of life offers the prospect of little other than pain and suffering.

Consider the case of Chris Hill, who suffered a hang-gliding accident that left him paralyzed from the chest down. Once an avid athlete and adventurer, he found himself unable to participate in the activities that made his life enjoyable. He repeatedly attempted to take his own life as a result of his condition, and eventually succeeded. In what he describes as an “open letter to anyone who wants to understand why I’ve checked out,” he explains that his desire to die resulted from his inability to participate in the activities that had once given his life meaning:

My life was just a miserable existence… Despite that, I gave it a go… I hated every second of it with a passion I’d never felt before. What good is a picnic if you can’t play with the kids and dogs and throw a Frisbee? What’s the point of going to a gig if you can’t dance when the music grips you? I used to be a player, not a spectator, and my new existence (life seems too strong a word) was painful, frustrating, and completely unsatisfying… Work was never a reason for living for me. And what of the future? Where would I go, what would I do? There’s no future for a wheelchair-bound journalist, not one with my interests anyway. I’d never be able to do any of the things, like travel and adventure, that drew me to journalism in the first place and ultimately made the long office hours worthwhile… I wish it didn’t have to be this way… I wish you could see death as I did, as a release, something to celebrate and be happy for me.45

Hill explains that the physical disabilities introduced by his accident made his life unbearable due to his inability to participate in the activities that had given his life meaning and pleasure and because of the indignities that he had to endure as a result of his condition. This is not to say that anyone with a physical disability is unable to enjoy life but, rather, that he was unable to adapt to his condition despite repeated attempts. This “note” addresses many of the concerns typical of terminally ill patients with marked eloquence and illustrates the way in which the inability to participate in the activities that make life enjoyable strips away the part of life that many consider to be truly valuable.
Losing Control of Bodily Functions

Often, the progression of a terminal illness will lead to the loss of the ability to control basic bodily functions. These can include the inability to move about freely, the inability to breathe without the assistance of a respirator, and the inability to control urination or bowel movements. The loss of control of bodily functions is closely related to the loss of dignity. Although the notion of dignity does not appear explicitly in this account of the leading reasons for requesting assistance in dying, it is closely related to each of these concerns and is perhaps the most prevalent here. Much like autonomy, the notion of dignity varies greatly among different individuals, and it is for this reason that we have a strong prima facie duty to respect the subjective notions of dignity that each individual may have. Although it is not the case that losing control of bodily functions should result in a loss of dignity or self-respect, this is a common and understandable reaction and often occurs as a result of the progression of terminal illnesses.\(^{46}\)

Becoming a Burden on Family and Friends

Much like losing control of bodily functions, the feeling of becoming a burden on family and friends is closely tied with the notion of dignity. Having the ability to function independently as an individual is generally taken for granted in our society, but when this ability is lost it becomes clear that it can be a source of comfort and pride. For those who have grown accustomed to being able to provide for their own basic needs, losing control of bodily functions and being forced to rely heavily on others for care can be demoralizing and humiliating. Even if family and friends do not feel burdened, the individual being cared for may feel a strong sense of guilt and shame resulting from his or her dependence on others and request assistance in dying as a result.

In a PBS special entitled “On Our Own Terms,” Bill Moyers introduced Jim Witcher, an individual who was seeking assistance in dying. Witcher was suffering from rapidly progressing amyotrophic lateral sclerosis, a condition which is commonly referred to as Lou Gehrig’s disease or ALS.\(^{47}\) This terrible disease progressively attacks the neurological system and gradually leads to death by paralysis. In Witcher’s case, it
worked its way up from his legs and eventually paralyzed his throat and lungs. Victims of ALS often express strong feelings of hopelessness as the disease progressively takes control of their bodies, robs them of the ability to participate in the activities that make life enjoyable, and makes them increasingly dependent on the care of others for even the most basic activities of daily life. Yet the disease leaves the mind intact, and some victims of ALS opt to utilize a respirator and can be kept alive with artificial nutrition and hydration. Utilizing medical techniques such as these has been known to extend the lives of ALS victims by up to 10 years. In this case, however, Witcher made the decision to starve himself to death when he was eventually unable to breathe or swallow on his own accord because he did not wish to live in a state of utter dependency and could not find a physician willing to illegally assist him in dying.

Suffering from Inadequate Pain Control

Suffering from inadequate pain control can be one of the strongest motivating factors for the request to hasten death. Luckily, pain control is one of the areas in which physicians can often be helpful. Allowing physicians to provide adequate pain control for patients nearing the end of life has become the focus of many advocacy groups. There is little controversy surrounding the current ability of physicians to provide as much pain controlling medication as necessary. It is an accepted medical practice to provide large doses of morphine or other pain relieving drugs to patients in great pain, even if doing so may hasten death. It is also acceptable to sedate patients to the point of unconsciousness if their pain is too great to be controlled by other means. In this way, obtaining a lethal medication can give patients a greater sense of control regarding their condition and allow them to live without having to fear that they will be forced to suffer the results of inadequate treatment, even if they may not want to use the medication otherwise.
Additional Factors

While the preceding motivations for requesting PAS may provide a reasonable grounding for the claim that certain patients can understandably desire and request euthanasia, there are often other factors involved that make adequate care at the end of life difficult to provide. One of the specific areas of concern, which is physical in nature, is the acute loss of strength that many patients experience at the end of life. Patients who suffer the consequences of increasingly poor circulation often face difficulty when confronted with the need of even the slightest physical exertion. They may feel fatigued, experience chronic shortness of breath, or become totally dependent on nursing care to engage in even the most basic physical activities.50

Chronic sleeplessness, as many people know from experience, can be extremely frustrating during the night and can also have detrimental effects throughout the day. Some patients may experience difficulty sleeping due to pain, fatigue, or shortness of breath. These patients may have to rely on the use of barbiturates in order to obtain an adequate amount of sleep, yet this has the negative effect of leaving them drowsy or mentally dull in waking hours. Feelings of nausea and vomiting are never pleasant, to be sure, but this is especially so when the experience is chronic. As with incontinence, chronic nausea requires intense nursing care for those who may already have difficulty carrying out even simple physical tasks and can be both mentally and physically taxing, disorienting, and embarrassing. Finally, bedsores are a common problem for those who are unable to move about because of a loss of strength, and even the best nursing care can do little to alleviate the pain and discomfort which is experienced as a result.

Furthermore, the manifestation of physical problems such as these does not occur in isolation; rather, physical symptoms often have a pronounced effect on the psychological condition of the patient. Incontinence, bedsores, and the loss of strength can be experienced by patients as degrading or humiliating. However, anxieties about the end of life do not focus only on these symptoms or on the fear of inadequate pain control, but also on the fear of not dying well. The notion of a “good death” is different for each of us, but to many it is one that can be thought of as quick, painless, and dignified. Many
people must bear the weight of physical symptoms when they might prefer death, or endure feelings of loneliness and isolation during sleepless nights that are wrought with fearful expectation and worry about what their future may hold. The practice of medicine is inherently limited in this respect. Even the best possible care can only do so much to relieve the physical and emotional suffering of patients who might legitimately and understandably wish to hasten an inevitable death.

Public concern, scholarly debate, and democratic action have become increasingly focused on evaluating the ways in which our society can improve health care in order to best protect the dignity and independence of those patients nearing the end of life. Requests for assistance in dying can be motivated by legitimate concerns; this much is clear. However, whether or not physicians can be morally justified in honoring such requests is another matter altogether. I argue that a physician willing to provide euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying can be morally justified in providing the kind of care that the patient desires. In the following sections, I will present the most widely regarded moral framework in medical ethics and utilize it in order to defend the moral permissibility of a paradigmatic and widely influential case of physician-assisted suicide.
Part II – Moral Framework and Evaluation

The Principles Approach

The principles approach to ethical issues in medicine has become the most popular moral framework for evaluating ethical dilemmas in health care, in the classroom, in clinical settings, and in conducting medical or psychological research on humans. Although the principles approach in its present form was originally developed by Tom Beauchamp and James Childress, the general form was first presented in the widely influential Belmont Report. The Belmont Report suggested that the rules of conduct presented in the Nuremberg code of ethics proved inadequate in evaluating complex cases, frequently came into conflict, and were generally difficult to interpret and apply. In response, the Belmont Report presented a short list of basic ethical principles and guidelines for evaluation intended to provide an analytical framework to guide the resolution of ethical problems regarding human research.

Simply put, the principles approach states that rather than attempting to apply a single, catch-all moral theory to every ethical situation (such as Utilitarianism or Kantianism), a short list of ethical principles should be given equal consideration in moral evaluation. None of the principles is to be given more weight in every situation by default, but various cases might prompt an ethicist to give one principle more weight in any given individual instance. These principles are autonomy, beneficence, and justice. They have been succinctly described as duties to: respect the capacity of individuals to choose their own vision of the good life and to act accordingly; to foster the interests and happiness of other persons and the society at large; and to act fairly, distributing benefits and burdens in an equitable fashion and resolving disputes by means of fair procedures. These three principles are not meant to represent absolute duties, nor are ordered or weighted in any specific way. Thus, one principle might be given more weight in any particular situation wherein the principles come into conflict. It should also be noted that some ethicists utilizing the principles approach posit an additional principle of nonmaleficence, which represents the duty to refrain from harming others. I will refrain
from referencing this posited principle, however, and consider this duty as an aspect of the broader principle of beneficence.

There are, of course, objections to the principles approach. For example, some have charged that it is vague and does not provide anything more than abstract notions which have the potential for thoughtless application, or that the approach cannot deal with conflicts between the moral principles. However, its proponents maintain that the flexibility of the principles approach allows for its adaptation to disparate ethical problems and allows individual ethicists who disagree over the morality of euthanasia, for example, to debate the issue at hand while utilizing a common vocabulary and framework for evaluation. Despite any supposed problems with the principles approach, however, it is the most commonly used and widely accepted moral framework in medical ethics and proves extremely useful in the evaluation of complex ethical issues.

The Principle of Autonomy

The principle of autonomy has been described by Beauchamp as such:

[Respect for autonomy] is rooted in the liberal moral and political tradition of the importance of individual freedom and choice. In moral philosophy personal autonomy refers to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice. “Autonomy” thus means freedom from external constraint and the presence of critical mental capacities such as understanding, intending, and voluntary decision-making capacity.

Respecting the autonomy of an individual is, thus, respecting the right of that individual to hold views based on their personal values and beliefs and to make decisions based on those values from their own perspective, while remaining free from the interference of others. Thus, we have a duty to respect the capacity of individuals to choose their own vision of “the good life” and to allow others to act in ways that agree with their own individual views, provided that the exercise of that autonomy does not interfere with the ability of other individuals to freely exercise their autonomy. This value is historically linked to Kantian ethics, which promotes the view that individuals ought to be respected not as “means,” but as “ends” that possess an intrinsic worth in and of themselves. As the leading medical ethics textbook in the U.S. states, “we recognize that people are entitled
to attempt to make their lives what they want them to be and that it would be wrong for us to take control of their lives and dictate their actions, even if we could.”

An interesting question might be raised at this point due to the fact that there are individuals who are unable to make or express autonomous decisions due to some physical or mental incapacitation. Does the principle of autonomy apply to individuals who have lost, or perhaps have never had, the capacity to make autonomous choices? In cases where the capacity for making autonomous decisions has been lost, living wills or advance directives are referred to in an attempt to respect the choices that patients presumably would have made if they were competent. Otherwise, health care decisions are typically passed on to the designated proxy, spouse, or relative (who are said to have insight as to what the wishes of the patient might have been). In this way, the autonomy of individuals who have been incapacitated can still be respected insofar as the wishes that they have expressed in the past influence the decisions made on their behalf.

However, there is extensive debate surrounding the legitimacy of advance directives and similar legal devices that is, in large part, outside of the scope of this paper. For example, it could be argued that it is unreasonable to assume that advance directives accurately reflect the actual decisions that the patient would have made if they were able to express their current wishes. A patient with ALS might, for example, claim that they would not want to utilize a respirator if they were unable to breathe without one, and yet feel quite differently when they actually find themselves in that position. While these issues certainly have relevance to the euthanasia debate conceived of broadly, they are related to distinct and extensively debated topics in medical ethics. Thus, I will restrict my arguments in this regard.

The Principle of Beneficence

The principle of beneficence presents a positive obligation to act in such a way as to promote the interests, happiness, and well-being of other persons and society at large. Whether or not the average person has a positive obligation to act beneficently towards others or simply has an obligation to refrain from intentionally harming others is a matter that is often debated. However, there is little controversy surrounding the claim that
individuals in health care have a professional obligation to assist others according to the principle of beneficence when they assume care for a particular patient. Physicians occupy a position in society which imparts upon them the professional obligation to assist in the active treatment of disease and injury for those patients with whom they are charged. Physicians generally have some measure of control over the selection of patients, but ER physicians, for example, are required by law to actively treat any and all incoming emergencies before even attempting to clarify the method of payment.

Beauchamp has characterized beneficence as obligating a physician or nurse to seek “all alleviation of disease and injury, if there is a reasonable hope of cure. The harms to be prevented, removed, or minimized are the pain, suffering, and disability of injury and disease. In addition, the physician and nurse are enjoined from doing harm if interventions inflict unnecessary pain and suffering on patients.” This characterization of beneficence agrees with notions of medical futility. For a treatment to be considered medically futile, it must offer little or no hope of curing the disease or injury and such treatments are often said to “cause more harm than good” to the patient. The concept of medical futility allows physicians to justify ceasing treatment when it appears that the treatment is doing little or no good in bringing about a recovery for the patient.

Physicians are not obligated or expected to cure or prevent every disease and no physician or nurse should be unreasonably charged with violating the principle of nonmaleficence due to the inevitable accidents that occur within any profession. However, it is certainly reasonable to demand that health care professionals provide a certain level of performance and care that is above and beyond the obligations of the average person. For example, a physician is expected to take the reasonable steps in order to ensure that a drug being prescribed will not harm the patient due to the presence of some other condition. It may be that a physician who gives a patient a prescription that causes them harm due to a condition that the physician could not have been reasonably expected to know about should not be punished, but physicians can be charged with culpable ignorance in cases where they act irresponsibly.

Acting with beneficence, in such a way as to promote the welfare or best interest of the patient, is considered by many to be the fundamental value underlying the entirety of medical ethics. However, what notions like the “best interest” or the “welfare” of the
patient really amount to are not explicitly addressed within the principles approach. These notions might rely on theories of individual welfare, preference satisfaction, hedonism, or other competing accounts; the principles approach allows for beneficence to be interpreted in many different ways. For the purposes of this paper, I attempt to strike a balance between accounts of individual welfare and preference satisfaction and advocate a view of beneficence that primarily rests on preference satisfaction, while not discounting the possibility that preferences may change over time or that physicians often have a great deal of knowledge and expertise which can be usefully applied in the evaluation of difficult cases.

The Principle of Justice

Similarly, it is frequently noted that there are many competing notions of justice. For example, some have suggested that there is much to be said for theories of justice based on the principles of equality, need, contribution, and effort. The principle of equality suggests that all benefits and burdens should be distributed equally to all individuals; the principle of need that those benefits should be distributed to those with the greatest need; the principle of contribution that benefits should be distributed in proportion to the social goods provided; and the principle of effort that benefits should be distributed according to the degree of effort put out in providing social goods.

Although the euthanasia debate is generally focused on the principles of autonomy and beneficence, the notion of justice can play an important role, for example, in claiming that the legalization of assisted suicide and not active euthanasia is unjust to those who are merely physically unable to self-medicate yet qualify for assisted suicide in every other regard. Many opponents of the legalization of euthanasia often point to the potential that those who are not physically, mentally, or economically stable might be subjected to unjust treatment if euthanasia were legally accepted. It would be considered unjust to take the life of an innocent person who did not request assistance in dying, for example, and many critics fear that even subtle pressure might provoke seemingly “voluntary” requests for assistance in dying from those who are particularly poor or otherwise vulnerable. These concerns are amplified when the potential abuses of the poor
or otherwise vulnerable are taken into account. Especially at the end of life, few individuals can be said to have full autonomy and there is concern that the legalization of euthanasia might promote the unjust treatment of those who are already in a disadvantageous position.

The Nature of the Principles

One of the most important features of the principles approach, which may be easily forgotten or overlooked, is the *prima facie* nature of the duties embodied in the moral principles. The notion of *prima facie* duties was first introduced by English philosopher W. D. Ross in an ethical theory that can be interpreted as an attempt to combine the best features of Mill’s Utilitarianism with Kantianism while simultaneously avoiding some of the more substantial problems with each. While Kantianism is often helpful in resolving moral conflict, the absolute nature of the duties presented by Kant can conflict with overwhelming moral intuitions. In particular, this moral theory can oversimplify difficult cases in which an action that will clearly produce the best results in a particular instance must be forsaken because of the absolute nature of Kantian obligations. For example, the absolute Kantian obligation to never lie might seem misguided if telling a lie would, say, save thousands of lives. In response to this problem, Ross suggests that a distinction can be drawn between *actual* and *prima facie* duties. Simply put, actual duties are those duties that hold *all things considered*, while *prima facie* duties are those duties that hold *all things being equal*.

The best way to illustrate the difference between these two types of duties is an example. Imagine that you promised to meet your friend for dinner, but as you are driving to the restaurant you unexpectedly come across another friend of yours who is badly injured and needs to be taken to the hospital immediately. Because you have made a promise you have a duty to go to the restaurant, but Ross would suggest that this is a *prima facie* duty. While you are normally obligated to keep your promises, the details of this particular case suggest that you have a *stronger* obligation to help your injured friend. Thus, although you had a *prima facie* duty to meet your friend at the restaurant as planned, your *actual* duty in this particular instance was to take your injured friend to the
hospital. While actual duties may conflict as well, the notion of *prima facie* duties provides a very important element to the principles approach; namely, that the principles are expected to conflict and must compete with each other in individual cases.

The *prima facie* duties suggested by the principles approach are to be acted on unless they come into conflict with another duty that is equal or stronger. These duties are binding only insofar as they represent strong *prima facie* obligations and are, in fact, expected to come into conflict with each other frequently. When one principle seems to represent the strongest obligation in any given situation, the importance of the other principles does not simply disappear; rather, they continue to carry great weight and ought to continue to exert a large influence on our moral thought. Thus, the principles can be seen as reflecting the “complexities of moral life in which a hierarchy of rules and principles is impossible.” As Beauchamp has written with regard to the principles approach in the evaluation of difficult moral situations in medical ethics:

> “A progressive specification of general principles is central to bioethics, especially in the formulation of institutional and public policy. However, we cannot reasonably expect that strategies of specification will always eliminate competing proposals for the resolution of contingent conflicts. In problematic cases, several specifications will emerge that are well-defended. Nonetheless, specification, together with a moral justification that defends one’s chosen specification, is essential in bioethics. Indeed, perhaps nothing is more central to the method of bioethics.”

The principles approach can be usefully applied to the euthanasia debate because it provides a basic vocabulary and framework for the moral evaluation of individual cases of euthanasia. In the following section, I will apply this method of evaluation to an individual case of physician-assisted suicide and argue that a physician who provides euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying can be morally justified in doing so.

**An Individual Case**

One of the most persuasive and widely read arguments in support of morality of physician-assisted suicide (PAS) is found in Timothy Quill’s article entitled “Death and
Dignity: A Case of Individualized Decision Making. In this article, Quill, a practicing physician, presents an actual case in which he provided PAS for a patient who had been under his care for eight years. This case provides strong support favoring a positive moral evaluation of Quill’s actions, and allows for a closer examination of the principles of autonomy and beneficence that leads many to conclude that Quill acted in a morally appropriate manner by providing PAS for his patient, Diane.

Diane was diagnosed with acute myelomonocytic leukemia. The symptoms of this disease become progressively more severe if left untreated, typically leading to the death of the patient within a few months. Diane had struggled with many problems throughout her life, including being raised in an alcoholic family and recovering from alcoholism herself, dealing with depression, and surviving vaginal cancer as a young woman. She was middle-aged, married, and had a son in college. The treatment options available to those with Diane’s condition had an established effectiveness, offering an approximate 25 percent chance of long-term survival. However, the treatment consisted of enduring several rounds of painful and debilitating chemotherapy over the course of several months, and would also require a long period of hospitalization.

Quill assumed that Diane would want to begin treatment immediately and had already started to make arrangements for her first few rounds of chemotherapy when Diane informed him that she had decided to refuse treatment. This came as a surprise to Quill, but it is firmly established, both morally and legally, that any adult can refuse treatment of any kind, provided that they have not been shown to be incompetent to make such decisions in a legal setting. Quill met with Diane on several occasions after she had made the decision to refuse treatment, in an effort to understand the reasoning behind her decision and to persuade her to change her mind. These meetings sometimes included her family, and were sometimes private. They were deeply personal in nature, but also provided Diane with an opportunity to learn more about her available treatment options and the nature of her disease. Diane remained strong in her conviction to refuse treatment and made it clear that she was convinced that she would die during the period of treatment and would suffer unspeakably during the process due to extended periods of hospitalization, lack of control over her body, and the side effects of chemotherapy.
Although Quill offered Diane his full support and best effort to minimize her suffering if she decided to choose treatment, Diane did not change her mind.

Diane’s family supported her decision, even though they expressed a desire that she choose treatment. Over the course of many meetings, Quill repeatedly had Diane demonstrate that she understood the details of the treatment that she was refusing, her odds of survival, and what the implications were if she chose to refuse treatment altogether. Even though Diane proved to have a remarkable grasp of her options and the implications of her actions, Quill still arranged several meetings with a second hematology consultant during which they discussed her condition and possible methods of treatment at length. Diane also met with a psychologist whom she had seen in the past. Eventually, Quill began to understand Diane’s decision from her perspective and agreed, in the end, that it was the right one for her. Being the former director of a hospice program, Quill explained to her that he knew how to use pain medications to keep patients comfortable and to lessen even severe pain throughout the progression of her illness. However, Diane made it clear that she had witnessed people lingering in what was referred to as relative comfort and that she did not want to be in that position herself. Instead of engaging in increasingly aggressive pain control as her disease progressed, Diane wanted Quill to assist her in obtaining medication that she could use to commit suicide when she felt that her life was no longer worth living.

Although Quill understood Diane’s motivations for making the request, it presented him with a very difficult moral problem. He knew that it would be illegal for him to assist Diane in committing suicide, and the American Medical Association Code of Ethics explicitly forbids physicians from participating in PAS. He felt uncomfortable with the prospect of actively assisting Diane in bringing about her own death in this manner because he had never engaged in euthanasia before. However, after exploring his own notions of his professional and personal obligations to Diane, Quill made the decision to assist her and informed her of a group called the Hemlock Society, an organization which provides information and guidance for those who wish to take their own lives in similar cases. After ensuring that all possible avenues of treatment were understood by her, Quill gave Diane a prescription for barbiturates that were an essential component of the lethal formula she learned of through the Hemlock Society. They met
regularly over the next several months, and Quill felt that she appeared to be making the most out of the time remaining to her. When her condition appeared to be rapidly deteriorating, Diane arranged a final meeting with Quill in order to say goodbye. Two days after that meeting, Diane’s husband called to inform Quill that she had died.

Although the decision to participate indirectly in Diane’s suicide was a very difficult one for him to make and one in which he violated the law, Quill believes that he acted in a morally appropriate manner. Quill explains that Diane taught him about the range of help that physicians can provide if they know the patient well, and if the patient feels that they are able to say what they really want to say. Although he believes that methods of controlling pain and suffering are often successful, Quill also believes that people can suffer in the process of dying and that the role of the physician and family in cases of prolonged dying is, unfortunately, typically limited to lessening, but not eliminating, severe suffering.

Typically, there have been two reactions to Quill’s case. Many people have found this case to be a particularly compelling and emotive one and feel that Quill did act in a morally appropriate manner. On the other hand, many people hold that no act of euthanasia is ever morally justifiable and, therefore, that Quill’s actions were morally wrong. Feelings regarding Quill’s part in assisting Diane to commit suicide may stem from moral intuitions, or from a complex web of carefully constructed moral beliefs. However, there is no way to engage in a debate over the morality of an act if the parties in disagreement substantiate their views merely by citing their moral intuitions. Therefore, it is beneficial to examine Quill’s case by utilizing the principles approach.

**Moral Evaluation**

**The Principle of Autonomy**
Most of the scholars who support the moral permissibility of euthanasia argue that the principle of autonomy is the most relevant aspect of the principles approach in cases such as this. One of the leading ethicists in the area, Dan W. Brock, has argued as such:

The central ethical argument for euthanasia is familiar. It is that the very same two fundamental ethical values supporting the consensus on patient rights to decide about life-sustaining treatment also support the ethical permissibility of euthanasia… individual self-determination or autonomy and individual well-being. By self-determination… I mean people’s interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life, and in being free to act on those decisions. Self-determination is valuable because it permits people to form and live in accordance with their own conception of a good life… A central aspect of human dignity lies in people’s capacity to direct their lives in this way… The value of exercising self-determination presupposes some minimum of decision-making capacities or competence… [Euthanasia] cannot be justifiably administered, for example, in cases of serious dementia or treatable clinical depression.\footnote{71}

An individual ought to have the right to make decisions of a deeply personal nature about how they want to conduct their lives, provided that doing so does not interfere with the right of others to do the same. The principle of autonomy applies to Quill’s case because Diane is making a choice as to how to act in order to best achieve her vision of a “good life.” She had already made the decision to refuse treatment due to her conception of her chances of recovery and her estimate of the degree to which she would be debilitated and hospitalized during the process. She maintained her decision after many sessions with Quill, and appears to have done so after careful consideration. However, when she made this decision, she was presented with another equally undesirable future; one in which she was likely to die slowly and become progressively more dependent on her friends and family for support and assistance in conducting her daily life. Her conception of the way in which she was likely to die was unacceptable to her, and this is why she requested that Quill assist her in dying when she felt that she no longer wanted to live.

When living itself becomes unbearable, many patients request assistance in dying. In cases such as these, life is no longer considered to be a “good thing,” it is not something that they want to continue because it is robbed of any value that it once contained. Life itself can become a “burden” when it is filled with little or nothing beyond pain and suffering. If someone can clearly and competently demonstrate that the medical condition in which they find themselves has taken away their desire to live and they request assistance in dying, this request should not be taken lightly. If we assume
that the patient is making a decision that, while we might not necessarily find agreeable, seems to be made with careful thought and reflection, it becomes difficult to justify interfering with the wishes of that patient.

When, if ever, should we not respect the autonomy of an individual and, instead, prevent them from living or dying in the manner that they wish? Making PAS illegal represents a much larger interference with autonomy than a physician simply refusing to assist a single patient because such laws act like a third party which comes between two individuals (the patient and the physician) and prevents them from acting in a way that they feel is morally justified.

Competency

Arguably, the most important feature of Diane in terms of this case is that she does appear to have competency. The most important reason that we might be obligated to restrict the autonomy of a person is if we feel that they are not competent to make important decisions for themselves. If a person is temporarily distressed, or unable to make objectively rational decisions for themselves, then they are said to lack competence and a restriction of autonomy might be morally justifiable. Such restriction can be justifiably enforced according to the notion of paternalism, which can be described as the interference with the autonomy of an individual by the state or another person with the intention of preventing that individual from causing harm to themselves.\(^72\)

Diane makes the decision to refuse treatment in the absence of severe pain and suffering, which is a common motivation behind initial requests for assistance in dying that can often be alleviated through the use of more aggressive pain control.\(^73\) Furthermore, Diane makes the decision to end her own life based on her perception of what constitutes a meaningful existence. This means that when she feels that the important aspects of her life are no longer in her control, she wishes to no longer live. Throughout Quill’s article, Diane appears to be making her decisions after hearing out Quill’s explanations of her treatment options and the details of her disease and Quill believes that she fully understood and respected the gravity of the choice that she was making. Quill even notes that Diane saw a psychologist during the decision-making
process, which lends support to the view that Diane was acting in a deliberate and considered manner.

A critic of Quill’s position might claim that Diane was incapable of making rational decisions in this case because she appears to have had some emotional or psychological problems in the past. It would be wrong to suggest that anyone who has seen a psychologist in the past is forever incapable of making important decisions, but it might seem reasonable to suppose that Diane (who had seen a psychologist before, who had come from an alcoholic family, who was a recovered alcoholic herself, and suffered from cancer in the past) may have been unable to deal with a problem of this magnitude and simply wished to escape it. On the other hand, it could be argued that Diane was no stranger to hard times, and that her ability to deal with major problems in life, such as this one, would be greater than the ability of the average person.

Quill remarks that he was surprised when Diane, a strong and independent woman who had experienced some hardships in her life, made the decision that she did, but again explains that he came to understand why she made them. This supports the claim that Diane was competent and acting in a carefully considered manner. Rather than running away from her problem, it can also be argued that she confronted it with bravery and resolve. She lived out the remaining days of her life in the manner of her choosing, and this, in many regards, is an admirable accomplishment.

*Informed Decision*

Quill’s article stresses the fact that Diane did appear to have a remarkable grasp of the details of her disease and of the treatment options available. This lends strong support to the view that she was mentally capable of making a decision that, although some might find disagreeable, she felt was the right one for her. Furthermore, the fact that Quill was reluctant to agree to her refusal of treatment but eventually was convinced that her decision was right for her supports the claim that Diane was making a *rational* choice and should be allowed to exercise her right to refuse treatment.

Diane’s decision was real, in that she was provided options from which she could choose. Quill’s eventual understanding of her motivations lends strong support to claims
that Diane was acting after a considerate amount of deliberation had taken place, even if her choice may have come as a surprise and had serious consequences. Diane wanted to avoid a long and painful treatment with fairly low probability of success, and so this part of her decision appears to be understandable. In much the same way, it is understandable that she wanted to avoid dying in a slow and painful manner and requested assistance in hastening her inevitable death.

Because of the fact that Quill, her primary physician, assumed that Diane would want to engage in the treatment option that was most likely to succeed in allowing her to continue to live a relatively normal life, there is merit to claims that Diane was making a genuinely bad decision for herself. However, Quill’s eventual understanding and respect for the decisions that Diane made lends strong support to the claim that Diane was acting in a rational manner. Quill claims that Diane demonstrated an impressive understanding of her condition and treatment options repeatedly and understood the gravity of her decisions. If we believe that Quill adequately explained the treatment and palliative care options available to her, it would be impossible to hold that Diane’s decision was not an informed one which was made after a period of substantial deliberation, even if we disagree with her conclusions.

Voluntary Request

Diane made her decisions with the support of her family, but it is important to note that they did not want her to either refuse treatment or to take her own life. In addition to her family, Quill also made a strong effort to dissuade Diane from her decisions and to ensure that she understood all of the options that were available to her. Thus, Diane made her decisions without being under the influence of her family or her physician. This is an important feature of the case because it underscores the fact that Diane was exercising her autonomy and acting truly as she wished to, rather than making decisions about how to conduct her life while under pressure from other persons. In fact, if any pressure was being applied to her, it would seem to have been aimed at dissuading her from making decisions that would lead to the hastening of her death.
Rather than feeling that she was a burden on her family, friends, or physician, Diane likely felt a strong sense of love and compassion in the responses to her condition from these people. Rather than acting in such a way as to promote her feelings of ending her life prematurely, it seems that the people surrounding her did everything that they could to encourage her to engage in treatment, and to do everything possible in order to better her chances of survival. Thus, Diane’s decision appears to have been voluntary, was made after carefully and competently evaluating her available treatment options, and reflects her desire to conduct her life in a manner in keeping with her personal beliefs.

**Possible Criticisms**

Some critics of the legalization of euthanasia have suggested that the promotion of the principle of autonomy in attempts to provide moral justification of euthanasia is both problematic and dangerous. One critic, Tania Salem, has suggested that “medicalizing” suicide, that is, authorizing physicians to engage in PAS with the necessary regulations, violates many of the aspects of autonomy that the supposed “right” is based on. She notes that legalization of PAS would require regulation in order to control the likely abuses, and that this would be done by requiring physicians to subjectively judge the validity of requests and also to ensure that no undue influences or pressures might have contributed to making the request. Thus, regulation of euthanasia would undermine the autonomy and privacy of the patient and would involve two people in the decision (the patient and the physician), when it is supposed to reflect deeply personal individual beliefs. This, along with other criteria likely to be set forth in the regulation of PAS, affront the very foundation of the supposed “right” to it by restricting the autonomy of the patient. She also notes that some supporters of medicalizing suicide, including Quill, have suggested that passing stringent psychological tests ought to be required of the patient, further violating the very principle of respect for autonomy that the “right” to PAS is supposed to be based on.

Another critic, John Safranek, has suggested that appeals to the principle of autonomy fail to provide justification for euthanasia, whether they are of the descriptive or ascriptive sort. Descriptive appeals to autonomy are formal, in that they are devoid of
normative value judgments. Appeals of this sort are not sufficient (but may be necessary) to identify actions as being either morally correct or immoral, as acts which are performed by autonomous agents (such as murder) can often be immoral. Autonomy in the descriptive sense cannot adequately serve to morally justify individual actions. Yet *ascriptive* appeals to autonomy, it is argued, are *normative* and merely push the problem of morality onto a debate over competing theories of “the good.” Regulation of PAS, for example, would contain subjective value judgments in that it would restrict the freedom of self-determination of those individuals that did not satisfy the criteria of the regulations based on prevention of “harm” to the self or others. Notions of “harm” are, Safranek claims, inexorably linked to theories of “the good.” Thus, it is argued, basing the morality of euthanasia on the principle of autonomy alone either leads to the justification of every act of euthanasia or moves the issue to competing theories of “the good” that cannot be adequately justified by the principle of autonomy alone.

However, it is clear that appealing *solely* to the principle of autonomy in order to morally justify individual acts of euthanasia is misguided. While an appeal to the principle of autonomy serves a vital purpose in the moral justification of euthanasia, relying on this one principle alone in order to morally justify individual acts of euthanasia is not in keeping with the nature of the principles approach and leads to intuitively unappealing consequences. However, invoking the principle of beneficence in conjunction with the principle of autonomy is useful in dealing with the objections raised by Salem and Safranek.

Salem maintains that regulation of euthanasia is necessary, and that this is agreed on by even the most outspoken supporters of the legalization of euthanasia. However, she argues, the regulation *itself* undermines the value of autonomy that any supposed “right” to euthanasia might be based on because it questions the decision of the patient, violates their privacy, and involves another person in the decision-making process that is supposed to be deeply personal and free from outside influence. While Salem makes a very good point, if the moral justification for euthanasia rests not *only* on the principle of autonomy, but also on the principle of beneficence, her argument will not hold. Undermining the autonomy of the patient is justified *by* the principle of beneficence. It is clear that it would not be beneficent to simply allow anyone at all quick and easy access
to euthanasia immediately upon their first request. As Salem herself suggests, regulation of euthanasia is necessary in order to reduce the potential for abuses, and this can be justified by an appeal to the principle of beneficence.

As for the objection raised by Safranek, I believe that he is right in suggesting that an appeal to the principle of autonomy alone either justifies every act of euthanasia prompted by a single request or pushes the debate over euthanasia onto competing theories of “the good.” However an appeal to the principle of beneficence can help to alleviate some of the confusion surrounding the issue. I maintain that it can be in the “best interest” of certain patients to provide them with access to euthanasia and that this can be considered practicing “good” medicine. A physician who provides the best available treatment in keeping with the wishes of the patient is doing a morally correct or “good” thing because such action constitutes respecting the autonomy of the patient while treating them in a caring and beneficent manner. Similarly, euthanasia can be justified by the autonomous decision of the patient and an appeal to the principle of beneficence.

The Principle of Beneficence

In the case of Quill, I strongly feel that he was acting *beneficently*, as I would want any physician to behave in a similar situation. This does not necessarily entail assisting Diane in committing suicide, but that he treated her with dignity, respect, and care. Diane did not want to participate in painful and debilitating treatments, and he repeatedly questioned her decision. He ensured that she understood the gravity of her decision and offered her the best available treatments. He brought in a consulting physician, and had long and emotional conversations with Diane that he described as being personal in nature, the kind of conversation that you would have with a trusted friend. He did everything he could to convince her to change her mind (to engage in treatment that he did not consider to be medically futile), but when he finally saw the situation from her perspective, he decided that she was making a decision that was right for her.

This case demonstrates much more than the value of simply respecting autonomy: it demonstrates *beneficence* on the part of Quill. He took the time and effort to evaluate Diane’s feelings and to ensure that she was acting with due consideration of her available
treatment options, rather than simply “respecting her autonomy” and throwing her life away haphazardly. In this case, Quill did more than many physicians might have in a similar situation in that he felt that he had to come to some understanding of Diane’s decision before he felt comfortable allowing her to refuse treatment. He did more than simply grant her every wish; he looked out for her best interests. While some might argue Quill violated the autonomy of his patient in that he attempted to convince her to go against her wishes for a time, I stress again that autonomy is not the only principle to be appealed to within the principles approach. The value of beneficence plays a vital role in this case, because Quill clearly demonstrates that he stretched himself beyond his initial level of comfort in order to provide the best treatment that he could, in accordance with Diane’s wishes and with his personal moral values.

Quill not only has duties toward Diane as an individual living within the same society, but he also has duties as a physician in dealing with an important medical decision on the part of his patient. This means that Quill is subject to a unique set of criteria for his actions, one which takes into account the duties that he has towards Diane as a medical professional. Quill’s duties in this regard include accurately diagnosing Diane’s medical condition, informing her of the details of her prognosis and of the condition itself, and informing her of any treatment options available to her. Quill succeeds in fulfilling these obligations to Diane (and more) by scheduling multiple meetings with her in which they discuss her condition as well as the treatment options available to her such that she was able to illustrate an acceptable and even surprising comprehension of these facts. This represents more than simply respecting Diane’s autonomy; Quill is treating her in the best possible way that he can, and this is beneficent.

Quill notes that he was the head of a hospice program, and assured Diane that he would do everything in his power to control her symptoms whether or not she chooses to engage in treatment. This is important to note because it illustrates the fact that Diane was receiving useful information about the nature of her disease and treatment options, but she was also offered reassurance that her pain and other symptoms were not going to be ignored, no matter what decision she made. This underscores the fact that her autonomy was being protected, and that she was being offered a number of possible alternatives by a physician who had an expertise in controlling pain.
Another appealing feature about this particular case is that Quill had known Diane for a number of years. Over the course of eight years, the two had developed a deeply personal relationship in which Quill felt that he had a personal investment in Diane’s wellbeing. This is important to note because it supports the idea that Quill never abandoned Diane, or treated her in such a manner as to disrespect her as an important individual. He made sure that her decision was not made abruptly, without the appropriate amount of thought for such an important issue, and did his best to convince her to engage in treatment until he better understood her decision.

Quill took extra time and arranged many meetings in which he discussed Diane’s decision with her in order that he could better understand her actions for himself. It is clear in reading his article that Quill had developed a strong bond with Diane, and cared for her deeply, not only as a patient but as a person as well. It is this aspect of the physician-patient relationship of the case that most strongly supports the view that Quill was acting beneficently, as a caring physician who wanted to provide his patient with the best care that he possibly could (in keeping with his ethical beliefs), which in turn supports his actions as being not only morally justifiable, but morally praiseworthy.

This individual case of euthanasia, as presented by Quill, is one in which the criteria that can be said to justify acts of euthanasia have been satisfied. Diane acts voluntarily; is competent to make the decisions that she does; seems to be well informed of the details of her condition and possible treatment options; obtains a second opinion; visits a psychologist; makes her decisions free from excessive influence or manipulation on the part of her physician or family; makes her decisions free from excessive pain and suffering; and has a long period of time in which she has the option to change her mind at any time. Quill makes a strong effort to ensure that Diane has understood the details of her condition and available treatment options; makes an attempt to understand her decisions from her perspective; allows her the opportunity to change her mind at any time; does not appear to manipulate her decision in any way towards choosing to refuse treatment or to hasten death; and has developed a caring relationship with Diane.

However, some critics of legalized euthanasia maintain that acts of euthanasia can never be morally permissible. In following sections, I will argue that broad and
generalized objections against the moral permissibility of individual acts of euthanasia fail to adequately justify currently acceptable medical practices and are often incompatible with moral intuitions. Patients experiencing irremediable suffering can legitimately request assistance in dying; this much is agreed on by even the most outspoken critics of legalized euthanasia. After addressing these broad moral concerns, I will focus on arguments which suggest that the potential abuses of poor or otherwise vulnerable patients would outweigh the benefits of legalizing and regulating the practice, regardless of whether or not individual cases of euthanasia can be morally justified.
Part III – Moral and Social Implications

The Sanctity of Life

Many people who argue that euthanasia can never be morally justifiable believe that the value of human life is immeasurable and should be respected to the greatest extent possible. One common formulation of such a belief is called the sanctity of life doctrine. In its most naïve and strongest form, the sanctity of life doctrine states that it is always wrong to take life. However, this formulation suffers from three serious flaws. First, it does not take into account the accidental taking of life. For example, even if someone is following all of the traffic laws and is keeping as alert as possible while driving, there is always a chance that something out of that person’s control could lead to the death of another person. It would be unreasonable to suggest that one is morally responsible for acts that are completely accidental and unintentional.

Additionally, the naïve formulation does not take into account the fact that many people find it morally acceptable to take some forms of non-human life without much justification. For example, it would be unreasonable to suggest that giving a loved one a flower is an immoral act because it brings about the death of the flower. Thus, a better formulation of the sanctity of life doctrine must specify human life as the object to be respected in the highest regard. Finally, the naïve formulation does not take into account the possibility that one might be forced to take the life of an aggressor in an act of self-defense. For example, imagine that a (rightly) convicted murderer escapes from jail and breaks into the home of the police officer responsible for sending him to jail. The murderer attacks the police officer with a knife, leaving the officer no recourse but to save her own life by killing the aggressor. It would be wrong to suggest that the police officer committed a moral wrong in this case because the act was done in self-defense when no other options were available. Thus, a much more reasonable formulation of the sanctity of life doctrine is that it is always wrong to intentionally take an innocent human life.\textsuperscript{78}
Difficult Cases

The *absolute* nature of the sanctity of human life principle can be seen as its most appealing feature. Because the principle prevents the intentional taking of life, it can be seen as providing a necessary safeguard that prevents violations of the respect for human life, which many people (rightly) regard as one of the most important things needing protection in the world. However, absolute principles such as this are often subject to great difficulties. It has been suggested by Jonathan Bennett that any hard and fast rule of the form “it is always wrong to…, whatever the consequences,” will fail because such rules can never hold up in difficult situations. Following strict and absolutist moral principles in difficult situations may lead to a knowing acceptance of unfavorable consequences in favor of simplicity, and this presents a serious difficulty for the sanctity of life doctrine.

Killing people is generally wrong and physicians are often required to do much more than simply refrain from killing patients; this has been agreed on. However, such duties should be conceived of as strong *prima facie* duties, not as *absolute* ones. If an absolutist moral principle such as the sanctity of life cannot hold up in difficult situations, then it should be disregarded in favor of a better explanation of the wrongness of taking human life. These difficult cases are arising with increasing frequency due to the rapid progress in medical technologies. As John Arras and Bonnie Steinbock wrote in a widely read text on ethics in modern medicine:

> [Much] of the ferment in contemporary biomedical ethics is due to the unrelenting pace of technological advance. The story is by now familiar: clever physicians, researchers, and technicians discover newer and better ways to do things, such as sustaining the lives of terminally ill patients… Before we know it, however, these new techniques and services begin to take on lives of their own, expanding well beyond the problems and patients for whom they were originally intended… The administration of artificial nutrition and hydration, originally intended as a temporary bridge to the restoration of patients’ digestive functioning, now is routinely delivered to thousands of patients who have irretrievably lost all higher brain functions… Often, what science and technology make possible soon becomes permissible and, eventually, normal and expected.80

The patients referred to in this quote as having “irreversibly lost all higher brain function” are in what is known as a *persistent vegetative state* (PVS). Meela Yoo, a Lawrence University student who submitted a thesis for honors in 1992 entitled “Ought PVS...
Patients be Maintained?” wrote that the PVS condition is “characterized by the irreversible loss of a functioning neocortex and the continuing existence of the brain stem. The loss of the functioning neocortex necessarily and sufficiently entails the [permanent] loss of consciousness. The neocortex processes, coordinates, and integrates the higher brain functions such as sensory input, memory, creative thought, and consciousness, and initiates voluntary activity.”

At the time this paper was written, a shift from maintaining PVS patients by artificially providing nutrition and hydration to allowing them to die by removing those life support devices was already beginning to take place. The Supreme Court trials discussed earlier had an enormous impact on the practice of maintaining PVS patients, and it is currently the case that the families of patients who wish to maintain a relative or loved one in a persistent vegetative state must initiate that request which is often met with resistance. These trials also sparked much debate over the morality of euthanasia, and prompted initiatives aimed at obtaining written wishes regarding medical treatment in advance of incapacitation (such as advance directives and living wills).

In her paper, Yoo argues that maintaining PVS patients is not morally obligatory because PVS patients cannot be considered to be Persons, and that the maintenance of such patients misuses scarce medical resources. The maintenance of a PVS patient, she believes, provides no benefit for the patient because they are unable to consciously perceive anything at all. Yoo suggests thinking of an individual as having two dimensions that together form a Person: the body and the personality. PVS patients have forever lost their personality and are unable to fully participate in society, do not have consciousness, and are not capable of rationality. Thus, PVS patients do not meet the personhood criterion, and society does not have a moral obligation to maintain them. Yoo also suggests that PVS patients should generally not be maintained due to the high opportunity costs involved. Although it can be argued that the moral dilemma surrounding PVS patients is not as serious as those surrounding acts of euthanasia, it is clear that there is a moral dilemma in these cases because it was once standard practice to maintain PVS patients indefinitely. Again, physicians often have duties to do much more than to simply refrain from killing their patients; they often have duties to keep patients healthy to the extent to which they are able, and to actively treat disease and injury. PVS
patients, however, do not meet the personhood criterion suggested by Yoo, and therefore she argues that physicians are not obligated to maintain them with medical procedures.

The personhood criteria for the moral wrongness of killing represents an exceptional attempt to identify the reasoning underlying the basic intuition that killing is generally morally wrong, and was highly regarded when introduced. It provides a starting ground for making medical decisions in difficult cases that is somewhat more stable than the sanctity of life doctrine. However, it too suffers from serious difficulties as it does not account for the wrongness of killing those who are incapacitated, temporarily unconscious, severely retarded, severely mentally ill, infants, or small children. Such individuals cannot be said to meet the requirements of personhood because they are unable to fully participate in society, do not have full consciousness, and are not fully capable of rationality. Thus, the personhood distinction fails to provide an adequate explanation for the strong intuition that killing generally represents a serious moral wrong.

Valuable Future

In an influential and widely read article entitled “Why Abortion is Immoral,” Don Marquis presents a theory that is designed to explain one aspect of the prima facie wrong involved in intentionally taking an innocent human life which substantially improves on the personhood criterion. Although his article is primarily intended to address issues of abortion, he notes that the theory can apply to cases of euthanasia:

What primarily makes killing wrong is neither its effect on the murderer nor its effect on the victim’s friends and relatives, but its effects on the victim. The loss of one’s life is one of the greatest losses one can suffer. The loss of one’s life deprives one of all the experiences, activities, projects, and enjoyments that would otherwise have constituted one’s future. Therefore, killing someone is wrong, primarily [but not necessarily only] because the killing inflicts (one of) the greatest possible losses on the victim. To describe this as the loss of life can be misleading, however. The change in my biological state does not by itself make killing me wrong. The effect of the loss of my biological life is the loss to me of all those activities, projects, experiences, and enjoyments which would have constituted my future personal life…

When I am killed, I am deprived both of what I now value which would have been part of my future personal life, but also what I would come to value… it would seem that what makes killing any adult human being prima facie seriously wrong is the loss of his or her future… this theory explains why we regard killing as one of the worst of crimes. Killing is especially wrong, because it deprives the victim of more than perhaps any other crime… [This theory] shares
strengths of both sanctity-of-life and personhood accounts while avoiding weaknesses of both. In addition, it meshes with a central intuition concerning what makes killing wrong… [But is not] an account of the necessary conditions for the wrongness of killing. Some persons in nursing homes may lack valuable human futures, yet it may be wrong to kill them for other reasons. 86

Thus, the valuable future theory suggests that the reason why we have a strong intuition that killing is a serious *prima facie* wrong is because simply being alive provides the basis for obtaining everything that can be considered a “good” by individuals, whatever those “goods” might subjectively considered to be. This theory supports the strong intuition that killing is generally wrong, but not by virtue of some doctrine that is taken to be immutably true. Killing is generally wrong because it deprives the individual killed of the opportunity to achieve or experience anything at all. This does not necessarily entail that killing is absolutely unjustifiable; even abortions *could* be morally justified in certain cases (perhaps those necessary to protect the life of the mother). The aim of the theory is to provide a plausible explanation for the moral intuition that intentional killing represents a serious *prima facie* wrong in most cases.

Marquis’ theory is more plausible than the sanctity of life doctrine or the personhood account, and yet it remains successful in justifying the accepted medical practice of allowing PVS patients to die. With the advancement of medical technologies, it has become possible to maintain the physical existence of a person who is permanently comatose for a very long period of time, but this provides no benefit for a PVS patient because they are unable to derive any value from that continued existence. Therefore, bringing such an existence to an end does not deny the patient any potentially valuable future. In this way, Marquis’ theory can be applied to the moral justification of removing life support from PVS patients without engaging in a debate over “personhood”; whether PVS patients are thought to be persons or not, they are not denied any potentially valuable future in the removal of life support.

Marquis’ theory provides justification for individual acts of euthanasia by demonstrating one way in which assisting someone in dying does not violate our human intuition that killing is seriously *prima facie* wrong; that is, assisting one who subjectively feels that they lack a valuable future and requests euthanasia can potentially be a morally appropriate action. Holding an absolute view such as the sanctity of life doctrine is unreasonable because it is impossible to consistently hold such a view while
practicing within the accepted norms of modern medicine. It is much more reasonable to assert that the intentional taking of an innocent human life is always *prima facie* wrong, as Marquis’ valuable future theory does. Thus, the valuable future theory remains in keeping with our intuitions that it is generally wrong to intentionally take an innocent human life, but suggests that acts of euthanasia *can* be morally justified in certain cases.

Although there might be good reason to reject the sanctity of life doctrine, some critics of legalized euthanasia argue that physicians are morally and professionally obligated to refrain from providing assistance in dying. Allowing physicians to actively assist patients in dying, it is thought, would be incompatible with their fundamental moral and professional commitment as healers and protectors of life. I argue that providing euthanasia for those patients who competently and voluntarily make the informed decision to request assistance in dying can be morally justifiable.

**The Role of the Physician**

Some opponents of legalized euthanasia have suggested that the practice of euthanasia itself undermines the “very soul” or “moral center” of medicine. Traditionally, it is argued, the role of medicine has been constricted to serve *one* particular goal: to heal. Classical ideology has, likewise, constricted the role of the physician to fit neatly into this framework and suggested that the physician is to be a healer: one who mends wounds and battles disease. Construing physicians as agents with the power and authority to bring about the death of patients, it is thought, would be deeply at odds with the fundamental goals of medicine.

One of the most widely regarded ethicists opposed to the legalization of euthanasia, Leon Kass, has argued that “medicine is essentially a healing enterprise,” and that “being a physician, teacher, or parent has a central inner meaning that characterizes it essentially.” Similarly, many critics of euthanasia maintain that “the essence of medicine – its inner normative meaning and purpose is healing, which physician-assisted death contravenes.” However, even some critics who are staunchly opposed to the
moral permissibility of euthanasia agree that the “historical role” of the physician as a healer alone is somewhat lacking. In one widely read article, Daniel Callahan argues that contemporary medicine has neglected the goal of helping patients to achieve a peaceful death and he challenges the traditional role of the physician as a healer alone:

Physicians have been given special knowledge about the body, knowledge that can be used to kill or to cure. They are also given great privileges in making use of that knowledge. It is thus all the more important that their social role and power be, and be seen to be, a limited power. That power may be used only to cure or comfort, never to kill… Yet if it is possible for physicians to misuse their knowledge and power in order to kill people directly, are they therefore required to use that same knowledge always to keep people alive, always to resist a disease that can kill the patient? The traditional answer has been: not necessarily. For the physician’s ultimate obligation is to the welfare of the patient [emphasis added], and excessive treatment can be as detrimental to that welfare as inadequate treatment. Put another way, the obligation to resist the lethal power of disease is limited – it ceases when the patient is unwilling to have it resisted, or when the resistance no longer serves the patient’s welfare. Behind this moral premise is the recognition that disease (of some kind) ultimately triumphs, and that death is both inevitable and not always the greatest human evil.

The physician, then, is not obligated to utilize every available means in order to heal, but rather to engage in an evaluation of the possible treatments and to make a decision with the help of the patient as to what the best course of action might be in any particular case. Maintaining life at any cost is clearly not the policy of most physicians; this fact is becoming increasingly evident. The emergence of an increasing number of palliative care and hospice programs, the amount of public debate regarding end of life care, and the increase in the number of classes focused on end of life care available in many medical schools are all indicative of this positive trend. Our current medical technology is such that physicians must often decide between numerous available treatments, and it is sometimes the case that the only reasonable option is (unfortunately) to discontinue treatment and focus on providing patients with the best possible pain control, while ensuring that they (at the very least) have an opportunity to live out the remainder of their days in relative comfort.

Callahan’s treatment of the role of the physician is particularly striking because he argues for the view that “the physician’s ultimate obligation is to the welfare of the patient,” and yet he maintains that the practice of euthanasia is fundamentally at odds with the medical profession. While he fully realizes that continued treatment can be detrimental to the welfare of the patient, Callahan fails to recognize that precisely the
same statement could be made about continued *existence*. An individual who has an objectively bleak future and does not consider life to be worth living might legitimately make the carefully considered and informed decision that they wish to hasten death in order to avoid continued existence which offers little prospect for anything beyond pain and suffering. Providing euthanasia or otherwise hastening the death of such patients at their request can be seen as *beneficent*, as providing end of life care in accordance with the wishes of the patient that adequately addresses their needs and desires in a caring and thoughtful manner. There is nothing inherently wrong with requesting the cessation of life supporting treatments; sometimes the burdens of medical care outweigh the benefits. Furthermore, this legitimate option for patients can be requested not only with the intent of avoiding unnecessary treatment, but also with the intent of hastening death.

While it may be the case that the practice of medicine ought to be governed by *some* ethical framework of ends and means, such as the flexible guidelines suggested by the principles approach, *the nature of medicine is too complex to be directed toward one fundamental goal*. There is no fixed and immutable aim which governs the practice of medicine. Morally appropriate actions in medical care are not determined by some external guiding force; medical care itself entails human intervention and is advanced through human innovation. Values independent of the patient being cared for are not necessary entities which must be respected at all costs. The treatment appropriate for one patient might not be the same for another, and there are cases in which treatment *itself* is inappropriate; even Callahan agrees on this matter. The qualities that make a “good” physician are not fixed and essential. A “good” physician, like Quill, is *many* things. Appropriate medical care must adapt to the particular *end in view* of the patient who is supposed to *benefit* from the care being provided; it is not governed by a fixed and external principle of medicine which derives its authority from its antiquity. Relying on the principles of autonomy and beneficence can provide basic guidelines for the practice of health care, to be sure, but even these principles are flexible and must be adapted in order to allow for moral evaluation in individual cases.

**Physicians as the Preferred Agents**
Some ethicists have suggested that physicians should not practice euthanasia even if it were legalized, for fear that this might undermine trust within the physician-patient relationship or confuse the nature of health care. However, there are strong reasons supporting the view that physicians are the best possible agents for performing euthanasia available in our society, rather than assigning such a role to psychologists, family members, or perhaps creating a “special class of medical technicians [to] provide the means of death or administer the lethal injection.”93 First of all, patients should not fear that the legalization of euthanasia might encourage physicians to provide euthanasia for those patients who did not voluntarily request it. If euthanasia were restricted to those patients who truly voluntarily requested it, trust could be “increased, not eroded, by knowledge that physicians will provide aid in dying when patients seek it.”94

Physicians are the most knowledgeable persons in our society when it comes to pain control. Thus, they are the social agents who have the best chance of successfully removing requests for assistance in dying prompted by inadequate care. Furthermore, physicians are often the first to receive requests for assistance in dying, and they would almost certainly be required to participate in the practice of legalized and regulated euthanasia to a large extent.95 Studies have demonstrated that requests for physician-assistance in dying represent a “relatively common clinical occurrence,” and physicians are likely the best suited persons to respond to such requests.96 Physicians are trained to respond to the individual needs of patients, and they have the technical background required to ensure that all available methods of treatment have been evaluated and to ensure that requests cannot be alleviated with alternative treatments. Furthermore, physicians are “bound to uphold professional standards and [are] trained to maintain greater objectivity about persons who are suffering than is always possible for family members.”97 Finally, it has been suggested that it would be preferable that the “same person who has been the ally of the patient in the fight against illness remain an ally to the end,” and that it is important for the “physician [to] experience the full consequences of his convictions… if it is emotionally difficult to aid a patient to die, the physician should not be able to evade that difficulty.”98

The role of physicians has been changing over time as technology has progressed, and it is indicative of the direction of that progress that pain management and hospice
care have made such great advances. Care provided at the end of life that takes the wishes of the patient into consideration often involves making decisions about when treatment has become futile. Appropriate end of life care often focuses not on ensuring that every possible treatment option has been attempted, but on providing relief from pain and suffering and providing conditions for living or dying that are in keeping with the wishes of the patient. There is no fixed and immutable aim which governs health care or strictly defines the role of the physician as a healer, and nothing else; the nature of medicine is too complex to be directed toward one fundamental goal.

In the following section, I argue that withholding or withdrawing medical treatment can be morally equivalent to engaging in assisted suicide, given the informed decision of a competent patient or proxy. Furthermore, because the requirements for withholding or withdrawing treatment are less restrictive than those which would govern the practice of euthanasia, there is no good reason to believe that the legalization of euthanasia would lead to greater abuse of vulnerable or poor patients than the currently accepted practice of letting die.

**Killing and Letting Die**

Although there may be compelling reasons to keep acts of withholding or withdrawing medical treatment and physician-assisted suicide (PAS) *legally distinct*, there is no adequate grounding for claims that there is a *bare moral difference* between these acts provided both were prompted by the informed decision of a competent patient or proxy with the goal of hastening death. The language used in debating this issue is often confused, and it has been suggested that the opposing sides in such debates utilize various emotive terms and phrases as it suits them. As one ethicist strongly opposed to the legalization of euthanasia puts it, “all social engineering is preceded by verbal engineering.” Thus, I will be using the relatively uncontested “withholding or withdrawing treatment” to designate acts which are generally termed “passive euthanasia” by advocates of PAS. Whatever language is used, however, the point remains
that these cases of withholding or withdrawing treatment and PAS require the physician to either (a) allow the patient to die, or (b) to facilitate in the suicide of the patient.

There are two common arguments regarding the distinction between killing and letting die that influence the euthanasia debate. The first sort of argument suggests that withholding or withdrawing of life sustaining treatment differs from active means of hastening death based on a moral distinction between \textit{acts} and \textit{omissions}. According to this reasoning, letting a patient die can be permissible while killing a patient cannot. Alternatively, some claims that a distinction between \textit{intention} and \textit{foresight} can be invoked in order to create a doctrine prohibiting physicians to intentionally hasten death, although similar actions might be morally permissible provided death was foreseen and not intended. Maintaining this moral distinction, it is thought, might serve to alleviate concern regarding potential abuses in medical care.

\textbf{Acts and Omissions}

Although it is still debated as to whether or not moral agents must accept responsibility for the consequences of events that they did not \textit{directly} bring about, physicians are often required to do much more than simply refrain from harming patients, and it is reasonable to suggest that they have a strong \textit{prima facie} duty in most cases to ensure that their patients continue to live. Physicians are often required to take active measures to promote the continued health of their patients, to prevent them from experiencing unnecessary pain, and to actively assist in their recovery from bodily injury or disease. Thus, any moral significance that might be thought to distinguish \textit{acts} from \textit{omissions} is irrelevant with regard to physicians because they have a professional obligation to take active measures in the treatment of their patients.

One of the most influential arguments rejecting a rigid moral distinction between acts of killing and letting die can be found in James Rachels’ “Active and Passive Euthanasia.”\textsuperscript{100} In this article, Rachels argues that prohibiting active euthanasia while allowing passive euthanasia (the refusal of life prolonging treatment) may rely on the faulty assumption that there is a bare moral difference between acts of killing and letting
die. He does this by presenting a thought experiment involving two similar cases that differ in one important way:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking a bath, Smith sneaks into the bathroom and drowns the child, and then 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, just as he enters the bathroom Jones sees the child slip and 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 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, whereas Jones “merely” let the child die. That is the only difference between them.\(^{101}\)

Despite the intuitive appeal of this argument, this one example does not support Rachels’ claim that there is never a moral difference between acts of killing and letting die, and it does not eliminate the possibility that there might be other reasons for maintaining a practical distinction between killing and letting die. Thus, the larger conclusion that Rachels draws regarding prohibitions against active euthanasia may be unwarranted. However, even those critical of Rachels’ larger claim concede that his argument is successful in demonstrating that there is no bare moral distinction between acts and omissions; that is, that killing is no worse in itself than letting die.\(^ {102}\)

Killing and letting die can be construed as morally equivalent actions, especially in cases where the professional obligations of the physician require the active treatment of the patient. Physicians have prima facie obligation to take active measures to ensure the continued survival of their patients. To clarify this point, imagine a physician who makes the decision to remove the ventilator supporting an otherwise healthy patient, knowing that the death of the patient was likely to result. Such a decision could be morally justifiable in certain circumstances, but it would not suffice to claim that the physician was justified because patient died a “natural” death, or because the physician merely “let the patient die.”

In cases of “merely” letting die, the physician is accountable for removing life support devices, regardless of any evaluation of the directness of his actions. If a physician is not justified in withdrawing or withholding life support and acted deliberately, with the knowledge that his actions were likely to result in the death of the patient, an act of letting die results in the same bad consequence as an act of killing and is
equally morally reprehensible. This does not mean that physicians are acting wrongly in all such cases, but rather that they are professionally obligated to justify their actions or omissions in cases of “letting die” just as they would in acts of “killing.”

**Intention and Foresight**

However, it could be argued that Rachels’ famous case of the “nasty cousins” fails to be persuasive because both Smith and Jones intended to kill their respective cousins. Thus, moral evaluation of the two agents is not dependent on whether they actively killed or “merely” failed to rescue, but on the assumption that they were both ready and willing to kill their innocent young cousins for personal gain. Similarly, it has been suggested that a physician can deliberately and knowingly engage in an act that results in the death of a patient provided that it was not the intent of the physician to bring about death, even if the death was foreseen. In cases of letting die, it is argued, the physician does not intend for the patient to die, but merely foresees it, and is thereby not morally responsible for the death of the patient.

This line of reasoning is most commonly utilized in the *doctrine of double effect* (the DDE). The doctrine is often used to morally evaluate acts that have both good and bad consequences. It explicitly denies the conclusion that intentional acts of killing can ever be morally justified and specifies four conditions that an act with some bad consequences must meet in order to be morally justifiable:

1. The act must be morally good or neutral independent of its effects;
2. The agent must intend only the good effect, although the bad effect can be foreseen and permitted, provided that it is not intended;
3. The good effect must not be obtained by way of the bad effect (otherwise the bad effect would be intended); and
4. The good effect must outweigh the bad effect.103

Those who hold the doctrine maintain that it can be in the best interest of a patient to refuse treatment even if it results in death, but the cessation of the undesirable treatment (as opposed to the hastening of death) must be the primary aim. The DDE can also be used to justify the use of extreme measures of pain control which may hasten death as an unintended side effect. For example, providing morphine in a dosage likely to cause
respiratory depression and lead to the death of the patient could be morally justifiable (where euthanasia would not) if it was not the intent of the physician to kill the patient, but merely to relieve the pain and suffering.\textsuperscript{104} In euthanasia, on the other hand, the death of the patient is the primary goal.

The DDE operates much like the sanctity of life doctrine, while also allowing physicians grounds for the moral justification of providing adequate pain control that is likely to lead to the death of the patient. In this way, the doctrine adds an additional proviso for foreseeable \textit{incidental} deaths that may be caused in the pursuit of \textit{justifiable} goals. While the DDE is certainly useful in this regard, it suffers from a defect similar to the sanctity of life doctrine in that it sharply rules out the potential that death might be the preferable option for particular individuals. It flatly denies the moral permissibility of individual acts of euthanasia, and overlooks the legally and morally supported actions of those individuals who feel that they lack a valuable future and want to withdraw life prolonging treatment with the goal of hastening death.

The DDE encounters two problems when utilized as an objection to PAS. First, it fails to adequately justify certain currently acceptable medical practices. Second, it does not produce intuitively acceptable implications unless it is considered jointly with the concept of authorized consent. As I mentioned previously, the DDE fails to justify the removal of life sustaining treatment from those patients who \textit{intend} death as a result. While some might argue that such an action would be morally impermissible, public policy is certainly clear that “patients are entitled to refuse life support, whether or not they \textit{intend} their own death in doing so.”\textsuperscript{105}

In such a case, the DDE might support the response that a physician removing life support does not do so because they \textit{intend the death of the patient}, but rather to \textit{respect the wishes of the patient}. Thus, the doctrine could still justify the removal of life support if the death of the patient were a foreseen but unintended consequence of achieving the good that is respecting the wishes of the patient. However, the point to be made here is not that intention plays \textit{no} role in the moral justification of this action, but that relying on intention \textit{alone} cannot adequately justify such actions without the support of authorized consent. In this case, the request of the patient is to be respected regardless of whether or not the patient intends death; \textit{the goal is to respect the wishes of that individual patient}. 
Furthermore, the intentions of a physician in such a case may be complex; the physician may intend only to respect the wishes of the patient, but may also remove life support with the intention of providing the patient with a more peaceful and dignified death. A physician removing life support *may or may not* be acting in accordance with the DDE, and yet there is no distinction in public policy that relies on this point.

The DDE also fails to provide adequate justification for a currently accepted medical practice which clearly hastens death: *terminal sedation*. In this practice, a patient who has pain so great that it cannot be adequately addressed with available medication is rendered unconscious through the use of extremely high doses of barbiturates and is then refused medical treatment, including nutrition and hydration. This practice is distinct from *total sedation*, in which the patient is rendered unconscious in order to control pain, but treatment is not removed. The practice of total sedation can be consistent with the DDE if the intention is to adequately control the patient’s pain, as can the practice of withdrawing nutrition and hydration (provided that authorized consent has been given), because doing so might make the dying process less painful. However, the DDE suggests that the *combination* of sedation and the removal of nutrition and hydration would be morally impermissible. What could motivate the removal of nutrition and hydration from a sedated patient other than the intention to hasten death? In fact, one survey found that 39 percent of physicians admit that they intended the death of the patient when sedating and then withholding or withdrawing life support.\(^\text{106}\)

One final point which can be made about the place of intention in the euthanasia debate is that it does not *necessarily* follow that a physician intends their patient’s death in PAS if they provide a lethal prescription to a patient who merely requests it in order to regain a personal sense of control, but does not intend to utilize it. Suppose in Quill’s case that Diane primarily expressed a concern about losing control over her dying process and requested a lethal prescription in order to regain a sense of control. She might have explained to Quill that simply having the *option* of using the prescription could enable her to live out the rest of her days in comfort and security, knowing that she *could*, if she ever felt it necessary, take her own life. She might not ever intend to utilize the medication to hasten death but, rather, might simply feel more comfortable knowing that she had the *ability* to determine the manner in which she died, if she chose to do so. Quill
might firmly hope and believe that Diane would not end up using the medication and could conceivably provide the lethal prescription to her without intending that she take her own life; that is, he could provide Diane the lethal prescription while *intending* that she would find satisfaction and comfort in knowing that she had the option of taking the medication, and merely *foreseeing* that she might actually use it to take her own life.

While the arguments I have presented may not offer a decisive refutation of the DDE, they may accomplish a great deal. If my arguments hold, then I have demonstrated that the DDE fails to adequately justify certain currently acceptable medical practices, and does not produce intuitively acceptable implications unless it is considered jointly with the concept of authorized consent. In these respects, relying on the DDE alone is problematic, and I suggest adopting an alternative method to be utilized in the moral and legal evaluation of difficult cases in medicine.

**Authorized Consent**

What, it might be asked, can provide an adequate basis for claiming that an act which hastens death *would be* morally impermissible, if such a basis cannot be found in a distinction between acts and omissions or intention and foresight alone? As I have argued, the DDE overlooks the issue of *consent* entirely, and cannot produce intuitively acceptable implication without also utilizing the notion of authorized consent. It is the absence of an autonomous decision by the patient or proxy decision-maker that generally makes acts which hasten death impermissible; an authorized choice is absolutely necessary for justifying the withholding or withdrawal of treatment and this requirement is maintained in the moral and legal justification of acts of euthanasia. Allen Buchanan has suggested the following to illustrate similar points:

Suppose Smith, who is connected to a ventilator and will die without it, competently decides he does not wish to live in such a state of dependency, and convinces his physician to withdraw this means of life support. However, before the physician can do so, Smith’s wicked nephew, Brown, steals into Smith’s room and shuts off the ventilator. When his foul deed is discovered, Brown lamely protests, with all the feigned indignation that he can muster: “I didn’t kill him, the disease did!” …The usual moral drawn from such examples is that killing is itself no worse than letting die. But the hollowness of Brown’s protest shows that we may draw a different conclusion. Withdrawing life-support can be killing in a straightforward sense: an act which results in death.
And if the act is done with the intention of bringing about death – whether as a means to getting fortune or as a means to relieving futile suffering – it is an act of intentional killing.\textsuperscript{107}

Clearly the actions of Brown and the near-actions of the physician in this case are extremely similar, and yet those supporting a distinction between acts and omissions might call the actions of Brown a “killing” and the near-actions of the physicians a “letting die.” Alternatively, those who maintain the DDE might argue that the physician did not \textit{necessarily} intend Smith’s death, while Brown \textit{clearly} did. However, these distinctions alone fail to be decisive in morally evaluating this case. Rather than forcing a choice between killing and letting die, acting and omitting, or intending and foreseeing, the rightness or wrongness of the act relies on the presence or absence of the autonomous request made by the patient or authorized proxy decision-maker.

In some strange sense, it could be argued that the actions of Brown were acceptable because they resulted in consequences which matched the wishes of Smith. However, the hollowness of Brown’s protest stems from the fact that he was unaware of the wishes of the patient. Had he been authorized to remove the life support, his actions would have been (at least) \textit{legally} justifiable \textit{regardless} of his personal motives. Brown’s actions were morally and legally impermissible for the same reason: he did not have \textit{authorized consent}. This is not to say that Brown’s wicked intentions do not play a role in our evaluation of his moral character, but where good intentions would not be necessary to justify his actions, the authorized consent of Smith most certainly would.

Whether the decision is being made in regard to withholding or withdrawing treatment or providing assistance in suicide, the primary method of moral and legal evaluation remains the same. The \textit{mode} of death is not the issue; it is not about who or what physically caused death. In cases of “letting die” there \textit{must} be valid authorization to stop treatment irrespective of the intention of the physician. The conclusion to be drawn here (if this line of reasoning is correct) is that acts of killing and letting die, whatever they may be construed to be, rely on the same justifications in order to be morally or legally permissible. If these practices are to be morally and legally evaluated in the same way, then \textit{there is no good reason to assume that one practice is likely to suffer from more abuse by virtue of the nature of the practice alone}. 

Distinctions in Death

Because of the similarities between allowing for the refusal of medical treatment and PAS, the legal right to refuse medical treatment can be (mistakenly) equated with a supposed “right to die,” and it could be suggested that the right to refuse medical treatment ought to imply a similar “right” to PAS. However, there are good reasons to maintain a strong legal distinction between killing and letting die, even if no bare moral distinction between the two practices can be found.

The legal distinction between killing and letting die has traditionally been grounded on the right to refuse treatment on an independent right to maintain bodily integrity.\textsuperscript{108} This legal doctrine is based on the common-law notion that physical invasion without consent is a legal wrong that can provide the basis for suit.\textsuperscript{109} This legal reasoning is appealing because it provides an easily distinguishable feature that the right to refuse treatment has, which any “right” to PAS would be unable to match. However, Dan Brock has argued that the right to bodily integrity is not independent of the right to self-determination or autonomy:

\textit{[Our] morality and laws take seriously the distinction between individual persons and the right of each person to have substantial control over and responsibility for what happens to him or her. Since persons are embodied individuals, and anything that happens to our bodies happens to us, one important component of this personal control concerns what is done to our bodies… If individuals should have significant control over their lives and what is done to them, this should include what is done to their bodies. The idea is that individuals should have a protected sphere of control or sovereignty in which they cannot be interfered with without their consent, and that control over what is done to one's body is at the core of that sphere… If something like this is the moral basis for a right to bodily integrity, then that right does turn out to be grounded in a broader right of self-determination or personal autonomy.}\textsuperscript{110}

The traditional grounding for the legal distinction between acts of killing and letting die is flawed, then, because the right to maintain bodily integrity is derived from a broader notion of respecting autonomy. A problem arises here because basing the right to refuse treatment on the principle of autonomy seems to suggest that there ought to be a “right to die” that is analogous to the existing right to refuse treatment. Thus, it could be argued that the legal right to refuse medical treatment ought to be extended \textit{as it stands} to an analogous “right” to euthanasia because there is no bare moral difference between the practices. While it may be true that the moral and legal distinctions between the two sorts
of practices is somewhat unclear, there are compelling reasons to keep the practices legally, if not morally, distinct.

**Rights and Restrictions**

One of the distinctions between the right to withdrawing or withholding treatment and the so-called “right” to euthanasia is that in cases of euthanasia, there is no particular individual that can be identified as having an *obligation* to perform the action. The right to self-determination of the patient does not entitle them to force physicians to engage in euthanasia if it conflicts with the moral beliefs of the physician because the physician has an equal right to self-determination that deserves equal respect. If a “right” to euthanasia is present at all, it consists merely of the right of the patient to *request* euthanasia of the physician, who is another autonomous individual whose self-determination must be respected. To clarify this last point, imagine a terminally ill patient in severe pain who requests the assistance of their physician in PAS. Assume that the physician honestly wants to help the patient in any way possible and believes that providing PAS represents the most appealing option available to the patient, but that providing PAS would violate certain ethical (possibly religious) convictions of the physician. It would be unreasonable to suggest that the physician would be obligated to provide PAS in this case because, to the mind of the physician, doing so would be immoral. Forcing such a physician to provide PAS for a patient who requested it would be wrong because it would greatly undermine the autonomy of the physician.

It might be argued that the more consistent stance to take on this issue it that physicians have a professional obligation and responsibility to participate in legitimate medical practices (including euthanasia, if legal) regardless of their ethical views on them. If a medical practice is truly legitimate, it could be asked, why should a physician be allowed to ignore the requests of a patient in need based solely on their personal moral convictions? First, the historical precedent set by the legalization of abortion suggests that this line of reasoning should not be followed. While physicians *are* obligated to perform abortions deemed necessary in order to protect the health of the mother, physicians are not obligated to perform abortions based solely on the autonomous choice
of a mother wishing to abort an unwanted or accidental pregnancy. The justification for this obligation rests on the notion that an immediate threat to the life of mother ought to outweigh the moral convictions of the attending physician. However, physicians could not be similarly obligated to provide euthanasia because the life of a patient could not be put in jeopardy if a physician were to refuse to take immediate action to assist the patient in dying. On the other hand, a physician who refuses to perform a medically necessitated abortion on moral grounds (or, perhaps, a Jehovah’s Witness who refused to perform a medically necessitated blood transfusion) would be directly jeopardizing the life of the patient in favor of his or her personal moral convictions.

Secondly, requiring physicians to provide euthanasia against their personal moral convictions would have the practical result of severely reducing the possibility of successfully legalizing euthanasia. Our country is already divided on the issue of euthanasia, and physicians are no exception. The prospect of being forced to engage in a practice that one feels morally uncertain about would likely cause many physicians to oppose such legislation, even if they might like to see euthanasia legalized otherwise.

A third reason why the participation of physicians should not be professionally obligated is that doing so might make it difficult for physicians to deny PAS to anyone at all. Physicians who truly felt that PAS would not be in the best interest of the patient and did not want to provide euthanasia might feel extreme pressure to participate despite any concerns which they had. Such physicians might wish to attempt to remove requests for PAS by utilizing alternative treatments or by exploring alternative approaches to pain control before seriously considering in PAS, and would lose those patients who might have benefited from alternative treatments or pain control because they would feel pressure to assist the patient in dying. Furthermore, obligating physicians to perform euthanasia despite their moral convictions could lead to a situation in which patients could bring about legal charges against physicians who refused to grant them assistance in dying, opening the door for “wrongful life” suits and promoting autonomy in a far too heavy-handed manner.

A fourth concern is that those physicians who do not want to participate in PAS for moral reasons would also be likely to disregard the law and refuse to participate anyway. It would be difficult to enforce such a regulation, and attempting to do so would
lead some physicians to either lie to the patient or to simply ignore their requests for assistance in dying. As a result, trust within the physician-patient relationship would be reduced, and patients might simply assume that any physician who refuses to provide assistance in dying is “just” morally objecting to the practice. This, in turn, might lead patients to disregard sincere attempts at assistance other than PAS from physicians, and to seek out alternative care prematurely, ignoring the possible benefits of alternative treatments or methods of pain control.

Finally, while the right to request the discontinuation of medical treatment can be extended to every competent and informed patient and must be respected by every physician, any supposed “right” to PAS cannot be extended in the same way. The right to refuse treatment applies equally to those who are suffering from a medical problem as to those who are not. This right can be universalized to cover every member of society, while it is generally agreed by those on either side of the issue that any “right” to PAS would have to be restricted through legislative regulations.

**Causation and Culpability**

The New York State Task Force on Life and Law also provides compelling (but misleading) reasons to keep these two “rights” distinct. The Task Force argues that characterizing the refusal of treatment as the cause of death undermines society’s commitment to respecting autonomy. They suggest that the “cause of death” should remain focused on the underlying medical problem, although it is reasonable to require a “deliberate judgment about legal and ethical accountability” as to the role the physician plays in hastening death. Doing otherwise, it is argued, would make physicians accountable for the refusal of treatment and lead to disastrous consequences in practice because physicians would be much less willing to allow patients to refuse treatment if they feared prosecution, which would lead to great violation of patient autonomy.

The Task Force suggests that the right to refuse treatment is clearly established both legally and morally, and if challenged (in efforts to justify euthanasia) could lead to a situation in which it would be difficult for patients to refuse any form of treatment, no matter how undesirable or invasive. Assigning accountability to the patient or physician
rather than the underlying disease makes those who refuse treatment responsible for bringing about their own death. Thus, if the moral distinction between killing and letting die were abandoned, patients could presumably lose more freedom than they already have because of a “technological imperative” that would establish that the mere existence of medical technology would require its use.

However, the cause of death in cases of refusing treatment is confused because the physician does play an important role in the death of a patient who competently refuses medical treatment. In the case of discontinuing ventilator support, “but for honoring the patient’s request, the patient would have lived.” In many cases, death comes about as a result of the decision to withdraw or withhold treatment, and this decision must be made with the consent of the patient or proxy. While it might seem reasonable to propose that the “cause of death” should not be attributed to physicians who remove ventilator support (because it is the underlying disease that directly kills the patient in such a case), the physician plays a vital role in allowing the death of the patient and is morally accountable for knowingly and deliberately allowing that death to occur.

Furthermore, most deaths are “negotiated” to a certain extent. Making the decision to give up the pursuit of genuinely futile treatment and accepting the inevitability of death is relatively common (and increasingly so, due to the rapid pace of technological progress). Making these difficult decisions does not reflect poorly on the parties involved or make them the ones to “blame” for bringing about the death, even though they may sometimes feel that way. Focusing on palliative care is often the only available option that has any likelihood of benefiting a terminal patient at all, especially if engaging in aggressive treatments would cause the patient pain and suffering while providing no foreseeable benefit. However, those who make such decisions are morally responsible for making them, whether or not they were the right decisions to make.

Suggesting that a “technological imperative” would take hold in our society if the refusal of treatment were equated with euthanasia overlooks the fact that (if what I am suggesting is true) killing is only morally equivalent to refusing treatment if the goal of refusing treatment is to hasten death. For example, consider Quill’s case of PAS involving his long-time patient, Diane. Diane made the initial decision to refuse treatment (distinct from her request for assistance in dying) because she felt that the
burdens of the treatment available to her outweighed the potential benefits. In this case, her refusal of treatment did not indicate a desire to hasten death, but rather a desire to avoid an undesirable treatment. Diane did express a desire to hasten her own death at a later time, but her requests for refusing medical treatment and her request for PAS were quite distinct. In this case, it clearly would have been wrong of Quill to kill Diane when she decided to refuse treatment because she did not refuse treatment with the goal of hastening death; she wanted to live out as much of her life as possible before dying. It is only when treatment is withheld or withdrawn with the goal of hastening death upon the informed request of a competent patient that PAS can be thought to represent a morally equivalent action.

While it is true that physicians assume a certain level of responsibility in caring for patients and that they often play a certain causal role in the dying process, the physician’s role in causation does not necessarily imply moral or legal culpability. The role that a physician plays in the dying process of a patient may be morally and legally justifiable, even if that role was largely active and participatory. While acknowledging the complexities of morally evaluating the actions of physicians, it should be remembered that physicians often actively participate in the dying process and that this does not necessarily make them morally culpable for their actions; often such participation is both morally and legally justifiable and gratefully received by the patient in need of care. What I mean to emphasize here is that acts of withholding or withdrawing life support are subject to the same moral and legal justifications which would be required in the regulation of physician-assisted dying.

Some of the most compelling criticisms of legalized euthanasia rely on so-called slippery slope (also known as thin edge of the wedge, foot in the door, or camel’s nose under the tent) arguments for their effectiveness. Objections to legalized euthanasia of this sort focus on the concern that the potential negative consequences of legalizing the practice are likely to outweigh the supposed benefits, regardless of whether or not individual acts of euthanasia can be morally justifiable.
The Slippery Slope

Although slippery slope objections are often presented together and are somewhat difficult to separate entirely, it is useful for debate to distinguish between two types of such arguments. In this section, I will address theoretical slippery slope objections, which suggest that it would be impossible to limit a right to assisted suicide in an acceptable way once that right was accepted.\textsuperscript{115} I will then, in a separate section, address practical slippery slope concerns, which suggest that it would be impossible to adequately enforce the suggested regulations of the practice of euthanasia.\textsuperscript{116}

Morality in Method

The first sort of slippery slope objection to the legalization of PAS is based on the concern that loosening the prohibition against killing patients will lead to the gradual acceptance of undesirable forms of euthanasia in medical practice, such as voluntary active euthanasia (VAE). The idea behind this sort of objection is that PAS does more to ensure the consent of the patient, and is thereby likely to suffer from less abuse than VAE. The conclusion to be drawn (if this fear is legitimate) is that PAS should not be legalized even if it seems acceptable in itself, because it is likely to lead to the acceptance of other, more undesirable practices. For example, some might fear that efforts to legalize PAS represent the first step on a moral decline that will be impossible to stop until both nonvoluntary and involuntary active euthanasia were accepted in practice, and the lives of poor or otherwise vulnerable patients were unjustly disregarded without remorse or consequence. Once we are on the slope, it is feared, we will never be able to get off of it.

In this section I argue that there is no \textit{bare moral difference} between PAS and VAE, and that those who advocate PAS and oppose the legalization of VAE often mistakenly assume that requests for VAE are less likely to be \textit{truly voluntary} by some virtue of the practice itself. However, the true force in claims that VAE is more likely to lead to abuse is grounded in the fear that physicians might take it upon themselves to administer active euthanasia to incompetent patients who did not authorize consent. The latter concern warrants further consideration, and is distinct from the former. While I do
believe that a strong legal distinction between these two practices is important and ought to be maintained, both practices are morally and legally justified in the same way and are therefore subject to the same practical abuses. Furthermore, the legalization of PAS alone raises problems because it is discriminatory and does not serve to advance the moral values supporting such legislation adequately.

It might be argued that a moral distinction between PAS and VAE can be grounded in the notion that the physician is the *immediate* cause of the death of the patient in acts of VAE, while this is not the case in PAS. However, such an argument is based on the faulty premise that the moral evaluation of an action is inextricably linked to the way in which they are physically brought about. Much like the troubled arguments which attempt to find a bare moral distinction between acts and omissions, arguments attempting to find a bare moral distinction between PAS and VAE must be similarly rejected. The same individual is accountable for assisting the patient in the cases of PAS and VAE; in both acts, the physician is an essential part of the deliberation process, plays a substantial role in the acquisition of the means of hastening death, and would be subject to the same moral and legal evaluation for participating in either act.

Perhaps the view that PAS ought to be legalized and not VAE rests in the idea that the patient’s self-medication somehow does more to determine the voluntary nature of the request to die. The legalization of PAS alone, it is thought, might alleviate some of the worries regarding the potential abuses of euthanasia in that PAS “leaves the fundamental decision about whether to use [the medication] to the patient alone… the physician is involved, but not directly; and it is the patient’s choice, [although] the patient is not alone in making it.”\(^\text{117}\) Similarly, Timothy Quill has argued that in PAS “ultimately the patient must be the one to act or not act… in voluntary [active] euthanasia, the physician both provides the means and carries out the final act, with greatly amplified power over the patient and an increased risk of error, coercion, and abuse.”\(^\text{118}\)

However, it is a mistake to think that the symbolic act of self-medication can somehow decrease the risk of error, coercion, and abuse of patients who authorize consent for euthanasia. While the legalization of VAE would allow for the possibility of administering active euthanasia to physically incompetent patients, there is no feature of PAS in itself which would ensure that the decisions of poor or otherwise vulnerable
patients were made free from the influence of their physician or family. In both practices, the physician plays an identical role up until the very last moment in which death is physically caused. As both Dan Brock and Nicholas Dixon have suggested, no compelling distinction in the moral evaluation of acts of PAS and VAE can be based on the means by which death is brought about: 119

[The] difference in causation has no significant effect on the patient’s control over either situation. In voluntary active euthanasia, just as in physician-assisted suicide, the physician’s participation is dependent on the patient’s voluntary request [analogous to the similarities in the moral justification of withholding or withdrawing treatment and PAS]. At any point in the process, from the time that discussions of active euthanasia first occur to the moment when the physician gives the lethal injection, the patient is free to change her mind and call a halt to the proceedings. The only moment when the patient has more control over her destiny in physician-assisted suicide than in active euthanasia is the split second between the insertion of the needle and the depression of the plunger… Deliberation and discussion about this request are likely to originate many months before any action is taken… [and] during this entire process, right up to the final split second, the patient has just as much control over her destiny. 120

The likelihood that poor or otherwise vulnerable patients would suffer from more abuse if active euthanasia were allowed is remote because both practices leave the decision up to the patient until the very last moment, long after the decision has been made. While it might be nice to think that requiring the patient to self-medicate would somehow ensure that their actions were voluntary, this notion only works insofar as the “natural check” built into PAS requires the patient to be conscious in order to receive euthanasia; that is, the patient must be physically competent to self-medicate. To be sure, this feature of PAS rules out nonvoluntary and involuntary euthanasia of the physically incompetent, but this “natural check” could easily be substituted by distinguishing between those patients who are merely physically incapable of self-medication from those who are mentally incapable of authorizing consent. Requiring patients to be mentally capable of authorizing consent in order to qualify for active euthanasia, rather than basing this distinction on the physical ability of the patient to self-medicate would similarly rule out the possibility for nonvoluntary or involuntary active euthanasia.

While the notion that legalizing PAS alone would rule out the possibility that physically incompetent patients could be administered nonvoluntary euthanasia without authorizing consent certainly requires further consideration, the point to be made here is that there is no quality of PAS in itself which ensures that the requests of competent
patients for euthanasia are truly voluntary; that is, that such requests were not made under the unsavory influence of the patient’s physician or family. The moral and legal evaluation of both practices rests on the same feature and therefore subjects those patients who are physically competent to the same abuses in this regard. Acts of active euthanasia and acts of physician-assisted suicide are morally and legally justifiable only if the actions of the physician were taken with the authorized consent of the patient.

**The Benefits of Active Euthanasia**

The legalization of PAS alone raises serious problems primarily because there are patients who might fully qualify to participate in PAS, but merely lack the physical ability to ingest medication without the assistance of another person. Not only are there patients who lack the ability to self-medicate entirely due to paralysis, such as those in the advanced stages of ALS, but there are those who simply “wait too long” to ingest the medication and find that they are physically unable to do so when they are truly ready to die. Such was the case with Kitty Rayle, featured in the PBS special with Bill Moyers that I previously mentioned. Her case is interesting because she lived and died in Oregon and participated in the Death with Dignity Act. Although she went through the legislative procedures in order to legally obtain the medication to end her life, she refrained from ingesting it until she was physically unable to swallow and died the very death which she sought to avoid.

Kitty Rayle’s story poignantly illustrates the dilemma that many patients who seek assistance in dying may face. It is an extremely difficult and emotionally draining task to judge the point at which one must ingest the lethal prescription before becoming physically unable to do so. This problem leads one to question the justification behind drawing the seemingly arbitrary line between handing someone a glass from which to drink a lethal barbiturate, and otherwise physically aiding someone who is incapable of self-medication when they would have qualified for assistance were it not for their physical inability to self-medicate. It should be stressed here that I am speaking only of assisting patients who are physically unable to self-medicate, as opposed to those patients who lack the cognitive capacity to either request or refuse assistance in dying.
The case of Jim Witcher, the ALS patient who was also featured in the PBS special I previously mentioned, represents an entire class of individuals who would be eligible for PAS aside from the inevitable loss of their physical ability to self-medicate when they might have liked to die.\(^\text{122}\) Patients such as Jim Witcher face gradual paralysis that slowly moves up through the body. After losing control of their arms, they eventually become unable to swallow or breathe without assistance. In a discussion about his intentions to bring about his own death in order to avoid inevitable suffocation or starvation, he laments that “the only thing that [is] unfair is that I’m going to have to do this before I would really rather do it… while I can still swallow and still hold a straw.”\(^\text{123}\) A difference in the physical causation of death alone cannot justify forcing patients in cases such as these to choose between either (a) committing suicide before they would have wanted, or (b) dying the very death which they sought to avoid.

It is difficult to justify withholding the ability to hasten death from those who are physically incapable of self-medication or those who wish to live out the days which might render them incapable of ingesting the medication by their own hand. The idea of fairness alone would seem to require that we make active euthanasia available to those who are unable to participate in PAS as a result of physical incapacitation (if PAS were made available), and it is unlikely that a seemingly arbitrary prohibition against VAE would hold if PAS was considered to be an acceptable medical practice. It would be unjust to restrict access to euthanasia to those individuals who are physically able to self-medicate; doing so would prevent the physically handicapped equal access to an acceptable medical practice based solely on their physical inability to self-medicate.

Finally, it must be remembered that VAE may be preferable to PAS from a patient perspective in many cases because the method of VAE is more predictable and effective than that of PAS. In the reported cases of PAS under the Oregon law, there have been cases in which patients have either regurgitated the medication once ingested, or have lived for days on end in a coma before dying.\(^\text{124}\) In a practical sense, if one wished to have a measure of control over the circumstance of their death, VAE would seem to be the preferable option for the patient. Thus, I suggest that there is a high probability that the practice of VAE would eventually be allowed in legislation originally intended to legalize only PAS (although it is possible that the practice of VAE would become
socially accepted before it was legally permitted), and that this move would further advance the values supporting the legalization of physician assistance in dying and would prevent the unjustifiable discrimination against an entire class of individuals in need based on the physical inability of mentally competent patients to self-medicate. However, there is much more to be said about the broad moral and social implications of legalizing voluntary active euthanasia.

**Distinct Options**

Despite the moral similarities between these two methods of hastening death and the reasons for legalizing VAE in conjunction with PAS, there are compelling reasons to keep these two practices *legally* distinct. The foremost reason to keep such a distinction is that some patients or physicians might wish to participate in one practice and not in the other. There have been participants in the ODDA who either (a) went through all of the legislative procedures in order to obtain the lethal medication and chose not to request a prescription, or (b) actually did obtain the lethal medication and chose not use it in order to hasten death. The reasons which might motivate a patient to begin the legislative procedure and yet choose not to hasten death are varied, but one of the major concerns which those patients who participated in the ODDA expressed was the fear of receiving inadequate pain control nearing the end of life. These individuals may have been motivated to obtain the prescription not because they were suffering from inadequate pain control, but rather to ensure that they had a “way out” in case they did receive inadequate pain control in the future.\(^{125}\) In this way, obtaining lethal medication can give the patient a greater sense of control regarding their condition, and leaving the option open (so to speak) allows them to focus on living out the rest of their life without the fear of suffering inadequate treatment or pain control.

Also, there are likely to be patients who simply may feel as though they cannot trust anyone but themselves with their own lives. This concern may be legitimate or not, but there is simply no good reason to ignore such fears. This concern alone suggests that there ought to be a strong legal distinction between PAS and VAE, despite any legislative efforts aimed at alleviating this fear. Thus, it would seem reasonable to allow patients
who voluntarily request PAS to explicitly refuse to grant the authorization for VAE to anyone. This would serve not only to help alleviate the fears of patients with similar concerns, but it would also allow for the definition of a clear boundary restricting the action of physicians who might otherwise be unsure of the best course of action to take should a patient who once requested PAS become somehow incapacitated.

Finally, it could be argued that the physical causation of the death of the patient deserves further attention. Even if the preceding arguments hold, being the immediate cause of death might prove to be an extremely stressful task for a physician who is inexperienced with euthanasia and might be somewhat troubled by the prospect of directly bringing about the death of their patient. While it should be remembered that VAE is often more predictable and effective than PAS and might be preferred by the patient, physicians ought to have the ability to refuse to administer active euthanasia if they find the practice to be incompatible with their personal moral values. However, even if PAS was thought to be the preferred method of euthanasia with respect to physicians, a physician who truly believed that euthanasia was in the best interest of a patient who competently requested it and lacked the physical ability to self-medicate would likely find comfort in the belief that they were engaging in a morally appropriate action by administering active euthanasia; that is, that they would be helping to grant a competent patient’s last request to hasten the inevitable end of a life which they find unbearable.

The Absence of Consent

It might be thought that the argument I have offered in favor of the legalization of VAE in conjunction with PAS overlooks the most important point in this subset of the euthanasia debate. This is because I have assumed in my argument that requests for VAE are just as voluntary as requests for PAS; that is, that there is no feature about PAS that ensures the voluntary nature of a request which VAE would be able to match. However, it could be thought, the issue that is likely to most concern those who support PAS and oppose VAE is another matter altogether. The underlying cause for concern is that allowing physicians to provide lethal injections to those patients who are unable to self-
medicate “opens the door” to allowing acts of nonvoluntary or involuntary active euthanasia (as opposed to voluntary active euthanasia).

First, it should be noted that the issue of involuntary euthanasia is often treated briefly (if at all) in the euthanasia debate. It would be absurd for anyone to argue that euthanasia could be justifiably administered in a medical setting to a patient who explicitly refused to authorize consent; administering euthanasia to such a patient would be legally and morally unjustifiable. Tom Beauchamp maintains that “involuntary euthanasia is universally condemned [emphasis added] and plays no role in current controversies.”126 Where there is little debate regarding involuntary euthanasia, however, there is substantial controversy surrounding nonvoluntary euthanasia. Nonvoluntary euthanasia can be defined as active euthanasia administered to an incompetent patient who neither consented nor objected and is unable to authorize consent due to incapacitation; that is, active euthanasia administered to an incompetent patient wherein some other person “authorized” the decision without the explicit consent of the patient.

The most troubling concern, then, is that that nonvoluntary active euthanasia might eventually become an accepted medical practice if voluntary active euthanasia is legalized. The most influential argument opposed to the legalization of euthanasia based on this sort of concern can be found in Daniel Callahan’s “When Self-Determination Runs Amok.”127 In this article, Callahan argues that justification of euthanasia, which is commonly based on the principles autonomy and beneficence considered together, may eventually cease to require the authorized consent of the patient and rely on beneficence (or “mercy”) alone to justify acts of nonvoluntary euthanasia:

[The] moral logic of the motives for euthanasia contain within them the ingredients of abuse. The two standard motives for euthanasia and assisted suicide are said to be our right of self-determination, and our claim upon the mercy of others, especially doctors, to relieve our suffering. The two motives are typically spliced together and presented as a single justification. Yet if they are considered independently – and there is no inherent reason why they must be linked – they reveal serious problems. . . . [Consider someone] who is suffering but not competent, who is perhaps demented or mentally retarded. The standard argument would deny euthanasia to that person. But why? If a person is suffering but not competent, then it would seem grossly unfair to deny relief solely on the grounds of incompetence.128

This argument has enjoyed substantial influence in debate regarding the legalization of euthanasia and represents one of the most noteworthy appraisals of this troubling slippery
slope concern. However, Callahan’s argument is not without critics. Gerald Dworkin has suggested, in conjunction with an evaluation of a similar view expressed by Leon Kass, that Callahan’s line of reasoning is flawed. Dworkin notes that the view that either autonomy or beneficence alone could justify euthanasia would, indeed, have unwanted implications. However, in response to Callahan’s claim that there is no inherent reason why the principles of autonomy and beneficence must be linked in order to justify euthanasia, Dworkin replies “of course they are not ‘inherently linked’; it is just that they are both required to make the moral case [emphasis added].”

In response to Callahan’s claim that it would be unjust to deny euthanasia to one who is suffering but did not authorize consent for euthanasia (one who is “perhaps demented or mentally retarded”) on the grounds of incompetence, I would reply that it would not be “grossly unfair” to deny euthanasia to such a patient because they did not request euthanasia in the first place. Administering active euthanasia to such a patient would be morally impermissible because they did not authorize consent. Callahan is mistaken in assuming that “relief” would be denied to that person “solely on the grounds of incompetence.” A request for euthanasia could not be denied in such a case because it was never requested. It would not be unjust to refuse active euthanasia to an incompetent patient who never explicitly requested it; rather, it would be unjust administer it.

Those who oppose the legalization of active euthanasia may still have concern about the possibility that a physician may, under the guise of beneficence, take it upon himself to administer a lethal injection to a patient who did not request it. This concern, it might be thought, necessitates the definition of a clear boundary restricting the action of physicians who might otherwise be unsure of the best course of action to take if a patient should become incapacitated. Such a boundary can be clearly defined by way of requiring the authorized consent of the competent patient in order to justify an act of euthanasia. Thus, only those who explicitly and competently authorize active euthanasia would be eligible for participation in the practice. Patients who had the opportunity to explicitly request active euthanasia in accordance with legal regulations and who chose not to authorize consent should never be administered active euthanasia; doing so would represent a serious violation of autonomy and a disregard for the wishes of the patient.
Forcing euthanasia upon persons who did not authorize consent amounts to an attack on the liberty of those persons. Deciding what constitutes a “good death” for another would deny the very basis of the moral justification of individual acts of euthanasia in the first place. To make deeply personal decisions about the manner in which another ought to live or die without the authorized consent of that person would be deeply misguided, despite any supposed “good intentions” which the acting physician might have. A patient who had the opportunity to authorize consent for euthanasia and chose to abstain from doing so made a choice, and that choice is one that must be respected. The authorized consent of the patient is absolutely essential for the justification of euthanasia, and a lack of consent should be construed as a refusal to consent. Thus, an act of nonvoluntary euthanasia ought to be relegated to the same category as the “universally condemned” practice of involuntary euthanasia because both practices lack a feature essential to moral and legal justification: authorized consent.

Although I have argued that there are compelling reasons to legalize active euthanasia in conjunction with physician-assisted suicide, there is good reason to pause at this prospect. The “natural check” of physician-assisted suicide would rule out the possibility that physically incompetent patients could be administered nonvoluntary euthanasia. There is certainly room for more debate on this issue, and I am not advocating that active euthanasia ought to be legalized in Oregon; rather, that this issue deserves careful consideration and further inquiry. The position I have been advocating is that there is no quality of physician-assisted suicide in itself which ensures that the requests of competent patients for euthanasia are truly voluntary. This aspect of slippery slope objections suggests that public policy which permits euthanasia may provoke broad social changes that have the potential to jeopardize vulnerable patients and to decrease the quality of care provided at the end of life. It is this concern, whether or not regulation of legalized euthanasia can adequately prevent the abuse of poor or otherwise vulnerable patients, which I will address in the following section.

Policy Abuse
Many critics of legalized euthanasia have argued that the potential abuses might eventually outweigh the supposed benefits if public policy were to allow the practice of euthanasia, even if it would theoretically be possible to limit such a right in an acceptable way. These practical concerns are often presented as slippery slope objections to the legalization of euthanasia and suggest (in addition to the theoretical concerns) that it would be impossible to adequately enforce the suggested regulations of the practice, even if such regulation might initially be effective. Thus, the obligation of the government to protect the lives of vulnerable citizens is thought to outweigh the conflicting obligation to respect the autonomy of patients who legitimately request assistance in dying.

Primarily, this sort of argument is based on the concern that the decision of a patient requesting assistance in dying might not satisfy the requirements of autonomy; that is, that we can never be absolutely sure that a patient requesting assistance in dying is competently making an informed and voluntary decision. The principles of autonomy and beneficence might support individual acts of euthanasia, it is argued, but an appeal to the principle of justice suggests that we have an obligation to protect our most vulnerable citizens from abuse which cannot easily be disregarded. Those patients who are poor or otherwise vulnerable would be subject to unjust treatment if euthanasia were legalized, it is thought, and might be forced to choose death as a result of economic or social pressures when they would not have otherwise.

One of the most widely regarded critics of the legalization of euthanasia, Sissela Bok, suggests that the societal obligation to respect the wishes of individuals who may legitimately request assistance in dying is outweighed by the obligation to protect vulnerable persons from potential abuses of public policy. She finds conflict between:

[On] the one hand, the legitimate desires of individuals for release from great and irremediable suffering; and, on other hand, the societal imperative to guard against the risk of abuses and errors and pressures to expand the practice of euthanasia, once the present strong prohibitions against killing, inadequately as they too often are, are relaxed even further.

I have argued that a blanket prohibition against euthanasia cannot be justified by claiming that individual acts of euthanasia are never morally permissible. I have also argued for the view that our current prohibitions against killing cannot produce intuitively acceptable results without also utilizing the concept of authorized consent. The issue that
I have not yet addressed is the concern that the regulations governing euthanasia might fail to adequately guard against the risk of abuses and errors.

**Medical Mistakes**

In this section, I argue that the risk of medical mistakes and inadequate treatment occurring within the legitimate practice of euthanasia is no greater than in the already accepted practice of withholding or withdrawing treatment; rather, strict regulations governing the practice of euthanasia would likely decrease the risk of medical mistakes and improve the level of care provided to the dying. Furthermore, the mere potential for medical mistakes does not adequately justify a blanket prohibition against euthanasia.

*Diagnosis and Prognosis*

The first concern to be addressed here involves the possibility that the patient requesting assistance in dying might not be accurately informed of their condition or available treatment options. If a patient were to voluntarily and competently request euthanasia based on an inaccurate diagnosis or prognosis regarding their condition, it might be argued, granting the request could lead the patient to commit suicide when taking such action was misguided and unnecessary. Such patients would fail to meet the requirements necessary to justify euthanasia in that they would not be making an informed decision, even if they were competent and acting voluntarily.

Consider what might have happened in Quill’s influential case if Diane had received an inaccurate diagnosis of her condition. Imagine in one case that she did have leukemia but was unaware that she was suffering from any disease; in a second that she was suffering from some other disease inaccurately diagnosed as leukemia; and in a third that she did not have leukemia but was told that she did. In the first case, there is little to be said. To be sure, it is unlikely that Quill would have made such an error; he only discovered her disease because he ran a test he thought to be unnecessary in order to rule out the possibility that she had leukemia. Furthermore, that he did multiple checks in order to verify the accuracy of the results lends favor to the view that Quill would have
properly diagnosed her condition. Yet, even if Quill somehow failed to realize that Diane was suffering from leukemia, this would fail to speak against legalized euthanasia because there would be no motivation for Diane to request assistance in dying if she had been told that she was not suffering from any disease at all.

In the second case, we would certainly expect Quill to run multiple tests in order to verify the diagnosis of this very serious disease (as he did). However, even if the mistaken diagnosis was left undiscovered, the primary decision made by Diane as a result of her diagnosis was to refuse treatment that would not have benefited her unless the diagnosis had been correct. If Diane was suffering from a disease other than the one she was diagnosed with and her request for assistance in dying was prompted by the symptoms of that disease, then the bad consequences of the misdiagnosis would be the same even if euthanasia was never considered; that is, she would receive inappropriate treatment or none at all regardless of a prohibition against euthanasia. While there is a possibility that the misdiagnosis might have been discovered and corrected at a later point, Diane would have been unlikely to request assistance in dying until she was in the advanced stages of the disease which she actually had. The possibility that treatment would be effective in restoring her to health at such a time, even if the misdiagnosis were somehow discovered, seems too remote to justify denying her the assistance that she might legitimately and competently request.

In the third case, the concern is that Diane might be prompted to request assistance in dying although she was not terminally ill. Thus, the legalization of euthanasia might result in patients seeking out death when they would not have otherwise. However, it seems unlikely that a terminal prognosis alone would provide enough motivation for an individual to request assistance in dying. Perhaps Diane might have requested a lethal prescription, but she would have been unlikely to have utilized it unless prompted by symptoms of the disease (which she would have never experienced if the diagnosis was wholly mistaken). Furthermore, even if some people were to request euthanasia as a direct result of receiving a mistaken diagnosis, it would be wrong to flatly deny patients the ability to make important choices which necessitate informed consent based on the mere potential of misdiagnosis.
Furthermore, it can be argued that “these identical risks are present in decisions to terminate life support, yet they do not justify an absolute prohibition on the exercise of that right.” In Quill’s case, a second physician was consulted in order to confirm the diagnosis and to ensure that all of the treatment options available to Diane had been adequately explained. These actions were prompted by Diane’s decision to refuse treatment and were not legally required. However, the regulations specified by the ODDA would have necessitated the consultation of a second physician if Diane had requested euthanasia. Thus, the strict regulations which would govern the practice of euthanasia would likely decrease the risk of medical mistakes by requiring the consultation of a second physician. Finally, care for the dying could be improved in a similar fashion by requiring that the alternative treatments and methods of pain control had been discussed with the patient. Thus, regulating the practice of euthanasia could serve to ensure greater accuracy in diagnosis and prognosis and improve the quality of care provided to dying patients, even if no scheme of regulation could ever absolutely guarantee that medical mistakes would not be made.

Impaired Judgment

The next concern regarding the risk of medical mistakes occurring within the legitimate practice of euthanasia is that patients requesting assistance in dying may suffer from impaired judgment and might not be truly competent. However, to suggest that a request for euthanasia could not result from careful and competent deliberation would be to deny that individual acts of euthanasia can be morally justified. Again, even those most staunchly opposed to legalized euthanasia maintain that individual acts of euthanasia can be morally justifiable and requests for assistance in dying legitimate; this is not the concern. Furthermore, this concern does not involve patients unable to competently authorize consent due to physical incapacitation. Such patients would not be “competent” in a narrowly defined sense of the word. The fear I will address here is that a patient who is physically capable of authorizing consent might be making a genuinely bad decision; that is, one made in haste or while under the influence of severely impaired judgment.
The first concern regarding the lack of patient competency is that the request for assistance in dying might be made in haste. Consider again the case presented by Quill, and imagine that Diane had not initially refused the treatment offered to her, but then discontinued treatment suddenly and without explanation. If Diane had never expressed a desire to refuse treatment prior to her sudden and unexplained withdrawal, Quill would likely be surprised by her actions and might even attempt to persuade her to resume treatment if he was worried that she carefully considered her decision. The point to be made here is that there is no regulation requiring physicians to determine whether or not refusals of treatment of life support were given appropriate consideration by the patient. The practice of euthanasia would be subject to less abuse in this regard because it would necessitate that requests for assistance in dying be verifiably sustained and informed; the currently accepted refusal of treatment or life support offers no similar check.

The practice of euthanasia is governed by legislation which necessitates that requests for assistance in dying be verifiably considered and informed. Because of the regulations, patients who make requests for assistance in dying are not, as it might be argued, subject to greater abuses through medical mistakes than those patients who refuse treatment or life support; rather, they are better protected than they would have been otherwise. Those patients who refuse treatment or life support are entitled to act as they please unless shown to be incompetent to do so in a legal setting. On the other hand, those patients who request assistance in dying are not only unable to hastily disregard their own welfare in a similar fashion; they are required to verify an understanding of the various treatment options available to them, to justify the motivating factors behind their request, and to demonstrate a sustained and considered desire to die. Thus, patients requesting euthanasia would be better protected, not worse, from the potential of making decisions under the influence of severely impaired judgment than those patients who make the currently acceptable decision to refuse treatment or life support.

It is clear that euthanasia should not be provided to patients who are suffering from severely impaired judgment, because such patients would be incapable of making carefully considered and truly autonomous choices. Thus, the principle of beneficence might suggest an obligation to promote the interests, happiness, and well-being of that patient and could be thought to justify the restriction of his or her ability to receive
euthanasia. However, it is not entirely clear as to what extent conditions which are common among the terminally ill, such as depression, influence patients to request assistance in dying. For example, a recent study found that “successful treatment of depression [does] not significantly alter treatment preferences [and] depression may or may not alter decisions about end-of-life treatment by elderly patients.”\textsuperscript{135} While it is certainly reasonable to expect patients who request assistance in dying to be able to demonstrate that their desire to die is sustained and informed, to suggest that a patient who requests assistance in dying must somehow absolutely prove that they are not suffering from depression would be misguided.

The regulations in Oregon seem appropriate in this regard because they provide physicians with the ability to recommend consultation if they are confronted with difficult cases: if either the attending or consulting physician suspects that the patient may be suffering from a psychiatric or psychological disorder or from depression that is causing severely impaired judgment, the patient must be referred for counseling. If the counselor determines that the patient is not suffering from impaired judgment, only then may the patient continue to be eligible to receive euthanasia.\textsuperscript{136} Although psychiatric disorders are the most common cause of severely impaired judgment, “clinical and legal consensus now demands that a mental disorder be demonstrated to seriously disrupt the relevant decision making capacity before a patient is declared incompetent and forfeits the right to make those specific decisions for him or herself.”\textsuperscript{137}

The Nature of Requests

In this section, I argue that the potential economic factors which might influence the decisions of patients are often exaggerated, and that decisions concerning the accepted practice of withdrawing or withholding life support are more likely to be influenced by economics than decisions concerning euthanasia; that is, unjust or inadequate treatment of the poor is unlikely to be advanced by the legalization of euthanasia. Furthermore, the potential that social pressures might lead patients to choose euthanasia when they might not have otherwise does not justify denying those same patients the very freedom to make such decisions; that is, to flatly prohibit patients from making autonomous decisions
based on the fear that their decisions might not be entirely autonomous represents a greater violation of the very autonomy which is thought to justify the prohibition.

Economic Pressures

One of the most compelling concerns regarding the legalization of euthanasia involves the possibility that patients who are unable to afford adequate medical care might choose to request assistance in dying for lack of a preferable option. Such requests would, on the surface, satisfy all of the available criteria and appear voluntary. However, requests for assistance in dying prompted by economic pressures or inadequate care would not be truly voluntary because such requests would be forced. This fear is often expressed by those critical of the legalization of euthanasia who, nevertheless, might agree that individual acts of euthanasia can be morally justifiable. Sissela Bok has suggested that:

[Powerful] incentives to reduce the costs of patient care are much more prominent than in the past. When treatments are already being withdrawn on financial grounds rather than patient needs, there may be temptations to accede too rapidly to requests for suicide assistance.\(^{138}\)

The concern that economic factors might force patients who are unable to afford adequate care into choosing assistance in dying when they would not have otherwise is most certainly compelling. There are many persons in our society without health insurance who might choose euthanasia based solely on their inability to obtain adequate health care at the end of life.\(^{139}\) Patients with health insurance might also be forced into choosing euthanasia due to the widespread inadequacies in health care when they would not have chosen euthanasia if they had access to acceptable care. Furthermore, euthanasia could be seen as a cheap and effective alternative to expensive end of life care; that is, patients might request it not based on their desire to die, but to save money.

Responding to fears about the potential influence of economics upon patients choosing euthanasia is somewhat difficult, however, because there is little evidence which suggests that economics is likely to have the impact on requests for assistance in dying that critics have feared.\(^{140}\) While there may be reason to fear the possibility that poor patients will be unjustly treated in the future if euthanasia is allowed, the available
information suggests that this concern is not well founded. In fact, one study coauthored by an advocate and a critic of euthanasia found that less than 0.07 percent of the total health care costs in our country would be saved if euthanasia were legalized.\textsuperscript{141} Furthermore, most of the patients who have legally obtained euthanasia in Oregon also utilized hospice care at some point during their illness, while all of the participants had access to such care.\textsuperscript{142} While some might assume that the care provided during the last few months of life relies on expensive technologies, the available evidence suggests that the legalization of euthanasia is unlikely to result in creating economic incentives for poor patients to choose euthanasia when such decisions would not have been made if better end of life care was available.

The next point to be made here is that the real economic pressure which might force poor or vulnerable patients to choose an option which they would not have otherwise rests in the currently accepted ability of patients to refuse treatment or life support. Even the small citation above from Bok reveals the faulty logic which is thought to support the argument that economic concerns will have a substantial influence on the decisions of patients who request assistance in dying. The true area of concern in this matter is in the nearly uncontestable right of patients or proxy decision-makers to refuse treatment without justification. It is aggressive treatment (not comfort care, palliative care, or aggressive pain control) which represents the prohibitive costs in obtaining adequate treatment.\textsuperscript{143} To suggest that the practice of euthanasia is likely to lead to more abuse of the poor than the currently accepted ability to refuse treatment would simply be unfounded. Furthermore, arguments suggesting that hospitals might promote euthanasia as an option to patients who would not have chosen it otherwise in order to save on costs are misguided. The regulations governing the practice of euthanasia require that patients requesting assistance in dying be informed of the treatment options and alternative methods of care available to them. While such regulations might not necessarily require that additional or expensive care be provided, “doctors and hospitals anxious to avoid expense would have very little incentive to begin a process that would focus attention on their palliative care practices.”\textsuperscript{144} In fact, studies conducted in the Netherlands suggest that medical decisions provoked by economic considerations are far more likely to result
from “decisions involving withdrawing or withholding medical treatment or the use of drugs to treat pain and/or symptoms rather than active euthanasia.”

Returning to the concerns that patients both with and without health insurance might receive a lower quality of care if euthanasia were legalized, it can be argued that the movement to legalize euthanasia is more likely to strengthen efforts to improve upon the current levels of care in order to help ensure that few patients choose the option. All available evidence suggests that relatively few patients would choose euthanasia if it were available and that we are going to continue to need to provide better care to the vast majority of patients at the end of life. Still, it is certain that some patients will choose to request assistance in dying as a result of receiving inadequate care when they would not have done so otherwise. This presents strong support for movements to provide better care to those in need, but the pursuit of this worthy goal does not amount to an objection to the legalized euthanasia. The unjust treatment of the poor is unlikely to be advanced by the legalization of euthanasia; rather, the available evidence suggests that efforts to improve care for the dying and efforts to provide legalized euthanasia can and ought to be pursued in conjunction with each other.

Finally, arguments suggesting that we ought to flatly prohibit the practice of euthanasia because some requests for assistance in dying might be motivated by a lack of adequate treatment are misguided. First of all, there are likely to be patients who have access to optimal care and would still prefer to receive assistance in dying because they perceive such a death to be better in keeping with their personal notions of dignity; this does not present a problem. However, there are likely to be patients who would not prefer euthanasia if they had adequate health care and yet request it because they are unable to obtain that level of health care which might adequately diminish their suffering. While it is true that movements to improve the quality of care at the end of life might serve to alleviate this problem, “it seems perverse to argue that the patients who would be helped were better pain management available must die horribly because it is not.” Such arguments suggest that these patients ought to be denied euthanasia which they might legitimately desire and, instead, must endure a condition which they find intolerable because they would not request euthanasia if their care was improved, even though their care will not actually be improved; this is simply cruel. Thus, the potential impact of
economic influences which might pressure patients to choose euthanasia is often exaggerated, and the unjust treatment of such patients is unlikely to be advanced by efforts to legalize the practice of euthanasia.

Social Influence

Finally, some critics of legalized euthanasia have argued that the practice ought to be prohibited for fear that requests for assistance in dying might not be entirely voluntary. Thus, it might be suggested that the influence of the attending physician or family might lead a patient to request euthanasia when they would not have otherwise. This concern is often subtly invoked by those opposed to the legalization of euthanasia in conjunction with slippery slope arguments. One ethicist strongly opposed to the legalization of euthanasia, Herbert Hendin, has suggested the following to illustrate such a concern:

In the selling of assisted suicide and [voluntary active] euthanasia words like “empowerment” and “dignity” are associated only with the choice for [the] dying. But who is being empowered? … [The] needs other than those of the patient often prevail. “Empowerment” flows toward the relatives, the doctor who offers a speedy way out if he cannot offer a cure… The patient, who may have said she wants to die in the hope of receiving emotional reassurance that all around her want her to live, may find that… she has set in motion a process whose momentum she cannot control. If death with dignity is to be a fact and not a selling slogan, surely what is required is a loving parting that acknowledges the value of life lived and affirms its continuing meaning.

The concern, then, is that a request for assistance in dying might be provoked by the attending physician or family of a patient when they would not have considered euthanasia otherwise. Such a provocation could be as slight as the “mere” mention of euthanasia as an option for consideration, or it could be the application of pressure so severe that a resultant request for euthanasia on the part of the patient could hardly be considered “voluntary.” If the request for assistance in dying was not made free from the undue influence of those who may not have the best interests of the patient in mind, it could be argued, the decision would not be autonomous; that is, the request would not be truly voluntary. Again, the force of this argument rests on the concern that the regulatory schemes which would govern the practice of euthanasia would be unable to ensure that requests for assistance in dying were, in this sense, truly voluntary.
However, the risk that vulnerable patients will be abused in this manner within the legitimate and regulated practice of euthanasia is no greater than in the already accepted practice of refusing treatment or life support. Again, legislation governing the practice of euthanasia requires the competently authorized consent of the patient. This check is most certainly not required in the currently accepted right to refuse life sustaining treatments; such actions are routinely authorized by proxy decision-makers who act on behalf of incapacitated patients who are unable to authorize or refuse consent. The regulatory scheme governing euthanasia would provide *increased* protection against these abuses because the decision must be informed, sustained, and (most importantly) *made by the patient*. Arguments which would seek to prevent the ability for such choices to be made that are grounded in the fear that a person might be swayed by the influence of others in their opinion are only made possible by the existence of the freedom of the patient to form his or her own opinion on the matter. This sort of concern could not be applied to cases in which treatment is refused on behalf of an incompetent patient by other persons. Such decisions are *necessarily* made without certainty that they accurately reflect the choices that the patient would have made if competent.

The risk that a patient might be influenced by physicians or family members who might not have their best interests in mind cannot adequately justify flatly prohibiting such patients to make such decisions entirely. Similarly, it has been argued that:

> [Even] people who are dying have a right to hear and, if they wish, act on what others might wish to tell or suggest or even hint to them, and it would be dangerous to suppose that a state may prevent this on the grounds that it knows better than its citizens when they should be moved by or yield to particular advice or suggestion in the exercise of their right to make fateful personal decisions for themselves. It is not a good reply that some people may not decide as they really wish – as they would decide, for example, if free from the “pressure” of others. That possibility could hardly justify the most serious pressure of all – the criminal law which tells them that they may not decide for death if they need the help of a doctor in dying, no matter how firmly they may wish it.\(^\text{151}\)

However, it has been argued that continued existence is ordinarily taken for granted as a fixed condition and that making euthanasia available would deny people the alternative of staying alive by default.\(^\text{152}\) The concern, then, is that the mere existence of the option for euthanasia might subtly pressure patients to request it. However, this fear ought to apply equally to the currently accepted ability of patients to refuse life sustaining treatment, yet
there is no evidence of widespread abuse in this regard or of any social movement to rescind this right.\textsuperscript{153} Again, the mere potential that social pressures might lead patients to choose euthanasia when they might not have otherwise cannot adequately justify denying the freedom to make such decisions entirely; that is, prohibiting patients from making deeply personal and important decisions based solely on the fear that their decisions might not be entirely autonomous represents the greatest possible violation of that very autonomy which such a blanket prohibition would seek to protect.

\textbf{Conclusion}

I have argued that individual acts of euthanasia can be morally justified and that euthanasia ought to be a legitimate medical option for those patients who request assistance in dying. Individuals ought to be free to determine for themselves the manner in which they wish to die. A physician willing to provide euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying ought to be legally permitted to provide the kind of care that the patient desires. Regulating the practice of euthanasia is necessary in order to minimize abuse, and such regulation is likely to \textit{improve} the quality of care provided at the end of life.

While it must be admitted by proponents of legalized euthanasia that some level of abuse is unavoidable, arguments suggesting that the legalization and regulation of the practice would incur an unnecessary risk are unfounded and misguided. Apart from the state of Oregon, our current medical system is such that legitimate requests for euthanasia must be ignored, refused, or granted covertly. Suggesting that all requests for euthanasia merely represent a “cry for help” would be mistaken; even some of the most widely regarded opponents of legalized euthanasia agree that such requests are often legitimate. Yet one such opponent, Sissela Bok, advocates the view that Death with Dignity initiatives constitute a societal “cry for help,” and argues that better health care ought to be pursued in favor of the legalization of euthanasia.\textsuperscript{154} While there is certainly an emotive appeal to this claim, flatly prohibiting euthanasia on the grounds that such requests might not be made if better access to health care was available, while
simultaneously failing to provide that better care, would be deeply misguided. The goals of better health care and legalized euthanasia are not mutually exclusive; rather, these legitimate goals can and ought to be pursued in conjunction with each other.

Again, it must be admitted by proponents of legalized euthanasia that the practice might be expanded beyond the bounds of initial regulation once it is permitted. One proponent of legalized euthanasia, Dan Brock, has suggested that it would either be a “mistake or dishonest” to deny this possibility.\textsuperscript{155} There is merit to claims that the Oregon Death with Dignity Act might eventually loosen regulation and, for example, allow nonterminally ill patients experiencing intolerable suffering access to euthanasia. Expanding regulation to include such patients might be wholly legitimate within the moral framework I advocate, yet such a move would substantially increase the number of patients at risk for abuse and certainly requires careful consideration. While restricting policy to exclude those nonterminally ill patients who might otherwise qualify for euthanasia would incur a moral cost, such a move could be justified through careful evaluation of accumulated experience regarding the extent to which the feared abuses of public policy actually occur in practice.

Similarly, it might be worried that active euthanasia could eventually be allowed in Oregon in order to provide relief to otherwise qualified patients who merely lack the physical ability to self-medicate. I have argued this very position, suggesting that requiring the authorized consent of a \textit{mentally} competent patient would adequately restrict the potential for abuse. Yet it might be thought that active euthanasia could also be justifiably administered to a wholly incompetent patient who explicitly authorized a proxy decision-maker to act on his or her behalf in an advance directive. Presumably, this would allow individuals the ability to assert continued control over their treatment while incapacitated. However, allowing such a practice would also substantially increase the number of patients subject to potential abuse. Again, this issue is relevant to the euthanasia debate conceived of broadly, but the legitimacy of advance directives is a distinct and extensively debated topic in medical ethics. These concerns regarding the broad social implications of active euthanasia certainly require further inquiry and careful consideration. Again, such debate can be advanced by the accumulation of experience with the more restricted practice of physician-assisted suicide. Careful evaluation might
well result in the considered decision that the increased potential for widespread abuse could adequately justify denying active euthanasia to those patients who are physically incapable of self-medication, despite the legitimacy of those individual requests.

There are limits to my argument, to be sure, and I have only addressed the moral and social implications of legalized euthanasia most prevalent in contemporary literature and public debate. Many of the concerns expressed by opponents of legalized euthanasia necessitate further inquiry and certainly warrant exercising caution in considering alterations to public policy; to suggest that we make radical changes in policy without first giving due consideration to legitimate concerns would be extremely misguided. However, it is reasonable to suggest that we initially permit only the more restricted practice of physician-assisted suicide regulated by carefully crafted legislation, as the citizens of Oregon have done. It would seem best to proceed with caution in this delicate matter and to gain evidence about the effectiveness of regulation in safeguarding against abuse and controlling the more restricted practice. The position which the federal government has taken is to allow individual states to form their own legislation regarding legalized euthanasia, pending information that suggests creating a federal stance. This is precisely what has been occurring in Oregon, and the continued accumulation of experience with legalized and regulated euthanasia is likely to be encouraged by those Supreme Court Justices who have determined that the “challenging task of crafting appropriate procedures for safeguarding… liberty interests is [to be] entrusted to the ‘laboratory’ of the states.”

There is still room for debate regarding the potential broad moral and social implications of legalized euthanasia; this much is certain. However, the point I wish to emphasize here is that the mere potential that legalized euthanasia might be expanded beyond the scope originally intended simply cannot justify the discontinuation of further inquiry and debate or a blanket prohibition of the practice. It would be sorely misguided to prohibit euthanasia based on purely emotive arguments which merely hint at the potential for future abuse and uncontrollable expansion of a practice which, by most accounts, can be morally justified. Even those who strongly oppose legalized euthanasia agree that the practice might be safely and legitimately allowed, provided that sound regulations such as those in the Oregon Death with Dignity Act are maintained.
Furthermore, the evidence and experience which has been accumulated in Oregon thus far suggests that legalized euthanasia restricted to physician-assisted suicide is unlikely to put poor or otherwise vulnerable patients at risk for abuse; rather, it is likely to improve the quality of care provided at the end of life and allows those relatively few individuals who legitimately request assistance in dying access to the kind of care they desire.

While the broad implications of legalized euthanasia may give good reason to pause at the prospect of legalization and regulation, the mere presence of these concerns cannot adequately justify flatly prohibiting the practice and abandoning further debate. The prospect of allowing physicians to assist in suicide or to directly kill patients who legitimately request assistance in dying may seem like a great leap to some, but thinking that “opening the door” to euthanasia will somehow hurl us down a slippery slope that knows no bounds is terribly confused. There are no sharp and fixed distinctions between moral actions (on the one hand) and immoral actions (on the other). The slippery slope is a *slope*, to be sure, but steps which might be taken in public policy will not be made without giving due consideration to the potential consequences; this is made evident by the universally acknowledged importance of the current euthanasia debate itself.

It has, however, been suggested that the risks incurred by the legalization of euthanasia might justify a blanket prohibition against the practice. One such critic, Alexander Morgan Capron, has argued similarly:

> Sometimes a physician (or another person) would feel justified in violating [a] prohibition [against euthanasia]. Should that person be punished? My belief, as I stated at the outset, is that in such circumstances the answer should be “no,” that the legal system should protect those persons. And my sense is that this is exactly what has happened, through prosecutorial discretion and jury nullification. Indeed, there is to the best of my knowledge, no case of a physician being convicted for aiding a suicide in the circumstances that would meet our stipulated definition of a “morally acceptable” killing.157

However, suggesting that a blanket prohibition against euthanasia is justified because it is readily available to those who request it and can be justifiably administered covertly and without fear of punishment is absurd. If anything, this argument serves to advance the position that euthanasia ought to be legalized and regulated; the presence of regulations would certainly be more likely to *prevent* abuses than *encourage* them. How could encouraging a *don’t-ask-don’t-tell* policy among physicians told that they may administer
euthanasia whenever they feel justified in doing so better protect vulnerable patients than regulating the practice? What about those patients who might legitimately request assistance in dying and are either refused help or ignored entirely? An advocate of euthanasia, Ronald Dworkin, has suggested that “the current two-tier system – a chosen death and an end of pain outside the law for those with connections and stony refusals for most other people – is one of the greatest scandals of contemporary medical practice.”

Recent studies have suggested that requests for assistance in dying are fairly common in practice, and that such requests are also not uncommonly granted. In the state of Washington, 26 percent of physicians surveyed reported receiving explicit requests for assistance in dying and also reported illegally and covertly granting 24 percent of those requests. Forty percent of oncologists surveyed in Michigan reported receiving explicit requests for assistance in dying, 18 percent reported engaging in physician-assisted suicide, and 4 percent in active euthanasia. Fifty-three percent of physicians responding to a survey in San Francisco reported granting requests for euthanasia from patients suffering from AIDS in at least one instance. However, nearly all physicians who grant legitimate requests for assistance in dying and can be morally justified in doing so act outside of the law, covertly, and without regulations to help guide their actions.

Individual acts of euthanasia can be morally justified and euthanasia ought to be a legitimate medical option for those patients who request assistance in dying. In Oregon, legally allowed physician-assisted suicide has not been disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking end of life care. Furthermore, Oregon physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications, to improve their ability to recognize psychiatric disorders, and have been referring more patients to hospice care since the passage of the Act. The results of the Death with Dignity initiative in Oregon have thus far demonstrated that the feared abuses are not occurring and that the goals of better health care and legalized euthanasia are not mutually exclusive; rather, they are born of a common desire to improve the quality of health care provided at the end of life. I firmly believe that Oregon should be allowed to continue with its self-proclaimed bold experiment, I support the
continuation of Death with Dignity initiatives, and I applaud the continuation of vigorous debate on the timely and important issue of euthanasia.
Part IV – Additional Materials

Appendix I: Glossary of Terms

The euthanasia debate can become confused simply because words mean different things to different people. Some terms that one side of the debate may consider neutral, the other side may not. Likewise, discussion carried out with a particular vocabulary may commit the participants to a particular conceptual framework. With this in mind, I have done my best to use relatively uncontested vocabulary throughout this paper. However, the following description of the terms commonly used in the euthanasia debate should not be taken as fixed and precise; rather, they are provided in order to better clarify the meanings of those terms as I have utilized them in this paper.

**Advance Directive** - A general term that describes two kinds of legal documents: living wills and durable powers of attorney. These documents allow patients to give instructions about their wishes for treatment should they be unable to participate in medical decisions due to serious illness or incapacity. Currently, each state regulates the use of advance directives differently.

**Comfort/Palliative Care** – An approach to care for the dying that emphasizes providing relief of discomfort rather than continuing aggressive treatment of illness or disease. Physical, social and emotional needs are the first priority, even when treatment such as providing high doses of pain medication may have hasten death. Also called palliative care, this approach essentially refers to the cessation of aggressive medical treatment.

**Euthanasia** – The act of painlessly putting to death a person who is suffering from an incurable and painful disease or condition. In this paper, I distinguish between *physician-assisted suicide* (PAS) and *voluntary active euthanasia* (VAE). In the first case, the physician provides lethal medication for the patient to use (typically large amounts of barbiturates). In the second, the physician physically brings about the death of the patient in a direct way (typically by administering a lethal injection).
Active/Passive Euthanasia - The active/passive distinction is commonly used to indicate whether the treatment resulting in death was administered or withheld. In "active euthanasia," death is hastened by the treatment given to a patient. In "passive euthanasia," it is treatments that are withheld or withdrawn which hasten death. I have chosen not to use this vocabulary because it has been suggested that it favors those supporting legalized euthanasia. Instead, I will generally speak of "withholding or withdrawing treatment" instead of "passive euthanasia." It should be noted that there is no legal or moral distinction between acts of "withholding" treatment versus acts of "withdrawing" treatment; these terms may, for our purposes, be thought of as interchangeable.

Voluntary/Nonvoluntary/Involuntary Euthanasia – These terms generally refer to whether or not euthanasia has been requested by the patient. "Voluntary" indicates the person has requested euthanasia; "nonvoluntary" indicates that the person has neither requested nor objected to euthanasia; and "involuntary" indicates the person has objected to it.

Futile Measures - A general term often used in the medical care of seriously ill patients to describe interventions that will have little effect on outcome or prognosis.

Hospice - An organization offering comfort or palliative care for the dying when medical treatment is no longer expected to prolong life. The term may also apply to an insurance benefit that pays the costs of comfort care (usually at home) for patients with a prognosis of six months or less to live.

Persistent Vegetative State (PVS) – Characterized by the irreversible loss of a functioning neocortex and the continuing existence of the brain stem. This loss necessarily and sufficiently entails a permanent loss of consciousness.

Proxy Decision-Making - A procedure allowing authorized individuals to make health care decision on behalf of another. If the patient’s wishes are not known, the decisions are said to be made in the patient’s "best interests." This authority is generally granted by a durable power of attorney or similar document.
Terminal/Total Sedation – Terminal sedation is the act of administering a sufficiently high dosage of medications to induce a coma-like state when symptoms such as pain, nausea, breathlessness, or delirium cannot be adequate controlled. Patients die after a number of days of secondary effects such as dehydration, malnutrition, or pneumonia. This practice is distinct from total sedation, in which the patient may be expected to recover and is sedated while life sustaining treatments are not removed.

Withholding or Withdrawing Treatment – To omit or cease life sustaining treatments that, if used, would prolong the patient's life. This includes technological interventions such as dialysis and ventilators and also simple treatments such as feeding tubes and antibiotics. This action may be prompted by the request of the patient or proxy decision-maker, an advance directive, or may be based on the concept of medical futility. Also, there is no legal distinction made between the two types of acts.

Appendix II: The Dutch Experience

The Dutch Upper House of Parliament voted to legalize active euthanasia and physician-assisted suicide in 2001, making the Netherlands the first and (at this time) the only country in the world to do so. The criteria which must be met under the law are the following: the patient must be suffering unbearable and unremitting pain, with no prospect of improvement; the patient must make a sustained, informed, and voluntary request for help to die; all other medical options must have been previously exhausted; a second medical opinion must be sought to confirm diagnosis and prognosis; the termination of life must be carried out with medically appropriate care and attention; and the physician is obligated to report the death to the municipal pathologist, specifying whether the cause of death was active euthanasia or assisted suicide.

Despite the recent legalization of euthanasia, the practice has been socially accepted for some time. Furthermore, physicians participating in individual acts of euthanasia conducted according to guidelines published by the Ministry of Justice have
been free from legal persecution since those guidelines were published in 1990. These guidelines did not recognize euthanasia as a legally acceptable means of hastening death, but had many of the features of the new law (including the reporting requirement). Thus, until the recent legislation was passed, physicians were not legally authorized to practice euthanasia, but would be free from legal prosecution were they to do so. This legal ambiguity was only recently addressed, and the number of reported cases of euthanasia has been steadily increasing since that time. The number of reported cases in 1999 was 2,216, but this number is thought to approximate only half of the actual cases for the year.¹⁶⁷ Studies indicate that the number of reported cases is gradually beginning to reflect the number of actual cases, primarily due to the increasing level of comfort in physicians who feel they can report cases without fear of legal prosecution.¹⁶⁸

Euthanasia as it is conceived of in the Netherlands makes no sharp distinction between active euthanasia and physician-assisted suicide. However, physician-assisted suicide is considered to be the preferable method of hastening death according to legislative guidelines.¹⁶⁹ For the Dutch, euthanasia is defined as the intentional taking of someone’s life at his or her explicit request, and the decision to end the life of another without that explicit request is not legally termed euthanasia. Such acts are considered unlawful “killings,” and involuntary euthanasia is regarded as a contradiction in terms.¹⁷⁰ General practitioners have the most extensive experience with euthanasia and the practice plays a small role in nursing homes (the physicians in such establishments receiving relatively few requests for euthanasia and honoring only one fifth of those requests).¹⁷¹

Although the Dutch experience has certainly influenced the euthanasia debate, it is important to remember that there are substantial differences between the Dutch and the American health care systems and therefore, in the likely implications of public policy regulating the practice of euthanasia. In order to highlight the distinctions between the Dutch and the American euthanasia debates, I have separated this section from the primary content of this paper. However, I am not suggesting that the Dutch experience is irrelevant to the American debate and should be disregarded, but rather that there is good reason to believe that the Dutch experience regarding euthanasia is likely to be quite different from the American experience. With that in mind I would like to point out the two leading reasons why the euthanasia debate in our society ought to be kept distinct
from that of the Dutch, despite the knowledge that might be gained by observing and investigating the Dutch experience.

First, the Netherlands provides universal health care to all of its citizens, while the health care system in America is unlike that of most any other country in the world. The majority of American citizens receive their primary medical coverage through their employers, who provide health care benefit packages for employees in addition to paying a salary. Those without such benefits are free to choose from any number of health care providers, but they must pay in order to remain insured, and those without the means of providing their own care must seek government assistance and face daunting requirements for eligibility. Unlike patients in the Netherlands, those in the U.S. might have to worry about the limits of insurance coverage and the possibility of bankrupting their families simply by remaining alive.

Due to the current state of the American health care system, it has been suggested that the possible negative consequences of the legalization of euthanasia might be greater in the U.S. as a result of the influence of the different economic pressures which our society faces. Along the same lines, the Dutch have historically had long and trusting relationships between patients and physicians (who often practice primarily in the homes of their patients), while the U.S. has substantially lower levels of trust in the physician-patient relationship. These issues regarding legalized euthanasia can be addressed in light of the Dutch experience, to be sure, but I believe that the potential for the decisions of patients to be influenced by the economics of the American health care system, the fear of decreasing trust between patients and physicians, and the worry about potential abuse of poor or otherwise vulnerable patients all represent concerns substantial enough to warrant consideration independent of the Netherlands.

Second, a consensus has yet to emerge regarding the relative success or failure of the recent legislative initiatives in the Netherlands. While some feel that the Dutch have provided a model for the rest of the world to follow, others feel that the Dutch experience has given good reason to not legalize these practices. Thus, the disparities between America and the Netherlands coupled with the lack of consensus regarding the success of their euthanasia policies restricts, to some extent, the amount of emphasis which ought to be placed on the Dutch experience. However, the Netherlands is certainly
useful in that it provides a rare opportunity to gain knowledge of the practical effects of the legalization of euthanasia through *experience*. The Dutch experience is of some value in the American euthanasia debate and should not be disregarded, but there are limits in the potential for its easy application to our society and in the validity of the varied conclusions which have been drawn on either side of the debate regarding the relative success or failure of the recent legislative initiatives.
Notes


On the Moral and Social Implications of Legalized Euthanasia


Meela Yoo, “Ought PVS Patients be Maintained?”, (Lawrence University Honors Thesis: 1992), 49.


On the Moral and Social Implications of Legalized Euthanasia

It should be noted here that Dixon is opposed to the legalization of euthanasia and argues that PAS and VAE are both subject to the same criticisms.


On the Moral and Social Implications of Legalized Euthanasia


Gerald Dworkin, “Public Policy and Physician-Assisted Suicide,” For and Against: Euthanasia and Physician-Assisted Suicide, (Cambridge University Press, Cambridge, UK: 1998), 67. The data collected by Helga Kuhse from a study conducted in the Netherlands was applied by Dworkin in order to reach the conclusion that death is cheaper for the health care system if caused by active euthanasia or the withdrawal of life support.

Dan Brock, “A Critique of Three Objections to Physician-Assisted Suicide,” Ethics, April 1999 v109 i3 p519(1)


Ronald Dworkin et al, “Assisted Suicide: The Philosophers’ Brief,” In Ethical Issues in Modern Medicine, edited by John Arras and Bonnie Steinbock, (California: Mayfield Publishing Company, 1998), 255. This article makes reference to the studies which reported these statistics.


Raphael Choen-Almagor, “Why the Netherlands? Understanding the practice of euthanasia and physician-assisted suicide in the Netherlands,” Journal of Law, Medicine, and Ethics, Spring 2002 v30 i1 p95(11), 2.


Raphael Choen-Almagor, “Why the Netherlands? Understanding the practice of euthanasia and physician-assisted suicide in the Netherlands,” Journal of Law, Medicine, and Ethics, Spring 2002 v30 i1 p95(11), 1.

Raphael Choen-Almagor, “Why the Netherlands? Understanding the practice of euthanasia and physician-assisted suicide in the Netherlands,” Journal of Law, Medicine, and Ethics, Spring 2002 v30 i1 p95(11), 1.


Raphael Choen-Almagor, “Why the Netherlands? Understanding the practice of euthanasia and physician-assisted suicide in the Netherlands,” Journal of Law, Medicine, and Ethics, Spring 2002 v30 i1 p95(11), 2.


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Bibliography


---. “A Critique of Three Objections to Physician-Assisted Suicide.” Ethics, April 1999 v109 n3 p519(1).


---. “Deciding Life and Death in the Courtroom: From Quinlan to Cruzan, Glucksberg and Vacco – A Brief History and Analysis of Constitutional Protection of the ‘Right to Die’.” *JAMA*, November 1997 v278 n18 p1523(6).


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