A good death: is euthanasia the answer?

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■ Euthanasia—particularly active voluntary euthanasia—and assisted suicide are subjects of continuing controversy. Historical attitudes, current concerns, the situation in the Netherlands, and the positions of various medical associations are reviewed. Major arguments for and against active euthanasia are presented, with special consideration to the role that health care providers might be asked to perform should active euthanasia and assisted suicide be given societal sanction. The authors conclude that better pain management and A willingness to provide care within already established ethical and legal guidelines, not the legalization of active euthanasia and assisted suicide, are the appropriate responses to current proposals for assistance in dying.

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THE WORD "euthanasia" comes from the Greek for a "good or easy death." Although "good death" might seem like an oxymoron to some, the term usually refers to terminating the life or hastening the death of a hopelessly sick or injured person or creature in a relatively painless manner for reasons of mercy.

■ *See Post, p.58*

Persons who request euthanasia usually do so to escape the physical and mental suffering that may characterize the terminal stages of a fatal disease. Persons who commit euthanasia usually perform the act out of compassion for the victim and to end the victim's intolerable suffering.

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In its broadest sense, euthanasia includes concepts of active and passive euthanasia, direct and indirect euthanasia, and voluntary and involuntary euthanasia. Related concepts are suicide and assisted suicide.

Active euthanasia refers to death that is actively and intentionally brought on by committing an act (such as a lethal injection), whereas passive euthanasia refers to death that results from omitting or neglecting a life-preserving measure (eg, not performing cardiopulmonary resuscitation). This distinction has given rise to discussions about the differences between withholding and withdrawing treatment. A generally accepted bioethical principle is that any therapy that can be withheld (ie, omitted) can be withdrawn. But some health professionals are reluctant to apply this principle if the patient will die as a direct result of withdrawing therapy. Part of this reluctance stems from the view that stopping the therapy is an act of commission which may therefore be perceived as active euthanasia, whereas withholding or never starting a therapy is more clearly an act of omission, or passive euthanasia.

Indirect euthanasia refers to an action that is primarily intended to relieve suffering or benefit the

patient in some way, but which has the potential side effect of hastening death. A common example of indirect euthanasia is the administration of large doses of narcotics to a terminally ill patient in unbearable pain: the primary purpose in giving the medication is to relieve pain, although it is recognized that the drugs may hasten death by depressing respiration or causing hemodynamic instability. By contrast, direct euthanasia is an act in which the death of the patient is the primary goal. Intention is the primary factor separating the administration of medicine to relieve suffering from the direct action of a "merciful lethal overdose," which has as its object to end suffering by bringing about death.

Voluntary and involuntary euthanasia are separated by the attitude and wishes of the individual whose life is at stake. Involuntary euthanasia (as in cases of infanticide and the killing of unconscious patients who have provided no advance directive), even when undertaken for merciful purposes, differs from voluntary euthanasia because the person killed has expressed no desire to die.

Suicide is the killing of self, and assisted suicide involves another person who provides the means or assists the victim with self-killing. Frequently, health care professionals, especially physicians, are included in assisted suicide proposals because they have the knowledge and the means to provide a patient with an effective and painless death, which is seen by the victim as preferable to using an excruciating or unreliable method.

Passive and indirect euthanasia have become generally accepted in the medical, legal, and ethical arenas and are less controversial. Involuntary euthanasia is considered unacceptable by most individuals and is not a significant part of the current euthanasia debate and proposals. This paper focuses on active, direct, voluntary euthanasia, and on assisted suicide. Our discussion also addresses the role of health care professionals in acts of euthanasia and assisted suicide.

We have attempted to present a fair and accurate overview of the background, the major arguments for and against euthanasia, and the formal positions of major groups and organizations on this controversial topic. We have also arrived at certain conclusions based on ethical, medical, and humanistic principles.

HISTORICAL PERSPECTIVES

As the euthanasia debate heats up in the final decade of the 20th century, it is easy to forget what came before. The increasing capabilities of medicine and growing patient expectations have combined to challenge the boundaries of what is ethically and socially acceptable, especially regarding terminal care issues.

Discussion about euthanasia has spanned the entire panorama of human history. Tales of primitive tribes include familiar stories of Inuit abandonment of hopelessly ill or useless elders on the frozen tundra.[1] But the tribal model of end-of-life ethics probably has only limited usefulness to modern cultures which are alienated from nature. Of greater help and significance for the contemporary debate is a review of the issues of euthanasia and suicide in the history of western thought.

Classical antiquity provides a variety of arguments for and against euthanasia and suicide.[2,3] The Pythagoreans were unconditionally against euthanasia, while Plato modified their view to permit voluntary, direct medical killing of the incurably ill or disabled. Aristotle opposed both euthanasia and suicide on the grounds that such behavior violates the implicit social compact that individuals have with the state. Further, he thought it cowardly, rash, and not in keeping with the call to practice virtue. In contrast, the Stoics supported the individual's decision for rational suicide or assent to euthanasia, especially when faced with the cruelties of disease. Finally, the Oath of Hippocrates ("I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect") is clear enough on the surface, though its meaning is still the subject of scholarly debate.

Later thinkers such as St. Augustine (fifth century) and Thomas Aquinas (13th century) opposed euthanasia: the former on the grounds that suffering was divinely ordained, and the latter on the grounds that euthanasia was against the laws of nature and charity—ie, that it was throwing the gift of life back in the face of the giver.[1] But Sir Thomas More (16th century), in his speculative work, *Utopia*, advocated acts that would ensure a painless exit from life.[1]

While Christian ideals continued to dominate European thought regarding euthanasia, suicide, and assisted suicide through the 19th century, nevertheless the general societal prohibition against these actions had modern era detractors. A reawakened interest in individualism, freedom, and the power of reason engendered pro-euthanasia and pro-suicide statements and sentiments from philosophers and essayists such as Francis Bacon (16th century), John Donne (17th century), Jean Jacques Rousseau (18th century), and Friedrich Nietzsche (19th century).[1]

Against this background the Euthanasia Society was

formed in Great Britain in 1936. Reactions against the societal prohibition of euthanasia led to legislative initiatives in the United States to legalize euthanasia—in Ohio in 1906, Nebraska in 1937, and New York in 1939. All of these initiatives failed.[1]

The most monumental and far-reaching historical experience relative to euthanasia began in the 1920s and flourished in the 1930s and 1940s, when the racist side of the eugenics movement emerged in Germany. The rise of the Nazis and their doctrines of racial purity and genocide led to the establishment of special centers for direct medical killing of the retarded, the disabled, the malformed, and "juvenile delinquents."[4] The German medical establishment (medical professors, health commissioners, and drug companies) directly participated in the national policy of eliminating the socially unwanted. The acts of starvation, injections, and gassings were done for "the benefit" of the victims who had to endure a "life unworthy of life."[4] Adolf Hitler personally issued the orders for the euthanasia of more than 5,000 children and more than 100,000 adults. His personal physician and confidant, Karl Brandt, oversaw the state policy of euthanasia, complete with an office established to produce fake death certificates and condolence letters to bereaved families. "Men in white coats with SS boots" carried out the killing orders.[4] The euthanasia movement has not yet recovered from the Nazi crimes involving direct medical killing, despite the efforts of contemporary euthanasia proponents to disavow any comparison between their proposals and Nazi crimes.

During the first few years after World War II, discussion arose concerning the appropriate use of painkillers and anesthesia for intractable pain and the moral obligation to use all means possible to sustain human life. In 1957, statements by the Roman Catholic Pope, Pius XII, distinguished the obligations to use "ordinary" and "extraordinary" means to promote life, and affirmed for the terminal patient the permissibility of using medically indicated pain medications, even if the relief of pain shortened life.[5]

Ethical questions pertaining to sustaining or ending life in the health care context have become even more significant with increased medical and technological capabilities in the latter half of the 20th century. Declining mortality rates and longer life expectancy, heightened awareness and commercialization of health, and the increased prevalence of chronic and degenerative disorders[6] have had an impact on society. Perhaps at no time in history has the question of euthanasia been so relevant to so many people.

CURRENT INTERESTS AND CONCERNS

Awareness, concern, and debate about euthanasia has significantly increased over the past several years. The case of Karen Ann Quinlan (New Jersey, 1976)[7] and others involving the foregoing of medical life-supporting therapies (eg, Conroy,[8] Brophy,[9] Bouvia,[10] Jobes,[11] Cruzan[12]) have generated discussion both inside and outside the health care professions about the differences and distinctions between promoting life and prolonging death.

Successful state-level efforts to enact legislation on living wills and health care durable power of attorney have codified patients' directives and wishes in the dying process.[13] An anonymous contribution ("It's Over, Debbie"), published in *The Journal of the American Medical Association*[14] and describing the apparent euthanasia of a young female cancer patient by a resident physician who did not know the patient, created controversy about a physician's role in euthanasia. The piece stimulated substantial reactions from health care professionals, the public, the media, and legal authorities, and sparked renewed interest in euthanasia practices in the Netherlands.

More recently, Dr. Jack Kevorkian and his "suicide machine," with which Mrs. Janet Adkins took her life, captured newspaper headlines and fueled the fire of ongoing debate over assisted suicide and euthanasia.[15]

The founding and continued existence of organizations focused on euthanasia and other issues of death and dying further exemplify the attention commanded by the euthanasia debate. The Hemlock Society, begun in 1980 by Derek Humphrey and claiming 30,000 members, is an educational organization advocating the rights of terminally ill people to determine the manner, means, and timing of death. The society holds annual workshops on such topics as the potency of narcotics and the stages of grieving, and publishes through its newsletter drug dosage tables for use in "self-determined" death.[16] The political arm of the Hemlock Society, Americans Against Human Suffering, promotes legislative change in favor of euthanasia.

On the opposite end of the spectrum, the International Anti-Euthanasia Task Force, formed in 1987 and based in Steubenville, Ohio, proposes through information and education to resist attitudes, programs, and policies that threaten the lives and rights of those who are medically vulnerable. This task force opposes living will legislation because of the claim that this has led to increases in mercy killing, murder-suicide, and double

suicides. Two other organizations, based in New York City and recently merged — the Society for the Right to Die and Concern for Dying — appear to take a middle-ground position by promoting the rights of people to refuse or forego medical treatment and to have their wishes carried out according to advance directives when decisional capacity (defined as a patient's ability to make his or her own decisions) is absent.

Recent attempts to legalize euthanasia indicate that the euthanasia controversy has gained momentum and will continue to be a significant issue in the foreseeable future. A 1988 effort in California fell short of securing enough signatures to place a "Death with Dignity" Act on a statewide ballot. The purpose of the California initiative was to create a legal right for a terminally ill patient to request and receive physician "aid-in-dying."[17] A new effort is now underway to force a statewide referendum on a Death with Dignity Act in Washington State (1991) and again in California (1992).[18] Similar in wording to the original California initiative, the new proposal would recognize aid-in-dying as a medical procedure that terminally ill patients could voluntarily request from their licensed physician.

Will such proposals to legalize physician-assisted euthanasia receive sufficient support to be enacted as law on the West Coast or elsewhere in the United States? The results of various polls and surveys show this to be a growing possibility. In 1985, a national Louis Harris poll asked the question: "Do you think the patient who is terminally ill, with no cure in sight, ought to have the right to tell his doctor to put him out of his misery?" A majority, 61%, said yes; this was up from 56% in 1981, 49% in 1977, and 37% in 1973.[19] Another national poll in 1985, conducted by Media General-Associated Press, used a similar question: "In general, do you think that people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course or not?" and 68% said yes.[18]

In 1987, a poll conducted by the Field Institute of San Francisco found that 64% of the surveyed Californians would give terminally ill patients the right to ask for and receive medication that would end their lives.[20] In 1988, 2,218 Colorado physicians responded to an 11-page study of current practices and attitudes conducted by the Center for Health Ethics and Policy at the University of Colorado at Denver. Some 60% said they had treated patients for whom active euthanasia might be justifiable if it were legal; of those, 35% would be willing to carry it out.[21] Finally, in a poll conducted for *Time/CNN* and published in March 1990, 57% of the respondents believed it is acceptable for physicians to administer lethal injections or medications to a patient who is terminally ill and unconscious but has left instructions in a living will.[22]

EUTHANASIA IN THE NETHERLANDS

The Royal Dutch Medical Association (KNMG) has issued opinions and guidelines about euthanasia since 1973.[23] Though active euthanasia is illegal in the Netherlands and is punishable by up to 12 years in prison, through verbal agreements between the Justice Department and the Medical Association, a physician will not be prosecuted for performing euthanasia if certain precautions are followed.[23,24] These include the following: the request or demand for euthanasia must be entirely voluntary on the part of an informed patient, ie, the decision is made freely and without coercion; the physician and patient must clearly understand the medical situation and prognosis; the discussion of euthanasia must be done in private to avoid covert or overt pressure; the request must be both clear and persistent; the patient must sign a paper requesting euthanasia; the reasons for euthanasia must be explored and are not to include loneliness, depression, societal or family interests, or pain; the patient must be given time to think about the decision; and the physician must obtain the opinion of other colleagues, who must concur with the decision to proceed with euthanasia.[23,24]

The KNMG emphasizes that euthanasia can only be performed at the request of the patient, otherwise it is homicide. According to the KNMG, there is no difference either ethically or legally between active or passive euthanasia, and withholding treatment may be considered euthanasia also under the law.[23,24] The KNMG, however, emphasizes that treatment designed to palliate the terminally ill or dying patient that may result in or hasten death is not considered euthanasia or even "indirect euthanasia." This includes the use of analgesics to alleviate pain, or chemotherapy to treat disease.[23–26] Additionally, it is illegal in the Netherlands to extend suffering.

In the Netherlands, suicide and assisted suicide are viewed as different from euthanasia. If a physician gives a medication (eg, barbiturates) that enables the patient to commit suicide, and the patient then takes the pills, this assistance is illegal and may be punished by 3 years in prison, though this is considerably less

than the potential 12-year punishment for euthanasia.

When a patient dies, forms must be completed and forwarded to the Justice Department. By law and by recommendations of the KNMG, the death by euthanasia should be designated as due to "unnatural causes."[27,28] This often creates a dilemma for the physician, since any death reported as such must be investigated by the Justice Department. The investigation delays burial and in many cases results in an autopsy and extensive interviews of relatives, friends, neighbors, and medical personnel. Because of these required intrusions and inconveniences, most physicians complete the death certificate of a person on whom euthanasia has been committed as having died of natural causes. This creates a further conflict because the falsification of the death certificate is a criminal offense, and it obscures accurate calculation of the number of acts of euthanasia in the Netherlands each year.

The KNMG is campaigning vigorously in the Netherlands to de-criminalize euthanasia when specific requirements and criteria are met. It also hopes to exclude euthanasia from being considered death by unnatural cause.

In the Netherlands, euthanasia wills or euthanasia testaments which delineate a request for euthanasia when confronted with a terminal illness can be completed by patients with decisional capacity. Such euthanasia wills or testaments are valid for 5 years, after which they must be renewed.

The number of cases of euthanasia in the Netherlands each year is not officially known or recorded. Estimates range from 5,000 to 10,000.[23–28] Conversations with physicians practicing in the Netherlands suggest that this is a reasonable figure. Common methods of euthanasia include high-dose oral phenobarbital; high-dose (approximately 100 mg) intravenous (IV) morphine; high-dose IV morphine followed by pancuronium after unconsciousness; Brompton's cocktail, which is a mixture of 200 mg of oral morphine and 50 mg of cocaine mixed in 60 mL of brandy and diluted with water; or 20 mg of diazepam plus 20 mg of IV morphine followed by pancuronium after unconsciousness.

Terminally ill children and minors pose a separate set of issues. If a patient between ages 16 and 18 requests euthanasia, the parents or guardians must be involved in the discussion, but they do not have the right of veto over the patient's decision. The KNMG officially objects to specific age designations and believes that parents must be involved in all cases of patients under age 18, but that any patient, including a minor, has the right to request euthanasia. Euthanasia cannot be done if the child refuses, even if the parents request it.

POSITIONS OF MEDICAL ASSOCIATIONS

Similar to the oath of Hippocrates (fourth century BC), the oath of Asaph (seventh century AD) had the physician promise to "kill not any man." After taking the oath, physicians were blessed by their masters with words that included "do not mix poison for any man or woman to kill his fellow man, nor disclose their constitution; do not give them to any man nor give any devious advice." More recently, various medical associations and organizations have specifically addressed physician participation in euthanasia and assisted suicide.

The American Medical Association

The American Medical Association's Council on Ethical and Judicial Affairs issued a report in 1988 which reaffirmed its opposition to intentionally causing the death of a patient. The report stated:

"What is termed 'active euthanasia' is a euphemism for the intentional killing of a person; this is not part of the practice of medicine, with or without the consent of a patient. Legally, a person who kills another person under these circumstances is guilty of homicide. A motive of mercy is not a defense."[29]

In an earlier opinion issued on withholding or withdrawing life prolonging medical treatment, the Council addressed the issue of what can be called passive and indirect euthanasia:

"For humane reasons with informed consent, a physician may do what is medically necessary to alleviate severe pain or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death." In addition, "the Council on Ethical and Judicial Affairs believes that the withholding or withdrawing of life-prolonging medical treatment or the alleviation of severe pain in a terminally ill or irreversibly comatose patient should not be characterized as euthanasia. The intention is to relieve the patient of the burden of treatment or suffering, not to kill the patient."[30]

The British Medical Association

In 1988 the British Medical Association (BMA) stated its opposition to active euthanasia in a report by its Working Party, which concluded as follows:

"Patients have the right to decline treatment but do not have the right to demand treatment which the doctor cannot in conscience provide. An active intervention by a doctor to terminate a patient's life is just such a treatment. Patients cannot and should not be able to require their doctors to collaborate in their death. If the patient does make such a request, there should be a presumption that the doctor will not agree."

"An active intervention by anybody to terminate another person's life should remain illegal. Neither doctors nor any other occupational group should be placed in a category which lessens their responsibility for their actions."

"Any doctor compelled by their conscience to intervene to end a person's life will do so prepared to face the closest scrutiny of this action that the law might wish to make and the law should not be changed—the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy, it is instead an affirmation of the supreme value of the individual no matter how worthless or hopeless that individual may feel."[31]

Other medical associations

The BMA report quoted above also summarized the present practices and positions of various European and Australasian medical associations. With the exception of the Dutch, these associations opposed direct, active euthanasia while allowing the foregoing of life supports and permitting the alleviation of pain. The following excerpts reflecting the positions of the various associations are taken from the BMA report.

The National Council of the French Medical Association remarks that the phrase "help to die" is ambiguous, and then asserts:

"[This phrase] creates and fuels confusion between medical assistance to the dying (which is one of the doctor's principle duties) and active euthanasia which is murder committed through pity or on request. The phrase is not acceptable and implies killing of a patient or helping him to commit suicide. This is not the role of the medical profession and the doctor has neither ethical nor legal power to do this. The doctor should strive to ease the suffering of his patient, but does not have the right to deliberately cause the patient's death. The doctor would be seriously at fault if he did so."

The Danish position is presented in the BMA Report as follows:

"Active euthanasia is considered illegal and even passive euthanasia is still questioned. Danish citizens trying to commit or committing suicide are not considered to be involved in a criminal act. If treatment of a patient is hopeless because it would only prolong an ongoing death process, it is not against commonly accepted principles to decide not to start or continue interventions that could only postpone the time of death. In cases where a medical judgment concludes that the treatment is hopeless and that his death is closely approaching, it is considered appropriate to prescribe the necessary pain relieving drugs even if this act has a non-intended effect and could carry a risk that death occurs a little earlier. At present, neither political nor medical discussions on the ethics of euthanasia seem to point to a change of views on active euthanasia."

The stance of the Medical Council in the Federal Republic of Germany is as follows:

"Under the guidelines of the Federal General Medical Council, every doctor is obliged to assist the dying patient by humane care and to relieve his pain and suffering by appropriate means. According to professional ethics, permissible assistance in dying includes the right of the doctor to forego medical and technically possible measures for the prolongation of life or resuscitation in the case of dying persons and thus not to postpone a certain imminent death. Interventions to terminate life and aiding and abetting suicide are according to our professional ethics to be rejected even when the patient demands them."

The Swedish Commission on Terminal Care takes the following position on active termination of life:

"Attempted suicide seldom reflects a well-founded, genuine and uncomplicated desire to end one's life, and so it is nearly always obvious that treatment must be administered. If however, the physician in charge is completely apprised of the background, then in exceptional cases it may be ethically more justifiable to refrain from action than to attempt as a matter of routine to resuscitate the patient. Active euthanasia should still be forbidden. If it was allowed, it should essentially be a patient's right to be killed and also a right or even duty for another person to kill 'ex officio."

The BMA Report summarized the views held in Australia and New Zealand with the following paragraph:

"The primary legal problem concerning euthanasia, voluntary or not, is that it is a euphemism for murder and that both are the product of willful, deliberate, and premeditated acts or omissions. Thus, a doctor who

administers a requested but lethal drug may be charged with murder regardless of common law. The philosophy that life is inalienable precludes any individual from giving permission for his own extinction, but unlike a murderer, a mercy killer is not motivated by malice or vengeance; rather he is motivated by the very compassionate human desire to painlessly end the subject's unbearable and continued suffering. The law, however, takes no cognizance of this distinction."

The World Health Organization

The World Health Organization has also attempted to address life-and-death decisions including euthanasia. It convened an Ethics Working Group, which submitted a report with the following neutral conclusions:

"Helping patients achieve a timely and dignified death should take precedence over a mere prolongation of life since patients have a right to receive and health care officials a duty to provide [adequate treatment] for pain. Countries should review their laws to eliminate legal impediments to the achievement of adequate pain relief. Studies should be undertaken to assess the frequency [of] and determine the reasons for patients' demands that their lives should be terminated, and in the light of our recognition, that we as a working group, are unable to recommend for or against euthanasia, countries should establish appropriate task forces to study the issue of active euthanasia."[32]

ARGUMENTS IN FAVOR OF EUTHANASIA

The arguments in favor of directly taking life on the request of a patient constitute a relatively new wrinkle in moral reasoning, one that is probably distinguishable from the longer-rooted debate about the crime of suicide or self-murder. Although the advocates of euthanasia usually identify themselves as current flagbearers of a moral viewpoint that has long contended for recognition, the newness of the contemporary context suggests that the current formulation of the question finds its roots in the 1950s.[33–37] The following are some of the principal arguments which have been advanced in favor of voluntary, direct euthanasia and assisted suicide.

'The patient has a right of self-determination'

The secular world is no longer dominated by concerns that the sanctity of human life is beyond human dominion. Individuals with decisional capacity have the right to determine how they live and die. Patients are now permitted to refuse medical treatment—including life-sustaining treatment—with the full knowledge, acceptance, and even desire that death will ensue. We do not indict, incarcerate, or convict patients who refuse chemotherapy, dialysis, respirators, or cardiopulmonary resuscitation. Patients, then, should also be allowed to exercise their autonomy by requesting and receiving euthanasia.[38]

Moreover, the argument that patient-requested lethal injections would be abused is equally valid against current lawful efforts to abate life-sustaining treatment, especially for incompetent patients who have left no prior expression of their wishes. Yet we permit such decisions to be made daily. If we agree that a competent patient can be removed from a respirator, what makes that same patient's wish for a life-ending injection any less entitled to due respect? If autonomy is to mean anything, it must permit patients to determine, not await their fate.

'Objections are based on false distinctions'

Physicians already intentionally omit treatment or commit acts (eg, the removal of a respirator) that result in the patient's death. They medicate patients to alleviate suffering, knowing that the unavoidable and accepted consequence of the treatment may be to hasten death. In short, we already permit what is necessary to palliate patients, even though the acts hasten and contribute to death.

Instead of admitting the significance of these practices, false distinctions are used by opponents of euthanasia to avoid the implications of what is obviously the direct taking of human life: these patients would live but for the physician's action.[39] Opponents of euthanasia ascribe the cause of death to the underlying disease or trauma instead of to human action. Such arguments deny reality and prevent us from taking steps necessary to eliminate the pain, suffering, and agony of death.

It is permissible to deny patients air, food, and water for death to occur. Moreover, suicide has been decriminalized, but the prohibition against attempting or assisting a suicide has been left standing; in no other circumstance does the law prohibit someone from assisting in an act that, if done alone, is lawful.

Given this "illogical" state of the law, supported by ethical values, especially autonomy, there is no logical reason why a competent, terminally ill patient, fully informed of the facts and consequences of such a decision, may not ask a physician to commit the pur-

poseful act of providing medication intended to end a patient's life, either directly (by injection) or indirectly (by prescription). To deny this conclusion is to elevate formal distinctions about such matters as omissions and commissions, and double effect and actual intent over the substance of what is actually occurring. Do patients and physicians really doubt that they are bringing about death when they remove a feeding tube or a respirator?

'We have a duty to end human suffering'

Patients who would previously have suffered a quick death are now made to endure the attenuated death which technology makes possible, dying of iatrogenic complications that are the direct result of our futile meddling. A patient who previously would have remained unconscious and shortly died now may be made aware of death and forced to await it, or die having never regained consciousness over several days after we withdraw artificial feeding. Is allowing a patient to die by not providing cardiopulmonary resuscitation and by letting the patient linger in the hope of cardiac or respiratory failure really better than active euthanasia? Part of medicine's mission is to end suffering, and that goal would be advanced by empowering physicians and patients to curtail protracted agony and make an inevitable end arrive swiftly and painlessly.

'It's already being done, so let's do it right'

Many patients desire euthanasia, many doctors are willing to provide it, and it already occurs in spite of the prohibitions against it. Continuing a senseless prohibition will only cause freakish displays such as that of Dr. Kevorkian's to capture headlines, instead of bringing this practice into the open and under professional control, as it is in Holland. It is time to openly allow euthanasia for dying patients.[40]

ARGUMENTS AGAINST EUTHANASIA

Arguments against euthanasia range from long-standing traditional views to newly-formulated responses to some of the lines of reasoning detailed above. The following are some of the major reasons raised in opposition to active voluntary euthanasia and assisted suicide.

'Euthanasia has potential for abuse'

Appropriately, autonomy in contemporary society is highly valued, but it is not absolute. The right to command respect for and compliance with one's wishes ends where societal peril begins.[41] With euthanasia and assisted suicide this peril is great.

Allowing euthanasia could lead to intolerable abuses, particularly for the weakest and most vulnerable (eg, the aged, the handicapped, the poor, the uninsured). Voluntary euthanasia could lead to involuntary euthanasia. The right of euthanasia could lead to the duty of euthanasia. Patients lacking decisional capacity would be at the "mercy" of surrogate deciders whose judgments would lead to irreversible outcomes. Subtle or not-so-subtle pressures (eg, finances, family distress or inconvenience) could be exerted on people to "choose" this option—they could be persuaded or feel obligated to die before their time and before they are ready. A glaring example of how a small beginning can lead to greater and greater abuse is seen in the principles and practices of Nazi Germany. Dr. Leo Alexander expressed this interpretation in 1949 when he wrote: "They started with the acceptance of an attitude, basic to the euthanasia movement, that there is such a thing as a life not worthy to be lived, and then spread to all 'useless eaters' and politically and socially unwanted persons."[42]

Even if euthanasia might be appropriate for an individual patient, the societal peril for such a societal sanction would be too great.

'We need better palliation, not more deaths'

In certain situations, euthanasia is a "techno-fix" solution for the inability to cure. It is a shortcut in the management of the hopelessly ill which would hinder efforts to find better ways to control pain, cure disease, explore alternative forms of supportive care (eg, hospice), and help patients better communicate about their fears and experience of dying. In most cases, care, communication, and support are the appropriate responses to incurable diseases and disorders. Further, administering death is not the only effective release from suffering pain. Modern methods of palliative medicine and palliative care can provide relief, release, and comfort from pain without killing the patient. Frequently a patient's request for euthanasia is a plea for better pain relief and management.[43,44]

Failure to provide adequate pain control represents not only bad case management, but a moral failure to fulfill one of the healing arts' core justifications. Consequently, an erosion of trust has become coupled with a desire by the public to wrest control of the dying process from the healing professions, especially medical practitioners who give low priority to relieving pain and "letting die."

Can pain relief be reasonably assured in the terminal patient? Levy[43] believes that 90% to 99% of terminal cancer pain can be controlled with the use of hospice and palliative care units. Walsh states that "an interested, competent medical practitioner can control pain in most cancer patients using a small number of well-known drugs."[44] If sedation or clouded consciousness are not objectionable to the patient in pain, then there is no reason why all terminal pain cannot be abolished with vigorous analgesia therapy, including patient-controlled analgesia, or with multidimensional treatment involving behavioral, anesthetic, or neurosurgical approaches.

'Euthanasia is professional betrayal'

Promotion of health and life is a fundamental principle, value, rationale, and goal for the professional ethic of all health care providers. Patients trust that physicians and other health care providers are committed to these basic values and goals, and that these goals are conditional, not absolute; they are goals that permit persons to pursue higher values such as love, work, contributions to society, travel, friendship, and the like.[45]

Participation in or promotion of euthanasia and assisted suicide would be a betrayal of this basic patient trust. Health care providers would become technical dispensers of death rather than practitioners in the art of healing and in the service of life. Patients will begin to "fear for their lives" when they approach a clinic or are hospitalized.

Because health and life are basic yet conditional values, a commitment to them does not prohibit the health care provider from allowing death to occur through withholding or withdrawing life supporting technologies under certain conditions. But the commitment to health and life does prohibit the health care provider from abandoning a patient or directly and intentionally eliminating a human life.

How would participation in euthanasia affect the health care provider? If it is difficult to kill enemies and criminals, how much more difficult is it to kill someone who has trusted you?[45] The psychological burden of the license to kill could become an intolerably high price to pay for health care providers, especially if it also leads to remoteness, aloofness, and indifference as defenses against the guilt associated with harming patients.[46]

'Life is a gift of God or Nature'

Many religions profess a "vertical" relationship between the individual and a deity who has gifted the person with life and dignity but who retains ultimate authority over human life. Persons have a responsibility of "stewardship" relative to their lives, but their lives are not totally at their own disposal. Because life is "God-given," we merely hold it in trust and should not put an end to it. This belief implies a divine prohibition against suicide, assisted suicide, intentional killing, and euthanasia.

Further, many individuals affirm a societal or communal interrelatedness between persons. This "horizontal" matrix of relationships prohibits such practices as slavery and cannibalism, viewing them as intrinsically wrong. The interrelatedness of persons limits an individual's freedom to dispose of life (whether the person's own or that of others) by intentionally and directly acting to bring about death.

The "vertical" and "horizontal" perspectives have been formulated into various "natural law" theories.[47] According to this philosophical or theological approach, some actions are by their very nature good or bad, right or wrong, or just or unjust, depending on whether they are in accord with the natural ends or purposes of human nature. Euthanasia and assisted suicide are violations of the "natural law" that can be known by all reasonable persons.

'Euthanasia entails pragmatic problems'

Societal approval of euthanasia as a "therapeutic option" would create a web of entangling issues and practical problems that would force a radical restructuring and rethinking of health care professions and industries. The following are some of the questions that would be raised if euthanasia were permitted.[48]

If some practitioners were humanely motivated to provide this assistance to their patients, where would they fit into medicine, nursing, or the allied health professions? (Anesthesiologists seem to be uniquely qualified because of their knowledge of pain relief, anesthesia, and the titration of potentially lethal drugs.) But if the medical profession were prohibited or refused to participate in euthanasia or assisted suicide, other individuals, such as pharmacists or paramedical personnel, might need to be trained to perform the killing. A new profession could be born—"the euthanologist." How would such individuals be listed in the telephone directory? What sort of liability insurance would they carry? Who would be responsible for their training and certification? Would they undergo peer review for quality assurance, and if so, what sort of conduct would justify the limitation or curtailment of their privileges?

What would happen if the wrong patients should die or if patients do not die quickly and effortlessly enough? Would health care resources supporting euthanasia be more readily available to patients suffering from some diseases than to others? Would third party payers (insurance companies or government programs) reimburse for the costs? If third-party reimbursement is not available, would some terminal patients who were unable to bear the cost of euthanasia then be victims of societal injustice? How would the pharmaceutical industry and research institutes respond to the call for developing and marketing effective life-ending agents? How would advertisements for such drugs be carried in professional journals, and how would the Food and Drug Administration test and regulate the manufacturer's claims about the drug's efficacy?

Society and its health care professions and industries are not prepared to face squarely such pragmatic questions and the corresponding concerns.

CONCLUSION

In the United States, cancer is responsible for more than 450,000 deaths a year. The best estimate is that more than two thirds of these patients suffer significant pain in the advanced stages of their disease.[49] A World Health Organization study estimates that 25% of terminally ill patients die with unrelieved pain.[50]

The effect of this pain is devastating, not only for patients, but also for the healing professions who have as one of their primary goals of caring the assuaging of pain. Inadequate control of pain "exacerbates the suffering component and demoralizes the family and the caregivers who feel they have failed in treating the patient's pain at a time when adequate treatment may have mattered most."[51] Pain dominates the dying patient's consciousness and represents a loss of control that often grows into the most feared suffering of a patient's final days. Pain prevents patients relating to others and frustrates any social interaction during the dying days. Not unexpectedly, then, pain and the fear of pain have become principal explicit and implicit arguments for euthanasia.

Patient fears of over-treatment and resulting prolongation of the dying process also stimulate the call for active euthanasia. It is ironic that some health care providers are contributing to the demand for managed death because of their desire to preserve life at all costs and their reluctance to discontinue treatment when it is ethically and medically appropriate to do so.

If the desire for relief from pain and suffering and for a painless unprolonged passing are the principal impetus behind the euthanasia movement, then attention and energy directed to legitimizing euthanasia would be counter-productive and unnecessary. The efforts of the medical and other health care professions should be placed rather on pain therapy, analgesia, psychosocial support of the sick and dying, and working within current ethical and legal guidelines for foregoing life-supporting therapies which prolong death.

Further, the actual number of people who would benefit from current euthanasia proposals is very small. Very few of the cases which are publicly debated under the rubric of euthanasia fit the requirements of patient competency and voluntariness, nor do they manifest signed, clear, and persistent requests. Many patients suffer and many are near death, but those among them who are willing and capable of asking for euthanasia in a manner acceptable to the proposals are a very small group.

Finally, not all acts of euthanasia would truly be merciful for the patients requesting them. Some patients might wrongly request and receive euthanasia based on a mistaken diagnosis. Examples from the Netherlands reveal that some attempts at euthanasia do not go smoothly, and instead result in increased and prolonged patient suffering. Persons might die who did not really wish to die, given the difficulties in knowing whether the request is genuine and truly in the best interests of the patient. There are familiar cases where a patient pleaded to die, only to recover with gratitude that the physician did not respond to the plea.

It is in the best interests of patients, society, and health care providers to continue the prohibition against euthanasia and to direct the attentions of health care professionals to better pain control, relief of suffering, and psychosocial support of terminally ill and dying patients.

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Erratum

The article by Onyekwere et al in the May/June issue of the *Cleveland Clinic Journal of Medicine* (Onyekwere OA, Morris H, Victor R, Fouad-Terazi FM. Factitious anisocoria and orthostatic hypotension. CCJM 1991; 58[3]:229–233) contained an error. On page 233, line 2, the sentence "...Drug and toxicology screening of urine and blood revealed a serum digoxin level of 1.8 ng/mL and the presence of tetrahydrocannabinol, phenothiazines, and salicylates..." should have read as follows: "Drug and toxicology screening of urine and blood revealed a serum digoxin level of 1.8 ng/mL and the presence of phenothiazines and salicylates. A final laboratory report indicates that tetrahydrocannabinol was not present."