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Euthanasia*

DAN W. BROCK, Ph.D.

Department of Philosophy and School of Medicine, Brown University, Providence, Rhode Island

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The principles of self-determination and individual well-being support the use of voluntary euthanasia by those who do not have moral or professional objections to it. Opponents of this posture cite the ethical wrongness of the act itself and the folly of any public or legal policy permitting euthanasia. Positive consequences of making euthanasia legally permissible respect the autonomy of competent patients desiring it, expand the population of patients who can choose the option, and release the dying patient from otherwise prolonged suffering and agony. Potentially bad consequences of permitting euthanasia include the undermining of the "moral center" of medicine by allowing physicians to kill, the weakening of society's commitment to provide optimal care for dying patients, and, of greatest concern, the "slippery slope" argument.

The evaluation of the arguments leads to support for euthanasia, with its performance not incompatible with a physician's professional commitment.

There is an emerging consensus that competent patients, or the surrogates of incompetent patients, should be permitted to weigh the benefits and burdens of alternative life-sustaining treatments according to the patient's values, and either to refuse any treatment or to select from among available alternative treatments. More recently, significant public and professional attention has shifted from life-sustaining treatment to euthanasia and physician-assisted suicide. Unfortunately, some of the most widely publicized cases, such as those of Dr. Kevorkian, have been sufficiently problematic that even most supporters of euthanasia or physician-assisted suicide did not defend the physicians' actions in them. As a result, the subsequent debate they spawned has often shed more heat than light on the subject. My aim here is to formulate and evaluate some of the central ethical arguments for and against euthanasia. Although my evaluation of the arguments leads me, with reservations, to support permitting euthanasia, my primary aim is to identify confusions in some common arguments, and problematic assumptions and claims that need more defense or data in others. My hope is to advance the debate by focusing attention on what I believe should be the real issues therein.

In the recent bioethics literature, some have endorsed physician-assisted suicide but not euthanasia [1]. Are the two sufficiently different that the moral arguments that apply to one often do not apply to the other? A paradigm case of the former is the provision by a physician of a lethal dose of medication to a patient who asks for it to end his or her life, and who then does so. A paradigm case of euthanasia is a physician him- or herself administering the lethal dose, often when the patient is unable to do so. The only difference that need exist between the two is who actually

Abbreviation: ALS: amyotrophic lateral sclerosis

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administers the lethal dose—the physician or the patient. In each instance, the physician plays an active and necessary causal role in providing the lethal dose.

In physician-assisted suicide, the patient acts "last"—for example, in the way Janet Adkins herself pushed the button after Dr. Kevorkian hooked her up to his suicide machine, whereas, in euthanasia, the physician acts "last" by performing the physical equivalent of pushing the button. In both, however, the choice rests fully with the patient. In both, the patient acts "last" in the sense of retaining the right to change his or her mind until the point at which the lethal process becomes irreversible. How could there be a substantial moral difference between them, based only on this small difference in the part played by the physician in the causal process resulting in death? Of course, it might be held that the moral difference is obvious—in euthanasia, the physician kills the patient, whereas, in physician-assisted suicide, the patient kills him- or herself. But this argument is misleading at best. In physician-assisted suicide, the physician and patient together kill the patient, a case of joint action for which both are responsible. I shall take the arguments evaluated below to apply both to physician-assisted suicide and to euthanasia and shall focus on euthanasia.

My concern here will be with *voluntary* euthanasia only; that is, with the case in which a clearly competent patient makes a fully voluntary and persistent request for euthanasia. A last introductory point is that I will examine only secular arguments about euthanasia, though of course many people's attitudes to euthanasia are inextricable from their religious views. I take this secular focus to be appropriate for public policy.

THE CENTRAL ETHICAL ARGUMENT FOR VOLUNTARY ACTIVE EUTHANASIA

The central ethical argument for euthanasia is familiar: that the very same two fundamental ethical values that support the consensus on patients' rights to decide about life-sustaining treatment also support the ethical permissibility of euthanasia. These values are individual self-determination or autonomy and individual well-being. By self-determination, as it bears on euthanasia, I mean people's interest in making important decisions about their lives for themselves, according to their own values or conceptions of a good life, and in being left free to act on those decisions. Respecting self-determination permits people to form and to live in accordance with their own conception of a good life and to exercise significant control over their lives. Most people are certainly much concerned about the nature of the last stage of their lives. Death is today increasingly preceded by a long period of significant physical and mental decline, due in part to the technological interventions of modern medicine. For many patients near death, maintaining the quality of one's life, avoiding great suffering, maintaining one's dignity, and ensuring that others remember us as we wish them to, become of paramount importance and outweigh merely extending one's life. Since there is no single, objectively correct answer for everyone, as to when, if at all, when one is critically or terminally ill, one's life becomes (all things considered) a burden and unwanted, the great variance among people on this question makes it especially important that individuals control the manner, circumstances, and timing of their dying and death.

The other main value that supports euthanasia is individual well-being. It might seem that protecting patients' well-being conflicts with a person's self-determination

when that person requests euthanasia. Life itself is commonly taken to be a central good for individuals. But when a competent patient decides to forgo all further life-sustaining treatment *or* requests euthanasia, life is no longer considered a benefit by that patient, but has now become a burden. Of course, sometimes there are conditions, such as clinical depression, that call into question whether the patient has made a competent choice, either to forgo life-sustaining treatment or to seek euthanasia, and a determination of incompetence can warrant not honoring the patient's choice.

I emphasize that the value or right of self-determination of patients does not entitle them to compel physicians to act contrary to the physician's own moral or professional values. Physicians are moral and professional agents whose own self-determination or integrity should be respected as well. If performing euthanasia becomes legally permissible, but conflicts with a particular physician's reasonable understanding of his or her moral or professional responsibilities, the care of a patient who requests euthanasia should be transferred to another. But the ethical and policy issue is the permissibility of performing euthanasia by those who do not have moral or professional objections to it.

Opponents of euthanasia commonly offer two types of arguments against euthanasia, which they take to outweigh or to override this support of euthanasia. The first argument is that, in any individual case in which a patient's self-determination and well-being do support euthanasia, it is nevertheless always ethically wrong or impermissible. The second argument grants that, in some individual cases, euthanasia may not be ethically wrong, but maintains nonetheless that ethically sound public and legal policy should never permit it. The first argument focuses on features of any individual case of euthanasia, while the second focuses on a social or legal policy that would permit euthanasia. I will initially consider the first argument.

THE ARGUMENT THAT EUTHANASIA IS ALWAYS THE DELIBERATE KILLING OF AN INNOCENT PERSON

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

In the context of medicine, what lends this ethical prohibition plausibility in part is the belief that nothing in the currently accepted practice of medicine is deliberate killing. Thus, according to this view, forgoing of life-sustaining treatment, whether by not starting or by stopping treatment, is allowing the patient to die, not killing, and so is not covered by the ethical prohibition against killing. Common though the view is that stopping life-sustaining treatment is allowing someone to die, I shall argue that the belief is confused and mistaken. Typical cases of stopping life-sustaining treatment are killing; they are not allowing to die, though they are cases of ethically justified killing.

Why is the common view that stopping life-sustaining treatment is allowing to die and not killing a mistaken one? Consider the case of a patient, terminally ill with amyotrophic lateral sclerosis (ALS) disease, who is completely respirator-dependent, with no hope of ever being weaned from the respirator. The patient is unquestionably competent but finds her condition intolerable and persistently requests to be removed from the respirator and allowed to die. Most people would agree that the patient's physician should respect the patient's wishes and remove her from the respirator, though this action will certainly result in the patient's death. The common understanding of what the physician does in removing the patient from the respirator is that the physician thereby allows the patient to die. But is that viewpoint correct?

Suppose the patient has a greedy and hostile son, who mistakenly believes both that his mother will never decide to stop her life-sustaining treatment and that, even if she did, her physician would not remove her from the respirator. Afraid that his inheritance will be dissipated by a long and expensive hospitalization, he enters his mother's room while she is sedated, extubates her, turns off the respirator, and she dies. Shortly thereafter, the medical staff discovers what he has done and confronts the son, who replies, "I didn't kill her; I merely allowed her to die. It was her ALS disease that caused her death." I think this answer would rightly be dismissed as transparent sophistry—the son went into his mother's room and deliberately killed her. But, of course, the son performed just the same physical actions, did just the same thing, that the physician would have done. If that is so, then the physician also kills the patient when he extubates her and stops the respirator.

I underline immediately that there are important ethical differences between what the physician and the greedy son do. First, only the physician acts with the patient's consent. Second, the physician acts with a good motive—to respect the patient's wishes and self-determination—whereas the son acts with a bad motive—to protect his own inheritance. Third, only the physician acts in a social role, in which he is legally authorized to carry out the patient's wishes to stop treatment. These, and perhaps other, ethically important differences show that what the physician did was morally justified, whereas what the son did was morally wrong. What they do *not* show, however, is that the son killed, while the physician allowed to die. One can either kill or allow to die with or without consent, with a good or bad motive, in or not in a social role which legally authorizes one to do so.

Suppose that my argument is mistaken: that stopping life support as well as euthanasia is killing. Euthanasia, though deliberate killing, still need not, for that reason, be morally wrong. To see this point of view, we need to ask: What is it that makes paradigm cases of wrongful killing wrongful? One very plausible answer is that killing denies the victim something that he or she values greatly—continued life or a future. Moreover, since continued life is necessary for pursuing any of a person's plans and purposes, killing brings the frustration of all of these plans and desires as well. In a nutshell, wrongful killing deprives an individual of a valued future and of all that the person wanted and planned to do in that future.

A natural expression of this account of the wrongness of killing is that people have a moral right not to be killed [2]. But in this account of the wrongness of killing, the right not to be killed, like other rights, should be waivable when the individual makes a competent decision that continued life is no longer wanted or a good, but is instead worse than no further life at all. In this rights view of the wrongness of killing,

voluntary euthanasia then does not violate that right. I turn now to the evaluation of public policy on euthanasia.

PUBLIC POLICY: WOULD THE BAD CONSEQUENCES OF EUTHANASIA OUTWEIGH THE GOOD?

The case against euthanasia at the policy level is stronger than that at the level of evaluation of individual cases, though even here I believe the argument is ultimately unpersuasive, or at best indecisive. There is considerable empirical or factual disagreement about what would be the consequences of a legal policy permitting euthanasia in the United States at this time, which is greatly exacerbated by the highly speculative nature of many of the feared consequences and by the general lack of firm data on the issue. There is also moral or evaluative disagreement about the relative importance of different good and bad consequences. Despite these difficulties, a preliminary account of the probable main good and bad consequences should help to clarify where better data and/or more moral analysis and argument are needed, as well as where policy safeguards must be developed.

Potential Good Consequences of Permitting Euthanasia

What are the likely good consequences of making euthanasia legally permissible? First, if euthanasia were permitted, it would then be possible to respect the self-determination of competent patients who want it, but now cannot get it because of its illegality. We simply do not know how many such patients and people there are. In the Netherlands, where euthanasia is legally permitted, a recent study estimated that about 2 percent of deaths were from euthanasia or physician-assisted suicide. No straightforward extrapolation to the United States is possible for many reasons, but, even with better data, significant moral disagreement would remain about how much weight or importance should be given to any instance of failure to respect a person's self-determination in this way.

A second good consequence of making euthanasia legally permissible benefits a much larger group. Polls of Americans have shown that a majority of the public believes that people should have a right to obtain euthanasia if they want it [3]. No doubt the vast majority of those who support this right to euthanasia will never in fact come to want it for themselves, but making euthanasia legally permissible would reassure the many who support euthanasia that, if they ever should want it, they would be able to obtain it. The legalization of euthanasia can be thought of as a kind of insurance policy that one will not be forced to endure a protracted dying process that one has come to find burdensome and unwanted, should there be no life-sustaining treatment to forgo.

A third good consequence of the legalization of euthanasia concerns patients whose lives, while they are dying, are filled with severe and unrelievable pain, and for whom euthanasia is the only release from their otherwise prolonged suffering and agony. This argument from mercy has always been the strongest argument for euthanasia in those cases to which it applies [4]. But how often are patients forced to undergo untreatable agony which only euthanasia could relieve? It is crucial to distinguish those patients whose pain *could* be adequately relieved with modern methods of pain control, though in fact it is not, from those whose pain is relievable only by death [5].

Specialists in pain control—for example, in terminally ill cancer patients—argue that there are very few patients whose pain could not be adequately controlled, though sometimes at the cost of so sedating them that they are effectively unable to interact with other people or their environment. Thus, the argument from mercy in cases of physical pain can probably be met in most cases by providing adequate measures of pain relief, short of euthanasia. This goal should be a high priority, whatever our legal policy on euthanasia. Dying patients often undergo substantial psychological suffering that is not fully or even principally the result of physical pain [6]. If the argument from mercy is extended to patients experiencing great and unrelievable psychological suffering, the numbers of patients to which it applies is much greater.

One last good consequence that proponents of legalizing euthanasia cite is that, once a decision "for death" has been made, it is often more humane to end life quickly and peacefully, as can be done by euthanasia, when that end is what the patient wants. Such a death will often be seen as a better death than a more prolonged one in which the patient may be robbed of his or her dignity.

Some opponents of euthanasia challenge these good consequences of permitting euthanasia, but most opponents of euthanasia cite a number of bad consequences that permitting euthanasia would or could produce.

Potential Bad Consequences of Permitting Euthanasia

I shall first consider an argument specifically against physicians performing euthanasia. The performance of euthanasia by physicians, it is said, would be incompatible with their fundamental moral and professional commitment as healers to care for patients and to protect life. If euthanasia by physicians became common, this sanction would weaken patients' trust in their physicians, as patients came to fear that a medication was intended not to treat or cure, but instead to kill. This position was forcefully stated in a paper by four prominent physicians and bioethicists:

> The very soul of medicine is on trial .... This issue touches medicine at its moral center; if this moral center collapses, if physicians become killers or are even licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty.

These authors go on to make clear that, while they oppose permitting anyone to perform euthanasia, their special concern is with physicians doing so:

> We call on fellow physicians to say that they will not deliberately kill. We must also say to each of our fellow physicians that we will not tolerate killing of patients and that we shall take disciplinary action against doctors who kill. And we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing [7].

How persuasive is this claim that permitting physicians to kill would undermine the very "moral center" of medicine? One point is that patients should not fear, as a consequence of *voluntary* active euthanasia becoming permissible, that their physicians will substitute a lethal injection for what patients want and believe is part of

their care. If active euthanasia is truly voluntary, then no patient should fear getting it without his or her own voluntary request. Patients' fear of losing control over their care and the circumstances of their dying should be lessened, not strengthened, if euthanasia were permitted, and this policy should strengthen trust in their physicians.

Might these authors, nevertheless, be correct that, if physicians should become killers, the moral center of medicine would collapse? This question raises what, at the deepest level, should be the guiding aims of medicine, a question that obviously cannot be fully explored here. I believe that the two values of respecting patients' self-determination and promoting their well-being should guide physicians' actions as healers, comforters, and protectors of their patients' lives and should be at the "moral center" of medicine. These two values support physicians' performance of euthanasia when their patients make competent requests for it. The proper aims of medicine and the limits on physicians' power will surely be one of the central themes in the continuing debate about euthanasia.

A second possible bad consequence of permitting euthanasia is the weakening of society's commitment to provide optimal care for dying patients. We live at a time in which the control of health care costs has become, and is likely to continue to be, the dominant focus of health care policy. If euthanasia is regarded as a cheaper alternative to adequate care and treatment, then pressure may weaken to ensure that the quality of life of dying patients is appropriately maximized by providing sometimes costly support and other services. Particularly if our society comes to embrace deeper and more explicit rationing of health care, frail, elderly, and dying patients will be in a poor position to be strong and effective advocates for their own health care and other needs.

Here are two reasons for skepticism about this argument. The first is that this same worry could have been directed at recognizing patients' or surrogates' rights to forgo life-sustaining treatment. And yet, there is no persuasive evidence that the gaining by patients and surrogates of rights to forgo life-sustaining treatment caused a serious erosion in the quality of care of dying patients from either a decreased willingness of payers to fund that care or a decreased commitment of professionals or families to provide it. The second reason for skepticism about this worry is that because only a very small proportion of deaths would occur from euthanasia if it were permitted, the vast majority of critically ill and dying patients will still have to be cared for by physicians, families, and others. Permitting euthanasia should not diminish people's commitment and concern to maintain and improve the care of these patients.

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

"Slippery slope" arguments of this form are problematic and difficult to evaluate [8]. In this argument's most extreme form, permitting euthanasia is the first and fateful step down the slippery slope to Nazism, a slope that, once we are on, we will

be unable to get off. Now it cannot be denied that it is *possible* that permitting euthanasia could have these fateful consequences, but that cannot be enough to warrant prohibiting an otherwise justified practice of euthanasia. A similar *possible* "slippery slope" worry could have been raised over securing competent patients' rights to decide about life support, but recent history shows such a "slippery slope" worry would have been unfounded. How *likely* and *widespread* would be the abuses and unwarranted extensions of permitting euthanasia? Opponents of euthanasia on "slippery slope" grounds have not provided the data or evidence necessary to turn their speculative concerns into well-grounded likelihoods. The character and likelihood of abuses of a legal policy permitting euthanasia depend in significant part on the procedures put in place to protect against them, though there is not space to detail those here. It is possible to reduce substantially, though not to eliminate, the potential for abuse of a policy permitting euthanasia. Any legalization of euthanasia should only be enacted with a well-considered set of procedural safeguards, together with an ongoing process of evaluation of the use of euthanasia.

While I believe necessary distinctions can be made, both in principle and in practice, to largely limit "slippery slope" worries, one legitimate "slippery slope" concern should be acknowledged. There is reason to expect that legalization of voluntary euthanasia might soon be followed by pressure for the legalization of some non-voluntary euthanasia of incompetent patients unable to express their own wishes. Respecting an individual's self-determination and recognizing that continued life is not always a good for someone can support not only voluntary euthanasia, but some non-voluntary euthanasia as well. Recent history with life-sustaining treatment is instructive. There, the right of competent patients has been extended to incompetent patients and exercised by a surrogate, who is to decide as the patient would have decided in the circumstances if competent [9]. It has been plausibly held to be unreasonable to continue life-sustaining treatment that the patient would not have wanted just because the patient now lacks the capacity to tell us so. The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient (acting with or without a formal advance directive from the patient) may well do the same in the case of active euthanasia.

This potential for legalization of voluntary euthanasia which in time could be extended to non-voluntary active euthanasia, with surrogates acting for incompetent patients, is the main, legitimate "slippery slope" worry about permitting euthanasia. Even if this practice is a likely outcome, however, its ethical evaluation is more complex than many opponents of euthanasia allow. Just as in the case of surrogates' decisions to forgo life-sustaining treatment for incompetent patients, so also surrogates' decisions for non-voluntary euthanasia for incompetent persons would often accurately reflect what the incompetent person would have wanted and would deny that person nothing that he or she would have considered a good. If non-voluntary active euthanasia were permitted, however, the potential for misuse and abuse would unquestionably be greater.

CONCLUDING COMMENTS ON THE ROLE OF PHYSICIANS IN EUTHANASIA

If euthanasia is made legally permissible, should physicians take part in it? Should only physicians be permitted to perform it, as is the case in the Netherlands? In

discussing above the objection that euthanasia is incompatible with medicine's commitment to curing, caring for, and comforting patients, I argued that it is not incompatible with a proper understanding of the aims of medicine, and so need not undermine patients' trust in their physicians. If so, then physicians probably should not be prohibited, either by law or by professional norms, from taking part in legally permissible euthanasia. Most physicians in the Netherlands appear not to consider euthanasia to be incompatible with their professional commitments.

There are also at least two reasons for restricting any legal permission to perform euthanasia *only* to physicians. First, physicians would inevitably be involved in some of the important procedural safeguards necessary to a defensible practice of euthanasia, such as ensuring that patients are well-informed about their condition, prognosis, and possible treatments, and ensuring that all reasonable means have been taken to improve patients' quality of life. Second, and probably more important, one necessary protection against abuse of any legalization of euthanasia is to limit who is given the authority to perform euthanasia, so that they can be held accountable for their exercise of that authority. That authority could quite reasonably be limited to physicians, whose training and professional norms give some assurance that they would perform euthanasia responsibly.

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REFERENCES

1. Wanzer SJ, et al: The physician's responsibility toward hopelessly ill patients: A second look. N Engl J Med 320:844–849, 1989
2. Brock DW: Moral rights and permissible killing. In Ethical Issues Relating to Life and Death. Edited by J Ladd. Oxford, UK, and New York, Oxford University Press, 1979
3. Painton P, Taylor E: Love or let die. Time (March 19):62–71 1990; 1991 Boston Globe/Harvard University Poll. Boston Globe (November 3): 1991
4. Rachels J: The End of Life. Oxford, UK, Oxford University Press, 1986
5. Angell M: The quality of mercy. N Engl J Med 306:98–99, 1982; Donovan M, Dillon P, Mcguire L: Incidence and characteristics of pain in a sample of medical-surgical inpatients. Pain 30:69–78, 1987
6. Cassell E: The Nature of Suffering and the Goals of Medicine. New York, Oxford University Press, 1991
7. Gaylin W, et al: Doctors must not kill. JAMA 259:2139–2140, 1988
8. Schauer F: Slippery slopes. Harvard Law Review 99:361–383, 1985; van der Burg W: The slippery slope argument. Ethics 102 (October):42–65, 1991
9. Buchanan AE, Brock DW: Deciding for Others: The Ethics of Surrogate Decisionmaking. Cambridge, UK, Cambridge University Press, 1989