

Assessing the Arguments for and against Euthanasia and Assisted Suicide: Part Two

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The human body is not made to endure all the years that one may live.

—The physician Abrenuncio to the Marquis.

Gabriel Garcia Márquez
Of Love and Other Demons

In Márquez's *Of Love and Other Demons* Abrenuncio the physician and the Marquis discuss the outbreak of rabies that is the centerpiece of the book, since the Marquis' daughter has been bitten by a rabid dog. Abrenuncio notes that the poor

had the courage to poison the food of their rabid kin in order to spare them of a ghastly death . . . People believe that we physicians do not know that such things occur . . . That is not true, but we lack the moral authority to endorse them. What we do instead is . . . commend them to St. Hubert and tie them to a pillar in order to prolong and intensify their suffering.¹

This second part of an examination of the arguments for and against euthanasia and physician-assisted suicide aims at public and deeper values at stake in the debate. This examination stems from a conviction, argued in the first part of the essay previously published,² that philosophical arguments for and against physician aid in dying line up rather equally on either side, and that our convictions for and against it stem from more profound concerns that include those of public policy. Philosophical analysis alone seems unable to tap these deeper concerns well enough, or articulate them well enough, to be persuasive enough to win one side to another.³ Of course, this is not a unique situation. It is found in other human life issues like abortion, capital punishment, killing in self-defense, and the just war debate.⁴

In the concluding part of this essay to be published later, I suggest combining direct, active, indirect, and passive euthanasia in a new way to guide further debate. For brevity, I will use the term *assisted death* to cover both euthanasia and assisted suicide as forms of aid in dying unless there is some crucial moral distinction that would return the conversation to one or another type of assistance. Both *euthanasia* and *assisted suicide* are emotionally loaded terms right now, and often provoke immediate judgment on both sides of the debate. The use of "assisted death" constitutes an attempt to remain morally neutral for the moment about the act of taking a life. (This neutrality is abandoned in the analyses found in the third part of this essay to be published later.)

Euthanasia or *assisted suicide* can mean so many things to so many persons that it is helpful to distinguish different forms. The forthcoming discussion in this essay will propose categories of motive that make a difference in the moral character of the act of taking a life. Many ethicists and judges themselves do

not think that motive or intention makes a moral difference in assessing the morality of assisted dying. This is a crucial piece of the public policy debate as well. The purpose of my focus on motive is not so much to contribute a philosophical argument against this somewhat “established” position; others have done that already.⁵ Instead my purpose is to shed light on different “moral kinds,” if I could call them such, of assisted dying. My argument will be that these moral kinds are sufficiently different to present different challenges to moral analysis of suspending the rule against killing.⁶ The question remains: do these differences in themselves mitigate the evil of taking another’s life, or can they make assisted death a moral act itself, a new social virtue of a technological society?

The Rule against Killing in Public Life

The broader debate about active euthanasia in society today exposes contradictions in our attitudes and behavior about the “rule against killing.” This ancient rule is embedded in western civilization, such that only strictly controlled killing is permitted; that is, under specified conditions a permission is morally granted to kill out of self-defense, in military engagements, and in capital punishment. The strict control has to do with the moral rules by which the rule against killing is temporarily and on a case-by-case basis suspended. For example, just war theory was developed to detail the particular circumstances under which a person could suspend ordinary rules against killing. Why does society, however, permit killing in self-defense and defending the rights of others in a “just war” or in capital punishment, but not permit killing out of mercy, or participating in the rational suicide of a patient by providing the means?

Although there are ancient answers to this question, one more recent answer must come from the backdrop of the Nazi mercy killing program. While our society is quite different from that of Nazi Germany and analogies are dangerous,⁷ there is serious and accurate concern that if permitted, physicians will very easily “tilt” in the direction of mercy killing, the same way the Nazi physicians did. This objection to the suspension of the rule against killing represents a conflation of all our desolate reflection on how physicians in Germany could have been so supportive of Nazi initiatives, especially those of “biological purity.” In a volume devoted to the Nuremberg Code, Elie Wiesel agonizes: “That doctors participated in the planning, execution, and justification of the concentration camp massacres is bad enough, but it went beyond medicine. Like the cancer of immorality, it spread into every area of spiritual, cultural, intellectual endeavor. Thus, the meaning of what happened transcended its own immediate limits.”⁸

Wiesel writes of a famous Jewish professor, Shimon Dubnow, whose own student, Johann Siebert, not only taunted him in the ghetto, but also eventually killed him. Wiesel wonders, “I couldn’t understand these men who had, after all, studied for 8, 10, 12, or 14 years in German universities, which then were the best on the Continent, if not in the world. Why did their education not shield them from evil? This question haunted me.”⁹ The editors of the book containing Wiesel’s essay ask explicitly, “How could physician healers turn into murderers? This is among the most profound questions in medical ethics.”¹⁰

The best answer to the question involves many different and complex factors. Society itself was primed to develop a biological rationale for its political platforms. The use of the best of the new science of genetics by the Nazis is well known. What is not as well known is that a good percentage of all practicing physicians joined the Nazi party early on, even before Hitler came to power. The sad record is that many more than the forty-some physicians prosecuted in the Nuremberg trials participated in planning and carrying out the various programs that now have become so infamous. What is worse is that most of these programs, such as the euthanasia program, were justified by international practices, particularly those led by laws and procedures in the United States.¹¹ Part of the justification for sterilizing the retarded was to clean up the genes of the rest of the race, and part of the reason for euthanizing the demented was economic, a “preemptive triage” to free up beds needed for soldiers in the war effort.¹² But both of these initiatives against “worthless life” were based on papers published around the world in which similar proposals were being made, e.g., in the *Journal of the American Psychiatric Association*, where killing the retarded—“nature’s mistakes”—was advocated.¹³

The lessons to be learned from this experience are that each individual must be treated as an end-in-him- or herself, that the evils of wartime triage should not become ordinary or accepted ethical practices, and that a desire to practice modern, genetically based healthcare will inevitably lead to efforts to “keep up” with the world literature, with standards of care elsewhere. Nazi physicians worried a lot about how the United States’ genetic laws were more advanced than theirs. A final point is this: Nazi physicians did not lose their sense of right and wrong. Their perception of the good was colored by society, mores, and their own craft and its standards at the time. The leading Nazi medical ethicist, Rudolf Ramm, said in 1942, “Only a good person can be a good physician.”¹⁴

As the discussion of euthanasia and physician-assisted suicide escalates in the United States, the practices of abortion and euthanasia spread around the world, and increased attention is given to genetic therapies, what is the “good” that will infuse the virtues in medical practice? Rational discussion in academic literature is not enough to provide the proper checks and balances on physicians in modern society. One person’s good is another’s evil. Training in the virtues, as Wiesel noted above, does not guarantee a good outcome; the mores and standards of society in conjunction with that training are essential. This is the reason that the virtues in medical practice must be coupled with a principle-based ethics.¹⁵ Further, neither one, nor the other, nor both conjoined guarantee good behavior. Only critically reflective medical ethics and self-critical individuals of good character can offer some hope for the future. Science and medicine do not just serve external interests. They are also informed by and give credence to those interests.

I now turn to distinctions among positions for and against assisting death.

Levels of Public Positions on the Issue of Assisting Death

The positions for and against assisting death are now well developed. Roughly, they fall into three distinct levels of argumentation. On each of the levels the contrasting or opposite positions share a fundamental view. This view is important for the larger debate as well, and contributes to my claim that essential

social values are at stake in the debate, about which some agreements can be reached.

On the most fundamental level, proponents and opponents assume that there is an objective standard in morality, while disagreeing on what the ultimate standard of that morality might be. Proponents argue in favor of autonomy of the individual as the final word on whether a person can control decisions to actively end his or her own life. This does not automatically mean that all proponents taking this view reach the conclusion that assisting death ought to be legalized. Other levels of argumentation and concern may intrude on that conclusion. Opponents appeal to an objective standard too, the rule against killing, arguing that no other value is as important to the personal integrity of both the patient and/or caregivers and society. Thus, the rule against killing cannot be overridden for reasons of mercy or compassion. However, some thinkers, while holding this objectivist objection to assisting death, might agree that in certain circumstances the rule against killing can be suspended under rigidly controlled conditions, e.g., as it might when anencephaly is diagnosed at twenty weeks gestation, and early induction of the pregnancy occurs without a chance that the fetus would survive.

The second level of argumentation is that of professional duties within the context of the doctor-patient relationship. For proponents of euthanasia, the duties to act in the best interests of patients and to be dedicated to pain relief, symptom control, and the relief of suffering require the ability to use death itself as a means of accomplishing these ends for the dying if nothing else seems to work. The classic argument in favor of euthanasia on this level found in the Netherlands is that of *force majeure*, the conflict of duties for the physician between preserving life and relieving suffering. The autonomy of the patient (level one principle) enters only insofar as the patient requests assistance in dying. The real control of the decision lies with the physician facing this conflict (in level two).¹⁶

Opponents on this level of argumentation point out that the doctor can never have a duty that requires killing another. This moves beyond the nature of the healing relationship and the social contract by which physicians are given power over persons in need. If a physician did, indeed, choose to end the life of the patient for reasons of mercy, opponents argue, the physician is not doing so *qua* physician but *qua* compassionate human being overwhelmed by the suffering of another.

Note that a position in level one of support for the autonomy principle may not lead to a position in level two of support for the physician's duty to end a life in the face of intractable suffering, since that position emphasizes the power of the physician rather than the rights of the patient, and leads to concerns in the third level of reinforcing such power in society precisely as we try to limit it in other areas. Similarly, one could support the notion of an objective standard against killing but accept, on level two, the very argument of conflict of duties that would lead to a temporary and very limited suspension of the rule against killing for the sake of mercy. In effect this is what the Dutch situation entails, as assisting death is still illegal and considered by the law and society to be objectively morally wrong, but physicians following established professional and legal standards are not prosecuted for violating the law.

The third level regards strategies, and has little to do with whether there are objective standards or even if there are duties within the relationship to the

patient, although appeal can be made to these values if needed. Basically, the argument on this level deals with appropriate laws and public accountabilities. Proponents argue in favor of specific legal initiatives, e.g., making assisting death legal after repeated patient requests and a second opinion. Opponents argue that specific strategies are insufficient to protect against abuse, or that such strategies abandon the traditional purpose of the state's interest in protecting life. One might then be an opponent of assisting death on the objective level, but admit of serious problems in modern-day care for the dying such that one might be open to specific strategies that would not compromise the general commitment of society to protecting and preserving life. Or one might be a proponent of the right of individuals to end their lives when they wish, but object to specific strategies as inadequate and/or burdensome to this right, and oppose such strategies when proposed as legal resolutions.

The point of making these distinctions is to illustrate how both proponents and opponents must try to be persuasive on many different levels, and that in the euthanasia debate one finds arguments and counterarguments that are hurled at the other side regardless of the level upon which the dialogue should be taking place. The complexity of the question is enormous enough without further clouding of the issues. Further, the types of arguments that are persuasive on one level are not as persuasive on the other. The most fundamental level requires logical analysis, but the strategems do not; they require political savvy and compromise. Sometimes one finds argumentation that is flawed because the type required by the level on which the discussion is taking place is misperceived by either a proponent or opponent.

In the end, the debate is twisted if our attention is misplaced—our society and the medical profession have done too little to help people who are dying as a result of previous technological medical interventions. I find arguments on either side lack persuasiveness without commitments to remedy this situation, as do many other commentators in the debate.

In addition to distinguishing the interacting levels of public policy debate about legalizing euthanasia and assisted suicide, the distinctions among motives or intentions are crucially important. They deserve more attention than they normally receive when lumped together in arguments about there being no moral difference between killing and letting die.

Categories of Moral Differences

The categories or moral kinds proposed are mercy, compassion, self-interest, pragmatism, foresight, and sacrifice or martyrdom. This is not an exhaustive list, and other motives to be analyzed would only add to my argument that such moral kinds are an important consideration in thinking about assisting death. Furthermore, my categories all are of the positive kind. Negative ones might include “dispatching” (e.g., hastening the death of a loved one early to get economic gains), “abandonment,” “emotional release” (from the burdens of care), and the like.

Intention

First we must discuss the thorny problem of intentionality. My focus is on the fundamental level of analysis here. At that level the common good as well as

the protection of individual rights requires a prohibition of killing. The problem lies with the absolutization of the rule against killing. Elsewhere I have questioned such absolutization when, in other less appropriate arenas of war and capital punishment (i.e., when the subject being “assisted” in dying is not terminally ill and has not made a request to die), some strict standards permitting the suspension of the rule against killing have been proposed even by religious bodies and have been widely accepted in history.¹⁷ The absolutization of the rule against killing with respect to euthanasia by similar bodies, then, makes no logical or morally persuasive sense. Put another way, if one is able to suspend the rule under some circumstances for social and individual protection, why must there be, at least a priori, no ability to do so when individuals face the imprecations of high technology medicine and its consequence of a long, lingering death?

My reason for focusing on intentionality, however, is to claim that rather than abandon this feature of moral analysis of acts by arguing that intentions do not make a moral difference in assisting death, we should face squarely the fact that intentions and motives do make a profound moral difference in accepting or rejecting assisting death. One suspects that claiming that there is no moral difference between killing and letting die constitutes a stratagem for forcing society to recognize how its behavior toward the dying patient is dysfunctional. If we can intend that death is a good thing for a dying patient, and actively bring such death to pass by withdrawing interventions, then why can we not directly intend to use death to relieve the suffering of those who are not dependent on machines but request to die?¹⁸

This was the argument of *Quill v. Vacco*, in the 2nd District Court of Appeals, heard by the U.S. Supreme Court. The argument was that the equal protection clause of the Constitution required giving patients not dependent on machines the same right to determine the moment of their death as those who are. The latter group of patients appear to have more power over the circumstances of their dying than the former, since they are able to request withdrawal of treatment to bring about their death as relief of suffering. The argument depends on there being no moral difference between intervening to bring about death and letting die.¹⁹ The Supreme Court rejected the claim that the equal protection of the Constitution applies to such circumstances, but accepted the argument that intention is not morally different in active and passive euthanasia.

To counter this point, I now turn to a brief exploration of each of the intentions I have already listed. These explorations are not exhaustive but are suggestive of fruitful avenues for more developed reasoning.

Mercy: Relief of Suffering

Assisted death to relieve suffering is a major moral quandary for most persons. When people die a much-desired death after a long and hopeless illness, the “courage of the poor” cited by Márquez’s Dr. Abranuncio prods us even more to question the antipathy and moral force of the rule against killing. This questioning is heightened by new ways of viewing suffering when dying, including that proposed by Timothy Quill, namely, as a breakdown of the care of the dying person, a kind of medical disaster requiring an emergency intervention. It is typical of our technological society to take on the human condition in this way, by being impelled to intervene in some way, even in the face

of death.²⁰ Usually, when we discuss euthanasia and assisted suicide we assume this motive of mercy.

Nonetheless, mercy on its own is an insufficient principle to justify taking the life of another, since the person making the judgment of what is merciful toward another may be influenced by social norms and conditioned responses that others in that society or in other societies would abhor. For this reason the repeated request by the patient is essential.

Compassion

In this second example, the motive for assisted death is not mercy (to relieve suffering) but compassion (to relieve an impossible quality of life). The distinction between mercy and compassion is subtle. Often the terms are used interchangeably. For the purposes here, though, there is a moral distinction between acting to relieve the suffering of others, and acting to relieve one's own suffering caused by sympathy for the quality of life of another. Objectively speaking, the difference might appear to be between euthanasia and mercy killing, but actually this distinction depends on the voluntariness of the request by the one suffering. Euthanasia is usually understood to apply to an active and repeated request by the suffering patient. Mercy killing applies to those who cannot make an informed request. Often their quality of life is such that others wish to "put them out of their misery." Thus many cases under this second heading also fall under the moral category of mercy killing.

Spouses kill their loved ones out of mercy or love, in hospitals, nursing homes, or at home, because of the sad state of life their companion has reached. In many cases the loved one is not "terminally ill," but suffers from advanced Alzheimer's disease or another degenerative illness. Juries usually determine that such killing stemmed from the spouse's own desperation and love. Granting that, a suspended sentence occurs. Rarely do such individuals get imprisonment. But the rule against killing is not suspended. Instead, judges and juries realize the press of compassion on the emotional state of the spouse or companion, and lessen the sentence.

Self-Interest

Intensive care nurses have been reported to hasten the death of many patients in their care, without the knowledge, apparently, of the doctors themselves.²¹ Caregivers experience a burn-out, wherein all their efforts only produce a constantly diminishing quality of life in their patients, and sometimes contribute to prolonging their suffering.

A few years ago, 4 nurses in Austria were indicted for killing 49 elderly patients in a long-term care wing of an enormous hospital. The nurses eventually admitted to these "mercy killings," noting that they did the first 4 or 5 for reasons of mercy. The elderly patients were suffering a long, lingering dying, in which they were senile and frightened. But later, the nurses noted, they began dispatching the patients for relief of their own professional suffering as they tried, day after day, to find meaning in caring for people who would never get better, and would only get worse.

Clearly, the morality of the first kind of mercy is different than the second in this category as well, even if one would object to either act. To dispatch a

person out of mercy for his or her suffering is morally different from dispatching an individual to relieve one's own anxiety and frustration. One might be able to defend the first form of assisting death, but not the second.

Pragmatism and Advanced Planning

Many patients properly anticipate the circumstances of their demise and try to plan ahead so that their death does not negatively impact on their loved ones. Unlike the motive of self-sacrifice (adumbrated below), this one is related more to prudential planning about the future. All persons have a right to have their dignity respected, and an essential feature of that dignity is just such rational planning for the future—indeed it is required by adult maturity in modern times to make such plans, e.g., about insurance, the children's college education, which nursing home will be appropriate later, etc. I argue that ensuring a good death is a heightened obligation in technologically advanced societies today.²²

The case of Jean Elbaum in New York State illustrates the tragic circumstances many people will face without adequate advanced planning. In 1986 Jean Elbaum was admitted to Grace Plaza Nursing Home after a stroke. From that time on she was incompetent. In October 1987 her husband, Murray, requested that fluids and nutrition be withdrawn based on her prior choices. Since New York is one of the few states that requires "clear and convincing evidence" as the legal standard for withdrawal of fluids and nutrition, the nursing home refused to comply, arguing that no adequate evidence of her wishes existed. Mr. Elbaum countered by refusing to pay for the care. After two levels of court review, the New York State Appellate Court, 2nd Division, ultimately concluded that sufficient evidence of Jean Elbaum's wishes did exist to meet the strict evidentiary standard, and it ordered the nursing home to comply with Mr. Elbaum's request or transfer Jean to a facility that would. Such a transfer occurred, and she died in August 1989.

However, the case continued, since a dispute arose about paying for the \$100,000 cost of unwanted care. After two more lower court decisions, the same appellate court made a shocking decision that Mr. Elbaum would be responsible for the cost of the care, since at the time of the initial request made by Mr. Elbaum to withdraw the care, a court had not determined the adequacy of evidence about Mrs. Elbaum's wishes.

Commenting about this case, Connie Zuckerman, an ethicist and lawyer, noted that healthcare facilities with all their know-how and expertise seem not to carry any obligation to work with families to resolve this kind of dispute, leading instead to "an almost exuberant arrogance" on the part of the nursing home.²³ Mrs. Elbaum had never "chosen" the nursing home or its care; she had been transferred there after her stroke.

This story is typical of many that patients and families share with one another in the community. Each of us, hearing this and like stories, shakes our head and announces that we do not want to be subject to this kind of torture nor do we want our families to bear such burdens near the end of our lives. In this common conviction is born an impetus for controlling the circumstances of our dying and for some, for legalizing euthanasia. The fact is that most healthcare practiced in institutions is by strangers. The patient does not know the caregivers, as he or she might know his or her primary care physician or nurse

practitioner. Instead, a veritable army of new persons approach the dying patient with their recommendations. Additionally, the caregivers do not know the patient, the patient's values, or the patient's value history conveyed by statements made by the family about an incompetent patient.

Normally, the patient's value hierarchy governs the medical interaction. In this hierarchy, the patient's ultimate values and life plans often influence and sometimes trump the therapeutic plan or medical indications that are usually the concern of the caregivers. When the patient becomes incompetent this hierarchy of values is reversed, and the lower values governed by medical care will tend to supersede the higher values the patient worked hard during her life to develop.²⁴ In this scenario, great danger exists that the patient's values will be ignored simply by not being known or conveyed. Should the patient now be incompetent and not have left any advance directives, care decisions usually turn on the physician's recommendations and the patient's family. The latter's discussion of what their loved one would want is tempered by their own fears of not abandoning that person during his or her dying process, and by the overwhelming nature of modern healthcare as personified in the specialists caring for the patient.

Given this kind of scenario, persons who plan for their deaths ahead of time, including a plan for active euthanasia or assisted suicide, may be considered by some ethicists as portraying a new civic virtue that would help exempt their loved ones from intense bickering at the bedside or legal battles before and after their death. Certainly the motive of bringing about this death, one planned ahead of time to reduce the suffering of dying and the burdens on family, differs morally from others I have considered.

Foresight

Closely related to pragmatism is foresight. The distinction between them largely lies in the specificity of latter surrounding the consequences of earlier medical interventions. Thus, a fifth motive for assisted death is to anticipate the consequences of prior interventions in the course of an illness that will make the later suffering more unbearable. Most persons are sympathetic to patients who must die a slow, lingering, painful death due to severe terminal illness. We can understand how, even when pain is controlled, the suffering that accompanies dying must also be addressed. For this reason a good argument can be made that doctors should assist in dying, in bringing about a good death, not just in the face of burgeoning medical technology, but also as an essential feature of their care for persons in such a technological environment. In other words, if one intervenes in the natural course of a fatal illness, then one must take additional responsibility for the consequences of that intervention, including the possibility of increased pain from metastases, etc.

For the most part assistance in dying can be accomplished by what is usually called passive euthanasia, by withholding or even withdrawing medical technology at the patient's request. Sometimes withholding and withdrawing may be accomplished in the absence of an explicit request, as the Appleton Consensus suggests.²⁵ Most medical technology was invented for the purpose of prolonging life. When it is used inappropriately, it unnecessarily prolongs the dying process. Withholding and withdrawing, then, are forms of taking responsibility for our technology. Indeed, there are important arguments about whether

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withholding and withdrawing themselves are morally equivalent,²⁶ but there is little dispute that under appropriate guidelines physicians may morally assist in dying in this manner.

Keeping inappropriate technology out of the dying process at the request of the patient and family is a way of honoring the primacy of human life and human values over the mere brute existence of machines. A more active direction of the dying process of withholding and withdrawing may be suggested under the rubric of foresight, so that the patient and physician work together to bring about a chosen pathway from among several that appear in both the natural history of the disease and clinical experience. I have called this process “death induction” in the past.²⁷ Here the plan is to bring about as far as possible a chosen dying process from among several possible ones. A good death (or at least the best death) is actively intended and managed. There would be far fewer moral objections to death induction than to active euthanasia, even though both patient and physician are intensely involved in the decisions. This is a point to which I will return in the third essay in this series.

Sacrifice or Martyrdom

A last situation is much more difficult for those who oppose direct assistance in dying for religious reasons, since it occurs in their own playing field, as it were. In this case, the individual requests of the doctor, a family member, a friend, or even sometimes an officially designated “enemy” some direct assistance in dying, but for a higher purpose, a symbol of some commitment to the others or to the Divine. This is to die out of love.

I have explored elsewhere the motive of martyrdom in asking to die, or in putting oneself in a position to die for the sake of others, or for the sake of one’s own beliefs in the face of persecution.²⁸ There are ancient and modern examples. In these cases the persons requesting help in dying are considered martyrs. It is remarkable how little their stories have been examined by religious medical ethicists in thinking about the ethics of killing out of love.

Consider, for example, the story of the martyrdom of St. Sebastian, a story that has been the subject of many famous paintings, poems, plays, and music. Sebastian was a handsome leader of the Praetorian guard during the time of the persecutions of Christians by the Roman Emperor, Diocletian. He showed compassion toward two young men, John and Paul, who were to be killed because they refused to sacrifice to the emperor. For this, Diocletian condemned Sebastian to be killed by his own archers, who loved and trusted him. Sebastian had to urge them on to do their duty and kill him. How much did Sebastian “participate” in his own death, then? He certainly willed it as a testament to his new faith. He also encouraged his soldier-friends to kill him. It appears from this and like stories that assisting a death from a motive of love and loyalty can be dignified and even holy under the proper circumstances.

Revisiting Intention

It seems obvious from these brief observations about different classes of intention that the motive for requesting assistance in dying does color the morality of the act, with motives ranging from morally repulsive ones to ones that bring

on recognition of one's holiness and even instant sanctity. To ignore intentions, then, is to ignore one of the most important moral characteristics of the debate about euthanasia.

As noted, for the most part, ethicists and legal scholars have come to accept the notion that there is no morally significant difference between the decision to withhold or withdraw treatment in order to let a patient die, and the decision to offer direct assistance in dying. In one Michigan court trial about Dr. Kevorkian's assistance at the suicide of individuals who were not terminally ill, Judge Breck noted that there was no legal distinction between a doctor withdrawing life support and a doctor injecting a patient with lethal drugs. "In both cases, the physician is causing death to occur."²⁹ Kevorkian once noted about intention:

The aim of suicide is to end a life. . . . The aim of this is to terminate unbearable suffering. I've made progress because for one more human being, suffering is ended.³⁰

It must be acknowledged, in the struggle to gain control of the dying process, that for some individuals, death is a good thing. If so, then bringing about that death is also a good and moral act. The debate in the United States and elsewhere should center on the methodology used to bring about a good death, not so much on the morality of intending the death of another.³¹

Nonetheless, traditional ethics does concentrate on intentionality. If one never intends the death of another, but instead intends the relief of suffering, even if the action done causes death or contributes to it, such as giving a high enough dose of morphine to alleviate pain, then that person has not interiorly or exteriorly taken over the role of God, has not assumed dominion over the life of another human being. Thus, it is argued, the parents of Nancy Beth Cruzan never intended that she die when they withdrew her feeding. They would have rejoiced if she were miraculously to recover and be herself again. But death was foreseen as the most obvious result of such withdrawal nevertheless. To this way of thinking, intentionality matters a great deal, since it maintains "purity of heart." No one assumes dominion over another person, but the end result, the relief of unbearable suffering, is the same.

Similarly, the distinction between active and passive euthanasia, or direct and indirect, hinges on intentionality. If one intends the death of another then there is no moral difference between active and passive euthanasia, as most ethicists and Judge Breck have argued. Especially in public life and the law, motives and intentions cannot always be discerned through conduct. Thus, motive is hidden and hard to discern in legal proceedings. This concern about intentionality bears weight in the public policy arena. Commentators are concerned that Kevorkian is motivated by a crusade to legitimate his kind of actions by steadily eroding the public concern about physician-assisted suicide and euthanasia.³² If it happens often enough, people tend to get used to it. Public discussion about such a serious matter should take place throughout society before efforts to get such actions legalized. Yet taking power over the dying process is both an intensely personal concern and a public policy concern. If it is not a legitimate act, then how can we ask our physicians for this kind of help at the end of our lives?

For proponents of autonomy, worries about intentionality seem to be a very fine point indeed. Their argument is that individuals have control over their

own lives, and that unbearable suffering demands a response from physicians.³³ Some members of the Hemlock Society disagree that physicians should control dangerous substances with which individuals might be able to kill themselves whenever they wished were they available without prescription. Since they have no qualms about the right to die being an individual's entitlement in society, any delays caused by the supposed need for advanced and thorough public discussion appears to them like a stalling tactic taken by conservatives to deny them their rights. The arguments in favor of gaining control over the dying process focus on the individual's need to be surrounded by loved ones and supporters as death approaches. Although physician-assisted suicide and euthanasia are morally distinct issues, from the point of view of empowerment over the dying process they are not.

Conclusion

The greatest danger in establishing public policy about euthanasia is to ignore lessons learned from world history. Some of the factors shaping today's debate are very close to those that shaped the discussion in Nazi Germany that led to social programs to eliminate the vulnerable and weak. The movement toward legalizing euthanasia was widely discussed, as it is in the United States today. It was from the arguments of mercy that Hitler signed into law the permission for certain designated physicians to kill patients (*Gnadentod*) judged "incurably sick by medical examination."³⁴ This order is not far from the suggestion of Dr. Jack Kevorkian that only certain, trained physicians, called obituarists, would be established to carry out euthanasia for those who request it.³⁵ Hitler's order soon was focused on the retarded and mentally ill, however. By 1941, 70,000 patients in mental institutions had been euthanized, paralleling similar mercy killing in other countries.³⁶ It takes a powerful state to unleash these destructive forces within the medical community itself.

Yet the power, rather than the empowerment, of euthanasia, stems from a social desire to provide an orderly and healthy society. Think of our current movement for environmental cleanliness and preservation. Greater and greater efforts will be made in the future toward underlining our "social responsibility" to monitor, control, and renew scarce resources. Without constant, honest critique of motive and intention as part of the euthanasia debate, how soon would it be before we, too, turned our attention to the high cost of caring for extremely elderly and debilitated persons? Already the discussion of euthanizing the demented elderly has begun in the United States.³⁷ Part Three of this essay will propose distinctions that will meet the objections of those who claim that even passive euthanasia actively directs a life toward death, and therefore bears the same moral weight as active euthanasia.

If quality of life judgments and social utility judgments are constantly held in check by both a public philosophy of examining intentionality and our cultural and historical memory of the Holocaust, then we will be well on the way toward providing a humane solution to the problem of suffering at the end of life.

Notes

1. Garcia Márquez G, Grossman E, trans. *Of Love and Other Demons*. New York: Knopf, 1995:19–20.

2. Thomasma DC. An analysis of arguments for and against euthanasia and assisted suicide: part one. *Cambridge Quarterly of Healthcare Ethics* 1996;5(1):62-76.
3. Thomasma DC. When physicians choose to participate in the death of their patients: ethics and physician-assisted suicide. *Law, Medicine & Ethics* 1996;24(3):183-97.
4. Thomasma DC. Assisted death and martyrdom. *Christian Bioethics* 1998;4(2):122-42.
5. See, for example, Brody B. Withdrawal of treatment versus killing of patients. In Beauchamp T, ed. *Intending Death*. Upper Saddle River, New Jersey: Prentice Hall, 1996:90-103.
6. This argument is different from the more theoretical analysis provided by Frances Kamm. Her position, like mine, is that there is a moral distinction between killing and letting die; yet she argues further that there can be permissible harms, such that some killing may be morally justified. Here I would distinguish between intending the death of another that can be a good, and directly killing that person. See Kamm FM. *Morality, Mortality*, vol. II. New York: Oxford University Press, 1996. Also see Baruch Brody's hesitations about her argument in his review: Brody B. When killing is justified. *Hastings Center Report* 1998;28(1):40-1.
7. For a summary of dangers of analogous reasoning comparing the Nazis to other societies, see Pellegrino ED, Thomasma DC. Dubious premises—evil conclusions: moral reasoning at the Nuremberg trials. *Cambridge Quarterly of Healthcare Ethics*, forthcoming.
8. Wiesel E. Preface. In Annas GJ, Grodin MA, eds. *The Nazi Doctors and the Nuremberg Code*. New York: Oxford University Press, 1992:vii.
9. See note 8, Wiesel 1992:vii.
10. Annas GJ, Grodin MA. Introduction. In Annas GJ, Grodin MA, eds. *The Nazi Doctors and the Nuremberg Code*. New York: Oxford University Press, 1992:3.
11. Proctor R. Nazi doctors, racial medicine, and human experimentation. In Annas GJ, Grodin MA, eds. *The Nazi Doctors and the Nuremberg Code*. New York: Oxford University Press, 1992:17-31.
12. See note 11, Proctor 1992:24.
13. See note 11, Proctor 1992:24.
14. See note 11, Proctor 1992:17.
15. Pellegrino ED, Thomasma DC. *The Virtues in Medical Practice*. New York: Oxford University Press, 1993.
16. Thomasma DC, Kushner TK, Kimsma GK, Ciesielski-Carlucchi C. *Asking to Die: Inside the Dutch Debate about Euthanasia*. Dordrecht/Boston: Kluwer Academic Publishers, 1998, forthcoming.
17. See note 4, Thomasma 1998:122-42.
18. The earliest and still one of the best of these arguments is that of Rachels J. Active and passive euthanasia. *New England Journal of Medicine* 1975;292:78-80. More recent is the argument posed by Patrick Hopkins: Hopkins P. Why does removing machines count as passive euthanasia? *Hastings Center Report* 1997;27(3):29-37. Once the metaphysical basis of causality is questioned, then the validity of the distinction also perishes.
19. If euthanasia is morally equivalent to letting patients die, then the assumption of arguments posed by the Second Circuit Court of Appeals has validity. These arguments rested on equal constitutional protection for the right to euthanasia. See, *Quill v. Vacco*, 80 E.2d 716 (2nd Cir. 1996).
20. Cassell E. The sorcerer's broom: medicine's rampant technology. *Hastings Center Report* 1993;23(6):32-6.
21. Scanlon C. Euthanasia and nursing practice—the right question, wrong answer. *New England Journal of Medicine* 1996;334(21):1401-2.
22. Thomasma DC. Ensuring a good death. *Bioethics Forum* 1997;13(4):7-17.
23. Zuckerman C. A matter of consideration, cooperation and the courts: the tragic case of Jean Elbaum. *Precepts: Division of Humanities in Medicine Newsletter* 1992;4(3):3, 6-7.
24. Pellegrino ED, Thomasma DC. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York: Oxford University Press, 1988.
25. Stanley JM. The Appleton Consensus: suggested international guidelines for decisions to forego medical treatment. *Journal of Medical Ethics* 1980;15(3):129-36.
26. Sulmasy D. Futility and the varieties of medical judgement. *Theoretical Medicine* 1997;18(1-2):63-78.
27. Thomasma D. Caveat philosophus: technology's abuse-potential in the decision to terminate life [editorial]. *Journal of the American Geriatrics Society* 1987;35:124-5.
28. See note 4, Thomasma 1998.
29. Kevorkian cleared of murder charges. *Chicago Tribune* 1992;July 22:3.

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30. Kevorkian helps another woman commit suicide. *Chicago Tribune* 1992;Nov 21:5.
31. Thomasma DC, Graber GC. *Euthanasia: Toward an Ethical Social Policy*. New York: Continuum, 1990.
32. See note 30, Kevorkian 1992:5.
33. Miller PJ. Death with dignity and the right to die—sometimes doctors have a duty to hasten death. *Journal of Medical Ethics* 1987;13:81–5.
34. See note 11, Proctor 1992.
35. Kevorkian J. *Prescription: Medicide—The Goodness of Planned Death*. New York: Prometheus Books, 1991.
36. See note 11, Proctor 1992:23–6; see also, Proctor R. *Racial Hygiene: Medicine Under the Nazis*. Cambridge, Massachusetts: Harvard University Press, 1988:179–89.
37. Thomasma DC. Mercy killing of elderly people with dementia: a counterproposal. In Binstock R, Post S, Whitehouse P, eds. *Dementia and Aging: Ethics, Values, and Policy Changes*. Baltimore: Johns Hopkins University Press, 1992.